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TAMING THE SHREW: REGULATING PRISONERS THROUGH WOMEN-CENTERED MENTAL HEALTH PROGRAMMING

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Abstract. The Correctional Service of Canada (CSC) has received international praise for its new policies with female prisoners serving federal sentences of two or more years. Regarded as progressive, even radical, other countries have looked toward Canada for inspiration in the design of their own policies [Carlen, (2002) *Criminal Justice* 2(2)]. CSC's ''women-centered'' mental health agenda, however, while rhetorically progressive, remains consistent with disciplinary processes which prioritize self-regulation and aim to correct or normalize those considered failed citizens [Kemshall, (2002), *The Howard Journal* 41(1), 41–58]. Using Nicolas Rose's concept of governance through self-regulation [Rose 1991, b Rose (1996). Inventing Ourselves: Psychology, Power and Personhood. Cambridge: Cambridge University Press; Rose (2000). *British Journal of Criminology* 40, 321–339] as a theoretical framework, we argue that correctional mental health practices privileges a psychological discourse which serves to regulate women prisoners as opposed to empowering or supporting them. We examine the over use of psychiatric labelling of women, such as that of Boderline Personality Disorder, and the resulting treatment regime, Dialectical Behavior Therapy, to illustrate that the CSC has constructed women prisoners as disorderly and disordered and thus in need of *taming*. This discussion is followed by recommendations for new directions in feminist mental health treatment for women in prison that more adequately confront the inherent tensions and contradictions of prison therapeutic services and that incorporate multi-faceted understandings of the mental health needs of women offenders. We conclude with some policy and research implications of adopting a feminist informed mental health correctional strategy.

Introduction

In Canada, the past 13 years have seen federal women prison reforms that involve the closure of the Kingston Prison for Women (formally Canada's only federal prison for women), and, beginning in 1995, the opening of five regionalized women's prisons across the country. The document, *Creating Choices,* which guided the establishment of the new facilities, is heavily imbued with feminist healing principles, such as

empowerment, holistic and *woman-centered* (Task Force on Federally Sentenced Women 1990). At the rhetorical level, *Creating Choices* held promise of a new vision of women's corrections. Although the rhetoric of Canadian women's correctional policy has changed, the operating assumptions and practices have not, thus leaving old regimes intact and entrenching progressive discourses within repressive systems (Hannah-Moffat 2001).

In this paper we examine Correctional Service of Canada's (CSC) conceptualisation of women-centred mental health services for federally incarcerated women. Our analysis is situated within Nikolas Rose's concept of governing citizens through self-regulation within contemporary neo-liberal society (Rose 1996, 1999a, b, 2000). Using this theoretical framework, we argue that correctional mental health policy privileges a psychological discourse which serves to regulate women prisoners as opposed to empowering or supporting them. We examine the over-use of psychiatric labeling of women, such as that of Borderline Personality Disorder (BPD), and the resulting treatment regime, Dialectical Behavior Therapy (DBT), to illustrate our argument that the CSC has constructed women prisoners as disorderly and disordered and thus in need of *taming*. We conclude our paper with suggestions for alternative approaches to mental health treatment for women in prison that more adequately confront the inherent tensions and contradictions of prison therapeutic services, and that incorporate multi-faceted understandings of the mental health needs of women offenders.

Self-Regulation, the "Psy-Complex," and Correctional Services

The delivery of mental health treatment services in prisons has long been a contested enterprise. The *psy-complex* (psychiatry, psychology and social work) has been integral to technologies of power and to regulating prisoners (Foucault 1977; Rose 1996, 1999b; Kendall 2000; Kemshall 2002; McCorkel 2003). Nikolas Rose argues that citizens within liberal democracies are largely governed through self-regulation rather than through force. He refers to this as *responsibilization,* a process through which citizens are encouraged to take responsibility for their choices and destinies and to govern themselves through shared moral norms and values (Rose 2000). Those who are thought to fail at self-regulation, such as criminal offenders, are prime targets for "such a re-moralization and responsibilization agenda" (Kemshall 2002: 43).

Psychology and other *psy* disciplines are integral to this process and have helped make it possible to govern human beings in ways that are congruent with the principles of liberalism and democracy (Rose 1996, 1999b; Kemshall 2002). Therefore, as a key mechanism of governance within advanced liberalism, psychological practices can be used to reinforce social authority and political power. Individualism is central to this process which ignores the impact of social factors on people's choices and behaviors. As a result, "[d]isadvantage and exclusion are reframed as matters of choice and not of structural processes" (Kemshall 2002: 43).

Feminist criminologists have long pointed out that women's offending patterns are related to structural factors such as poverty, systemic racism and violence against women, and have called for prison programming that is responsive to women's gendered experiences (for example see Bloom 2003). Yet in practice, criminal justice and correctional policy often dilute a structural analysis, privileging instead individualizing discourses such as those drawn from psychiatry. In this way, women's gendered, classed and racialized experiences of exclusion are reconstructed as being a result of individual psychological and cognitive deficits (Fox 1999a, b; Pollack 2000b; McCorkel 2003). Consequently, *technologies of government* in the form of mental health treatment are invoked to encourage self-regulation, the goal of which is to either control or contain the *ungovernable* or to create self-regulating moral citizens (Rose 2000).

Women-Centred Mental Health Correctional Policy

In 1990, the Task Force on Federally Sentenced Women produced *Creating Choices,* a document calling for sweeping reforms to federal women's imprisonment in Canada.[1] In short, the report called for a recognition that women offenders in general did not pose a serious danger to society and that well over the majority have substance abuse problems and are survivors of abuse, trauma, and domestic violence. The report advocated a holistic woman-centered approach to prison programming that recognized the gendered and racialized experiences of women offenders and that provided them an opportunity to heal from past abuse and become empowered to take control over their lives.

The contradictions and tensions between the discourse of *Creating Choices* and the realities of prison operations have been thoroughly critiqued in recent years for failing to result in substantial correctional

reform (Kendall 1994, 2000; Hannah-Moffat 1995, 2000, 2001, 2002; Hannah-Moffat and Shaw 2000b; Pollack 2000a; Carlen 2002). In fact, the entrenchment of progressive feminist and Aboriginal discourses within a correctional framework joins a well established tradition of women's prison reforms that only result in a different form of regulating women rather than in radical change (Hannah-Moffat 2001).

More recently, academic researchers and community advocates have identified mental health treatment as another site in which the contradictions between the ideals of *Creating Choices* and the realities of correctional mental health treatment clash (Elizabeth Fry Society of Greater Vancouver 2001; Canadian Human Rights Commission 2003; Kendall and Pollack 2003). *Creating Choices* highlighted the fact that well over the majority of imprisoned women have experienced childhood physical and sexual abuse as well as domestic violence and sexual assault as adults. The report implicitly linked women's lawbreaking to the psychological impact of experiences of abuse and violence. Although the spirit of *Creating Choices* seemed to be to provide better policy and programmatic responses to female incarcerated survivors of abuse, its placement within a correctional framework, that focuses upon criminogenic factors and individualization of crime, undermined this intent (See Pollack 2000b for a further discussion of this issue). Although rhetorically women-centered mental health policy (Laishes 2002) holds promise, in practice the treatment models used by CSC bear little resemblance to the holistic empowering paradigm advocated in *Creating Choices*. Instead, correctional treatment regimes utilize pathological and medical constructions of women offenders that typically ignore the psycho-social realities of women offenders. This appears to be at least in part because of the CSC's reliance on cognitive-behavioral treatment approaches. The following is a discussion of correctional cognitive-behavioral treatment that provides the backdrop against which recent women-centered correctional mental health programming has been developed.

Programming the Criminal Self: Cognitive Behavioral Treatment Regimes in Prisons

Cognitive-behavioral programming is considered by correctional authorities in both North America and Britain to be Awhat works@ to reduce recidivism (Hannah-Moffat and Shaw 2000a; Gorman 2001; Kendall 2002). Although the research upon which this assumption is

based has been conducted with male offenders, it has recently been posited that cognitive-behavioral programs are also the most effective intervention with female offenders (Blanchette 1997; Motiuk and Blanchette 1998; Dowden and Andrews 1999; Loucks and Zamble 1999).

When applied to corrections, a cognitive-behavioralist approach is based on the premise that criminal offending is a result of the offender=s inability to think logically, reason appropriately, and to make rational decisions (Gorman 2001). At the core of cognitive-behavioral programming is the notion of a *criminal mind* [2] and programs are designed to counter criminal thought patterns and restructure an offender=s way of thinking (Kendall and Pollack 2003). Both Fox (2001) and McCorkel (2003) have researched prison therapeutic programming and have illustrated the power of this method of *social control* to become one of *self-control* (McCorkel 2003). McCorkel's (2003). Research illustrates how these self-regulatory processes are particularly gendered in the context of a women's prison. McCorkel's ethnography of a state prison for women explored the ways that a therapeutic community for substance abusers, which primarily used encounter groups, taught women how to control their emotions. This was accomplished through embodied surveillance (symbolized by posters of a large blue eye placed throughout the women's living unit with ''Everywhere you go, everything you do, the eyes are always watching you''), aimed to change and enforce the behavior of women's ''manipulative'' and ''criminogenic selves'' (McCorkel 2003: 66). The basic premise of this program relied upon gendered notions of women's deviance that implied that women prisoners have an inability to control their emotions and are unable to be autonomous. The goal of therapy was to insert ''into the minds of inmates … institutional norms guiding conduct and behaviour … [and] …institutional claims about gender and subjectivity'' (2003: 73).

Fox's (2001) work shows that prison cognitive-behavioral programs rely upon decontextualizing offenders' behavior so that the offender can remain focused upon his/her personal failings and can internalize the construct of a *criminal identity* (Fox 2001). If program facilitators acknowledge external factors, such as violence or poverty, they are thought to be feeding in to the offenders' denial and rationalizations of their offense. Her research shows how cognitive-behavioral programming encourages participants to adopt the criminal personality story line to the exclusion of all other constructions of self and experience.

Both these authors illustrate how therapeutic programming in women's prisons rely upon a decontextualized notion of women

criminals as emotionally out of control and psychologically disordered. Therapeutic programming, reliant upon cognitive-behavioral models, utilizes self-regulatory strategies that encourage the internalization of these constructs. The following is a discussion of the particular form of self-regulation through therapeutic programming that exists in Canadian women's prisons.

Disordered and Disorderly Women

Research with incarcerated women consistently illustrates that women in prison have experienced extraordinarily high levels of childhood abuse and violence against women (Heney and Kristiansen 1998; Covington and Bloom 2003). Common effects of childhood sexual trauma in particular are self-injurious behavior (such as cutting oneself), depression, and suicidal feelings (Herman 1997; Warner 2001). Furthermore, the powerlessness experienced as a child is replicated by the power dynamics of the prison environment, thus increasing the potential to reactivate former coping mechanisms (Heney and Kristiansen 1998).

While these issues are widely acknowledged as coping strategies common to survivors of childhood sexual abuse, the correctional system privileges a medical formulation that constructs these behaviors as pathological. This can be seen in the CSC's emphasis on women offenders as having personality disorders (Laishes 2002; McDonagh et al. 2002a, b). The invocation of psychiatric ideologies, however, does not result in an approach that considers the impact of gender (or race or culture) on women's mental health (Williams et al. 2001), but rather, perpetuates the invisibility of social and cultural influences upon women's behavior and sense of self.

One of the dominant psychiatric labels attributed to women offenders is BPD. BPD is an official psychiatric diagnosis characterized by extreme emotionality, impulsivity, aggressive behavior, dichotomous thinking, confused identity, self-injurious behavior and suicidal ideation. The BPD label is generally a pejorative one, both because the behaviors exhibited by those given this diagnoses are often difficult for others to deal with and because BPD has traditionally been thought to be permanent and untreatable. The office of the Solicitor General of Canada (1998) reflects these sentiments in the following statement:

> Part of the trouble in understanding BPD is that it isn't a disease that can be cured with medication. Instead, it's a problem that permeates

> all the way down to the person's soul and manifests itself in extreme behaviours. It's hard to understand how someone who seems to be functioning well one minute can dissolve a minute later into a desperate, angry basket case (Solicitor General Canada, 1998).[3]

In the mental health field it is also commonly felt that people with BPD are extremely difficult for therapists to deal with in that change is slow, resistance to therapy is strong and patients are angry, aggressive, and manipulative. Many mental health workers are reluctant to work with women diagnosed with BPD because they are often thought to be untreatable and unpleasant (Rivera 2002). Although not officially designated a female mental illness, about 75% of those who receive this diagnosis are women (Wirth-Cauchon 2001). A high percentage of those with this diagnosis have a history of childhood trauma. Sam Warner (1996, p. 65) suggests that this label is applied to women who do not fit into gender role stereotypes and that it is "a new name for an old problem; disorderly women".

With the paradigmatic symbol of out-of-control disordered woman offender, the stage is set for a new form of cognitive-behavioral treatment. This new form of treatment is an adapted version of DBT that when implemented within a correctional framework, functions as a technology for the *responsibilization* (Rose 2000) of failed citizens; women prisoners.

Restoring Order: Dialectical Behavior Therapy

Deveoped by Marcia Linehan, DBT is described by her as an integrative cognitive- behavioral treatment (Linehan 1993a, b). Such an approach is said to be appropriate for women with BPD diagnoses, as they are thought to fail at more psycho-therapeutic oriented models. The focus of DBT is to change patients' thoughts and feelings and ultimately alter their behavior. As DBT was developed for women with a BPD diagnosis, the problematic behaviors targeted are such things as controlling their emotions, suicide attempts, self-injury and angry outbursts. The therapeutic goals of changing how women cope with their emotions and distorted thought processes are in the service of eliminating these problematic behaviors.

The entire model of DBT is consistent with notions of criminalized women. Both women with the BPD label and female offenders are constructed as groups whose cognitions, emotions and behaviors are

out of control, extreme and dangerous (Wirth-Cauchon 2001; Kendall 2000; Jimenez 1997). Given that the DBT treatment model conforms to correctional cognitive-behavioralism and more specifically, to constructions of female prisoners, it is unsurprising that it has found a welcome home in women's prison programming.

The notion of dialectics is a central organizing principle of DBT. Originating in classical philosophy, dialectics entails a logical debate between two opposing views. One perspective is presented (the thesis), a conflicting standpoint is posited (antithesis) and out of this process, a shared understanding is reached (synthesis). This method is proposed as being appropriate for women with BPD since they are characterized by rigid dichotomous thinking and an inability to synthesize contradictory events, perspectives or feelings. Irrational behavior, such as suicide attempts and/ or explosive anger, is understood to be the result of this cognitive deficiency. DBT thus adopts a dialectical approach whereby patients are taught about inter-relatedness, synthesis and change.

DBT incorporates dialectics into the therapeutic relationship. Since women with BPD are viewed as being unable to maintain stable, reciprocal relationships, DBT encourages the establishment of such associations through the therapist's own modelling of appropriate behavior, coping techniques and dialectical thinking. For example, one of the strategies that DBT therapists are instructed to use is called ''irreverent communication'' (Linehan and Heard 1992: 260). As with all the strategies for DBT therapists, it represents one half of a dyad that is to be employed in combination with another technique. Irreverent communication refers to sarcastic and indifferent therapeutic responses designed to introduce a new viewpoint and temporarily unbalance the patient. It is to be used in conjunction with such strategies as validation, understanding, and empathy. The example provided by Linhehan and Heard (1992: 260) of this therapeutic method is to respond to a patient who says she is thinking about killing herself with the comment: ''that would make it difficult to come to therapy''. Although such an approach may be appropriate under very specific and unusual circumstances, we feel it has great potential for misuse and misunderstanding, particularly for women in prison who so often have their feelings, behaviors and words misconstrued and dismissed.

Another component of DBT is particularly worrisome in the prison context. This is the concept off *distress tolerance*. Essentially, distress tolerance is the process of ''learning to bear pain skillfully'' by ''tolerating and surviving crises'' and ''accepting life as it is in the moment'' (Linehan 1993b: 96). Teaching distress tolerance to prisoners, has

odious implications. Not only may it encourage women to accept and internalize their oppression, it could furthermore serve to thwart their legitimate protest against the prison regime. By encouraging a simple acceptance of the oppositions, tensions, and incongruities embedded within prisons, critical analysis and understanding is discouraged. Fundamentally, the failings of the prison regime are framed as rooted within prisoners' pathology. This way, the institution becomes legitimized while prisoners are discredited.

A final problem with the use of the DBT model is the use of "behavioral chain analysis" within the prison context. Behavioral analysis is designed to "figure out what the problem is, what is causing it, what is interfering with the resolution of the problem, and what aids are available to help solve the problem" (Linehan 1993b: 254). In explaining their use of "behavior chain analysis" (used to intricately detail and analyse how an "egregious" behavior occurred) ,McDonagh and colleagues state that participants in DBT find this method "aversive" and thus they have imposed a 24-hour rule to complete the first draft (McDonagh et al. 2002b: 38).

In order to trace the antecedents of bad behavior, women prisoners are to follow the chain of events and the cognitive responses that precipitated their egregious actions. However, the women are expected to do so in accordance with the institutional construct of the criminal woman. Writers such as Foucault (1977), Rose (1999b), and Fox (2001) have argued that this process of self-reflection and self-construction is a form of covert social control, through which prisoners learn to exercise discipline over themselves and ultimately become self-governing.

The CSC claims that DBT was adopted by them because it is "non-pathologizing, client-centred and empowering" (McDonagh et al. 2002b, p. 3). However, both the correctional context and the DBT model itself contradict these notions.

Re-examining Women-Centred Mental Health Services for Women in Prison

As stated above, women inmates are typically constructed as being unable to cope and make good decisions and as angry, emotional, needy and irrational. The gender specificity alluded to in correctional policy, while rhetorically progressive, is little more than an assertion that women offenders are different from male offenders because of the high rates of personality disorder diagnoses given to this population.[4] The

diagnostic process is privileged as are its related assumptions and interventions.

Therapeutic strategies such as DBT are integral to the process of instilling "self-surveillance" (Kemshall 2002: 49) characteristic of advanced liberal societies. Self-surveillance or self-regulation picks up where state regulation leaves off: individuals are rewarded for internalizing expert discourses, such as those of the *psy* sciences, which privilege middle class morality, rationality and autonomy and which obscure and ignore structural inequalities. The dismantling of social welfare systems, increasing privatization of public institutions, a shrinking secure labor market and a rapidly growing prison industrial complex (Mauer and Chesney-Lind 2002) all provide fertile ground for the proliferation of the disciplinary use of therapeutic discourse. Not surprising, as Kemshall writes, "as the social and its attendant notions of social justice and social processes have retreated, the space subsequently left has been filled by individualization with the attendant notions of individuality and blame" (Kemshall 2002: 52).

New Directions for Mental Health Practice with Women Prisoners

Feminist informed mental health practitioners outside the correctional system have challenged the tendency to label post-traumatic stress responses as pathological and disordered (Henderson et al. 1998; Ussher 2000; Warner 2001; Williams et al. 2001; Rivera 2002) This research is particularly important because while it acknowledges the reality of the psychological distress and difficulties of women given personality disorder diagnoses, it simultaneously de-privileges psychiatric discourse, concretely deals with issues of power in the therapeutic relationship and within the context of service delivery, and explores the relationship between social inequalities and psychological distress. These models, variously called feminist (Ussher 2000; Rivera 2002), post-structural feminist (Warner 2001), gender-appropriate (Henderson et at. 1998), and/ or woman-focused (Williams et al. 2001), are designed for the same population with which the CSC is concerned, survivors of childhood trauma who are self-injurious, angry, and suicidal. Although some of the treatment strategies may also be similar (many draw on both cognitive behavioral techniques as well as psychodynamic approaches), the philosophical frameworks and policy implications are dramatically different. For example, Williams et al. (2001: 100) state that "grafting individualistic approaches to trauma

onto existing psychiatric ideologies does not serve the interests of women using mental health services, especially those using secure psychiatric services.'' They argue that social inequalities should be the starting point for understanding women's health which requires a paradigm shift for psychiatry and for correctional services. Such a paradigm shift is exactly what is required for CSC to truly implement mental health policy that recognizes the impact of poverty, violence and other forms of social exclusion on the lives of women offenders (Laishes 2002). To expect such a shift is not unreasonable as notions about what works with offenders have undergone paradigm shifts in the past (Gorman 2001; Kendall 2002; Pollack 2004). Thus, ideas regarding offender rehabilitation and treatment are heavily influenced by the ideological and political climate of the time. As such, notions about criminals, rehabilitation and mental illness are social constructs, created by the dominant discourses of the era.

Behaviors commonly exhibited by many women in prison, such as angry outbursts, substance abuse, self-injury, and dissociation may be regarded as normal self-protective measures cultivated in response to traumatic events. These self-protective strategies are often reactivated within the prison when events and/or relationships replicate abusive dynamics or when women have flashbacks or memories of past abuse. Responding to women's coping strategies punitively only reinforces the need for them to self-protect, thereby perpetuating, rather than alleviating, women's distress and difficult behavior. Not only do these approaches define women's post-traumatic responses as symptoms of a disorder, but an illness-based approach to trauma survivors can be counter-productive in treatment. Rivera (2002) found that patients in her hospital-based program greatly benefited from having the ''illness frame'' inherent in the personality disorder diagnoses challenged. In fact, the psychiatric discourse can be used by patients as a shield that prevents women from taking responsibility for honestly facing themselves and understanding the underlying reasons for their behavior. Part of this process is to discourage the overuse of psychiatric jargon which often reinforces power differentials between clients and professionals (Rivera 2002). This language can be alienating and perpetuates the notion that clients are deficient and disordered, premises that underlie many correctional practices with women.

Feminist-informed mental health scholarship also attends to the power issues that emerge within the client/therapist dyad and offers concrete strategies for dealing with these power imbalances. Warner

(2001), for example, suggests that for survivors of abuse the therapeutic relationship itself, regardless of where it is taking place, carries with it the potential for the re-enactment of abusive dynamics. In order to mediate this power imbalance, Warner (2001) advocates *visible therapy* in which the therapist makes explicit the tactics of therapy by explaining not only what the therapist is asking but also why s/he is asking it. This demystifies the therapeutic process and forces therapists to be clear about their own purposes (e.g. diagnostic, therapeutic, investigative, risk assessment, etc.), thus providing clients with the knowledge necessary to make informed decisions about how to engage in therapy. Her framework lends itself to a therapeutic process in which women prisoners can challenge dominant constructions of themselves as pathological, criminal, bad and sick (the internalization of which can impact behavior which perpetuates these constructions), and begin to *re-story* their experiences and self-concept. Visible therapy provides possibilities for client collaboration in the therapeutic process as well as for transparency in the therapist's methods and agenda. Within the prison context, this approach would encourage therapists to be transparent about their role and obligations to the institution and to actively resist pathological constructions of female prisoners and their responses to abuse.

Such approaches necessitate that mental health professionals be comfortable with loosening their grip on expert discourses and acknowledging the skills and awareness possessed by women in prison. Given that the prison context is a heightened example of the ways in which expert discourses frame and define women's experiences, their lawbreaking and their program needs (Pollack 2000a), allowing women to articulate and define their own needs and experiences can be particularly transformative (Pollack 1994).

In order to counter some of the negative stereotypes and the extreme power imbalances between therapist and prisoner, programming can include formats, procedures and practices that provide actual opportunities for women to exercise some degree of power over their treatment and healing. This involves flexibility and creativity on the part of mental health professionals, rather than the importation of canned correctional programs implemented in male prisons. For example, programs that support and build positive relationships with other women have been found to increase women prisoners' sense of self-worth (Pollack 1994) and positive interpersonal skills (Burke 2002). These relationships can be positively utilized through self-help and peer counselling groups.

Conclusion

The tension between offering support services to women in prison and the possibility that these services will be complicit in perpetuating the regulation of women prisoners is a challenging one. As discussed in this paper, there are possibilities for alternative practices that reduce this risk by challenging the dominance of individualizing and pathologizing discourses. Key components of feminist informed mental health approaches involve challenging how women prisoners are constructed and modifying practices so that they not only acknowledge the contradictions of therapy within prisons, but actively challenge the individualization and pathologization of women's behaviors. Furthermore, as the Canadian Association of Elizabeth Fry Societies (CAEFS) points out, the Mental Health Strategy for Female Offenders (Laishes 2002) conflates social marginalization with mental health issues. "[B]y translating social disadvantage into mental health needs, CSC pathologizes a significant portion of federally sentenced women and subjects them to a greater degree of control based on the attribution of mental disability" (CAEFS 2003: 39) The focus on the impact of gender oppression on both women's lawbreaking and women's mental health is, of course, necessary and important. Recasting structural oppression, however, as a mental health issue simply paves the. way for the individualization of social problems and the invocation of psychiatric discourses and practices. Thus, while correctional mental health policy should indeed acknowledge the impact of structural oppression on women's lives and behaviors, it should not define the consequences of gender, class and racial discrimination as mental health needs.

A policy implication of adopting a feminist-informed treatment approach is the contracting out of mental health services to non-correctional personnel. Advocates for women prisoners have recommended, for example, that women be given the opportunity to attend counselling sessions in the community in accordance with the recommendations of *Creating Choices*. This would allow women to receive mental health services (such as sexual abuse counselling) from agencies that while accountable to the correctional system, do not adopt a pathologizing approach. In addition, prison mental health policy can incorporate other treatment methods, such as those used in visible therapy (Warner 2001) that attend to issues of power in the therapeutic relationship, and more psychodynamic approaches that allow room

for an understanding of social context on women's psychological functioning (Rivera 2002). Emphasis can also be placed on peer learning and peer support, thereby recognizing and utilizing the skills women prisoners themselves possess and depathologizing their behavior. Such measures hold the potential to allow current correctional mental health policy to live up to its progressive and women-centered rhetoric by applying methods and approaches that may in fact provide opportunities for women's empowerment. In addition, mental health treatment programs for women prisoners can benefit from further research and evaluation by those outside the correctional system. This may require correctional systems to partner with other organizations and individuals in critically reflecting on current practices and the ways in which women-centered and/ or feminist service provision can be implemented within the prison context as well as in the community. Such partnerships carry the potential to enhance community re-integration processes by linking prison and community services, thereby providing appropriate follow up for women who are released from prison.

Notes

1. The Task Force on Federally Sentenced Women was comprised of Correctional Service of Canada personnel, former prisoners, feminist community agencies, Native women organizations, and advocates for incarcerated women. (See Shaw 1992).
2. See Andrews and Bonta (1998, revised edition). *The Psychology of Criminal Conduct for the* cognitive behavioral model currently guiding prison programming in Canada. In it they warn against getting "trapped in arguments with primary prevention advocates who believe that a society-wide focus on unemployment, sexism or racism will eliminate crime." Instead, they state that crime is a result of criminal personalities that transcend gender, class, ethnicity and race.
3. It is notable that McCorkel (2003) also found that a notion of a "diseased self' underpins correctional substance abuse programming for women in a U.S. prison.
4. McCorkel (2003) arrives at a similar conclusion. She states that "… there is widespread acknowledgment within the system that women are different; but the source of the difference is attributed to psychological rather than structural elements" (2003: 72).

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