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Strategizing and Fatalizing: Self and Other in the Trauma Narratives of Justice-Involved Women

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Abstract

Jail admissions in the United States number nearly 1 million women annually. Many have limited access to public support and must seek assistance from family, friends, and strangers to maintain health and safety after release. This study sought to learn more about how women with a history of interpersonal trauma and criminal justice involvement perceive and manage social relationships. In-depth, story-eliciting interviews were conducted over 12 months with 10 participants who were selected from the convenience sample of an ongoing parent study in a Midwestern urban jail. Embedded trauma narratives were analyzed for self-presentation, form, and theme. The trauma narratives registered a continuum of agency, anchored at either end by patterns of strategizing talk and fatalizing talk. Providers and advocates can improve support for justice-involved women post incarceration by becoming familiar with and responding to patterns of strategizing and fatalizing in their personal narratives.

Keywords

incarcerated women; trauma; social support; narrative inquiry; Midwest US

In this study of narratives about trauma, I sought to develop understanding of how women with recent history of incarceration perceive and manage interpersonal social ties for health and safety. For health care and social service providers, recognizing how justice-involved women understand themselves in relation to others as they attempt to manage resources for survival during crisis can be an important initial step in improving how women are supported in the community. In trauma narratives, women's constructions of self-in-representation registered along a continuum of agency that was distinguished by two modes: strategizing talk and fatalizing talk. Strategizing and fatalizing modes of talk in trauma stories distinguished women's presentation of self, action, and motivation, encompassing both what the women said and their ways of saying. Although women rarely adhered exclusively to either strategizing talk or fatalizing talk, a closer look at cases that were exemplary of the types may illuminate a model from which to begin to build better

All errors and weaknesses are my own.

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Supplemental Material

Supplemental material for this article is available online.

understandings of how women manage health under the highly challenging conditions of reentry after incarceration.

Women's Incarceration and Women's Health

Jail admissions in the United States total over 11 million per year, with daily population censuses for jails numbering about 2 million (Minton & Zeng, 2015). Women make up approximately 15% of those totals, their rates increasing 18% between 2010 and 2014, whereas men's rates of jail incarceration decreased by 3.2% (Minton & Zeng, 2015). Much has been written about the distinctive pathways that lead women to incarceration, and it is well documented that rising rates are tied to trends in the policing, charging, and sentencing of drug and property crime in underresourced, often racially targeted communities (Alexander, 2010; Wacquant, 2010). Justice-involved women, including both those who are incarcerated and those under criminal justice supervision in the community, often come from and return to underresourced areas, where jobs and social capital to improve socioeconomic status are lacking (Sered & Norton-Hawk, 2014; Western & Pettit, 2010). In addition, incarcerated women struggle with substance abuse disorders, mental illness, and severe personal trauma at higher rates than women in the general population, including experiences of childhood sexual abuse (CSA), intimate partner abuse, and adult rape (Grella, Lovinger, & Warda, 2013; Lynch, Dehart, Belknap, & Green, 2012). In seeking to gain control over the cycle of incarceration, women with a history of incarceration face multiple barriers that affect their health and safety (Lorvick, Comfort, Krebs, & Kral, 2015; Swavola, Riley, & Subramaniam, 2016).

Trauma and Trauma Narratives of Justice-Involved Women

High rates of lifetime trauma from interpersonal violence afflict women with a history of incarceration (Grella et al., 2013). Reports of CSA and adult sexual violence are prevalent in incarcerated populations, with studies finding CSA rates for incarcerated women between 32% and 68%, and sexual violence as high as 86% (Briere, 1996; Cusack, Herring, & Steadman, 2013; DeHart, Lynch, Belknap, Dass-Brailsford, & Green, 2014). Women who experience traumatic life events often adopt coping strategies such as drug and alcohol abuse that lead to revictimization and additional health risks (Cusack et al., 2013). Symptoms from unresolved trauma responses can take a toll on physical health and are associated with dysregulation of stress responses and associated health outcomes, including musculoskeletal pain and digestive, endocrinal, cardiac-respiratory, and immunologic conditions (Pacella, Hruska, & Delahanty, 2013; Weiss, 2007).

Trauma has special significance in a study that focuses on how women narrate relationships. In her landmark text *Trauma and Recovery*, Herman (1992) explained that trauma, a psychic injury or wounding, refers to the profound disruption in a survivor's understanding of self in relation to the world, a loss of perceived "control, connection, and meaning" (p. 33). Caruth (1996) has stressed that the key aspect of trauma is the difficulty with which survivors understand and make meaning of negative experience owing to the peculiar way trauma is recorded in memory, its tendency to be unanchored contextually—not part of the flow of recalled experience but separated and locked out. Survivors often can only incorporate the

meaning of traumatic experience into their lives indirectly and belatedly. Janoff-Bulman (1992) has argued that trauma entails such a shattering of a person's basic assumptions about the self in its connection with others that it might require construction of a whole new self-narrative or schema. The process of recovery from trauma can be an extended and uneven process marked by reexperiencing, avoidance, and dissociation (Bromberg, 2003; Janoff-Bulman, 2004), sequelae that interfere with a survivor's ability to make sense of, form, and manage relationships (Golin et al., 2016; Herman, 1992).

As women with significant lifetime trauma might suffer retraumatization through unintended triggering of symptoms within the carceral setting, trauma-informed corrections has been a focus of research in recent decades (Harner & Burgess, 2011; Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015). However, the attention to targeted, trauma-informed support during incarceration rarely extends beyond release for these women. Post incarceration, many receive only minimal social assistance and inadequate mental and physical health care (Belknap, Lynch, & DeHart, 2015; Mallik-Kane & Visser, 2008; Richie, 2001). To change how women are supported in the community after release, providers can begin by hearing what women are already doing, taking stock of the particular ways in which justice-involved women with a history of trauma perceive self and other in managing health and safety risk through informal social support.

Research Question

Research Question: What do trauma narratives of justice-involved women reveal about how they perceive and manage social ties to access support for health and safety?

Conceptual Framework

The study drew on a conceptual framework that incorporated aspects of feminist standpoint and relationality theories, narrative inquiry methodology, and concepts related to social network and social support theories.

Feminist Standpoint and Relationality

Feminist standpoint theory and its emphasis on relationality informed the overall objective of the study: to learn from justice-involved women's own accounts of trauma how they manage social ties for health and safety. Feminist standpoint theory holds that women share certain ways of viewing and understanding the world as a result of being socialized *as* women in a specific social structure at a specific historical juncture (Ramazanoglu & Holland, 2002). While subject to a good deal of variation and modification due to intersectionality (i.e., the synergistic role played by factors of socioeconomic status, race, and religion in forming women's experience), feminist standpoint theory argues that an emphasis on relationships represents a primary way in which women know and experience the world (Freedberg, 2015). Connectedness and transaction rather than autonomy and detachment thus become key motifs around which feminist epistemology (Haraway, 2014) and feminist approaches to philosophic and scientific inquiry take form (Gilligan, 1982; Harding, 2004; Miller, 1986; D. E. Smith, 1990). The relational aspect of feminist theory

further supports a focus on stories about trauma, as trauma is often defined as the rupturing of connection or relationship (Comstock et al., 2008; Herman, 1992).

Narrative Inquiry for Health Research

Story-based or narrative research assumes that narrative is a basic means by which humans make sense of and communicate experience (Bruner, 1990; Polkinghorne, 1988). Often, narrative refers to the temporal ordering of a series of events or conditions by a speaking (or writing) subject (Mishler, 1995), whereas story refers to a more purposeful performance that might involve greater attention to scene-setting and evaluation of meaning than is found in the mere narration of events (Maynard-Moody & Musheno, 2009; Mishler, 1995). Notwithstanding distinctions made between story and narrative, the two are often used interchangeably in the social sciences to refer to segments of talk that form a plotted sequence, though it might not be chronologically ordered in the telling (Riessman, 2008). I use the terms narrative and story interchangeably in this article. Narrative inquiry has been developed for social science research by Clandinin and Connelly (2000), Gubrium and Holstein (2009), Hall (2011), Maynard-Moody and Musheno (2014), and Riessman (2008), who argued that personal narratives provide rich, detailed information about how people infuse experience with meaning and emotional valence, which in turn inform attitudes and behaviors (see also Sandelowski, 1991).

The narrative analytical methods used in this study were specifically adapted from Riessman (2008), who demonstrated how narratives convey meaning through thematic, structural, and performative dimensions, as well as through intertextual connections—the way stories told in one context converse with stories told in another, as in the broad social narratives or stories that a culture tells itself about itself. Inquiry based on personal narratives has had special significance for the health sciences (Priest, 2000), where stories and storytelling are employed as a mode of intervention (Charon, 2006; M. J. Smith & Liehr, 2013) and as a method to build knowledge about the subjective experiences and needs of patient populations (Draucker & Martsof, 2010; Polzer, Mancuso, & Rudman, 2014). For health researchers, storied data can render visible the emotional and perceptual patterns that organize the ways in which people manage health and safety risk in their worlds (Bally et al., 2014; Lee, Fawcett, & DeMarco, 2016).

Accessing Support Through Social Connection

This study focused on justice-involved women's stories about relationships to understand how they perceive self and other in mobilizing social support. According to social network theory, the webs or networks of social relationship that bind persons to one another in a community often serve as a conduit for social support (Berkman, Glass, Brissette, & Seeman, 2000). Social support might take form as emotional, material, instrumental, and informational resources exchanged across specific relationships (Cohen, 2004; Uchino, Bowen, Carlisle, & Birmingham, 2012). In low-resource situations, support from close network connections might be necessary for survival or "getting by" (Briggs, 1998, p. 178; Domínguez & Watkins, 2003). For a population, with limited resources, it is important to observe that social support operates according to a principle of reciprocity, the achievement or promise of some form of give and take (Uehara, 1990).

The central tendency in the conceptual framework for this study—which includes feminist standpoint theory, narrative inquiry methodology, and social support theory—is relational. It is thus well suited to investigating what trauma stories of women with justice involvement have to say about how women perceive and manage social ties to access the social support they need to protect health and safety.

Method

Recruitment and Case Selection

Women were invited to interview for this study from a larger, ongoing interventional and ethnographic study (Ramaswamy et al., 2017b). That parent study had two aims, the first being to assess changes in women's cervical cancer knowledge, attitudes, and self-efficacy to screen and seek treatment before and after a brief education and empowerment program delivered in the jails. The second aim of the parent study involved interviewing and observing a subsample of the women after release to learn more about how women navigate health care and social service barriers (Ramaswamy et al., 2017b). The convenience sample ($n = 182$) for the parent study included English-speaking women in three county jails in a Midwestern metropolitan area from September 2014 to March 2016 (Ramaswamy et al., 2017a, 2017b).

The story-based, relationship-focused interview study reported here involved a purposeful selection of 10 cases from the parent study sample. Selection was based on the variety and complexity of the women's social networks and experiences of trauma as expressed in the interventional phase of the parent study. In determining which participants to invite, I evaluated women's discussion during the interactive group sessions, inviting participants who reported numerous, shifting, and overlapping roles and relationships in the most detail. Invitations for the story-based relationship interviews were issued on a rolling basis between December 2015 and July 2016. Recruitment of participants for the story interviews ended when I judged that the data were yielding sufficient complexity of form, richness of detail, and diversity of experience to answer the research question (Patton, 2015) about how women narratively represent the management of relationships to protect health and safety in stories of trauma.

No one who was invited to participate in the interviews declined, and (unusual for work with this population) none of the participants was lost to follow-up during the 12 months of interviewing.

Data Collection Procedures

Two in-depth, semistructured interviews were conducted with each of the 10 women who agreed to participate. All interviews were audio recorded, transcribed verbatim, and stored in Dedoose (a password-protected online data management system) and on a secure server at the University of Kansas Medical Center. Interviews in both the initial and follow-up series averaged 60 minutes and ranged from 31 to 91 minutes. The average time between each woman's initial and follow-up interview was 5 months, with a minimum of 3 weeks and a maximum of 12 months.

In the initial interview with each woman, a life-story trope was employed in which the participant was invited to imagine her life as a book, similar to what McAdams (2008) described, but with each chapter centering on one or more key relationships. The relationships could be with family, friends, intimates, or acquaintances. Participants were encouraged to order their chapters and the stories within them however they liked and were not held to the book format if they seemed resistant to it. After a woman narrated her last chapter, she was asked which (if any) of the chapters she would remove from the story and why, what she would make up and add in as a chapter, and what title she would give her overall story. In the follow-up interview with each woman, I presented a typed outline or a verbal description of the book's chapters and key contents for verification and invited additional storytelling prompted by that frame.

All interviews were conducted in person, with the exception of one follow-up, which took place on Skype after the participant moved out of state. Most interviews occurred in the community, at sites that included participants' residences, the researcher's car, coffee shops, a public library, a church-choir changing room, and various McDonald's restaurants. Three interviews were recorded in a private meeting room in the jail.

Data Analysis Procedures

Each transcribed interview was reviewed and cleaned against the original recording before being loaded into Dedoose, where I open-coded transcriptions independently (Saldaña, 2016). Two members of the parent study analytic team, who also read the transcriptions, met with me biweekly throughout data collection to discuss themes based on field notes, coding, and analytical memos (Emerson, Fretz, & Shaw, 2011). Over the course of data collection and analysis—a yearlong, iterative process of reading, coding, memoing, and discussion of my interview data and field notes with colleagues—I discerned the presence and main attributes of a framework of strategizing and fatalizing talk in the management of relationships for social support.

The unit of analysis in this study was two-part and included the overall life stories constructed by the women in interviews and field encounters and the embedded trauma stories. The larger life stories were constructed as described above from the chapters narrated by the women. Embedded trauma stories were extracted for analysis based on a trauma event series that had a discernible abstract or beginning (often instigated by an interview prompt) and an ending, in which, after recounting the shifts in action or condition, a participant gave some form of resolution and provided a “coda” (Labov & Waletzky, 1967, p. 39). The coda or ending was usually a sentence or two that brought the account into the present perspective. Embedded stories of trauma could extend a few lines or a few pages; some were peppered through with probing questions, whereas others issued forth as an unbroken flow of narration. The four trauma stories analyzed in this report were selected on the basis of their detail, complexity, and to a lesser extent their completeness of form. I selected stories that illuminated the characteristics of the two poles of strategizing and fatalizing to better define those modes of talk, though what was in fact more common was a combination of the two, an example of which I also present. For each case, I contextualize

the trauma narrative(s) with detail from the participant's life story and include my interpretive analysis to clarify the reasoning by which I drew conclusions from the findings.

Ethical Issues

All participants gave informed, written consent to interview as part of the enrollment process in the parent study. Prior to each interview, I further reviewed the purpose, benefits, and possible risks of the substudy and obtained assent to continue participation and to audio record. To protect participants' autonomy, I reemphasized in each encounter that the women were under no obligation to continue with the parent study, the interview study, or any particular line of discussion within an interview. I stressed that the project would probably not benefit the participants in any direct way but I also let them know that their contributions might help care providers and program designers improve conditions for women in like positions by designing better services. I warned women that our discussions could cause unwanted memories or emotions, and I reminded them that the parent study team could give referrals for mental health with experienced providers affiliated with the project if requested. During informed consent, the women were apprised of our obligation to report child abuse or endangerment, and I remained alert to any such disclosures during all encounters.

Participants in this study were initially encountered during an incarceration, and most continued to be subject to criminal justice supervision, several returning to jail during the course of the study. As such, they were deemed vulnerable and merited special protections as human subjects. Amplifying their potential for harm and exploitation was the continuing involvement of many of the women in drug use, drug sales, and prostitution—illegal activities that participants discussed freely in the interviews. A National Institutes of Health Certificate of Confidentiality was obtained to protect recordings and other materials in this research from seizure or discovery by law enforcement. Data were stored in password-protected computers and on a secure university server. Initials and pseudonyms were used to identify the women in notes and transcriptions. All the names that appear in this report are pseudonyms, most of them chosen by the women themselves.

Women were remunerated US\$10 for each interview. The amounts were applied to debit cards held by the women as part of their ongoing participation in the larger investigation. The substudy was approved through the parent study by the institutional review board at the sponsoring university medical center. The programs administrator at the jail where three of the interviews took place additionally approved the audio-recording of interviews.

Findings

The objective of this study was to achieve depth and detail of data in specifically selected cases rather than representativeness or probabilistic generalizability (Miles & Huberman, 1994; Patton, 2015). Even so, demographic information in a qualitative study can provide a snapshot of a group of cases and give some idea where diversity of experience was achieved or lacking in case selection (Sandelowski, 2001). The supplemental file provides a summary of characteristics of the 10 participants in the interview group and some indication of trauma exposure as revealed during interviews. Of particular note, various combinations of interpersonal violence, drug abuse, sex exchange, and insecure housing put these women at

elevated risk of infectious and chronic disease and injury (Kelly, Cheng, Spencer-Carver, & Ramaswamy, 2014). Four women reported exchanging sex for food, shelter, money, or drugs either regularly or intermittently during the 12 months, and two others had done so in the past. All the women reported a history of substance abuse, and, in either their initial or follow-up interviews, all but two of the women acknowledged continuing drug use during the period of the study—including the two incarcerated women, who described using while in jail.

One of the most pressing risks related to health and safety in the women's day-to-day lives and the one to which women most often attributed shifts in relationships was the threat of injury or death due to violence. Most women reported multiple interpersonal traumas. Six women described being raped as adults, often multiple times. Seven were beaten by boyfriends, husbands, or johns severely enough to require hospitalization. Three described abductions by abusive partners that involved being held captive for a period of time. Two reported having been hospitalized with gunshot wounds. Three of the women described the death or life-threatening injury of an infant in the home. Indeed, the women's stories at times gave an impression of constant crisis, yet within the narration of trauma was also evidence that the women labored to shape meaning in ways intended to facilitate support or minimize harm.

Strategizing Talk and Fatalizing Talk in Narratives of Trauma

The initial interviewing and analysis of data in this study was guided by the broad question, "What do trauma narratives of recently incarcerated women reveal about how they perceive and manage social ties to access support for health and safety?" The trauma stories displayed in the list titled "Trauma Narratives" (Supplemental file) and explicated below represented comparatively extreme moments of health and safety risk in the women's lives. Janoff-Bulman (1992) has argued that research based on extreme events might provide particular insight into "basic aspects of human thought and behavior" (p. 3). The trauma narratives analyzed herein indicated that justice-involved women in volatile environments with compromised access to resources perceived relationships of support and their own capacity to engage them along a continuum extending from greater (strategizing) to lesser (fatalizing) ascriptions of agency.

Strategizing talk

In strategizing talk, women emphasized agency and an implied self-efficacy, sharing in some form the goals, plans, and actions that made up a process of mobilizing social support.

Natalie—Natalie's criminal justice history included a 4-year stay in prison and more than 10 short-term jail stays, mostly for drug-related offenses. Chapters in Natalie's life story described relationships with her mother, the fathers of her children, two same-sex partners in prison, and the man she married during the year of this study. Key events in Natalie's life story included rape by an acquaintance at age 14, the birth of her children, the loss of her parental rights, and the sudden death of her mother. Natalie identified herself as an alcoholic and reported abusing methamphetamine and prescription opioids. Natalie's overall life story

was shaped by her almost constant maneuvering to secure sanctuary, both physical and emotional, for herself and formerly for her children.

The embedded trauma stories within Natalie's life story exemplified the use of strategizing talk. In her first chapter, Natalie described leaving her mother's home at age 15 to live with a teenage boyfriend, Darren, aged 14, in his mother's house. Natalie spent nearly 7 years and had two daughters with this partner in a relationship characterized by severe physical and emotional violence. The extended, disjointed account of her first opposite-sex relationship included allusions to being punched, kicked downstairs, and raped. However, despite the recitation of chronic, severe abuse, in the story labeled "I Finally Did It," Natalie first narrated a predicament over which she perceived she had little control and then, despite that lack of control, followed with strategizing talk: variously establishing intent, assessing options, making plans, and taking action.

Structurally, Natalie set two plots in motion in "I Finally Did It," an elaborately planned scheme that involved a secret job and savings but required time to bring to fruition, and a second, the fight, enacted on the fly, its results put to immediate use. The movement of the narrative from one to the other highlighted Natalie's tactical aptitude as she pivoted abruptly from describing the first approach (i.e., getting a secret job, saving money) to seize on and develop the circumstances surrounding the second (i.e., staging a disclosure). In the second gambit, she transformed the "something stupid" of a minor fight with Darren's mother into a narrative of imminent danger. Strategizing was made even more apparent in the final lines of "I Finally Did It," when Natalie pointed to her reasonable assumption that, even though her mother had not responded to previous requests for sanctuary, appealing to fear of HIV and the safety of her granddaughters would prove more successful. Natalie's strategizing talk took form in "I Finally Did It" through her presentation of self, which focused on the depiction of a woman isolated and yet continually plotting to rebuild connections. Her emphasis was on strategizing—with little help and much hindrance from others—to manage relationships in a way that would secure her own and her children's safety.

Similar to other trauma stories that featured strategizing talk, in Natalie's second trauma story, "[M]aybe Now I Could do a Little Bit More," the presentation of a self in isolation, lacking either formal or informal social supports, was parlayed paradoxically into a hard-bought agency. The entire first passage of the second narrative was dominated by expressions of helplessness and bewilderment, exemplified by her anguished wondering: "Where's my support group? . . . What the *hell* is going on?" In Natalie's storytelling, alienation did not lead her to submit to circumstance but to reassert agency: though utterly alone, she was "working on this"; once the children are in the care of family members, she would be able to "do a little bit more" to achieve time with her kids; and, in narrating what occurred after the sexual molestation of her daughters by their cousin, she underscored—with a single, important "[b]ecause"—that it was her own rage that impelled her brother finally to step-up.

Although not always successful and certainly filled with heartache, frustration, and sometimes recklessness, Natalie's narrative constructions of her own efforts to achieve safety highlighted strategizing talk, wherein plans were laid and goals for safety were

pursued by an individual who evaluated motivations to manipulate relational ties and assert agency over events. Natalie chose as the title for her overall story “Don’t Throw Me No Pity-Party,” sounding a kind of credo against being defined as powerless by others.

Jennifer—Jennifer, a white woman in her late 30s, also emphasized strategizing talk in her approach to managing support in a trauma narrative. Jennifer’s strategizing talk underscored differently from Natalie’s the ways a woman with criminal justice involvement might find herself having to navigate relationships to get help. The first interview with Jennifer took place in a residential transition program where she was completing court-ordered substance abuse treatment after leaving jail. Five months later, our second interview was conducted on Skype, following Jennifer’s move to a distant state for a job. The jail incarceration in which I initially encountered Jennifer was her first, and Jennifer had no prison experience at all.

Jennifer’s overall life story featured strategizing talk that took form through evaluation and assessment, indeed, a running analysis of the causes behind her actions, feelings, and attitudes. For instance, although Jennifer began her life story by relating an idyllic-sounding childhood and adolescence, that narration of early life was followed almost immediately with premonitory ruminations on what Jennifer identified in hindsight as sources of future trouble. She explained that what she once considered to be a “normal,” carefree childhood she now recognized as lacking in emotional connection, steeped in the heavy drinking of her parents’ social circle and the superficiality of bonds among her own friends. As a form of strategizing talk, Jennifer’s analysis functioned to control interpretation of her life history by making explicit the connections between causes and effects, between her early life and the later perceptions, choices, and actions that comprised the particular, embedded trauma story in which she lost custody of her middle child.

Jennifer’s trauma story, “And These Were the Last Strings,” followed a “downward spiraling” series of events. After college, Jennifer married and had a child, eventually divorced her husband (he was granted custody of the child), and, weary of the frequent travel associated with her career, accepted a less challenging position that left her idle much of the time. Jennifer explained that this led to boredom, and boredom led to vulnerability to substance abuse. Just before becoming pregnant with her third daughter, Jennifer returned a positive drug test. Then, in what she denominated the one real trauma in her life, Jennifer lost custody of her second daughter and was soon after incarcerated.

In her narrative, Jennifer focused on assessing intentions, weighing costs, and guiding her audience’s interpretation. Her strategizing talk in “And These Were the Last Strings” highlighted a process of risk assessment, outlining the factors that she, as a drug user and a mother, considered in determining whether to initiate a relationship with an agency that might help her address her addiction. First, Jennifer was challenged to identify the right source of help—whom to entrust with her predicament. The right assistance, she observed, was “not very easily found.” She then reviewed the costs of disclosing drug use and asking for help, which included potential loss of a child, breaking up the family, and feeling marked as a drug user. Jennifer’s strategizing talk highlighted the extent to which a perfectly rational perception of a punitive function (the state’s power to remove children) might impede viability of support functions (the state’s provision of help for substance use) in the

perception of a help seeker. Jennifer also cited the slightly different cost of managing loss of face (E. Goffman, 1967), because, as Jennifer pointed out, asking for help at all was opposed to the bootstraps view of what she ascribed to herself: “I was brought up to get through it on my own.”

Jennifer’s trauma narrative stressed that, if strategizing is the mode in which a woman imagines herself to manage relationships, a lack of legibility or transparency around support—in this case for drug-abusing women with children—might prove prohibitive. To Jennifer’s exasperation, nothing about the process of seeking support before or getting formal help after losing her child was “straightforward,” except the threat (“grab it or you’re gone”) related to what Foucault (1990) might have called an imperative to confess. Jennifer recognized that “grab it [*and*] you’re gone” was equally likely, as confessing drug use and getting help for it could very well mean the dismantling of a family. When asked what she would entitle her overall life story, Jennifer tellingly proposed “What Not to Do,” a clause that implies a scene of learning, where persons who encounter her story might strategically equip themselves with lessons based on her experience to improve their own capacity to make choices and achieve desired outcomes.

Fatalizing talk

Fatalizing talk was dominant when women expressed a sense of compromised self-efficacy in making decisions and managing relationships for support in their narratives. In fatalizing accounts, women represented crisis and their own roles in it as either foreordained and out of their control or as radically unpredictable and incomprehensible. In fatalizing talk, women ascribed situations and outcomes to fate, God, or chance and identified themselves as detached, confused, surrendering, and dazed observers.

Cicely—A Black woman in her mid-30s, Cicely, was mother to four school-aged children, all living by court order with relatives or adopted out. Cicely reported over 10 incarcerations and one prison stay. In her first interview with me in June and again in the follow-up interview in October, Cicely acknowledged recent use of cocaine, methamphetamine, and phencyclidine. When I saw her in a field encounter a month after the second interview, she claimed to be in hiding, saying that a local dealer had a “hit” out on her.

In her overall life story, Cicely made frequent declarations of self in which she seemed intent on establishing agency: no-nonsense, goal-driven, someone who gets stuff done. In the chapter she created around her relationship with the father of her first three children, for instance, Cicely outlined her role as the family supporter, “the breadwinner,” and “a go-getter,” working two and then three jobs to provide for the household. In a formulation that she repeated in almost identical terms in the two interviews, Cicely stressed her attitude about roles in her relationships: “[I]f you ain’t about to go get it, then get out of my face, so I can go get it myself.” Based on such self-defining moments, one might expect Cicely’s trauma narratives to be dominated by strategizing talk. What instead emerged in both Cicely’s life story and her stories of crisis was more aligned with a second cluster of story attributes, those defining of fatalizing talk.

Cicely's life story had a reactive, chaotic quality to it, a disjointedness that was especially evident in the recounting of her early years, where she reported moving from mother's and grandmother's homes in one part of the country; to father's, aunt's, and paternal grandmother's homes in another; to foster homes; to a state-administered children's home; to an uncle's home; to being on the run; to living at 16 with a much older male partner. Similarly, her embedded trauma narratives, which were numerous, featured disorder, including lots of motion but not much focused direction. Events appeared to occur at random or as inevitable, and other people's motivations were elided altogether or depicted as inscrutable. Exemplary of fatalizing talk around the management of relationships in Cicely's narratives of trauma was the protracted and circumlocutory account she gave of her relationship with Ángel, a long-term partner with whom Cicely had two children. At the center of that relationship, and arguably an organizing force in her life story as a whole, was the embedded trauma narrative of the death of Cicely's child, James.

Cicely volunteered the story of James's death, here titled "'Til Today I Still Don't Understand," but she clearly found it difficult to narrate. She wove her way to the infant's death gradually. Cicely prefaced with a description of Ángel's strange writing in a secret journal that he called his "manifesto," a detailed, daily chronicle of everything he and she said and did. Then, in another instance of what might be called foreshadowing in a work of fiction, Cicely described how during a home visit a social worker or public health nurse told Cicely that her son lagged developmentally, that "when he was about six months, he was probably about maybe four—you know, his level." In the same segment of narration, Cicely recounted having a mysterious premonition or "prevision," in which, overcome by a sudden conviction that her child would not be with her much longer, Cicely told her mother, a month before his passing, "I don't think he's going to make it." Finally, immediately before the events of the morning of James's death, Cicely shared that she believed she had previously witnessed Ángel trying to smother her older child (by another man), when that child was 6 months old. By these means, Cicely created a context of inevitability, retrospectively constructing the infant James's death as an event destined or foretold.

Cicely's fatalizing talk became more intense as she narrated the trauma. In telling the trauma story, Cicely portrayed herself as baffled and helpless, unable to control and struggling to piece together the meaning of events. A dreamlike passivity reigned over "'Til Today," marked in Cicely's delivery by a liberal use of the coordinating "and," the substitution of pronouns ("he," "him") for names, and rhetorical cushioning through repetition of the qualifier "kinda." The account was structured less through a replay of its teller's actions than a series of unanswered questions, bookended by the twin suspicions that Ángel tried once to smother her older son and now might be responsible for the death of her younger one. Within the story, Cicely's questions flowed unanswered from one to the next as she queried what Ángel was doing with James on the bed and what he was doing afterward with the bottle in the closet, why her child was pale and motionless, why the child vomited so much during cardiopulmonary resuscitation (CPR), where Ángel was while she was at the hospital, and what the police and/or courts eventually determined to be true about James's death and Ángel's role in it. Even 8 years after the event, Cicely constructed a story of trauma in which the self she narrated moved through events as a perplexed observer—detached, alone, full of wondering horror, noting without comprehension the gaps left unfilled. Cicely's fatalizing

talk exemplified vagueness and passivity, qualities that were nowhere as clear as in her final, aggrieved admission of inaction due to uncertainty: “I stayed with him . . . I was torn. I didn’t know.”

Cicely’s fatalizing talk was at odds with repeated and explicit references to herself in strategizing terms (“And I’m a go-getter, and I will make it fuckin’ happen, and we ain’t got something, we about to go get it”). In her embedded trauma narrative, she created a mood of helplessness and detachment, deploying formal elements such as questions, gaps, digressions, and foreshadowing to call into relief her diminished role as an agent who could manage social ties to get support for herself and her children. When Cicely acknowledged relationships—the nurse/social worker, her mother—they were perceived not as opportunities for support, even failed ones, but instead functioned as part of the story’s machinery of inevitability. Through fatalizing talk, Cicely created what might have been emotionally necessary detachment from a memory that continued to be too painful to bear. She could recollect and narrate the scene of trauma but only through an observer’s lens of detached bewilderment.

Gradations

I have concentrated on explicating extreme cases of strategizing and fatalizing in the interviews, though more frequent in the interviews were the many gradations between the two. In “It was Just *Boom*,” Neta highlighted how the two modes of talk might be found working in conjunction in a single story.

Neta—Neta was a 45-year-old Black woman with multiple jail incarcerations and more than a decade in prison. “It was Just *Boom*” presents the conclusion of a story in which Neta described moving several 100 miles from her home and extended family network to live with a partner whom she met in drug rehab. The man beat her viciously over several months, policed her every move, and at one point pushed her out a third-story window. In Neta’s narrative, the crisis was no random, unpredictable, inscrutable, or fated event. Neta instead began the story with strategizing talk, reasoning from cause to effect, citing her accountability. Neta judged that it was her own transgression of a well-known rule that led to her predicament: “Tried to get clean again. Went to treatment. I did the big no-no.” In what followed, however, Neta switched from an agentic approach to explain the abuse (i.e., “my mistake”) to a fatalizing approach to narrate its resolution. That is, once the action shifted to escape, Neta minimized cause–effect and motivation (“It was just *boom*”). She assigned management of events and relationships to her abuser’s sister. The action was both sudden and other-initiated—for example, “she asked me,” “she put me”; indeed, the sister issued the imperative and gave it urgency: “If you gonna leave, it’s time to go now.”

As did other women in the interviews, Neta performed a mix of strategizing and fatalizing in her storytelling about crisis. She moved along a continuum of agency, from strategizing talk to fatalizing talk when she shifted from blunder (self-attribution) to remedy (other attribution). It is worth remarking that the use of strategizing talk in Neta’s story, while possibly reflecting a useful guideline (i.e., avoid hooking up with others in recovery), signaled as well a kind of victim blaming in which Neta assigned to herself responsibility for

the abuser's lack of regard for her human rights. Neta's account of trauma not only highlighted the quality of continuousness in the continuum of agency but also undermined the too-easy assumption that strategizing talk, with its assertion of self, is necessarily beneficial and, by implication, that fatalizing talk is necessarily harmful.

As summarized in Table 1, the continuum of agency, for which strategizing talk and fatalizing talk map two poles, was reflected in women's narratives through (a) presentations of self, (b) recurring emphases in theme, and (c) patterned structural and the performative elements. If the modes of strategizing and fatalizing talk designated two poles in theory, in practice they more typically overlapped and alternated, often co-occurring in individual stories, with neither mode proving neatly characteristic of all the stories of trauma told by any one woman.

Discussion

This study examined how strategizing talk and fatalizing talk occurred in trauma narratives in which women with history of incarceration described their struggles to access social support for health and safety. In their accounts of crisis, the storytellers constructed selves and organized and gave meaning to events. When participants like Natalie and Jennifer engaged in strategizing talk, they presented themselves as beleaguered fighters who made or at least tried to make accurate assessments about how, when, and from whom to seek support. Strategizing talk marked stories in which women demonstrated a sense of agency in the midst of crisis. In contrast, in trauma stories where fatalizing talk was more dominant, the women's self-presentation highlighted helplessness, a quality exemplified by Cicely, who depicted herself as overwhelmed and passive, moving through events as a dazed observer rather than as an actor. In fatalizing talk, events unfolded along thematic lines that stressed randomness and the unfathomable, unpredictable will of others—or, alternatively, destiny, the unfolding of something preordained and inevitable. As might have been the case with Cicely, fatalizing talk probably reflected the need of storytellers to buffer unbearable memories—functioning to protect women from painful feelings of reexperiencing, regret, guilt, or abandonment—or as a stopgap for the perceived lack of coherence and connection in event, intent, and outcome that researchers have associated with the recall of trauma (Bromberg, 2003; Janoff-Bulman, 1992).

Feminist Standpoint and Relationality

A central premise of feminist standpoint and relational theory is that women tend to prioritize connectedness over autonomy in understanding self and exercising judgment (Comstock et al., 2008; Miller, 1986). Such tendencies are no doubt found among individuals of any gender group, but according to some feminist–relationalist perspectives, historically, women's socialization might have led them to organize identity, action, and ethics around mutuality over autonomy, cooperation over competition, and collaboration over conflict (Gilligan, 1982; Mackenzie & Stoljar, 2000; Miller, 1986; Miller & Stiver, 1997). The disruption, absence, or denial of social bonds that occurs in trauma (and, for that matter, in incarceration) might be especially difficult for women to cope with (Covington, 1998). The embedded narratives of trauma analyzed for this study indicated that women

longed for but were often thwarted in establishing socially supportive relationships. Researchers have found that both during and after incarceration, the psychological effects of complex trauma can produce a combined fear of and need for connection that complicates women's ability to access support through social relationships (Fedock, Fries, & Kubiak, 2013; Fuentes, 2014; Kubiak, 2005). Thus, the strategic talk in both Natalie's and Jennifer's narratives was full of accusatory and alienated references to parents and siblings, making clear the women's perceptions of ruptured connection—of abandonment or isolation in times of extreme need. For Natalie, in particular, this seemed to lead to a still more tenacious insistence on self-reliance. In contrast, Cicely employed fatalizing talk in her trauma narrative to express a sense of broken connections and the unfathomability of others' perspectives and motivations. The effect of interpersonal trauma on relationality for women is a basis for the argument of Covington (1998, 2007) and others who have been involved in the gender-responsive corrections movement, which stresses women's prioritization of relationship and susceptibility to retraumatization as a rationale for criminal justice system reform (Bloom, Owen, & Covington, 2002; Harner & Burgess, 2011; Wright, Van Voorhis, Salisbury, & Bauman, 2012). The present study contributes to this conversation by illuminating what health care and service providers outside of corrections might hear when justice-involved women with significant lifetime experience of interpersonal trauma seek to position themselves narratively as agents in quest of support within the community.

Managing Social Relationships for Support in a Context of Trauma

Social support is governed by principles of direct and generalized exchange undergirded by trust, in which members, even in underresourced networks, assume that everyone gives and everyone takes, so that a kind of balance is maintained across relationships (Domínguez & Watkins, 2003; Lourel, Hartmann, Closon, Mouda, & Petric-Tatu, 2013; Plickert, Côté, & Wellman, 2007; Uehara, 1990). For women whose material and psychological resources are overlapped, the requirement of exchange means that even support accessed through family and close friends can be perceived as highly restricted, hedged in with caveats and hazards (Hawkins, 2010; Offer, 2012; Offer, Sambol, & Benjamin, 2010; Radey, 2015). In Natalie, Neta, and Cicely's life stories, close social bonds were subject to limitations similar to those cited elsewhere in the literature on underresourced networks, including exhaustion of bonds due to demands that are too frequent or too great (conditions that become more likely when drug abuse, violence, homelessness, and repeated incarcerations are prevalent; A. Goffman, 2014; Harknett & Hartnett, 2011) and resultant feelings of guilt, resentment, and social isolation (Offer, 2012; Ray, 2015). Only Jennifer presented a divergent case. Jennifer's socioeconomic status and absence of reported physical and/or sexual trauma meant that she almost certainly enjoyed structural and situational advantages unavailable to others in the study, including a social support network with more resources on which she could draw for support. Yet, even Jennifer's trauma narrative—delivered in a primarily strategizing mode—highlighted how frustrating and at times discouraging the navigation of support could be.

Implications and Recommendations

The women in this study struggled with drug abuse, poverty, and unstable housing. Nearly, all the women carried a disproportionate share of traumatic loss or injury, much of it

involving recurrent interpersonal violence. Given the dearth of public assistance available to women so situated and the high unlikelihood of increased programmatic focus on their needs in the near future, it is urgent for health care and service providers to learn how to hear and build on women's own perceptions of and strategies for accessing informal ties for support. Careful attention to women's narratives should provide lessons for more effectively supporting them in what works and helping them find alternatives for what does not. Health care and service providers who practice in community and clinical settings should be educated in and prepared to give trauma-informed care (Harner & Burgess, 2011). They can further understand that health and safety challenges among women in this group are met within a limited horizon of real and perceived choices related to agency and relationship. Bourdieu's concept of *habitus* is useful here, as Bourdieu explained how the perceptions that shape action (for him, "practice," 1980, p. 54) occur within contexts that are already structured by socioeconomic determinants (Bourdieu, 1980; Bourdieu & Wacquant, 1992). What might look like poor personal decisions from the outside might not have the look of decisions *at all* from the women's perspectives. To recognize the operations of a continuum of strategizing and fatalizing talk in women's trauma stories is to acknowledge an underlying dialectic of structure and agency in women's attempts to cope (Rutten & Gelius, 2011; Sweetman, 2003). As an organizing tool, the model of strategizing and fatalizing talk can focus attention on how women manage agency and relationship, self and other, in accessing social support.

Health care and service providers who meet with women during or after an incarceration, and who hear their stories in the course of assessing or advising women, need to be aware of both modes of talk and the perceptions about agency and relationship that they imply. However, simply listening for and supporting women in recognizing the ways in which strategizing can facilitate and fatalizing can obstruct the management of social ties might not be enough. In some cases, strategizing talk might mean asserting inappropriate personal responsibility when structural contingencies or other people should be held accountable for a situation. Similarly, fatalizing entails inaction, detachment, and displacement of self, but those might be strategies for survival as well as avoidance, and in certain cases they might represent the best strategies for staying safe. Assisting women in meeting their health and safety needs will require something more than administering an instrument—and probably more than careful listening and dialogue at an individual level. Because this is a population with distinctive shared needs, population advocates, lawmakers, service administrators, and program designers should also have familiarity with how justice-involved women perceive structurally constrained choices. Strategizing and fatalizing talk provide a preliminary framework within which to begin thinking about how to push for programs and policy changes to create coordinated services and more supportive environments and opportunities. These will be necessary to help women recast their stories, learn to reconceive options, and, in particular, ensure that access to resources exists to move women beyond simply getting by.

Limitations

In this study, I derived theory through thematic and structural analysis of narrative data from in-depth interviews with 10 women. I sought to achieve credibility and trustworthiness for

the model by sharing sizable segments from the narrative data and a fairly detailed demonstration of interpretive process in the findings, thereby giving readers means to judge the applicability of interpretations to other, similar situations (Guba & Lincoln, 1985). To further strengthen trustworthiness, I used repeat interviews and consulted with a team whose members iteratively and independently memoed on the interviews and regularly discussed interpretations over a yearlong period. Regardless, judged by standards of probabilistic research that seeks to make statistically generalizable claims about populations, the small number of cases might be deemed a limitation by some. I would offer that narrative analysis, the holistic reasoning about underlying realities through detailed analysis of languaged data (Patton, 2015; Polkinghorne, 1988), tends to be information rich, requiring a few detailed cases (Malterud, Siersma, & Guassora, 2016). Indeed, given detailed enough narrative data, analysis might be better performed through interpretation of a few cases than many (Creswell, 2014; Maynes, Pierce, & Laslett, 2008). Another limitation of the study would be that the derivation of a strategizing–fatalizing model does not on its own give much specific guidance as to use, a limitation that might be expected in an exploratory study where next steps could take several directions, including the further refinement of constructs and the operationalization and validation of the model for future use in interventions. Finally, to be more complete, this study might have included consideration of the obverse of strategizing and fatalizing talk, the strategizing and fatalizing silences, or spaces where women who have experienced much trauma leave traces of self in relation to other through what is left unsaid.

Conclusion

Strategizing talk and fatalizing talk emerged from narrative analysis of women's trauma stories as two ends of a continuum that mapped perceived agency in accessing support through interpersonal ties. The women who participated in the interviews were complex individuals, every one of them navigating her own set of highly challenging circumstances. In the community and in clinical situations, health care and other service providers working with justice-involved women can learn to recognize patterns of self–other management to better capitalize on the knowledges and aptitudes that women already evince in accessing support through social ties. Where ways of managing those relationships lead to greater health and safety risks for women, a clearer, more incisive understanding on the part of providers might suggest openings where new interventions can be targeted. Of course, the framework presented in this analysis will only be useful if those who are in positions to give support cultivate the ability to listen closely and respectfully for the nuanced ways in which women express strengths and weaknesses through the stories they tell.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Strategizing Talk and Fatalizing Talk in Trauma Narratives

	Strategizing Talk	Fatalizing Talk
Self-presentation	<ul style="list-style-type: none"> • goal-setter and planner • independent or oppositional • evaluating and judging 	<ul style="list-style-type: none"> • erasure of self, surrender of power • overwhelmed, swept up
Formal elements	<ul style="list-style-type: none"> • outlines, plans, lists • action interspersed with focused analysis • focused, straightforward descriptions • event-based narration 	<ul style="list-style-type: none"> • questions, vague modifiers, pronouns vs. proper nouns • declarations of confusion, being overwhelmed • digressive descriptions • emotion-based narration • dreamy voice
Thematic emphases	<ul style="list-style-type: none"> • agency: getting things done, power over events • self-improvement, turning things around • accountability: taking or assigning responsibility • assessing of situations, others' intentions, likely outcomes 	<ul style="list-style-type: none"> • religion, God's will • inscrutability of others' motivations • unpredictability of events • playing a part in a design (teleology) • short-termism: foreshortened horizons • resignation: taking things as they come