Messina N, HSOA J Addict Addictv Disord 2026, 13: 216
DOI: 10.24966/AAD-7276/100216

HSOA Journal of Addiction & Addictive Disorders

Commentary

The History of Research and Recommendations for Addressing Trauma in Carceral Settings for Women

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Abstract

The high rates of trauma exposure, Post-Traumatic Stress Disorder (PTSD), and related substance use disorders among incarcerated women suggests a significant need for trauma-specific treatment for women in correctional settings. Despite this need, there is a dearth of well researched and effective interventions focused on current or historical trauma. This commentary outlines the evolution of research on gender-responsive and trauma-specific programs for women in carceral settings. Recommendations on how to create trauma-informed, trauma-specific, and trauma-responsive environments are also reasserted.

Introduction

For over five decades, the development of risk classification assessments, corrections-based treatment, and the associated outcome research have been focused on men. Thus, it is no surprise that existing treatment frameworks and correctional policies have been established from a male perspective. Women have also been incarcerated for over five decades, without suitable recognition of the body of literature to guide policy and procedures specifically for their needs. Compared with their male counterparts, criminal justice-involved women have different pathways into, and out of, crime and substance use; they respond to supervision and custody differently; they have a higher prevalence of co-occurring mental health issues, lifelong trauma, and other complex interpersonal and financial disadvantages [1-7].

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Citation: Messina N, Covington S (2026) The History of Research and Recommendations for Addressing Trauma in Carceral Settings for Women. HSOA J Addict Addict Disord 13: 216.

Received: December 31, 2025; **Accepted:** January 13, 2026; **Published:** January 20, 2026

Changing Policies and Availability of Research Impacting Women

Critical policy changes and harsher sentencing laws for drug-related crimes had a crucial role in the rise in women's incarceration [8]. Between 1980 and 2022, the number of incarcerated women grew by 700% — double the rate of men [9]. Over 230,000 women reside in prisons and jails across the country [10]. Furthermore, the number of incarcerated women has risen globally by 53% since 2000 [11]. Policy changes specific to community-based substance use treatment for women occurred between 1984 and 1990 in response to public outrage over drug-exposed infants. The findings from research on these community-based programs showed that services that addressed women's needs resulted in higher rates of completion, reductions in substance use, increased treatment satisfaction, and improved health and well-being [12-16]. Gender-responsive treatment committees, needs assessments designed for women, and gender-responsive and trauma-specific programs for justice-involved women were also developed over the following decade and became more accessible [17-24]. However, the application of appropriate care for women within carceral settings remained sparse, and government block grants for ancillary services in the community were not sustained by mid to late 1999 [13,25].

Naturally, corresponding research on the effectiveness of specialzed treatment for women in jail and prison was difficult to generate without extramural funding to establish and evaluate custody-based programs focused on women's needs. Today, a large body of treatment outcomes research on justice-involved women exists. One must recognize the plethora of available randomized controlled trials (RCTs), meta-analysis and literature reviews [7,26-32]. Criminal justice-involved women are highly traumatized, marginalized women in vital need of services responsive to their specific needs.

Women-Centered Pathways into and out of the Justice System

As the knowledge base on justice-involved women grew, advocacy for appropriate care continued. A pathways perspective recognizes the specific challenges and strengths in women that arise from social hierarchies and lifelong trauma and abuse [7,33-35]. Hierarchies have created differences across gender and gender roles (e.g., patriarchy and sexism) that speak to the lived realities of women [36]. Also, a very high number of women in criminal justice settings have experienced physical, sexual, and emotional abuse throughout their lives [37]. These complex disadvantages and victimization continue for women during incarceration [5]. Women consistently report a higher prevalence of Adverse Childhood Experiences (ACEs), such as neglect and emotional, physical, and sexual abuse, than their male counterparts both nationally and internationally [31,38]. One study compared the occurrence of ACEs reported by 427 incarcerated men and 315 incarcerated women in California and found the women had significantly greater exposure to ACEs than did the men [4]. Studies also show a stronger correlation for women among types of ACEs, continued victimization into adolescence and adulthood, a more

pronounced intergenerational impact, and greater severity of chronic mental and physical health outcomes [4,38,39]. ACEs are also highly correlated with adolescent pregnancy, homelessness, prostitution, and Interpersonal Violence (IPV) [7,40-42], as well as recidivism and female perpetrated violence [27,43-45]. Recent statistics from Canada indicate that women are over-represented in cases of complex trauma (70.0% compared to 58.8% of men) [46]. In the United States [4,41], the United Kingdom [47], and Switzerland [48], women in the justice systems also have higher rates of mental health issues and trauma and abuse than women in the general population.

Based on the pathway's studies, researchers also began to explore distinctive factors associated with treatment and criminal justice outcomes for women relative to men. Pelissier et al., [49] assessed commonly analyzed predictors of post-release recidivism among 1,842 men and 473 women who participated in gender-neutral treatment. Among the 32 variables included in the model, only one variable was significantly unique to women (i.e., a history of mental health treatment increased the likelihood of recidivism). Hamilton et al., [50] included women-centered variables in their analytical model. They found that the predictive factors of recidivism for 8,815 women were primarily related to social support (e.g., minor children, no child support, legal contact restrictions) and victim/offender characteristics prevalent among women (e.g., IPV and sex work). Brennan et al., [51] identified eight reliable yet complex pathways to women's recidivism, linking multiple women-centered factors to previous literature, including sexual/physical abuse, lower social capital, poor relational functioning and extreme mental health issues.

Other studies also found risk factors that are more prevalent among women are trauma-related factors associated with cooccurring disorders, IPV, involvement with child protective services, homelessness and dependency on others for financial support [2,7,24,30,41,52-57]. However, pre-incarceration experiences tell only one part of the story. Victimization within a correctional facility is also a concern. Violence within correctional institutions can take many forms, including coercion and physical and sexual victimization [5]. In a survey conducted in 2008 to determine sexual victimization by those recently discharged from prison, approximately 10% said they were victimized during incarceration by other residents and by staff members [58]. Women who have experienced sexual victimization prior to prison are three to five times more likely to experience sexual victimization in prison than are women without such histories [59].

Trauma-Specific Treatment Outcomes

Trauma-specific services are designed to address violence and trauma, the related symptoms specifically, and to facilitate healing and recovery. To become trauma-specific, custodial settings (and community programs) for women provide therapeutic approaches that focus on trauma [60]. In 2003, the National Institute of Corrections published a groundbreaking report, Gender-Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders [53]. This report documented the need for a new vision that recognized the need to focus and integrate trauma-informed services into the justice system. Since this time, supporters have also been proposing to move corrections forward by adopting the Guiding Principles and other published "Blueprints" outlining gender-and trauma-responsive policies and practices. There is now a growing evidence base documenting the effectiveness of trauma-specific interventions for justice-involved women, at various levels of supervision, measuring outcomes beyond abstinence and recidivism, and when compared to gender-neutral or mixed-gender programs, to validate the recommended trauma-responsive policies and provision of trauma-specific services [13,14,17,27,28,29,32,37,61-69].

With funding from NIDA, Messina et al., [28] conducted an experimental study comparing post-release outcomes of 115 prison-based treatment participants. Women were randomized to a 20-session trauma-specific treatment program (i.e., Helping Women Recover, Covington, [18,20], and 12-session Beyond Trauma, Covington, [70]) or a prison-based therapeutic community model. Helping Women Recover and Beyond Trauma are manualized curricula with a facilitator guide and participant workbook. The gender-responsive treatment group had significantly greater reductions in post-release substance use, remained in voluntary residential aftercare longer (2.6 months vs. 1.8 months, $p < 0.05$), and were less likely to have been re-incarcerated within 12 months after parole (31% vs. 45%, $p < 0.05$; a 67% reduction in recidivism). While both groups improved on mental health outcomes, the findings show the beneficial effects of treatment components explicitly focused on women's needs.

A series of recent research studies (data collected from 2014-2019) conducted with 1,118 women convicted of serious or violent offenses who participated in brief or intensive interventions designed for women also showed consistent and positive results. The first study included a sample of 39 women in a security housing unit (SHU: used to house residents at the highest risk of committing violent offenses against staff and/or other residents). The pilot study assessed the efficacy of a six-session manualized intervention designed for women who have experienced trauma associated with ACEs (i.e., Healing Trauma: A Brief Intervention for Women, Covington & Russo [21]). Results demonstrated preliminary support for the effectiveness and feasibility of the brief intervention for women in the highest risk classification. The SHU women exhibited significant improvement across measures of depression, anxiety, Post-Traumatic Stress Disorder (PTSD), aggression, anger, and social connectedness from the trauma-specific brief intervention [64]. Effect sizes were moderate to large, with the most significant impact on physical aggression (Cohen's d .82).

The Healing Trauma SHU pilot study was replicated with 682 high-need incarcerated women (i.e., those with co-occurring disorders, frequent disciplinary infractions, or conflict with staff/others). Using a peer-facilitated model, the women exhibited improvement on over 90% of the outcomes measured [65]. Significant reductions were found for anxiety, depression, PTSD, psychological distress, aggression, and anger. Significant increases were seen in empathy, social connectedness, and emotional regulation. Effect sizes were small to moderate, with the most significant impact on depression, PTSD, and angry feelings (Cohen's d ranged from 0.51, 0.41, and 0.42, respectively). Anger expression measures approached significance ($p = 0.061$; $p = 0.051$). Building upon the pilot studies with funding from the National Institute of Justice, Messina and Calhoun [31] conducted an experimental study assessing an intensive 20-session manualized trauma-specific violence intervention (i.e., Beyond Violence, Covington, [71]) among 123 women primarily incarcerated for violent crimes (e.g., murder, attempted murder, manslaughter, assault). Results from the participants randomized to the Beyond Violence (BV) program had significantly lower mean scores than the control participants on depression ($F=4.97$), anxiety ($F=9.12$), and PTSD ($F=4.68$). Findings also showed that the BV participants had significantly lower mean

scores than the control participants on physical aggression (F=6.11), hostility F=4.23), indirect aggression (F= 9.42) and expressive anger (i.e., anger used to manipulate or threaten) (F=7.15).

A previous experimental study comparing BV with a 44-session Assaultive Offender Program in a women's prison in Michigan, Kubiak et al., [27] found similar positive changes in anger and aggression for the BV participants. While both groups experienced improvement in anger and mental health, women randomized to the BV intervention had stronger declines in anxiety (F=5.32) and state anger (i.e., outward expression or control of others) (F=8.84) than women in the gender-neutral anger program. Furthermore, a longitudinal follow-up study showed that the women who participated in the BV program were significantly less likely to recidivate (i.e., arrest or time in jail) than women in the gender-neutral anger program during the first 12 months following their release from prison [27].

In summary, women with complex problems, histories of ACEs, and serving sentences for property, drug, or violent offenses benefited from various trauma-specific interventions when compared to treatment as usual. These curricula evaluated were explicitly designed for the primary needs of justice-involved women, addressing the gaps in programs focused on trauma, substance use, and violence prevention. The content of the interventions, the method of delivery, and the applicability to the needs of the population are the essential components for enhancing women's recovery.

Trauma-Informed and Trauma-Responsive Correctional Settings

Creating a trauma-informed and trauma-responsive organization within a prison, jail, or detention facility is a unique challenge that requires a visionary leader – one with administrative power – who must convey the benefits of a trauma-informed organization to the staff. Doing trauma-informed work means knowing about adversity and trauma and its effects on individuals, communities, and society more generally. All staff members in correctional settings need to understand the process of trauma and its link to mental health problems, substance use disorders, behavioral challenges, and health problems in women's lives. Staff members also need to understand how individuals may be affected by and cope with trauma and victimization.

First, current organizational policies, procedures, and practices must be assessed to determine if they support or interfere with a trauma-responsive environment. This often includes a walkthrough by an objective outsider who is knowledgeable about trauma responses and triggers. Second, once the assessment is conducted and issues are identified, an action plan is created. The Covington and Fallot Implementation Plan and Goal Attainment Scale is designed expressly for the purpose of assessment and action [60]. The scale helps the organization identify problems and determine who is responsible for implementing changes, as well as the completion timeline. Simultaneously, ongoing training for all staff members at all levels of the organization must occur. Priority areas for training include basic information about trauma and the self-care needs of staff members.

Being trauma-responsive involves ensuring that there are policies and practices in place to minimize damage and maximize opportunities for healthy growth and development in all populations at risk. It also consists of the creation of an environment for healing and recovery. Prisons that have implemented trauma-informed services have experienced substantial decreases in institutional violence. After staff members became trauma-informed and created a trauma-responsive institutional environment in the mental health unit at the Framingham facility in Massachusetts, there was a 62% decrease in inmate assaults on staff members and a 54% decrease in inmate-on-inmate assaults [72,73]. There was also a decrease in other behavioral and mental health situations: a 60% decline in the number of suicide attempts, a 33% decline in the need for one-on-one mental health watches, and a 16% decline in petitions for psychiatric services.

Conclusion and Recommendations

Acknowledging the existing literature on the needs and recovery processes of justice-involved women is vital to the implementation of appropriate assessments, treatment services, supervision, policy recommendations and continued research for further advancement. Covington and Bloom [74] suggested an essential shift of the field's central question of "what works" to "what is the work?" The authors state that the work requires a theoretically based model recognizing the centrality of trauma in women's lives, which necessitates trauma-informed training and trauma-responsive organizational approaches specific to this population. Integrating trauma-specific interventions has the potential to improve rehabilitation outcomes and reduce adverse events.

A gender-responsive and trauma-informed approach considers the social issues of gender inequalities and individual factors that impact justice-involved women[1]. A gender-responsive approach to programming would address substance use, trauma, economic marginality, relationships, and mental health issues through comprehensive, integrated, and culturally relevant services and supervision. Prison administrators and government officials may feel that rehabilitation programs are not a proper investment for women who often have short-term sentences. Yet, brief trauma-specific interventions have been shown to be feasible and could be effective re-entry services. Ignoring the critical needs of women has long-term consequences and high costs to society, given the involvement of social services and the intergenerational cycle of trauma, substance use, and criminal involvement. Women's gender-related needs are the pivotal factors to address in guiding assessment, treatment development and gender-responsive policies to aid in women's recovery. The recommendation of the Gender-Responsive Theoretical Framework and Guiding Principles for Corrections as a paradigm of care for justice-involved women was essential in 2003 and remains so as we move towards 2026.

Conflict of Interest Statement

Dr. Messina is the CEO and President of Envisioning Justice Solutions, Inc. Dr. Covington is the Co-Director for the Center for Gender & Justice. The authors declare that there is no conflict of interest and there was no funding provided for this commentary from any person or organization.

[1]Becoming gender-and trauma-responsive are terms which are inclusive of men, women, and gender-diverse populations. Gender identity and histories of trauma are important factors that should be included in treatment opportunities for all justice-involved populations. Men can also benefit from trauma-specific programming, as histories of trauma are not unique to women. The prevalence, type, and impact of lifelong trauma may vary by gender, but that is not an argument against incorporating treatment components that address trauma for both men and women [63].

Acknowledgment

We are grateful to those who contributed decades of scholarly works, dedication to theoretical and program development, research, dissemination of information, committee involvement, and the creation of policy guidelines for criminal justice-involved women. These criminologists, psychologists, sociologists, LCSWs, nurses, substance use treatment professionals, corrections professionals and relentless thinkers are cited throughout this article. We are also forever grateful to the peer facilitators who provided years of program facilitation in prison, as well as care and attention to the program participants. Finally, we wish to acknowledge the bravery of the women with lived experience who volunteered to participate in the programs and the research, and for sharing their stories over the years.

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