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Houses of Healing

A Group Intervention for Grieving Women in Prison

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This study examines the impact of female inmate participation in a facilitator-led group on psychosocial (anxiety, depression, self-esteem) and spiritual well-being. A convenience sample of 36 women (21 intervention, 15 comparison) was recruited from a women's prison in the Northeast. Participants in the groups described positive outcomes in the interviews and in the quantitative measurements of anxiety, depression, and self-esteem. Trends in the data, however, indicated an additional differential effect related to program involvement for depression and anxiety scores. The spirituality scores were high at all times for both groups, with slight increases over the period of the study.

Keywords: *women; prison; groups; grief*

Since 1998, the number of women in prison under the jurisdiction of federal and state correctional authorities has increased more than 500%—from about 13,400 in 1980 to about 84,400 in 1998. From 1990 to 1998, this number almost doubled—from about 44,100 in 1990 to about 84,400 in 1998 (U.S. General Accounting Office, 1999). Although the majority of inmates are males, the number of women in prison is growing at a faster rate than that of men (Bureau of Justice, 2000; Freudenberg, 2002; U.S. General Accounting

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Office, 1999). The increase in the female inmate population is thought to be partially related to sentencing laws that are intended to get tough on crime, particularly drug offenders (U.S. General Accounting Office, 1999).

Despite the steady increase in the growth rate of women in prison during the past two decades, little research has focused on the health care of women prisoners (Coll, Miller, Fields, & Matthews, 1998; Jordan, Schlenger, Fairbank, & Caldwell, 1996; Maeve, 1998; Singer, Bussey, Song, & Lunghofer, 1995). According to Singer et al. (1995), this paucity of research is related to three factors: the majority of women commit nonviolent crimes and therefore are not considered a significant threat to society, women represent a small percentage of the total prison population, and they have unequal economic and political status resulting in unequal access to both services and research.

The majority of incarcerated women come from impoverished backgrounds, consisting of prolonged disadvantage and neglect, resulting in a variety of negative physical and psychological outcomes (Bureau of Justice, 2000; Covington, 1998; Henderson, Schaeffer, & Brown, 1998; Maeve, 1998; Singer et al., 1995; Taylor, Williams, & Eliason, 2002; Watterson, 1996; Young, 1998). High rates of victimization during childhood and/or adulthood have been reported (American Correctional Association, 1991; Bradley & Davino, 2002; Browne, Miller, & Maguin, 1999; Gallagher, 2000; Maeve, 1998; Parsons & Warner-Robbins, 2002; U.S. Department of Justice, 1999; Visher & Travis, 2003). The U.S. Department of Justice (1999) found that 6 in 10 women in state prisons have experienced physical or sexual abuse in the past, whereas the American Correctional Association (1991) found that 53% of women reported being physically abused and 36% reported being victims of sexual abuse sometime in their lifetime.

Women in prison who had been sexually abused as children often reported unstable family characteristics, including growing up in a single-parent household, having a parent with an alcohol, drug, or psychiatric problem, and feeling emotionally or physically neglected (e.g., felt unloved, felt unsafe, not enough to eat; Mullings, Marquart, & Hartley, 2003). Incarcerated women frequently present with a variety of mental health problems such as poor self-esteem, emotional dysregulation, substance dependence, and poor coping skills (Fogel & Martin, 1992; Henderson et al., 1998; Jordan et al., 1996; Maeve, 1998).

Women in prison struggle to survive and cope with demoralizing conditions that Negy, Woods, and Carlson (1997) described as the "prison milieu" (p. 225). Crowding, monotony, lack of privacy, loss of freedom and

relationships, limited autonomy, absence of personal goods, and safety concerns may add to already existing feelings of inadequacy and powerlessness, poor self-esteem, and mental health problems (Anderson, Bankson, & Zephirin-Atkins, 1998; Negy et al., 1997; Owen, 1998; Toch, 1992).

Haney (2002) reported that common psychological effects of the prison environment include not only a dependence on the structure and the potential for adoption of exploitive norms found in prison cultures but also interpersonal distrust, hypervigilance, alienation, social withdrawal, a decreased sense of self-worth, and stress-related reactions from retraumatization and other difficulties experienced in prison.

Relational ties to those outside prison are extremely important, but considerable stress is experienced in attempting to maintain these relationships while in prison (Maeve, 1998; O'Brien, 2001; Visher & Travis, 2003). Between 70% and 80% of incarcerated women have children younger than 18 currently cared for by the incarcerated woman's mother, grandparents, or spouse or intimate (U.S. Department of Justice, 1999). "Many women report that being separated from their children is the hardest part of doing time" (Owen, 1998, p. 127). In 1998, the U.S. Department of Justice (1999) reported that 72% of women on probation, 70% of women in local jails, 65% of women in state prisons, and 59% of women in federal prisons had minor children. More than 1.3 million children younger than 18 had mothers involved in the correctional system.

As women in prison attempt to cope with complex stressors, some have noted that the need for and provision of programs and services offered in prison constitute an important intervention tool (American Correctional Association, 1991; Brennan & Austin, 1997; O'Brien, 2001; Pearson, Lipton, Cleland, & Yee, 2002). However, there are few resources in correctional facilities that specifically address the needs of women in prison. According to Freudenberg (2002), few women actually receive help while in prison. Farr (2000) noted that a number of court proceedings have ruled that women have fewer programs in prison than do men and that, when programs do exist, they may be inferior when compared to similar men's programming. In addition "correctional services for women have been underfunded and often not well matched to empirically documented needs" (Farr, 2000, p. 14). Similar to the economic constraints that exist, correctional facilities also have few individual counselors who are usually consumed with crises, leaving little time to meet with individual inmates.

Grieving women in prison are faced with additional challenges. Women in prison typically report the inability to express their feelings, have their grief validated, or employ coping strategies that are available to people on

the "outside" (Ferszt, 2000, 2002; Potter, 1999; Toch, 1992). As a result, they often "stuff their feelings," which frequently leads to depression and episodes of explosive anger. During previous studies with this population, Ferszt (2000, 2002; Ferszt, Hayes, & DeFedele, 2004) found that pressure to remain in control and to hide one's emotional pain was high. One woman summed up the impact of not having dealt with major losses while in prison as "you get out and it just HITS you; you can't take the pain, so you just start using to numb it" (Ferszt, 2000).

Van Wormer (2001) suggested that women in prison must have an outlet to express feelings of loss, grief, and guilt related to mourning the loss of loved ones or freedom, pain associated with victimization, guilt related to past harms, feelings of helplessness, and self-blame. Negy et al. (1997) reported that denial and behavioral disengagement, defined as feelings of helplessness, are those coping mechanisms most related to negative psychological adjustment while in prison, often resulting in negative psychological and physical outcomes for those women who rely on them.

Given the documented needs of women in prison, advocates have suggested that broad-based programs allow for a more comprehensive and holistic approach that places the individual within the context of her relationships with others and environment. Carp and Schade (1993) and Negy et al. (1997) have suggested that programs should attempt to address issues related to self-esteem, abuse history, and life skills training aimed at learning additional coping skills that would be beneficial inside and outside the prison environment.

The restorative justice approach for programming and services offered to women in prison represents a change from the more punitive approaches found in the criminal justice system (Holquist, 1999). Programs based on the principles of restorative justice differ from punitive approaches in that there is a "presumption of health over pathology, a focus on self-actualization and personal growth, and a recognition that the personal is political, and the political, personal" (Van Wormer, 2001, p. 32). Restorative justice focuses on supplying rehabilitative services using a "reparative approach" while simultaneously emphasizing the importance of taking accountability for harm inflicted on oneself, the victims, and the community (O'Brien, 2001, p. 294). Bradley and Davino (2002) reported that for an incarcerated woman prison could potentially offer "an environment of relative physical and psychological safety . . . (and) may be an effective time for a woman to address the effects of prior victimization" (p. 352).

Similar to the principles of restorative justice, personal empowerment is defined by Van Wormer (2001) as "taking personal responsibility for one's

actions and one's life" (p. 28). Personal empowerment is considered an important construct in that it (a) incorporates how individuals think about themselves in terms of their levels of self-efficacy, perceived competence, and mastery; (b) includes an interactional component, which refers to social and relational processes of individuals within a given context (e.g., their community or family); and (c) involves a behavioral component related to actions being taken by the individuals to improve their outcomes (Zimmerman, 1995). Prison-based programs that incorporate these goals would offer an opportunity for women in prison to build self-efficacy and self-sufficiency to meet current demands as well as those that are present after release.

Houses of Healing: A Prisoner's Guide to Inner Power and Freedom (Casarjian, 1995) was adapted into a 12-week facilitated course and has been utilized by clinicians across the country as a framework for establishing groups and promoting personal healing among women and men in prison. Participants are taught skills, including relaxation, meditation, cognitive reframing, stress management, and constructive ways to transform anger, resentment, unhealthy guilt, and shame to promote increased awareness of unhealthy emotional responses and learned behaviors as well as to explore the beliefs they have about themselves, their life journey from childhood to prison, and the impact of a lifetime of losses and silenced grief. These goals are accomplished primarily through reading, writing, group discussions, and facilitator-led experiential exercises that are conducted in a safe and supportive environment.

Method

Design

Despite positive reports from inmates, correctional and clinical staff, prison chaplains, and wardens about the program, to date research demonstrating program efficacy has not been provided. The current study combines both quantitative and qualitative methods, representing a mixed-methods evaluation design (Banyard & Miller, 1998; Reichardt & Cook, 1979; Tashakkori & Teddlie, 2003). Mixed-methods evaluations yield a number of benefits, including the ability to (a) accomplish more purposes than is possible when using single-method strategies, (b) integrate and layer results to provide for a more comprehensive illustration of the program experience, and (c) attenuate the biases of a single method. Based on these

benefits, the use of mixed-methods evaluation designs provides the opportunity to make stronger inferences while simultaneously allowing for more complex and divergent views. Within this context, the purpose of the study is to examine the impact of a Houses of Healing program on the psychosocial (anxiety, depression, self-esteem) and spiritual well-being of grieving incarcerated women.

Participants (Sample and Setting)

A convenience sample of 36 (21 in the intervention group, 15 in the comparison group) women were recruited from a northeastern women's medium-security correctional facility from September 2004 through July 2, 2005; this period included two administrations of the program. Participants ranged from 19 to 49 years old ($M = 34$) across the two groups. As shown in Table 1, most identified as Latina or Hispanic (38%) or Caucasian (27%) and had completed high school or its equivalent (66%). In terms of family structure, most indicated they were single (66%) and had children (66%).

Multiple losses were identified by 45% of the women, with the majority being the death of a close family member or significant other (100%) and/or loss of children because of imprisonment (33%). Of the women, 55% were taking one or more psychiatric medications prior to imprisonment, and 61% had been previously incarcerated.

Measures

Semistructured interview. Individual interviews took place at the end of the 12-week program and included a number of open-ended questions on the overall impact of the program: "Can you describe, in as much detail as possible, your experience as a participant in the Houses of Healing program? Was there anything that was particular helpful? Difficult? Are there any suggestions you would like to make regarding this program?"

Depression. The Beck Depression Inventory–II (BDI; Beck, 1996) is a 21-item self-report instrument measuring depression severity in adolescents and adults 13 years and older. The BDI has shown high levels of internal consistency ($\alpha = .92$) and corresponds to the criteria of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Items are rated on a 4-point scale ranging from 0 to 3 for each item, which are then summed to indicate more severe symptoms associated with depression.

Table 1
Demographics and Background Information

	Intervention Group ($n = 7$)		Control Group ($n = 7$)	
Variable	*n*	%	*n*	%
Ethnicity				
White	2	29	3	27
Hispanic	4	57	3	27
African American	1	14	2	18
Cape Verdean	0	0	2	18
American Indian	0	0	1	9
Marital Status				
Single	3	43	9	82
Married	2	29	0	0
Separated	1	14	0	0
Divorced	0	0	2	18
Widowed	1	14	0	0
Religion				
Catholic	2	29	4	36
Protestant	2	29	2	18
Mormon	0	0	1	9
None	3	43	4	36
Education				
Bachelor's degree	2	29	1	9
2 yrs. college	1	14	0	0
High school diploma or equivalent (e.g., GED)	3	43	6	55
7th to 9th grade	1	14	4	36
Number of prison terms				
First offense	4	57	3	27
Second offense	2	29	1	9
Third offense	0	0	2	18
Three or more	1	14	5	45
Reason for current offense				
Robbery	2	29	0	0
Armed robbery	1	14	1	14
Assault	1	14	0	0
Drug related	2	29	3	43
Breaking and entering	0	0	1	14
Larceny	0	0	1	14
Violation of parole	0	0	3	43
Writing bad checks	0	0	1	14

(continued)

Table 1 (continued)

Variable	Intervention Group (n = 7)		Control Group (n = 7)	
	n	%	*n*	%
Prostitution	0	0	1	14
DUI (with person in other vehicle seriously injured)	1	14	0	0
Taking psychiatric medications prior to prison				
No	2	29	6	55
Yes (medication name below)	5	71	5	45
Benzodiazepine	1	20	0	0
Antidepressant	1	20	2	40
Antidepressant + mood stabilizer	2	40	0	0
Antidepressant + antipsychotic	0	0	2	40
Antidepressant + mood stabilizer + antipsychotic	1	20	1	20
Significant loss				
Death (individual named below)	5	100	11	100
Parent	2		4	
Sibling	1		1	
Grandparent	1		3	
Significant other	1		1	
Child	1		1	
Niece and nephew	1		0	
Other loss	5	71	5	45
Children to Department of Children, Youth, and Families	3		4	
Abortion	0		3	
Miscarriage	2		1	

Self-esteem. The Rosenberg Self Esteem Scale (RSE; Rosenberg, 1965) is a 10-item self-report measure of global self-esteem that can be used with adolescents and adults in clinical and general populations. Each item relates to overall feelings of self-worth or self-acceptance and is rated on a 4-point Likert-type scale from 1 (*strongly disagree*) to 4 (*strongly agree*). Cronbach's alphas for the RSE have indicated adequate reliability, ranging from .87 to .89.

Spirituality. The Spiritual Perspective Scale (SPS; Reed, 1986) is a 10-item self-report scale that measures participants' perceptions of the extent to which they hold spiritual views and engage in spiritually related interactions.

Items are rated on a 6-point scale from 1 (*low spiritual perspective*) to 6 (*high spiritual perspective*). The SPS has also shown to have high levels of internal consistency in past administrations ($\alpha = .90$).

Anxiety. The Hamilton Anxiety Scale (HAS; Hamilton, 2001) is a 14-item self-report scale assessing the participant's severity of symptoms related to anxiety, including sleep disruption, physical symptoms, worry, and depression. Symptoms are rated on a 5-point scale from 0 (*not present*) to 4 (*severe*). Reports on the HAS have shown high levels of internal consistency in past administrations ($\alpha = .90$).

Procedure

After receiving approval from the university's institutional review board and the department of corrections medical board, the group facilitator supplied the principal investigator with a list of names representing those individuals who had signed up for the program and another list of those individuals who were placed on a waiting list for a second administration of the program. This latter group served as the comparison group for subsequent analyses.

At the onset of the project, each participant met with a member of the research team who discussed the project and obtained consent, if the individual chose to participate. To participate in the group, participants could have had no prior participation in the Houses of Healing program and had to have a sentence long enough to complete the group, an ability to speak and read English, and no psychiatric or medical conditions that would interfere with their participation.

All participants were administered the four questionnaires before and after involvement in the program, as well as at the midpoint of the program. At the first class, participants received a copy of the book *Houses of Healing: A Prisoner's Guide to Inner Power and Freedom* (Casarjian, 1995) and a journal for daily entries. At the end of every class, participants received daily assignments. A semistructured interview was also conducted at the end of program involvement. Of the 36 participants who were recruited, 7 in the intervention group and 11 in the comparison group completed the program during either of its two administrations.

Data Analyses

In-depth interviews with the women who completed the 12-week program served as the primary framework for interpretation of the results.

Researchers have suggested that a qualitative approach to inquiry, primarily through interviews, is a preferred means of collecting data among those working with women in prison because their experiences are often not easily quantifiable (Ferraro & Moe, 2003; Richie, 2001).

Interviews were conducted in a private room and ranged in length from 45 minutes to 1 hour. Detailed notes were taken throughout the interviews, summarized, and reflected back to the women for validation. The interviews were conducted in a conversational style, and the women spoke freely about their experiences. Themes emerging from the qualitative interview were coded using a thematic analysis and were merged with constructs within the quantitative scales (Miles & Huberman, 1994).

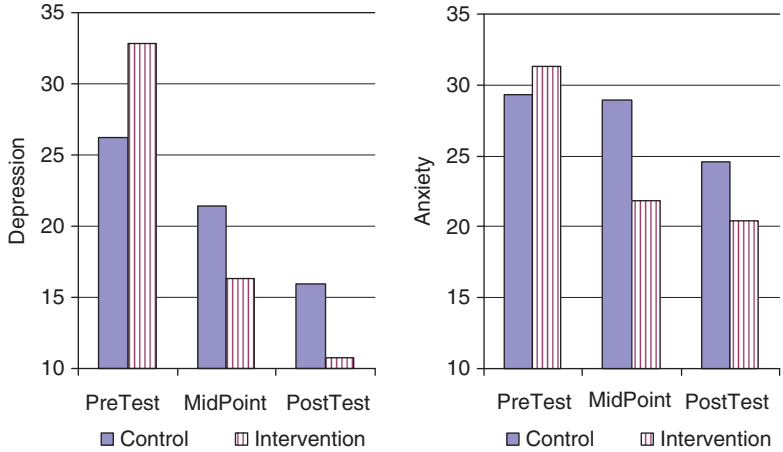
A number of social scientists and evaluators have used a process of triangulation, whereby multiple methods are used, to gain a more comprehensive examination of a phenomenon (Denzin & Lincoln, 2000; Fine, Weis, Weseen, & Wong, 2000; Shaw, 1999, 2000; Waszak & Sines, 2003; Weiss, 1998). Within this context, quantitative analyses served to further inform and interpret emergent themes found during the in-depth interviews. Thus, results from the quantitative analyses were placed within the larger qualitative themes, allowing for both meaning and measurement to be merged into a synthesized interpretation.

Results

All of the women who participated in the Houses of Healing program discussed the positive experiences they had had as a result of participating in the program. For many, the course was a powerful catalyst for beginning the process of self-discovery. It gave these women a space in which to discuss painful feelings in an atmosphere of support, caring, and trust.

Bivariate correlations among pretest scores indicate that pretest depression and anxiety scores were significantly and positively correlated, $r(18) = .69$, $p = .00$, depression and self-esteem were negatively related, $r(18) = -.52$, $p = .03$, and depression and spiritual well-being were negatively related, $r(18) = -.56$, $p = .02$. At posttest, similar relationships were found between the measures. At posttest, depression and self-esteem remained negatively related, $r(18) = -.69$, $p = .00$, whereas spiritual well-being was found to be positively related to self-esteem, $r(18) = .49$, $p = .04$. Comparisons between the two groups at pretest indicated no significant differences on depression, $t(16) = -0.45$, $p = .66$, anxiety, $t(16) = -1.23$, $p = .24$, self-esteem, $t(16) = 1.23$, $p = .24$, or spirituality, $t(16) = 0.04$, $p = .97$, scores before the program began.

Figure 1
Estimated Marginal Means for Depression and Anxiety Over Time by Group



Results from the repeated measures ANOVAs paralleled those described by the women who participated in the program. Results indicated decreased anxiety and depression scores over time, $F(1.59, 25.42) = 8.99$, $p = .00$; $F(2, 32) = 15.19$, $p = .00$; respectively, for both the intervention and comparison groups. There were also trends indicating an interaction between time and group for both anxiety and depression, $F(1.59, 25.42) = 2.97$, $p = .08$; $F(2, 32) = 2.57$, $p = .09$; respectively, which suggests that those women who participated in the intervention program had lower depression scores than did those in the comparison groups over time. Figure 1 shows the estimated marginal means for anxiety and depression over time for both the intervention group and the wait-listed comparison group (also see Table 2).

Some noted that this was the first time they were able to examine their chaotic pasts and the multiple losses they had endured since childhood. Feelings of shame from sexual abuse, prostitution, and substance abuse and overwhelming guilt for the suffering they had caused others as a result of the poor choices they had made were discussed by most of the women. One woman stated, "I've been carrying this burden deep inside me for 30 years."

Six of the women interviewed asked if the program could be continued "on the outside." One woman added that she had had numerous therapists

Table 2
Descriptive Statistics for Outcome Measures by Group

	Control (n = 11)		Intervention (n = 7)		Total (N = 18)	
Outcome Measure	*M*	*SD*	*M*	*SD*	*M*	*SD*
Anxiety						
Pretest	29.36	9.51	31.29	7.67	30.11	8.66
Midpoint	28.91	9.35	21.86	4.14	26.17	8.37
Posttest	24.55	8.24	20.43	5.29	22.94	7.35
Depression						
Pretest	26.27	12.69	32.86	7.63	28.83	11.23
Midpoint	21.45	10.88	16.29	5.88	19.44	9.41
Posttest	15.91	10.49	10.71	10.03	13.89	10.35
Self-esteem						
Pretest	27.91	7.57	24.14	3.34	26.44	6.419
Midpoint	28.91	6.19	29.00	6.45	28.94	6.102
Posttest	29.64	7.09	31.00	6.16	30.17	6.591
Spiritual well-being						
Pretest	42.73	12.71	42.43	16.05	42.61	13.64
Midpoint	46.64	14.66	46.14	16.59	46.44	14.95
Posttest	47.82	13.83	47.57	13.13	47.72	13.16

over the years but this was the only time that she was ever able to look at painful issues and begin to make positive changes in her life. Another woman stated,

> I've never felt this good about myself, and I'm proud of what I've accomplished. Before I started this group I wanted to die. I had difficulty in dealing with my sexual abuse. By sharing with the group, I was able to deal with my shameful past and grow as a person.

Similar to the experiences described by this woman, three other women who had prior experiences with individual counseling all acknowledged that "it never helped me the way this group has."

Women who participated in the program described not only increased accountability and responsibility for their actions but also increased self-awareness and self-understanding that had led four of the women to shed tears during the interview, as they explained how "far they'd come." Another participant explained her feelings of demoralization and shame:

> We feel like bad people; I hated myself before this Houses of Healing started, but now I've learned to forgive. I had a lot of hate inside of me; but I learned why I did what I did. And now I have to accept responsibility for that.

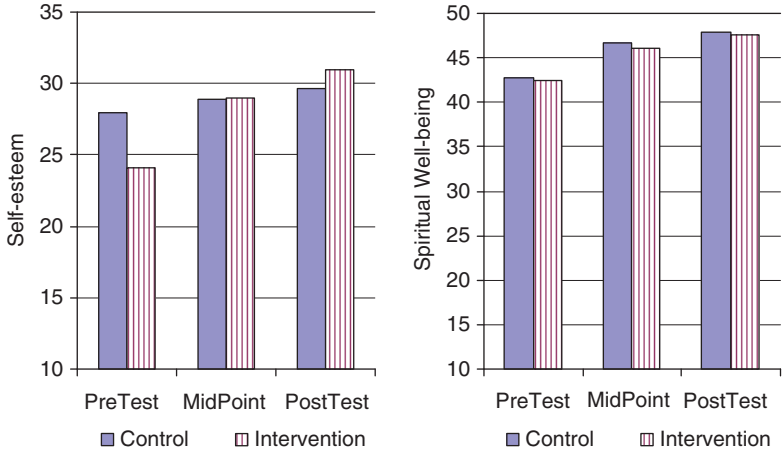
Within these groups, many of the women commented that they were not alone and were able to begin the process of forgiving themselves for the crimes they had committed and others for the crimes that had been committed against them.

The women who participated felt confident in their ability to use the skills they learned in the program and to proceed on their journey toward personal healing. In examining the self-esteem scores over time (see Figure 2), results indicated there were significant increases in self-esteem scores for both groups, $F(2, 32) = 4.42$, $p = .02$. However, when examining the program impact on self-esteem (e.g., time and group interactions), no statistically significant difference was found, $F(2, 32) = 1.64$, $p = .21$.

This similar pattern of results was also found with spiritual well-being, whereby there was no significant change in spiritual well-being scores over time, $F(1.41, 22.53) = 1.85$, $p = .19$, or interaction between time and group, $F(1.41, 22.53) = 0.01$, $p = .99$, indicating a similar rate of change for both the intervention and control groups over the three time points. As presented in Figure 2, spiritual well-being scores were high at the pretest and remained high throughout the entire program. These findings are consistent with those of previous studies examining spirituality among women and men in prison, which have reported increased levels overall (Negy et al., 1997; Parsons & Warner-Robbins, 2002). Van Wormer (2001) stated that spirituality is a journey "from isolation to intimacy, from alienation to meaning, and from running away to reaching toward" (p. 349). This author suggested that, among women in prison, spirituality becomes a number one means of coping with stress and becomes closely related to individuals' psychological and physical health.

As Carp and Schade (1993) reported, prison-based programs that incorporate an opportunity for women in prison to build self-efficacy and self-sufficiency will allow for increased skills to meet current demands as well as those that are present after release. A number of the women who participated commented on the number of stressors and the stigma they encounter when they are released from prison. These women noted difficulties in finding decent work, affordable housing in a better neighborhood, and better schools for their children. Related to these needs, participants again noted the importance of offering a program similar to this one outside the prison environment so that they could further build on and support the progress that they made in prison.

Figure 2
Estimated Marginal Means for Self-Esteem and Spirituality Over Time by Group



Discussion

Similar to reports by clinical and correctional staff, women in prison, and others, the current study provides supportive evidence for positive outcomes as a result of the involvement of women in prison in the Houses of Healing program. Participants reported improved psychological well-being, increased self-esteem, increased hopefulness, a greater capacity to regulate emotions, and the use of positive coping skills to deal with stressors. This increased sense of personal empowerment was found not only in reports of increased personal responsibility and accountability for past behavior but also in terms of increased sense of self-understanding, feelings of self-efficacy and mastery, and competence to meet future demands.

These changes were reflected in both the qualitative and the quantitative results, which generally paralleled each other. Comparisons between the intervention and control groups across the three time points on anxiety and depression scores indicate the existence of a trend toward significance ($p <$ .10). These results indicate that despite low sample sizes, there is some evidence to suggest that depression and anxiety scores for those participants

receiving the Houses of Healing program decreased a greater amount from pretest to posttest than did scores for women in the control group. The positive impact of the program, after both administrations, suggests that participants felt more hopeful and positive about themselves and more efficacious in their ability to use the skills they were taught to regulate their emotions and increase coping skills.

Although the quantitative data indicated no difference between the intervention and comparison groups over time, interviews with women from both groups at the end of the program indicated that women also felt more positive about themselves. Women reported feeling more forgiving of their past mistakes and increased self-understanding and awareness. One possibility for the lack of a differential effect between the intervention and comparison groups over time may be the lack of specificity of the measure employed. In recent years, researchers have criticized more global constructs of self-esteem (Crocker, 2002; Crocker & Park, 2004), suggesting that it should be conceptualized in a more multidimensional way that provides a relevant context to what is being examined. Crocker and Wolfe (2001) suggested that global measures of self-esteem and well-being may not adequately represent changes over time as compared to more domain-specific measures in which the individual places much importance on his or her self-concept.

Conclusions and Implications

Given the steady increase in the number of women entering prison and the high recidivism rate (Bureau of Justice, 2000), developing and evaluating programs are essential. The need for the continuation of the Houses of Healing program was supported by the women in this study as well as by others in past anecdotal reports. However, conducting research in correctional facilities poses many challenges. A number of factors can easily affect an inmate's emotional state, including unscheduled appointments, court dates, distressing news, family sickness, loss of visiting privileges, crises, and tension on the wings with another inmates or correction staff. These complexities and challenges of conducting research in correctional facilities also raise critical issues related to the reliability of the use of instruments in the collection of data. Maintaining an adequate sample size is very difficult. Inmates are often released earlier than anticipated. Although the sample size in this study was small, important clinical results were identified, warranting further investigation. A research study examining effects over time, in prison and after release, with a larger sample would be ideal.

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