Chapter 30
COVID-19 and the Injustice System: Reshaping Clinical Practice for Children and Families Impacted by Hyper-Incarceration

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Introduction

The emotional effects of parental incarceration can be exhibited by children through trauma-related stress symptoms such as depression, anxiety, challenges in forming relationships, concentration problems, sleep difficulties, emotional withdrawal, substance misuse, and significant feelings of shame and stigmatization. These impacts can often last well into adolescence and young adulthood (Manning 2011; Murray et al. 2012; Miller and Barnes 2015; Phillips et al. 2006). To underscore the extensive nature of this issue in the United States (US), nearly 2 million children have at least one incarcerated parent, according to the Bureau of Justice Statistics, a number that is likely underreported as it does not take into account the custodial states of individuals who are a child’s guardian or who perform other significant caretaking functions (Manning 2011; Miller et al. 2013; Murray and Farrington 2008).

Despite the large number of children and families affected by incarceration, limited research has been conducted to explore the effects of parental incarceration on children, as well as what policy interventions exist to mediate the toll exacted upon these children and families (Manning 2011). Existing research implies that parental incarceration is associated with numerous traumatic effects (Manning 2011; Murray et al. 2012; Miller and Barnes 2015; Phillips et al. 2006). However, no research attempts to interpret the traumatic and psychological implications of hyper-incarceration based on what is known about systemic racism and traumatic experience, nor does any research describe best practices for the treatment of this specific population. While current treatment methods such as relational-cultural and...
attachment-focused interventions have offered new methodologies for treating children and families experiencing trauma associated with systemic racism, an extensive literature search found no evidence in peer-reviewed journals that this treatment orientation has been applied to children of incarcerated parents.

Nationwide, the known infection rate for COVID-19 in jails and prisons is about 2.5 times higher than that in the general population (Equal Justice Initiative 2020). Therefore, children of incarcerated parents remain a growing population who presently experience both the traumatic impacts of COVID-19 within their own communities, as well as the fear and anxiety associated with health concerns for their incarcerated loved ones. Poehlmann (2005), at the time, noted that there was no known empirical investigation into how parental incarceration impacts the quality of a child’s attachment relationships. At the present time, there is no known published research indicating how fear associated with increased health concerns for loved ones in correctional facilities imposes a problematic pattern of attachment for children and their future relationships.

This chapter argues in favor of mental health providers utilizing relational-cultural theory and attachment theory in the expansion of the treatment of children affected by parental incarceration during the coronavirus pandemic. At present, these practices are deployed within a limited set of circumstances, even though mental health providers largely recognize their potential for broader use. The current rise in infections of COVID-19 in both jails and prisons traumatically affects children of incarcerated parents. Mental health providers can benefit from incorporating relational-cultural and attachment theory in their work with this population, as well as understanding the impact of dual exposure to trauma brought about by the COVID-19 pandemic and clinical implications of shared trauma.

Background

As mentioned earlier, the Bureau of Justice Statistics reports that nearly 2 million children have at least one incarcerated parent, a number that is likely underreported (Manning 2011; Miller et al. 2013; Farrington and Murray 2008). For the majority of caretakers, parental incarceration reinforces the racialized systemic oppression brought forth by hyper-incarceration, with its associated external stressors such as financial insecurity, elevated emotional stress, strained interpersonal relationships, and increased difficulties associated with the supervision of children (Turanovic et al. 2012).

Most children of incarcerated parents are under the age of 18 (Mumola 2000) and experience numerous sources of material and emotional insecurity. For example, children of incarcerated parents are more likely to receive public assistance, to experience interrupted phone or utility service due to nonpayment, and to experience residential insecurity through missed mortgage and rental payments causing families to move into shelters (Geller et al. 2009). These examples are symptoms of the greater socioeconomic systemic oppression that exists for children even before
a parent is incarcerated, and these conditions tend to worsen after incarceration (Miller and Barnes 2015; Phillips et al. 2006).

These material and emotional consequences have been exacerbated during the COVID-19 pandemic. Families are no longer able to send care packages to loved ones due to concerns about contamination and disease prevention. Without access to care packages from relatives, the only opportunities for discretionary spending are through the custodial commissary, which is a lifeline for hygiene products like toothpaste, facial tissue, soap, and laundry detergent. Because caregivers and family no longer purchase their own supplies for their incarcerated loved ones, they are now restricted to providing actual currency, which increases the financial strain on family members to provide twice the amount of money they were contributing prior to the coronavirus pandemic.

With COVID-19’s resultant intensification in physical, psychological, and environmental stress, children of incarcerated parents report increased rates of traumatic stress. Mental health practitioners working in healing spaces for children and families impacted by parental incarceration must provide expansive awareness of the significant impact of medical neglect, health disparities, and collateral consequences of COVID-19 for children with incarcerated loved ones. Unpacking the micro, mezzo, and macro systems of oppression specific to this population will reinforce safety in the lives of the impacted children through the therapeutic relationship. Applying practices such as relational-cultural and attachment theory will help enable the child to narrate their own experiences of how COVID-19 has impacted them and provide a forum to discuss commonplace losses, like limitations of visitation privileges, familial stress, and increased fear and worry for the well-being of their incarcerated loved ones. In implementing these practices, it behooves clinicians to be aware of how the increased children’s needs during the COVID-19 pandemic impact them. That is, in addition to helping children negotiate these difficult times, clinicians also need to address the impact of COVID-19 on their own personal and professional lives.

Evidence Supporting Disruptions in Attachment for Children of Incarcerated Parents

Children develop representations of relationships that are less optimal when attachment figures are unavailable due to discontinuity in care or the occurrence of some prolonged separation (Toth et al. 2002). Consistent with attachment theory (Kobak 1999), the majority of children initially reacted to separation with sadness, crying, and calling for or looking for their mothers. Other common reactions include confusion, worry, anger, acting out, fear, developmental regression, sleep problems, and indifference. Although many of these responses are similar to reactions exhibited by older children following the loss of a parent to incarceration, such as loneliness, fear, anger, and aggression, young children’s sleep patterns and maintenance of
developmental milestones appeared highly vulnerable to disruption. Lack of mother-child contact during imprisonment may result in children viewing the mother as unavailable when needed, which may have implications for children’s representations of attachment relationships. Now that parents are unable to see their children in person due to new restrictions in jails and prisons after the increased reports of infection rates for COVID-19, children report feeling even more detached from their parental figure and fear that this means they will “never see them again” (Zahir, age 8, personal interview).¹

**Prevalence of COVID-19 in Jails and Prisons**

As noted previously, the infection rate for COVID-19 in US jails and prisons is 2.5 times higher than in the general population (Marshall Project 2020). This is especially concerning when considering the demographic of those at risk who are over the age of 50. In the US prison system, there are over 150,000 people over the age of 55 (Marshall Project 2020). Adults who are incarcerated report a higher prevalence of infectious diseases and chronic conditions compared to noninstitutionalized populations (Marshal Project 2020). Therefore, when COVID-19 became widespread in several state prisons, it impacted incarcerated Black people at higher rates than Black people outside of the prison system, and the consequences of infection in custodial settings was more lethal.

Across the United States, by April 2020, 48% of incarcerated people who had died of COVID-19 were Black, compared with 40% of people who died outside of correctional facilities (Marshall Project 2020). The heightened risk of infection imposed upon members of Black communities, including those who are incarcerated, should be a warning cry for mental healthcare workers of the looming mental health crisis associated with parental incarceration: as infection rates in jails and prisons increase, so, too, does the emotional and psychological burden on children and family members of those incarcerated.

**Psychosocial and Medical Implications of COVID-19 for Parents and Children**

The Prison Policy Initiative (2020) reports that while a typical US jail has reduced its population by more than 30% since the onset of COVID-19, state prisons have been much slower to release incarcerated people. Because social distancing is extremely difficult in correctional facilities, incarcerated individuals come in close

¹All individuals or parents/guardians where appropriate provided written consent for the inclusion of their narratives in this chapter.
contact with each other and with correctional staff – the latter of which serves as vectors to a variety of community settings where they may contract the disease – all of which contributes to higher rates of infection within the custodial setting. Contamination and viral spreading within custodial settings is exacerbated further by the overcrowding that is commonplace in custodial settings. Furthermore, the appalling conditions for solitary confinement add significant psychological stress to incarcerated individuals living with the pandemic.

As infection rates continue to rise, children report feeling “angry and scared” that their parent “is going to die” (Kaleah, age 12, personal interview). Numerous children have shared meaningful narratives in their therapeutic community-based settings that exemplify how they internalize their anxiety, worry, and depression:

When the lockdown first started, I remember thinking I was going through what my daddy was going through. I felt like, ‘I wonder if this is what he feels like every day.’ When my mom told me that more people were getting Coronavirus in jail where my dad is, I was so scared because I know they don’t have doctors there that care about them. I began to fear for my own life when I went outside and then couldn’t stop thinking about if my dad was okay. I feel anxious all the time both for myself, my mom, my grandma, and my dad. I feel helpless. (Kaleah, age 12, personal interview)

The increased spread of COVID-19 in correctional facilities results in various operational changes that materially impact the day-to-day life of incarcerated parents and their children. To adhere to social distancing guidelines, most facilities have instituted a ban on physical visitation and have placed restrictions on the quantity and frequency of phone calls (Marshall Project, 2020) with loved ones, resulting in increased separation anxiety, grief, and loss for both children and caregivers. Arlene, an incarcerated mother at a correctional facility in New York, shares:

The visits are all we have to look forward to, the only thing keeping us going some days are our children. So when this is taken away, we feel hopeless and fearful that our own mental health, along with the medical neglect we all receive, will only get worse and we’ll have nothing to live for. (Arlene, age 33, personal interview)

Thus, children and parents now experience unprecedented threats from medical complications of disease contraction and greater separation as a result of social distancing, which compound the pre-pandemic social and emotional stress experienced by both incarcerated parent and child. The collateral consequences of both medical fear and social and emotional distress for children and parents separated by incarceration highlight the unique traumatic experiences and stressors facing families directly impacted by mass incarceration. Forms of attachment common for incarcerated individuals, such as phone calls, in-person visits, care packages, and letter writing, have now become compromised during COVID-19, and this poses additional barriers for the emotional security of the child.
Application of Relational-Cultural Theory in Treatment for Children of Incarcerated Parents

Constant and recurrent traumatic events that impact interpersonal security can lead to long-standing social and emotional consequences that affect various areas of individuals’ health and well-being across their life span. Additionally, it is often understood that people who experience interpersonal traumas experience a sense of betrayal, powerlessness, and stigmatization (Deitz et al. 2015). When this impacts children, there is a likelihood that it can contribute to a distorted self-concept and worldview (Walsh et al. 2010).

Relational-cultural theory (RCT) employs a practice that allows for individuals to focus on connection with others throughout their life span, and by forming and maintaining healthy relationships, they can build a sense of safety and well-being (Jordan 2010). Moreover, RCT suggests that connecting with others and forming growth-fostering relationships serve as a healing mechanism (Jordan 2010). An RCT application can provide a framework and lens from which clinicians can partner with children on how to best recognize, form, and maintain healthy relationships during a time that can feel unsettling and ambiguous. Therefore, the use of RCT with children of incarcerated parents during COVID-19 is an approach that can be especially useful when naming the systems of oppression that have directly impacted the child’s and parent’s beliefs of safety and security in the world at large. Mental health providers working with individuals who have experienced trauma rooted in interpersonal victimization must consider all systems that traumatize the individual, family, and community and employ an anti-racist framework of safety within the therapeutic relationship that directly names those systems when addressing intergenerational systemic trauma. The emphasis RCT places on connection with oneself and others may help to diminish trauma symptoms and facilitate healthy functioning.

Application of Attachment Theory in Treatment for Children of Incarcerated Parents

The attachment theory literature highlights the importance of emotionally open communication in relationships. Telling children about difficult situations in honest, sensitive, and developmentally appropriate ways affirms their trust in caregivers. In contrast, when information is hidden, distorted in a manner that contradicts the child’s experience, or includes details that frighten a child, distrust or mental health problems may ensue (Bowlby 1973). Attachment theory provides an intervention by which a child can address the stigmatization they experience as children of incarcerated parents and offers a clinical approach to help them heal from emotional,
physical, and material consequences resulting from the traumatic loss of an incarcerated parent.

Barriers to Relational-Cultural and Attachment Theory Implementation and Fidelity

Therapists often struggle to identify and assess appropriate clients for treatment. While the model works most efficiently for children who present higher rates of depressive symptoms and have a willingness to engage in the therapeutic process, children who are experiencing stronger symptoms of trauma avoidance and mistrust in authoritative figures may struggle to initially connect to their therapists. This can cause critical delays in the application of therapeutic models such as RCT or attachment theory that may suggest a time-specific framework. In addition, one study found that symptom arousal and clinical withdrawal increased during the assessment period, suggesting that service initiation may increase symptom intensity, especially in cases where avoidance is common and where children may have difficulty tolerating these arousal symptoms early in the therapeutic process (Konanur et al. 2015). Therefore, adhering to the timetable in the model may prove to be difficult.

Advantages of Relational-Cultural and Attachment Theory Applications for Social Workers

Both relational-cultural and attachment theories recommend experience-dependent learning, which allows for the possibility that persistent, sensitive, and supportive parents may provide some corrective attachment-related experiences for the child. Both the incarcerated parent and the caregiver who may reside at home can offer a model of care and support that challenges the view that children may hold of caregivers as untrustworthy and of themselves as undeserving of attention and care. In addition, mental health practitioners can use the trusting and safe relationship employed throughout both models to help build the child’s understanding of social interactions and provide a safe context in which new relational skills can be developed (Haight et al. 2003). It is important to note that all traumatic events occur within a sociocultural and historical context. More specifically, COVID-19 presently reinforces to children impacted by parental incarceration that several systems of oppression, including medical, mental health, and the injustice system, represent unsafe spaces that hinder healing and recovery. Therefore, even if another person does not acknowledge, address, or name the presence and power of that traumatic event, all traumatic experiences are embedded in a relational context, and it will be difficult for the therapist to undo in their rapport with the child and family. Each
model is best understood in the context of relational movement, which is the process of individuals moving safely through connections and disconnections and back into newly defined and improved connections with others through their own narrative experiences (Comstock et al. 2008).

**Shared Trauma and the Collective Experience of COVID-19**

Tosone (2012) describes “shared trauma” as “affective, behavioral, cognitive, spiritual, and multimodal responses that mental health professionals experience as a result of primary and secondary exposure to the same collective trauma as their clients” (pg. 12). Transitions to virtual therapeutic care, or teletherapy, during the COVID-19 pandemic appear to be contributing to clinician burnout, as well. According to several clinicians interviewed as part of my research for this chapter, clinicians report teletherapy directly contributing to their feeling “overwhelmed, exhausted, and isolated.” The barrier imposed by COVID-19 and the limits it places on clinicians’ abilities to meet in person for therapeutic sessions impact the ability for the treated children to experience the security of the in-person attachment and consistency found within a safe therapeutic alliance achieved through in-person meetings. Therapists interviewed noted that children’s trauma symptomatology has increased significantly and has been notably demonstrated by children impacted by parental incarceration through the narratives they share.

Simultaneously, therapists must navigate their own fears about virus contraction for themselves and their own loved ones, uncertainty about their security of employment and housing, and parallel feelings of worry and fear about how rapidly COVID-19 has changed their lives and disrupted daily routines that are necessary to one’s own mental health. Tosone (2012) continues to explain that clinicians can experience shared trauma in ways that resemble compassion fatigue or secondary trauma in their own personal responses which can include feelings of exhaustion and depletion of empathy (pg. 3). In our collective clinical experiences, therapists have shared:

> It is hard to show up for clients when I’m struggling to know how to show up for myself. All of this feels so new. I don’t feel like anyone has a blueprint to manage our own emotions of uncertainty during a pandemic, let alone our clients. Even our supervisors who we look to for answers are going through their own fear and discomfort. (Gen, LMSW, personal interview)

The Black Lives Matter uprising and protest events related to the unarmed killing of George Floyd by Minneapolis police officers have added additional challenges for clients in treatment. These protests and uprisings remind many clients of the legacy of systemic racism, inclusive of the lack of accountability for a brutal police force that disproportionately causes lethal harm to persons of color. Therapists working directly with Black clients explained how critical it has been for them to hold space for the increased fear, anger, and rage expressed by their clients through
their narratives. The shared trauma of both client and clinician caused to them by the persistent lack of acknowledgment of police brutality and the impacts of systemic racism has opened up space for more vulnerable connections by both the client and clinician. The challenges of treating populations of color in the mid of these uprisings is particularly acute for therapists who are persons of color (POC). In one community-based setting in Brooklyn, New York, a POC therapist bravely noted:

I had a hard time trusting my white colleagues and white supervisor which impacted my overall emotional well-being and safety, while being asked to still show up for my clients who were talking about how the injustice system was tearing apart their family. I felt my community and my own family were being torn apart and it was past time to acknowledge the level of systemic issues even within my own social service agency. (Sondra, LMSW, personal interview)

Examples of how to best address shared trauma for clinicians during this time are found within the “perceived level of support available to clinicians from their professional and educational organizations, agency-based work settings, supervisors, and colleagues” (Tosone 2012, p. 7). For clinical supervisors, encouraging supportive time off for mental health care, which normalizes the emotional and psychological implications of worry and fear related to the COVID-19 pandemic, has allowed staff to feel seen and heard during a time where they have to prioritize their own mental health alongside of the clients they work with. The utilization of supervisors and clinical staff of more expressive and humanizing language affirms the experience of both the client as well as the clinician who cannot be expected to be as productive during COVID-19 as they once may have been. By honoring the traumatic feelings and experiences of racism, combined with a global public health crisis and its associated medical traumas, clinicians have the opportunity to collectively take care of ourselves and one another. Clinicians must do this through constant validation of emotions and experiences that allow for clinicians to feel it is possible to move through fear while continuing to unpack the experiences shared by clients in all mental healthcare spaces.

Conclusion and Further Reflection

COVID-19 has underscored how significantly dangerous prisons and jails are during a viral outbreak. Public health professionals, correction officers, injustice reform advocates, politicians, and community organizers convey similar beliefs that decarceration will help protect both incarcerated people and the larger communities in which they live (Prison Policy Initiative 2020). Children with incarcerated parents, who are already predisposed to the development of trauma symptoms, face a new and additional risk to their emotional well-being as a result of their incarcerated parents facing a rising risk of infection and mortality due to the pandemic’s widespread increase in the facilities where they must remain. Therefore, it is essential that mental health practitioners meaningfully and intentionally address the crisis
and familial trauma experienced by the loved ones of those who remain the most at risk for infection.

By directly addressing and naming the racist implications of medical and mental health neglect in the correctional systems, clinicians will offer empathic recognition of how institutionalized racism and medical oppression have caused collateral psychological consequences for the children of incarcerated parents. Because attachment-based work and relational-cultural practices identify that isolation from others is a primary source of emotional suffering, clinicians can use their trusted relationship as the primary vehicle for therapeutic growth and change. In the reflective use of countertransference during the COVID-19 pandemic, clinicians should be encouraged to unpack their own shared trauma and feel safe to name their own feelings of exhaustion, pain, and anger related to the pandemic and the political uprising.

During a global pandemic and a time of impactful isolation, clinicians can address how essential connection is to address social withdrawal that prolongs and compounds trauma into emotional pain. Therefore, by prioritizing and centering the relationship of all family members through these practices and providing a non-pathologizing and culturally sensitive framework for therapists to use with children of incarcerated parents who have traumatic stress from systems of oppression, there will be increases to connection and self-worth by addressing and normalizing current conditions of connections and disconnections. Providing shared trauma psychoeducation may normalize clinician’s, children’s, and parent’s symptoms; reduce distress related to symptoms (e.g., shame, excessive self-blame, fear of losing their loved ones); and assist in the development of adaptive coping skills (Kress and Paylo 2015). Strengthening therapeutic community and feelings of resiliency will be essential during uncertain times as we collectively continue to navigate all of our health and wellness during the global pandemic.

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