EFFECT OF INCARCERATION ON PRISONERS DIAGNOSED WITH MENTAL HEALTH CONDITIONS: TRAUMA, TREATMENT, AND TRANSITIONING

by

Ingria Haywood

Liberty University

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

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2023

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Abstract

A mental illness is a medical disorder that affects a person's behavior, thoughts, and emotions. It also has an impact on social and cognitive functions. Misuse of substances, biological factors, or abuse, whether as a victim or a bystander to repeated abuse, are all variables that contribute to mental illness. The prevalence of mental illness among incarcerated prisoners is alarming, and it is nondiscriminatory in that it affects both men and women. Several variables contribute to inmates' susceptibility to mental health problems. Anxiety disorders, depression as a mood disorder, dementia, and schizophrenia are examples of these. A diagnosis of mental illness will occur for around half of all Americans at some point in their lives. Inconsistent treatment or no treatment for incarcerated persons has been an issue of concern, resulting in increased disruptive behaviors that endanger staff, prisoner safety, and the ability to successfully transition back into society, resulting in higher recidivism rates. In addition, inconsistent treatment or no treatment can involve being released from prison and reintegrating into the community. In this regard, there is an increased likelihood that mentally ill prisoners have high rates of recidivism and a stronger propensity to commit crimes after being released from prison. This research will serve to investigate the relationship between inmates diagnosed with a mental illness, treatment, and long-term effects after release. The connection between mental health and prison will be explored through interviews with certified or licensed counselors and therapists.

Keywords: mental illness, mental health, prisons, incarcerations, criminal, trauma

Dedication

This dissertation is dedicated to every prisoner who suffers from mental issues: those prisoners who are no longer detained, prisoners who are still incarcerated, and those who are about to enter the prison system. Please be aware that your mental health is a public health crisis, an epidemic of mental illness directly correlating to mental illness within the prison system. This is a major crisis that is not being discussed nearly enough. I understand that your medical emergency is frequently disregarded because your wounds are invisible to others. Please be assured that they have been noticed. I admire your bravery and sincerely hope that my words bring you some solace and reassure you that you and your mental health concerns are both heard and valued.

Acknowledgments

I give all the thanks and glory to my heavenly Father, who gives me strength daily. Completing this task, I'm more confident that he is the source of all light.

To my husband, my soulmate, love, and lifeline: Gregory, thank you for being so supportive and staying up late with me countless times to see it through. You've been there every step of the way, even in ways you couldn't see.

To my two gifts from God, Seven and Inga: thank you for allowing Mommy some school time. You two have been my strongest supporters. I love you both very much.

To my three bonus children, you three have been my cheerleaders from the beginning. You three encouraged me when I wanted to give up. Your encouragement kept me going. I love you three very much.

To Dr. Mullane, my dissertation committee chair, you have been excellent the whole time we have been together. From our first phone meeting, you believed in me and said, "Ingria, you can do this." I thank you for believing in me.

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List of Abbreviations

American Psychiatric Association (APA)

Any Mental Illness (AMI)

Attention-deficit/hyperactivity disorder (ADHD)

Augmentative and alternative communication (AAC)

Autism spectrum disorder (ASD)

Bureau of Justice Statistics (BJS)

Children's Health Insurance Program (CHIP)

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

Federal Bureau of Prisons (FBOP)

General education diploma (GED)

General strain theory (GST)

Military police (MP)

National Alliance on Mental Illness (NAMI)

National Health Service (NHS)

National Institute of Mental Health (NIMH)

National Institutes of Health (NIH)

Post Incarcerations Syndrome (PICS)

Posttraumatic stress disorder (PTSD)

Qualitative data analysis software (QDAS)

Serious mental illness (SMI)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

Overview

The purpose of this research was to understand the connections between mental illness and prison. The criminal justice system and mental health are undeniably interlinked (Fraser et al., 2009). Prison stakeholders face increasingly critical challenges because they must manage the high prevalence of mental illness and health disorders among prisoners. Prison stakeholders, including the criminal justice system itself, need to develop effective strategies that address prisoners with mental illnesses adequately. Without such strategies, the prison system risks becoming a modern-day asylum that provides little or no treatment for the mentally ill (World Health Organization [WHO], 1999). The data needed to guide the development of those strategies are lacking, thus creating a gap that this study aimed to fill.

This introductory chapter is presented in seven sections. The first section, "Background," includes description of the historical, social, and theoretical contexts for the connections between mental illness and prison. The second section, "Situation to Self," introduces the research design as a phenomenology based on an ontological philosophy and constructivist paradigm. The third section, "Problem Statement," provides the argument that existing data on mental illness in prisons are insufficient and further research is needed. The fourth section, "Purpose Statement," shows that this study aimed to discover the connections between mental illness and prison through the perspectives of prison therapists with first-hand experience counseling prisoners with mental illness. The fifth section, "Significance of the Study," includes explanation of how the study contributes to the existing body of knowledge on mental illness in prisons in

three main ways. The sixth section, “Research Questions,” is a presentation of the questions derived from the problem and purpose statements that served as the foundation for this research. The seventh section, “Definitions,” includes detailed definitions of terms pertinent to the study, followed by a chapter summary.

Background

This section provides the historical, social, and theoretical contexts important in understanding the connections between mental illness and prison to support the argument that prisoner mental health has not been adequately investigated. Many studies of prisoner health focus on the ramifications of incarceration for physical health, such as the spread of infectious and sexual diseases (Fazel & Baillargeon, 2011), rather than mental health.

Historical Context

The number of prisoners in the United States has grown over time. In 1980, approximately 500,000 persons were incarcerated in U.S. prisons. Today, approximately 2 million people are incarcerated (Vera Institute of Justice, n.d.). Although the proportion of prisoners with mental illness has increased exponentially, the funding and personnel to effectively manage the increased numbers is not in place (Sainsbury Centre for Mental Health, 2011).

Social Context

To understand the social context, a brief primer on mental disorders and illnesses is in order. The precise expressions of mental illness vary across different persons, but are characterized by negative impacts on moods, thoughts, and behaviors. Some individuals may experience periods of stability with minimal symptoms, while others may suffer

from severe symptoms over extended periods of time (Fazel & Baillargeon, 2011). The term *mental illness* refers to diagnosable emotional, mental, or behavioral disorders that meet the criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) by the American Psychiatric Association (National Institute of Mental Health [NIMH], n.d.). The *DSM-5* defines a mental disorder as a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. In the context of prisons, mental disorders typically include major depression, anxiety, psychosis, schizophrenia, bipolar disorder, psychopathy, and personality disorders (Ireland & Qualter, 2008). A person's mental illness symptoms impact everyone who is exposed to them because the symptoms represent significant disturbances in an individual's cognition, emotion regulation, behavior, and ability to function socially. This suggests that, because most prisons are severely overcrowded (Sainsbury Centre for Mental Health, 2011), the ramifications of poor mental health care in prisons radiate far beyond the individual with the illness.

Worldwide, the proportion of prisoners with mental health issues has become a major concern. The WHO (2021) estimated that 10 million people with mental disorders are incarcerated worldwide, putting the prevalence of mental disorders among prisoners between an estimated 3% and 25%. The National Health Service (NHS) England (2019) reported that mental health problems are prevalent among prisoners, with 24% requiring primary care services and 10% requiring acute mental health services. The prevalence of

mental illness among prisoners is significantly higher than in the general population; in some countries, there are more persons with issues of mental illness in prisons than in psychiatric hospitals (Cislo & Trestman, 2013). In U.S. prisons, a lack of healthcare, brutality and unsafe living conditions have spurred many human rights violations (Golembeski & Fullilove, 2008).

In the United States, meta-analyses revealed that serious mental illness among adults in jail or prison in the U.S. is substantially higher than in the general population (Prins et al., 2021; van den Bergh et al., 2011). Some estimates suggest that up to 20% of prisoners have a serious mental illness (Borschmann et al., 2020). Other estimates suggest that half of all prisoners have a mental illness or substance use disorder, and one out of every five prisoners has a serious mental illness, such as schizophrenia or bipolar disorder (NIMH, n.d.). Another major concern is the proportion of prisoners with mental illness who have comorbid substance use disorders. The combination of mental illness and comorbid substance abuse can lead to more severe symptoms or exacerbate the risk of self-harm and suicide (NIMH, n.d.). The associated uncertainty adds more strain to life in prison.

Another social context for the connections between mental illness and prison is inadequate mental health care. Persons with serious mental illnesses are overrepresented in the prison population but have limited access to adequate mental health care services (Fazel et al., 2014; Prins et al., 2021) or inadequate diagnosis (Fazel et al., 2014). Only 30% of prisoners receive mental health care (Cislo & Trestman, 2013). A study conducted in the United Kingdom found that 90% of prisoners with mental health issues did not receive adequate care (Prins et al., 2021).

There are many reasons for inadequate mental health care in prisons, including inadequate funding for mental health services, lack of coordination between mental health services and criminal justice agencies, and punitive attitudes toward individuals with mental health issues (Steadman et al., 2009). Other reasons are associated with the lack of qualified mental health professionals or an adequate number of them (Steadman et al., 2009). Additional reasons pertain to coping with overcrowding (Sainsbury Centre for Mental Health, 2011) and to other oppressive prison conditions (Borschmann et al., 2020).

Another social context for the connections between mental illness and prison is reoffending. Prisoner mental illness is interlinked with repeat offending or recidivism (C. Wallace et al., 1998). In a systematic review and meta-analysis, Fazel and Yu (2009) found a significant association between mental illness and repeat offending. These disorders are highly prevalent among the prison population, and those diagnosed with mental illness often cycle through the criminal justice system repeatedly. Alternatively, effective mental health interventions and vocational training (Cislo & Trestman, 2013; Hossain & Brantingham, 2021; Sainsbury Centre for Mental Health, 2011) and diversion from custody for individuals with mental illness (Sainsbury Centre for Mental Health, 2011) are associated with reduced risks of reoffending.

Theoretical Concept

Historically, prisons have been a means of punishment by sequestering a person from their lifestyle and removing their freedom of movement. Contemporary prisons are viewed as more humane alternatives to death sentences due to the absence of physical pain. However, this dismisses the infliction of psychological trauma. Regardless of

location, prisons characteristics that have the potential to inflict psychological trauma include confinement, isolation, loss of privacy, imposition of strict controls on prisoners, and low levels of mental stimulation. Prison life is organized along strict protocols. These create a repetitive static inmate-guard-environment relationship, social organization, and specific customs, traditions, and hierarchy comprising each prison culture. These characteristics predispose prisoners to social tension and disputes. It may be that these conditions are particularly distressing to younger offenders who are unaccustomed to authority, to confinement in conditions without privacy, to bullying, to psychological and physical victimization; or to emotional and social loneliness (Ireland & Qualter, 2008).

Few environments impose greater inescapable social pressures and strain than prisons. Thus, the theory applied to this study is Agnew's (2001, 2012, 2015) strain theory. Although humans endure countless types of strain, Agnew (2001) and other criminologists have argued that delinquency and crime are related to specific strains (Aseltine et al., 2000; Mazerolle et al. 2000; Piquero & Sealock, 2000). Agnew (2001) accredited criminal behavior to strains that (a) are perceived as unjust, (b) are perceived as overwhelming, (c) felt by persons who have low levels of social or self-control, and (d) entice or pressure a person to engage in criminal coping. General strain theory (GST) predicts that strain increases the likelihood of negative emotions, such as frustration and anger that, in turn, generate tension to take counteractions to relieve the pressure, which results in criminal coping. Remedial counteractions include assaults against society, called "crimes," thus forging the connection between strain and crime (Agnew, 1992).

Situation to Self

The researcher's motivation for conducting this study was to explore the impact of incarceration on prisoners with mental health conditions to identify ways to improve mental health services in prisons. The research design was phenomenological. Regarding the researcher's philosophical assumptions, the view was ontological, in that reality is real and measurable. Ontology is "the science of being" because it asks, "What exists?" It is the science of what exists in the world, literally. The ontological philosophy is that reality is a fact without explanation (Dudovskiy, 2022). It is the branch of philosophy that investigates dimensions of reality by their components and the relationships among those components.

In this study, three ontological components of prison therapists' knowledge were collected. The first component was the knowledge the therapists have gained about the nature and prevalence of mental illness among prisoners. The second component was their knowledge about prison characteristics that they perceive as either exacerbating a prisoner's current mental illness or creating it. The third component was their knowledge of the adequacy or inadequacy of prison mental health care. The ontological philosophy incorporates the axiological perspective because it is motivated by the need for greater social justice and the promotion of human rights.

Regarding the paradigm, constructivism holds that knowledge is socially constructed and shaped by individual experiences and interactions. The importance of subjective interpretation in the research process was emphasized. This paradigm was particularly relevant for this study, as the experiences and perspectives of prisoners with mental health conditions are central to understanding the impact of incarceration on

mental health outcomes. In this way, constructionism relates to phenomenology, which is the investigation of lived experiences (Dudovskiy, 2022).

Problem Statement

The general problem that initiated this research is the lack of adequate mental health care in prisons, underscored by the increasing number of calls for improved mental health services on humane as well as moral grounds (Vera Institute of Justice, n.d.; National Alliance on Mental Illness [NAMI], n.d.-b.; NIMH, n.d., WHO, 2021). The Prison Reform Trust (2021) stressed the urgent need to improve the quality of mental health care in prisons to adequately address the mental health needs of prisoners. This call is supported by the HM Inspectorate of Prisons (2019), which sets out criteria for assessing the treatment of prisoners and expects prisons to provide access to mental health care. The HM Inspectorate of Prisons provides criteria for assessing the treatment of prisoners. Reviews of mental health care in prisons highlight the need for early intervention (NHS England, 2019; Prison Reform Trust, 2021). There is an urgent need to address the mental health needs of individuals in custody and improve the provision of mental health services in prisons to reduce recidivism rates and improve public health outcomes.

The specific problem is the role of trauma in the above three components of mental illness among prisoners. Prisoners are a protected population and rarely available for study. However, prison therapists also have valuable first-hand experience with the issues, constituting the population of interest composed of certified counselors and therapists who have worked with incarcerated populations.

Purpose Statement

The purpose of this research was to understand the connection between mental illness and prison. Specifically, the purpose of this qualitative phenomenological study was to discover the connections between mental illness and U.S. prisons through the perspectives of the individuals with front-line responsibilities to manage prisoners with mental illness: prison therapists. The central phenomenon was generally defined as the nature and prevalence of mental illness among prisoners, factors about prison life that potentially exacerbate or create mental illness, and the adequacy of services for prisoners with mental illness. The theory guiding this study was Agnew's (2001, 2015) GST because it provided a framework for predicting the nature of human behavior under pressure, and few environments impose greater social pressure than prisons.

Significance of the Study

The significance of this study was that it makes three main theoretical and empirical contributions to the knowledge base of the connections between mental illness and prison. Prison therapists are the individuals with the front-line responsibility of managing the impacts of prisoners' mental illness on prison life. Narrative data drawn from their perspectives were solicited during interviews.

Significance rests on three primary goals. First, this study aimed to identify the nature and prevalence of mental illness among prisoners. The significance of this study was to inform mental health organizations about potential ways to improve the provisioning of adequate mental health support for prisoners (NHS England, 2019). Second, this study served to identify factors that exacerbate existing mental illnesses among prisoners or that create mental illness among prisoners. It is well known that

incarceration significantly impacts both physical and mental health (van den Bergh et al., 2019) and is linked to negative emotional reactions such as anxiety and depression; however, little data exist on the role of prison characteristics that exacerbate existing mental illness or create it. This study is significant as it aimed to inform broader criminal justice reform by providing insights into how the criminal justice system can better serve prisoners in terms of mental health (WHO, 2021). Third, the study aimed to identify gaps in the current mental health treatment programs in prisons, which is significant by informing practices that could improve the effectiveness of mental health treatments in prisons. Although these contributions emanate from the theoretical basis of GST, they have practical significance for stakeholders. The primary stakeholders are the prisoners with mental illness themselves, the other prisoners who interact with them or who are inescapably exposed to them, and the prison therapists and other prison staff who work with them. The practical significance is improving the quality of life for people who work or live in prison.

This is particularly true among minority groups, prisoners with disabilities, gender-nonconforming individuals, and those with drug addictions (Barnert et al., 2019; Council of Europe, 2018). Investing in mental health care services has benefits for individual prisoners and other stakeholders as well as reduces costs (Fazel & Baillargeon, 2011). Addressing the mental health needs of prisoners by providing appropriate support can reduce the likelihood of recidivism and promote successful reintegration into society. Moreover, addressing broader social and economic factors, such as systemic inequalities and lack of access to education and healthcare, can also reduce criminal behavior (National Institute of Justice, 2020). By adopting a holistic approach to criminal justice

reform, it is possible to improve outcomes for prisoners and society. Ultimately, for many reasons, improving the mental health services available to prisoners and ensuring that they receive adequate treatment and support is important.

Research Question(s)

The research questions (RQs) addressed in this qualitative study were as follows:

RQ1: What is the nature and prevalence of mental illness among U.S. prisoners?

RQ2: What prison factors exacerbate existing mental illness among U.S. prisoners?

RQ3: What prison factors create mental illness among U.S. prisoners?

RQ4: What is the availability of mental health services in U.S. prisons?

RQ5: What is the effectiveness of mental health services in U.S. prisons?

Definitions

Correctional institution: A facility where individuals convicted of a crime are incarcerated as part of their sentence. These institutions may include prisons, jails, and other detention centers. They are intended to provide punishment and rehabilitation for individuals who have violated the law (NHS England, 2019).

Incarceration: Confining someone in prison or other correctional institution as a punishment for a crime they have committed. It involves depriving individuals of their liberty and subjecting them to a restricted and often harsh environment (Incarceration, n.d.).

Mental health conditions: A wide range of conditions affect an individual's mental well-being and ability to function. These conditions include

anxiety disorders, mood disorders, personality disorders, psychotic disorders, and substance abuse disorders.

Recidivism: Refers to the tendency of a person who has been released from prison to reoffend or engage in criminal behavior again. High recidivism rates are often attributed to a lack of support and resources for individuals during and after incarceration (National Institute of Justice, 2020).

Reentry: Refers to the process of reintegrating into society after release from prison. Reentry may involve finding housing, employment, and other support services to help individuals rebuild their lives and avoid reoffending (National Institute of Justice, 2020).

Stigma: A negative attitude or belief about a particular group of people, often based on stereotypes or misinformation. The stigma surrounding mental health conditions can prevent individuals from seeking treatment and contribute to their marginalization and social exclusion (American Psychiatric Association [APA], n.d.-a).

Transitioning: Refers to the process of moving from one state or condition to another. In the context of incarceration and mental health, transitioning may refer to reintegrating into society after release from prison or receiving mental health care during and after incarceration. This be a challenging process that requires support and resources.

Trauma: A psychological response to an event or experience that is deeply distressing or disturbing. Trauma can result from various experiences,

including physical or sexual assault, natural disasters, accidents, or military combat (National Institute of Justice, 2020).

Trauma-informed care: An approach to health care that recognizes the prevalence and impact of trauma on individuals' health and well-being. Trauma-informed care involves providing sensitive, supportive, and empowering care for individuals who have experienced trauma (NHS England, 2019).

Treatment: A process or action to address a health condition or problem. In mental health, treatment may involve therapy, medication, lifestyle changes, or a combination of these approaches to alleviate symptoms and improve functioning (NHS England, 2019).

Summary

The purpose of this research was to understand the connections between mental illness and prison. To manage the high prevalence of mental illness and health disorders among prisoners, prison stakeholders need to develop strategies that address prisoners' mental illness needs adequately or risk turning prisons into 21st century asylums for the mentally ill who obtain little or no treatment (WHO, 1999).

This chapter addressed the historical, social, and theoretical contexts of the problem in this study. Historically, prison populations have increased numerically, but proportions of prisoners with mental illness have increased exponentially. Socially, everyone exposed to a person with mental illness is affected. Mental illness is a diagnosable emotional, mental, or behavioral disorder(s) that meets *DSM-5* criteria. In the context of prisons, mental disorders typically include major depression, anxiety, psychosis, schizophrenia, bipolar disorder, psychopathy, and personality disorders

(Ireland & Qualter, 2008). Worldwide and in the United States, the proportion of prisoners with mental health issues has become a major concern because the prevalence of mental illness among prisoners is significantly higher than in the general population. A second social context for the connections between mental illness and prison is inadequate mental health care, for which there are many reasons. A third social context is the strong connection between lack of mental illness care and recidivism. This study's theoretical foundation was Agnew's (2001, 2015) GST because few environments impose greater social pressure and strain than prisons.

The chapter also included description of the research design as a phenomenology based on an ontological philosophy and constructivist paradigm. The general problem that initiated this research was the lack of adequate mental health care in prisons, underscored by an increasing number of calls for improved mental health services. The specific problem was the role of trauma in mental illness among prisoners. The focus of research was to obtain new data from people who have first-hand experience with the issues, so the population of interest is certified counselors and therapists who have worked with incarcerated populations. The purpose of this research was to understand the connections between mental illness and prison.

The significance of this study is that it makes three main theoretical and empirical contributions to the knowledge base on the connections between mental illness and prison. First, identifying the nature and prevalence of mental illness among prisoners is significant because this information can inform mental health organizations about potential ways to improve mental health support for prisoners. Second, identifying factors that exacerbate or create mental illness among prisoners is significant because this

information can provide insights that improve mental health support for prisoners. Third, identifying gaps in current mental health treatment programs in prisons is significant because gaps can be filled to improve the effectiveness of these prison programs. These aims all have the practical significance of improving the quality of life for people who work or live in prison, including prisoners with mental illness themselves, other prisoners who interact with them, and prison therapists and other prison staff who work with them.

CHAPTER TWO: LITERATURE REVIEW

Overview

The purpose of this research was to understand the connections between mental illness and prison. Mental illness is any disease of the mind (APA, n.d.-b). In its worst form, it is the psychological state of emotional or behavioral problems that are serious enough to cause the life of the afflicted person to spiral out of control. Serious mental illness is a mental, behavioral, or emotional disorder that, exclusive of developmental and substance use disorders, results in serious impairment of one or more major activities of life (APA, n.d.-b). Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder. Serious mental illness may require the afflicted person to obtain psychiatric intervention from a counselor, therapist, psychologist, or psychiatrist. In this dissertation, the term “mental illness” is used interchangeably with the term “mental disorder.”

Mental illness takes many forms, and it does not discriminate (APA, n.d.-b), affecting persons in all walks of life. It can occur regardless of gender, geography, income, social status, race, religion, spirituality, sexual orientation, cultural identity, or age. Whereas mental illness can emerge at any age, three fourths of all mental illness begins by age 24 (APA, n.d.-b). Early identification and intervention are essential at a young age (Crick, 2022). Enclosed prison populations are particularly vulnerable to infectious diseases and mental health issues or illness (NAMI, n.d.-b). Some illnesses develop in response to the many stresses of prison life and some existing mental illnesses are exacerbated by them. According to NAMI (n.d.-b), mental illness occurs among members of prison populations at twice the rates as those of members of the public at

large. Common mental illness among the incarcerated include depression, mania, anxiety, and posttraumatic stress disorder (PTSD; Reingle Gonzalez & Connell, 2014). Yet, as this literature review will show, the opportunities for obtaining the necessary psychiatric intervention are much more limited among members of the prison population than the public at large.

This chapter is divided into three main sections. The first section identifies the theoretical framework as Agnew's (2001, 2015) GST. The second section presents the related literature; it too is presented in three main sections: "Mental Illness," "Prison Life," and the "Connections Between Mental Illness and Prison Life." The third section is the summary.

Theoretical Framework

The GST

The theoretical framework of this research was the GST (Agnew, 1992, 2001, 2010, 2015), which is a criminological theory used to explain the source or societal motivations for committing crime. The basic idea is that delinquency and crime are related to specific strains, of which there are many (see Agnew 2001 for a summary; Aseltine et al., 2000; Mazerolle et al., 2000; Piquero & Sealock, 2000). Agnew (2001) attributed criminal behavior to four characteristics of strains: (a) strains perceived as unjust, (b) strains perceived as substantial in magnitude, (c) strains felt by persons who have low levels of social or self-control, and (d) strains that entice or pressure a person to engage in criminal coping. The GST predicts that strain increases the likelihood of negative emotions, such as frustration and anger which, in turn, create pressure to take counteractions to relieve the pressure. Remedial counteractions to relieve the pressure

include assaults on society that constitute criminal behavior, forging the connection between strain and crime (Agnew, 1992).

Agnew (2001) recognized many hundreds of types of strains but differentiated two major types: objective strains and subjective strains. He defined objective strains as events or conditions that are disliked by most members of a given group. He defined subjective strains as events or conditions that are disliked by the person who is experiencing or has experienced them. Agnew (2001) treated both types of strains as equivalent in terms of their impact on crime, arguing that both objective and subjective strains result in crime largely as a function of the characteristics of the person who experienced the strain.

Further, Agnew (2010, 2015) argued that strain is most likely to lead to crime when a person lacks the resources and skills to manage the burden and pressures of the strains they feel in a legitimate or legal manner. Detrimental health-related consequences are linked to limited or no access to affordable healthcare (Crick, 2022). In addition, the person who releases the pressures of strain through crime generally lacks conventional social support, rates low in social control, blames their strain on other people, and are inclined to commit crimes (Agnew, 2010, 2015). Furthermore, Agnew (2010, 2015) argued that the impact of strain on crime emerges as a function of the type of strain a person experiences in conjunction with that person's individual characteristics. That is, reactions to certain types of strain, whether objective or subjective, are more likely to result in crime than are reactions to other types. Events and conditions that are the most likely to be classified as objective strains and to result in subjective strain are the loss of positive stimuli, the presentation of negative stimuli, or goal blockage (Agnew, 1992,

2001). In the 30 years of its existence, the GST has accumulated a significant amount of empirical evidence (Agnew, 2015).

Because the GST offers explanations of phenomena beyond criminal behavior, in recent years criminologists have expanded its primary scope (Froggio, 2007). Along the lines of an expanded application of the GST, the empirical framework of this research was applied to life in prison. One example of the expansion of the GST addressed the loss of positive stimuli; Agnew (2001) cited the loss of a lover or death of a friend. Once a person is incarcerated, the losses of personal freedom, spontaneous movement, choice, and contact with loved ones are also considerable losses of positive stimuli. It is an understatement to say that prison produces strain. A second example of the expansion of the GST is that strain also includes confrontation with negative stimuli; Agnew (2001) cited physical assaults and verbal insults. A person who is incarcerated sustains regular exposure to verbal insults, if not physical assaults (Reingle Gonzalez & Connell, 2014). It would be an understatement to suggest that the verbal and physical assaults one sustains in prison from inmates and staff alike produces strain. Finally, a third example of the expansion of the GST is that strain includes the frustration of blocked goals. Incarceration is an unquestioned source of blocked goals because of its constriction of personal freedom, regardless of the security level of the prison (addressed in the second section of the related literature below). Specification of these new categories of strain is the GST's greatest strength (Agnew, 2015).

Maslow's Hierarchy of Needs

Implementing the concept of Maslow's (1998) hierarchy of needs into the conversation about mental health and imprisonment allows a deeper insight into the real

problem incarcerated people are facing. The Maslow's theory provides a lens through which the psychological and physical effects of prison life can be examined. It provides insights into how the processes of unmet needs, and the development or aggravation of mental illnesses are intertwined. It is often the case that the physiological needs (Need 1) of inmates turn out to be undertreated at the base of Maslow's pyramid. Prisons, by their very essence, often fail to fulfil their inmates' needs in the area of food, sleep, and basic comfort. These shortages of such basics not only threaten the body's health, but also turn into a profound psychological stressor, sometimes leading to aggravation of existing mental disorders or development of new ones. The unfulfilled craving for the physiological necessity can result in the feeling of survival stress and desperation which ultimately reduces the mental well-being and stability.

Elevating to Need 2, safety and security, prisons frequently do not create a space where those incarcerated are safe and secure. The all-encompassing environment of distrust, violence, and terror in prisons is capable of triggering states of hypervigilance and anxiety, which have similarly traumatic effects on people outside of the prison. Such a constant stress setting where safety and security are at risk act as accelerators of mental health issues like PTSD, anxiety disorders, and depression. The third level, Need 3, speaks to love and belongingness. The very essence of incarceration is to cut individuals off from their usual circles of support by disconnecting them from their families, friends, and the community at large. The loss of these social supports and the ensuing loneliness and isolation are significant emotional stressors that can deteriorate one's mental health and consequently cause depression and a feeling of hopelessness. The prison setting, where it is innate to form meaningful connections is restricted, takes away from inmates

this vital necessity, which in turn adversely affects their psychological well-being and resilience.

The prison setting takes a heavy toll on the self-esteem (Need 4). The fear of being an inmate and the sense of dehumanization of prison life can cause a decline in self-worth and self-confidence. Such an erosion of self-esteem can be a breeding ground for mental health issues, resulting in feelings of worthlessness and doom. The scarcity of avenues for accomplishment and recognition within the prison system, among other factors, continues to limit the satisfaction of this need, leaving inmates caught in a vicious cycle of disillusionment and self-doubt. With that in mind, the top of Maslow's (1998) hierarchy, self-actualization (Need 5), never becomes a reality for the inmates. The prison setting which is characterized by the natural restrictions on personal growth, autonomy, and pursuit of one's own potential, curtails the chances for self-actualization. Offenders are confronted with great difficulties in participating in activities that involve creativity, learning, and rehabilitation which could lead to pursuit of purpose and satisfaction. This unrequited need for self-actualization may become a scourge for many prisoners who feel frozen and hopeless about their own progress or recovery. It serves to illustrate that the denial of vital needs has immense effects on mental well-being by the means of Maslow's hierarchy of needs.

The prison environment, in denying these basic needs, thus only worsens the mental health problems by adding the new ones. This realization is key to the reforms within the correctional system that should be made in order to deal with inmates' holistic well-being, which is achieved through meeting basic needs as the foundation for mental health and rehabilitation. Moreover, the inclusion of Agnew's (2001) GST emphasizes

the fact that strain and stress of prison life, which are associated with injustice, overbearing circumstances, low self-esteem, and the urge toward criminal behavior, be parallel to unmet needs in Maslow's hierarchy. The fact that, together with overstrain, the unmet needs aggravate the mental health problems stresses the importance of dealing with both the environmental factors in prisons and the personal problems of the inmates to solve the mental health crisis in correctional institutions.

Related Literature

This section encompasses a review of the related literature and divided into three main sections. The first section addresses mental illness, the second describes prison, and the third draws connections between mental illness and prison.

Mental Illness

This section on mental illness is presented in six parts, beginning with definitions of mental illness in general. The second part provides statistics on percentages of mental illness among members of the public, while the third part addresses gender differences in mental illness. The fourth part includes descriptions of several of the main types of mental illness. The fifth part comprises the etiology of mental illness in terms of the specific role of trauma and the sixth part address types of treatment.

Definitions of Mental Illness

Mental illness is any disease of the mind but is distinct from intellectual disability in that persons with mental illness do not necessarily have reduced cognitive, social, or mental functioning (APA, n.d.-b). Mental disease is also distinct from regular stress and sadness. Whereas most people occasionally experience minor episodes of stress and sadness, chronic symptoms become a mental disorder when they affect a person's ability

to perform daily functions of life. Finally, mental illness is defined to be exclusive of developmental and substance use disorders (APA, n.d.-b). It can be challenging to differentiate persons with intellectual handicaps or substance use disorders from persons suffering from one or more mental disorders.

The NIMH (n.d.) divided mental illness into two broad categories. The category of *any mental illness* (AMI) is defined a mental, behavioral, or emotional disorder that can vary from no impairment to mild, moderate, and even severe impairment. Individuals with AMI often fail to manage daily tasks to the degree of their impairment, which may manifest as an inability to do their jobs effectively or maintain healthy relationships. By interfering with daily tasks involving relationships, employment, and education, a mental disease can make life miserable (Dellazizzo et al., 2020).

The category *serious mental illness* (SMI) is a mental or emotional behavioral disorder producing functional impairment that is severe enough to substantially interfere with major life activities and ability to function on a regular basis. Distinct from developmental and substance use disorders (APA, n.d.-b), SMIs are psychological states of emotional or behavioral problems that result in serious impairment of one or more major activities of life or are serious enough to cause the life of the afflicted person to spiral out of control (APA, n.d.-b). These problems require the afflicted person to obtain psychiatric intervention from a counselor, therapist, psychologist, or psychiatrist. The various dysfunctions associated with these problems are unintentional and often uncontrollable. The enormous pain caused by these emotional or behavioral problems is not just a reaction to ordinary occurrences. Mental illness is a disease just as pneumonia and arthritis are diseases. In the same way that a physical sickness can worsen if it is not

identified and treated, untreated mental illnesses can worsen as well, which reinforces the need for adequate treatment. The burden of mental illnesses is particularly concentrated among those who experience disability due to an SMI.

Mentally ill individuals struggle significantly with thinking, feeling, or acting in specific ways; signs of mental disease include affected thoughts, feelings, and actions (APA, n.d.-b). Depending on the issue, the environment, and other factors, a wide range of indications and symptoms of mental illness may exist. Some indications and symptoms include insomnia or a loss of sleep, uncontrollable dread and worry, changes in sex drive, suicidal thoughts, and significant high and low mood swings (Hall et al., 2019). A key distinction is that mental illness significantly increases suffering and impacts functioning negatively, making it a challenge to manage the demands of daily living (Dellazizzo et al., 2020). Mental illness not only has a significant impact on how a person functions daily; there is often an intensifying decline in the ability to manage life's essential needs and responsibilities over time (Hall et al., 2019).

Statistics on Percentages of Mental Illness Among Members of the Public

According to the APA (n.d.-b), every year nearly one in five (19%) U.S. adults experiences some form of mental illness, one in 12 adults (8.5%) has a diagnosable substance use disorder, and one in 24 adults (4.1%) has a serious mental illness. Worldwide, mental health has become a major concern (Li et al., 2022).

In the United States, the 2021 statistics from the NIMH (n.d.) estimated that 57.8 million adults or older (aged 18+ years) had AMI (22.8% of U.S. adults). Young adults aged 18–25 years had the highest prevalence of AMI (33.7%) compared to adults aged 26–49 years (28.1%) and aged 50 and older (15.0%). The prevalence of AMI was highest

among adults who were of two or more races (34.9%), followed by American Indian or Alaskan Native adults (26.6%). The prevalence of AMI was lowest among Asian adults (16.4%).

According to a NAMI (n.d.-b) 2020 report on AMI, there were 52.9 million adults aged 18+ with AMI in the United States, representing 21% of the total U.S. population. Persons aged 18–25 again emerged with the highest prevalence of AMI (30.6%), followed by persons aged 26–49 (25.3%) and persons aged 50+ (14.5%;). Over 14 million adults aged 18+ were suffering from SMI in the United States. This number represented 5.7% of the total U.S. population. Prevalence was higher among females at 7% than for males at 4.2%. SMI was more prevalent among young adults (18–25 years) than older individuals (26–49 years) and those 50 and older (3.4%), with a prevalence of 9.7% compared to the other age groups.

Gender Differences in Mental Illness

Most modern societies are structured so that men and women have different cultural tasks, responsibilities, statuses, and power levels. These differences affect their mental health, how they seek healthcare, and how the healthcare system responds. Biological differences between men and women also have specific health linkages to behaviors, mood, and psychological and physical issues. Whatever the actual impact of the societal and biological combination, gender is associated with significant differences in women's mental health versus that of men.

In the United States, the 2021 statistics from NIMH (n.d.) estimated that the prevalence of AMI was higher among females (27.2%) than among males (18.1%). In 2020, the prevalence of mental illness was also higher among women (25.9%), as

compared to men (15.9%; NAMI, n.d.-b). Similarly, the prevalence of SMI was higher among females (7.0%) than for males (4.0%).

Gender differences in emotional-related behavior starts as early as the adolescent years (Henry, 2020). In comparison to teenage boys, teenage girls experience significantly more suicidal thoughts and attempts, eating disorders, and depression during adolescence (Dellazizzo et al., 2020). Male adolescents are more prone than are female adolescents to experience anger management problems, participate in risky behavior, and commit suicide. Teenage boys are more likely to "act out," whereas teenage girls are more likely to direct negative feelings inward (Dellazizzo et al., 2020). Men are more likely to struggle with drug use disorders and antisocial behaviors, while women direct negative feelings inward, blocking feelings that may be experienced as melancholy and anxiety much more frequently in adulthood. Due to genetic and biological factors, women are also more likely than men to have depression and anxiety disorders.

Main Types of Mental Illness

Recent statistics serve to make the point that while mental illness in the United States is widespread, specific mental illnesses vary in prevalence. Statistics are followed by descriptions of specific mental illnesses that could arise or become exacerbated by incarceration.

Table 1 shows that mental diseases are widespread in the United States. In America, over one in five adults suffer from a mental disease (52.9 million in 2020, NAMI, n.d.-b). Mental illnesses range in severity from mild to severe (APA, n.d.-b), but prevalence has been broadly estimated, with anxiety and depression at the top the list.

Table 1

Estimated Prevalence of Select Mental Illnesses

Type of mental illness	Percentage per year	Estimated number of sufferers
Anxiety disorders	19.1	48 million
Major depressive episode	8.4	21 million
PTSD	3.6	9 million
Bipolar disorder	2.8	7 million
Borderline personality disorder	1.4	4 million
Obsessive compulsive disorder	1.2	3 million
Schizophrenia	1	1.5 million

Although there are numerous mental illnesses, the following sections describe the main types of well-known mental illness. Specifically addressed are anxiety disorders, depression as a mood disorder, dementia, and schizophrenia.

Anxiety Disorders. Whereas it is normal to experience periodic anxiety, people with anxiety disorders suffer frequent intense, excessive, and persistent concerns and fears about everyday situations that extend well past the occasional anxieties sustained by most people. Anxiety disorders are characterized by the recurrence of rapid, acute feelings of fear or panic that peak in a matter of minutes. Hyperventilation is common. These unsettling, difficult-to-control, and prolonged feelings of apprehension and panic are disproportionate to any threat that may be looming (Follette & Vijay, 2018). To stop these feelings, individuals with anxiety disorders attempt to avoid situations or locations. Anxiety attacks on this level hamper the accomplishment of daily tasks. The initial signs

may appear in children or teenagers and may last through adulthood. A few examples of anxiety disorders are social phobia, generalized anxiety disorder, and particular phobias.

Depression as a Mood Disorder. Mood disorders are a set of mental illnesses. A mood is a persistent emotion that lasts for longer than 2 weeks (Hagan et al., 2018). In contrast to the typical ups and downs that most people experience, mood disorders are significant abnormalities in the regulation of mood that impinge on a person's emotional affect and behavior. Co-occurring mental and physical diseases are common among those who suffer from mood disorders.

A well-known mood disorder is depression. People with depression experience extreme melancholy regardless of their circumstances. When someone is depressed, their mood causes them to feel so hopeless and dejected that little can be done, outside of professional psychiatric care, to improve their outlook. When depression is severe enough to be classified as a psychiatric disease, medications such as antidepressants are required for treatment (Follette & Vijay, 2009). One in five persons will suffer depression at some point in their lives, and the prevalence of depression among those with intellectual disabilities is noticeably higher. Almost half of the people with depressive disorders also experience anxiety disorders.

Dementia. Dementia can occur at any age but tends to emerge in older adults (Hagan et al., 2018). Dementia is not a single illness; rather, it is a collection of symptoms that adversely impact thinking and social functioning such that well-known daily living skills, which had been learned in the past, become problematic because dementia progresses to mental deterioration that impairs day-to-day activities substantially or totally. A form of dementia is Alzheimer's disease, which along with

other dementias, is frequently linked to long-term, progressive memory loss (Hagan et al., 2018). Compared to the general population, dementia affects those with intellectual disabilities more frequently. For example, people with Down syndrome are more prone to develop Alzheimer's as they age. Yet, in patients with intellectual difficulties, warning signs could appear first as physical deterioration symptoms. Some clients may have trouble speaking, hearing, or seeing. They might spend extended periods of time without moving. Their walk could become altered, and they may experience balance issues and keep falling. Those who have never experienced seizures may begin to do so. Some people find it extremely challenging to master new material when their condition worsens. They grow confused and may not recognize their relatives and caregivers. Extreme anxiety and fear are prevalent during all stages of dementia.

Schizophrenia. Schizophrenia is a term used to describe a variety of rare, but severe, incapacitating psychiatric diseases characterized by detachment from reality, flat affect, irrational thoughts, delusions, and hallucinations (Baranyi et al., 2018). There are some symptoms that many people share, such as hearing voices and talking to oneself, even if not everyone will experience them (Alegría et al., 2021). According to the WHO, some 70 million people currently have schizophrenia (Crane, 2021). 1% of people worldwide are affected by schizophrenia (Perera et al., 2019). Schizophrenia is more common in people with intellectual disabilities than in the general population, and such people are more likely to be admitted to the hospital due to their symptoms. Schizophrenia affects individuals from all areas of life but tends to emerge in young adults and typically manifests between the ages of 15 and 30 (McGuinness et al., 2022).

Although the precise origin of schizophrenia is unknown, it is thought that a mix of genetic, environmental, and neurochemical variables may have an impact (NHS Inform, 2023). Dopamine and other neurotransmitter abnormalities are thought to contribute to the emergence of the illness. Its start may also be influenced by environmental variables like stress levels that are too high, viruses that were exposed to, or problems during pregnancy.

Medication, counseling, and psychological support are frequently used to treat schizophrenia. The main treatment option for schizophrenia is antipsychotic medication, which helps ease or eradicate positive symptoms, including hallucinations and delusions (Burlingame et al., 2020). It is common to utilize both first-generation (typical) and second-generation (atypical) antipsychotics, and the selection of drugs is based on the patient's individual needs and response to therapy (Begemann et al., 2020). Finding the best medication and dosage for people with schizophrenia requires close collaboration with a medical practitioner.

Other forms of mental disorders include bipolar disorder, borderline personality disorder, obsessive-compulsive disorders, panic disorders, and PTSD. Mental illness is often accompanied by widespread occurrences of risky behaviors like drug abuse, self-harm, and suicide.

Etiology of Mental Illness via Trauma

This section includes the argument that mental illnesses are likely to be caused by several factors, a full coverage of which is beyond the scope of this study. This part first briefly addresses genetic inheritance, physical trauma or abnormalities, and psychological factors from sociological and traumatic conditions (Zarse et al., 2019). Because this

research will be primarily focused on the role of trauma in the development of mental illness or the exacerbation of existing mental illness, this part culminates with a lengthy section on the relationship between trauma and mental illness because prison can involve a range of traumatic experiences for a prisoner.

Genetic Inheritance. One factor in the etiology of mental illness is genetic inheritance. This can result in the transmission of mental diseases down family lines, such as depression. If there is a history of mental illness in the family, a family member is more likely to develop that disease. However, it is currently thought that numerous genetic anomalies, rather than just one gene, are linked to various forms of mental disease (APA, n.d.-b). The mental equilibrium of such persons can tip when they experience trauma, whereupon the mental illness can manifest and even overtake them (Hagan et al., 2018).

Physical Trauma or Abnormalities. It is well-recognized that people who have sustained a serious percussive head injury in an accident or head injuries sustained on a regular basis, as in sports that involve percussive contacts, have specific brain and central nervous system damage, which can lead to mental illnesses (Hagan et al., 2018). Brain disorders such as Huntington's chorea can also potentially contribute to mental illnesses. Before birth, a disruption in the early stages of fetal brain development may also lead to autism and other ailments (Bakels et al., 2021). Trauma experienced during childbirth may also affect the brain because trauma alters brain chemistry and normal development (Cainelli et al., 2020). In addition, some mental illnesses are connected to biological elements, such as chemical abnormalities in the brain. For example, neurotransmitters are substances that help nerve cells transmit the electrical impulses across the nervous

system, enabling communication between body parts and brain. Should this equilibrium change, messages across the nervous system are not sent or received correctly, which results in mental illness.

Psychological Factors From Sociological Conditions. A third factor in the etiology of mental illness is psychological, which implicates a large range of influential factors (Cislo & Trestman, 2013). One dimension of psychological factors is sociological conditions. Sociologically, mental illness might be understood as a departure from accepted norms of interpersonal conduct or as an inability to fulfill one's assigned social roles. The process of socialization is the process by which a person adopts the socially and culturally acceptable actions of their group. Socialization is strongly correlated with the formation of personality (APA, n.d.-b). Through socialization, children develop personality and self-awareness as they gain cultural knowledge. Maladaptive behavior patterns or personality traits, and ultimately various mental disorders, may be the result of disturbing or shocking socialization events or the effect of the many cultural and social groups one belongs to (APA, n.d.-b). Mental diseases should be recognized as social issues because they are directly related to elements of society. With the frequency of various types of mental illness, criminality, and drug and alcohol addiction have revealed that maladaptive behavior patterns are more common in poorer urban areas than socially affluent areas. The onset of mental illness in a person frequently has negative effects such as labeling, stigma, humiliation, and guilt. Both socially and financially, mental illness exacts a significant price.

Psychological Factors From Traumatic Conditions. Trauma is another dimension of psychological factors in the etiology of mental illness (Cislo & Trestman,

2013). According to the APA (n.d.-b), trauma is the emotional reaction to a shocking experience. Trauma is defined as an occurrence involving bodily violence, self-injury, or trauma to the person (DeVeaux, 2013). Trauma is referred to as a life-changing event and is frequently interchanged with PTSD.

There are countless events that traumatize, but mental health professionals recognize two main categories of traumatic experiences. Type I trauma stems from damage, pain, or shock caused by an unusual or unexpected incident. Type II trauma stems from injury, pain, or shock induced by shocking events that are anticipated, continuing, or occur many times over a period as per the *DSM-5*.

There are many sources of trauma, which can be psychological, physical, or violent. The loss of a loved one, betrayal, or childhood neglect are all forms of psychological trauma that can have devastating effects on a person's mental state of mind. Domestic abuse, rape, being a victim of a natural disaster, or suffering from serious illnesses or injuries are other sources of violent trauma, which unfortunately are prevalent (Baranyi et al., 2018). Mental illnesses can emerge from the psycho-physical trauma of living with social and environmental ordeals such as poverty, gang-infested areas, hostile or risky environments like war zones, and even regions vulnerable to catastrophic earthquakes and other natural disasters (Lamb & Weinberger, 2020). A child's brain chemistry can be altered by growing up in a dysfunctional family with narcissistic or neglectful parents, with direct or indirect abuse, or with neglect. Chronic exposure to such trauma during childhood can put the brain's chemistry out of balance (Lamb & Weinberger, 2020). Trauma can also occur after a long-distance observation of some formidable event.

All traumatic events are intensely distressing. Whether traumatized by sexual, emotional, or domestic abuse, or even bullying, traumatized persons struggle to come to terms with the residual shocks of their devastating experiences. Trauma results in continual vigilance and fear, which can cause mental disease or exacerbate existing conditions of mental disease.

People react to adversity differently (Baranyi et al., 2018). The victim's closest friends and family may not detect trauma, which emphasizes the value of talking to the victim after a stressful occurrence even if the victim does not display signs of distress initially. Symptoms may start within 1 month of a traumatic event, although in many cases, symptoms do not emerge until years later. The length of time that a person experiences the symptoms of PTSD varies. A traumatized person often has more powerful PTSD symptoms when stressed or confronted with reminders without warning.

Just as trauma has wide range of causes, it also has a wide range of symptoms, which vary in intensity (Mayo Clinic, 2022). Some signs of trauma are common. Traumatized individuals frequently appear disturbed and confused. When speaking, they frequently appear distant or unresponsive and may not respond to conversations as they normally would. Anxiety is another hallmark of a trauma survivor and can include manifestations of trauma-related anxiety including night terrors, jitters, irritability, poor focus, and mood changes (Mayo Clinic, 2022).

Posttraumatic symptoms cause significant impairment in social, work, and family relationships when they interfere with a person's ability to manage their daily activities over longer periods. Whereas symptoms vary from person to person, interference with daily activities is usually one of four main types: intrusive memories, avoidance, negative

changes in thinking and mood, and changes in physical and emotional reactions (Mayo Clinic, 2022). Symptoms of intrusive memories are recurrent and unwanted upsetting memories of the traumatic event, reliving the event in the form of flashbacks, dreams, or nightmares (e.g., children are particularly likely to experience uncontrolled reenactment), and severe physical and emotional reactions to anything that stimulates recollections of the traumatic event. Symptoms of avoidance are conscious efforts to avoid recollections of the traumatic event and avoiding people, places, or activities that trigger upsetting reminiscences. Symptoms of negative changes in thinking and mood are tenacious negativity, hopelessness, detachment, numbness, lack of interest in previous interests, memory problems, and difficulty with social relationships. Symptoms of changes in physical and emotional reactions include being easily startled or frightened, remaining alert and on guard for danger, self-destructive behavior, sleeping trouble, concentration trouble, uncontrolled outbursts, and overpowering feelings of guilt, shame, or both. Trauma symptoms may appear for days, months, or even years following the traumatic occurrence.

Acute Versus Chronic Trauma. Finally, there is the important distinction of trauma as acute or chronic. Acute trauma is defined as a single, isolated traumatic event, such as physical assault, rape, car accident, and terrorist attack (NIMH, n.d.). Acute trauma is frequently linked with short-term PTSD with fewer potentially serious and persistent symptoms (NIMH, n.d.). These are only broad guidelines because every person deals with trauma in a different way (Kira et al., 2014). Chronic trauma is defined as repeated and continuous traumatic incidents (NIMH, n.d.), such as personally enduring ongoing maltreatment from a spouse or family member or witnessing it being forced

upon another family member. Prolonged trauma is generally recognized as having substantial long-term effects on a person's mental and emotional well-being, as well as their potential physical health (Kira et al., 2014). Unlike acute trauma, chronic trauma has been the subject of much research regarding its connection to harmful long-term effects. Examples of persistent, harmful long-term trauma include marital violence, bullying, chronic illnesses, invasive medical treatments for chronic illnesses, homelessness, neglect, and malnutrition or deprivation. Substance abuse and mental illness has a higher prevalence in the homeless community (Kaplan et al., 2019). A mental health issue, poor academic performance, and difficulties with the police as a minor are all more likely in youngsters who have experienced persistent trauma. Chronically traumatized mothers are more likely to experience brain alterations that affect their ability to comprehend empathy and generational trauma (Kira et al., 2014).

It is common to experience trauma after a formidable occurrence. As argued above, the severity and duration of mental disease can range from mild to severe (Hall et al., 2019). Over the course of a person's life, their mental health may change. Some people only need to endure one disease episode before fully recovering, whereas some people experience ill effects periodically or chronically for extended periods (Saha et al., 2020). However, when the residual impacts are so strong that they make it difficult for a person to function normally, the situation requires professional assistance to address the stress and dysfunction brought on by the traumatic incident and return the person to emotional well-being. Thus, commensurate with mental illness itself, treatment is highly variable.

Types of Treatment

This section is based on the underlying assumption that mental diseases and physical ailments ought to be treated equally because the body and the mind complement one another (Dellazizzo et al., 2020). The operation of the body and mind must be understood in tandem. The brain is a distinct organ within the body that is prone to harm, just like every other organ. When the brain is unwell, the condition affects not only the brain, but the rest of the body, too. Health is compromised overall. While around half of all Americans will be diagnosed with some level of mental illness at some point in their lives (NAMI, n.d.-b), not everyone will receive the necessary support.

The NIMH (n.d.) defined mental health services as inpatient treatment or counseling, outpatient treatment or counseling, or prescription medication for problems with emotions, nerves, or mental health. The NIMH (n.d.) statistics estimated that 26.5 million (47.2% of the 57.8 million American adults with AMI) received mental health services in the past year. More females with AMI (51.7%) than males with AMI (40.0%) received mental health services. A lower percentage of young adults with AMI (44.6%, 18–25 years of age) received mental health services than did adults with AMI (48.1%, 26–49 years of age; 47.4%, 50+ years of age).

The NIMH (n.d.) statistics estimated that 9.1 million American adults with SMI (65.4 % of the 14.1 million American adults with SMI; 5.5% of the American adults with SMI dysfunction) received mental health services in the past year. More females with SMI (67.6%) than males with SMI (61.3%) received mental health services. A lower percentage of young adults with SMI (57.9%, 18–25 years of age) received mental health services than adults with SMI (67.0%, 26–49 years of age; 71.0%, 50+ years of age).

Talk therapy, usually called psychotherapy or counseling, is a type of mental disease treatment that entails communication with a qualified therapist or counselor. This treatment represents an attempt to enhance mental health, assist people in understanding and addressing their emotional and psychological challenges, and assist them in creating applicable coping mechanisms.

During talk therapy sessions, individuals express their thoughts, feelings, and behaviors privately and securely (Slavich & Sacher, 2019). The therapist offers encouragement, listens intently, and helps patients understand their issues. Depending on the needs of the patient and the mental health issue being treated, they may employ a variety of therapeutic modalities and procedures. Most of the time, symptom management is successful when talk therapy is combined with medication. Several types of treatment are available for individuals diagnosed with mental illness. Most of the time, symptom management is successful when talk therapy is combined with medication. What works best for one person may not be as effective in providing enough treatment necessary for another person. Individualized treatment is a successful option for some. Others benefit from treatment in a group setting. A support group setting allows individuals to see the successes that others have experienced, opening a doorway for newer individuals to express themselves without fear of criticism. In order for the treatment processes to be effective, individuals have the opportunity to meet with a clinical counselor who can provide psychotherapy. Psychotherapy allows individuals to deeply explore their feelings, emotions, and behaviors (e.g., changes in mood, social withdrawal, changes in sleep patterns, changes in appetite, agitation or restlessness, impaired thinking or concentration, self-harm or suicidal tendencies, substance abuse)

linked to them, allowing individuals to find a better way of dealing with recognized and unrecognized trauma (Rasmussen et al., 2007).

Psychotherapy can be enhanced by medication, case management, and self-investment. The combination of psychotherapy and medication has strong outcomes for successful management of mental illnesses (APA, n.d.-b; NIMH, n.d.). Medication does not cure mental illness; it helps by mitigating symptoms. Additionally, for individuals with mental illness, a case manager would be another important element of treatment. A case manager can help develop plans and strategies to facilitate recovery. To see results, an individual needs to formulate and implement a self-help plan. The individual with the mental illness is the most crucial component of the plan. The individual must recognize, address and admit to their mental illness and hold themselves accountable.

The social structures impacting family, employment, income assistance, and medical care have a substantial impact on an individual's ability to manage their mental illness effectively (Lamb & Weinberger, 2020). The U.S. government does not provide free or inexpensive mental healthcare, so many people struggle to pay for care (Dvoskin et al., 2020). Mental healthcare in the United States can be expensive, and many people face challenges in accessing affordable care (Alegría et al., 2021). While some government-funded mental health services and programs are available, such as Medicaid and the Children's Health Insurance Program (CHIP), they may have eligibility requirements and limitations.

Another reason why mental health conditions go undiagnosed and untreated is misunderstanding. It might be daunting for people with intellectual disabilities to talk about their unusual experiences; for example, individuals with intellectual disabilities

may struggle to express themselves or comprehend complicated language verbally. As a result, communication may become more difficult, which may cause frustration or dependence on alternative communication tools such as sign language or augmentative and alternative communication (AAC) systems.

Cognitive capacities are frequently limited in people with intellectual disabilities, impacting learning and academic success (Zarse et al., 2019). It is common for people with intellectual disabilities to have difficulties with reading, writing, understanding basic math, and solving problems.

Some people with intellectual disabilities may have trouble interacting with others. They could struggle to establish friendships, comprehend social cues, or exhibit acceptable social behavior. Feelings of loneliness or trouble integrating into social situations may result from this.

Sensitivity to sensory inputs like sound, light, touch, or textures may be increased or decreased in people with intellectual disabilities. As a result, individuals may feel sensory overload or engage in sensory-seeking activities, intentionally seeking out particular sensory stimuli. People with intellectual disabilities may also struggle with executive functions, which include self-control, organization, and planning ability (Zarse et al., 2019). They might have trouble organizing, managing their time, making decisions, or controlling their impulses. Autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), anxiety disorders, and mood disorders are co-occurring mental health illnesses that may be more common in people with intellectual disability. These ailments may also affect how they live and feel if they struggle to

articulate or to understand their thinking and behavior differences because of their mental illnesses.

Medical experts rely on data gathered from client interviews to identify psychiatric disease. Clients with intellectual disabilities might not possess the language or memory ability required to convey what has happened (Dellazizzo et al., 2020). They may not recognize that their symptoms reflect mental illness. They may not understand that they can or should treat their mental health issues. Some patients could be uncertain whether their experiences are normal because they have had little opportunity to interact with others. People may neglect their mental illness symptoms. Untreated illnesses can worsen and cause a sense of disconnection from reality in sufferers, significantly impacting their capacity to make decisions.

A third reason why mental health conditions go undiagnosed and untreated is stigma often viewed as a sign of disgrace. It is a strong motive behind failing to seek treatment for mental illness (NIMH, n.d.). The stigma surrounding mental illness prevents many people from discussing personal experiences with amazing thoughts, unexplained hopelessness, or intense despair. Many people are reluctant and embarrassed to ask for assistance due to the stigma attached to mental illness, so many people hide their symptoms and forgo getting the necessary help (NIMH, n.d.). Even if there has been a significant advancement in the acceptance and comprehension of mental illnesses, there is still room for improvement. Despite the reality that it is common and may affect anyone, mental illness remains strongly associated with stigma (NIMH, n.d.).

The previous discussion included the argument that trauma can cause a person to develop a mental illness, or it can exacerbate an existing condition. The following section includes the argument that few ways of living are more traumatic than prison.

Prison

Over 1 million inmates serve prison sentences in U.S. prisons annually (Vito & Maahs, 2021). A prison is a social institution where criminals are held to serve their sentences after being convicted of one or more crimes. There are two main types of prisons: juvenile and adult prisons. Juvenile prisons, also known as juvenile homes, are social institutions where minors under the age of 18 are held after being found guilty of criminal behavior. Adult prisons are correctional facilities for offenders 18 years of age and older (Agnew, 2015). This proposed study will be focused on inmates in adult prisons. An inmate or prisoner is a person confined to an institution such as a detention center, jail, or prison. The time they spend imprisoned is their sentence.

This section on prisons is presented in five parts. The first part address types of crimes and lengths of related sentences. The second part provides definitions of prisons versus jails and detention centers. The third part describes security levels of prison. The fourth part describes life inside prison. The final part provides recidivism statistics.

Types of Crimes and Lengths of Related Sentences

In the United States, crimes can be classified as either federal or state offenses, with federal crimes frequently being the most serious offenses. These include capital felonies, encompassing heinous crimes such as rape, murder, substantial child abuse, and human trafficking. The penalties for such offenses may be incredibly harsh. Capital offenses can result in a death sentence or a life sentence without the possibility of parole.

While the punishment for these crimes varies from state to state, felonies are divided into five classes based on their seriousness. The most serious crimes are classified as Class A felonies, which entail the harshest punishments. Depending on the state, this class may result in the death penalty or even life in prison. Even though a Class B felony is a little less serious, it still carries a maximum sentence of more than 25 years. Class C felonies are punishable by a 10- to 25-year prison term, while Class D felonies are punishable by a 5- to 10-year sentence. Class E felonies are at the least serious end of the felony spectrum, typically carrying a maximum fine of $100,000 and a sentence of up to 1 year in jail. The seriousness of the offense—Class A crimes are the most serious and Class E crimes are the least serious—generally determines the severity of the punishment.

Table 2 shows the most recent crime statistics from the Federal Bureau of Prisons (FBOP, n.d.-a) listed in descending magnitude of occurrence. Nearly half of the crimes were related to drug offenses, while about one in five crimes involved weapons, explosives, or arson. Just over 10% involved sex offenses and less than 5% of the crimes that occurred involved homicides and robberies.

Table 2

FBOP Offense Statistics as of March 2023

Crime type	Number of crimes	Percentage
Drug offenses	66,125	44.80
Weapons, explosives, arson	31,961	21.60
Sex offenses	17,676	12.00
Immigration	7,592	5.10
Burglary, larceny, property offenses	7,182	4.80
Extortion, fraud, bribery	6,476	4.20
Homicide, aggravated assault, and kidnapping offenses	4,748	3.20
Robbery	4,033	2.70
Miscellaneous	814	0.60

Crime type	Number of crimes	Percentage
Courts or corrections	603	0.40
Continuing criminal enterprise	247	0.30
Banking and insurance, counterfeit, embezzlement	207	0.20
National security	45	0.10
TOTAL	147,709	100.00

Sentences are prison terms or the period that an offender spends in prison. Sentencing depends on criminal severity and related characteristics. For instance, criminals who commit felonies spend more time than those who commit misdemeanors or less serious crimes. However, too many factors go into determining the length of a sentence to be summarized here.

Definitions of Prisons Versus Jails and Detention Centers

Detention centers, jails, and prisons serve different purposes (FBOP, n.d.-b). Specifically, they are designed to hold inmates for sentences of different lengths, which are related to crimes of varying severity. A detention center is designed for pretrial confinement. They have the primary goals of education and rehabilitation so that offenders can rejoin society as productive citizens (Vito & Maahs, 2021). Jails are used for housing inmates for short periods, as in temporary confinement and as holding facilities, and are intended to house people who are either awaiting trial or serving a brief sentence. Jails exist primarily to hold inmates until their cases are decided (Vito & Maahs, 2021). However, prisoners of detention centers and jails are often housed together. When minor sentences are served consecutively, it is possible to spend longer than a year in jail because misdemeanor convictions are frequently considered “light” in comparison to felonies. Jails are usually operated by local law enforcement via city and county governments. Jail programs include work release and boot camps; some jails even

provide educational, drug abuse, and employment-related programs. In addition to helping inmates change their lives for the better to reduce the chances of returning to jail or prison (i.e., recidivating), many of these programs also offer the advantage of keeping the offenders busy and reducing the likelihood that they will cause issues for the jail staff (Wymore & Raber, 2021).

In contrast to jails, prisons are built to house people who have been found guilty of more serious crimes, including felonies. They are typically used for housing inmates who have sentences greater than 1 year and therefore prisons have a much larger holding capacity than jails (Narvey et al., 2021). Prisons are generally operated by state and federal governments, although some are privately owned (Narvey et al., 2021). Depending on their degree of confinement, offenders can choose from a variety of prison programs. Halfway houses, job release programs, and community restitution centers are examples of programs in minimum and medium security prisons. The majority of those who qualify for these programs are serving out their sentences. Inmates do not have the ability to choose the type of prison where they will serve their sentence but must learn to live with the constraints of its particular level of security. Thus, any type of incarceration could impose short- and long-term impacts on prisoners who may need ongoing health care.

Security Levels of Prison

According to the FBOP (n.d.-b), there are distinct levels of prison security: minimum, low, medium, and high. As of March 2023, U.S. inmates were housed in low- (35.5%), medium- (33.9%), or high- (12.5%) security prisons (see Table 3).

Table 3

FBOP Statistics: March 2023

Security level	Number of inmates	Percentage of inmates
Minimum	22,956	14.5
Low	56,210	35.5
Medium	53,701	33.9
High	19,826	12.5
Unclassified	5,776	3.6

The security levels of prisons that are briefly described below refer to prisons housing male inmates. The security of men's and women's prisons show fundamental differences related to the fact that women inmates tend to commit less severe crimes and behave with less violence than do male inmates. Prisons designed to house male inmates tend to have more severe security levels than those housing female inmates in terms of staff, but also in terms of the buildings themselves. Men's prisons have extra tall walls, tall watch towers, barbed wire fencing, and other serious security measures. In contrast, these types of high-level security measures are often absent at women's prisons (FBOP, n.d.-b). Prisons have different levels of security for people who have been found guilty of a crime based on their sentence and who they are. Inmates in less-secure prisons will have different requirements for selection compared to those serving longer sentences for violent crimes. Inmates who are disruptive, violent, prone to escaping, have physical or mental illness, or are young, among other factors, are often placed in separate or special prisons (Andersen, 2004).

Minimum-Security Prisons. Minimum-security prisons usually house inmates convicted of nonviolent crimes such as embezzlement or fraud. Though serious, crimes of

this nature are not violent. Therefore, perpetrators are not considered to be a risk for becoming violent. Because they are not considered dangerous and, moreover, are trusted to complete their sentences without attempting to escape (FBOP, n.d.-b), these facilities or camps tend to have fewer security barriers and prison staff tends to be at a minimum. Thus, prisoners in minimum-security prisons have the most freedom because minimum-security prisons impose the lowest levels of restrictions on prisoners' movements and activities (FBOP, n.d.-b). Inmates housed in minimum-security prisons usually serve prison sentences of up to an approximate maximum of 10 years. Thus, minimum-security prison could pose short- and long-term impacts on prisoners who may need ongoing mental health care.

Low-Security Prisons. A low-security prison in the federal system houses low-security federal prisoners (FBOP, n.d.-b). The major difference between a minimum-security prison and a low-security prison is that the former has double-fenced perimeters, electronic detection systems, and increased staffing. The inmate-to-staff ratio is also higher than in minimum-security prisons, but lower than in medium-security prisons. Federal inmates sentenced to low-security prisons represent all backgrounds and crime categories, ranging from drug offenders to white-collar offenders. In low-security facilities, where the level of supervision and restrictions is lower than in medium- or high-security prisons, where sex offenders and higher risk inmates are typically housed. Prisoners at a low-security federal prison may have a history of violence, but those caught fighting, drinking, using drugs, or committing other serious infractions are transferred to medium-security federal prisons. Therefore, low-security federal prisons are relatively safe, with minimal gang involvement and violence. Inmates designated to

or transferred to these institutions may wait several months for placement (Vito & Maahs, 2021). While overcrowded, these facilities offer a boisterous, but relatively relaxed atmosphere (Drucker, 2011).

Several physical and psychological disadvantages that could exert short- and long-term impacts on prisoners who may need ongoing mental health care. Low-security prisons tend to be crowded. Due to overcrowding, prisoners have been subject to minimal subsistence and rehabilitation services (Edgemon & Clay-Warner, 2019). Inmates are primarily housed in dormitories or cubicles. Significant disadvantages are lack of bed space, communal bathrooms, communal shower facilities, and therefore, no privacy to limited privacy. Low-security prisons typically house inmates who are serving a minimum of a 20-year sentence. Thus, negative impacts on mental health could be long-term.

Medium-Security Prisons. As the levels of incarceration increase, so does the level of security, the physical structures that house inmates, surveillance, and limits on inmate movements within the facility (Vito & Maahs, 2021). Medium-security prisons are designated to house inmates who can be relatively trustworthy in open conditions and who pose less danger than do maximum-security prisoners in case they escape; they may or may not have a history of violence. Outside, medium-security prisons have reinforced perimeters strengthened with electronic detection systems and double fencing. Inside, they have a higher staff-to-inmate ratio than do low-security prisons, along with greater internal controls. Medium-security prison guards are armed; there is more restriction of movement meted out according to the severity of the offense (Vito & Maahs, 2021). Inmates are housed in cells rather than dorms, but otherwise medium-security facilities

tend to allow for more movement within the facilities. Medium-security prisons provide a variety of work and treatment programs; medium-security prisoners are expected to work, attend educational programs, or participate in other activities that prepare them for release (Bradley, 2021). Nonetheless, medium-security confinement could create short- and long-term impacts on prisoners who may need ongoing health care.

High-Security Prisons. This is incarceration at its highest level. Also known as maximum-custody prisons, these most secure or maximum-security facilities are designed to house the most violent offenders: prisoners who are considered dangerous, disruptive, or likely to try to escape. More recently, "supermax" prisons are designed to provide custody levels beyond maximum security for particularly treacherous inmates. At supermax prisons, there tends to be higher rates of psychological distress (Edgemon & Clay-Warner, 2019). These include terrorists or political prisoners who have been deemed a threat to national security, inmates from other prisons with a history of violent or disruptive behavior, and inmates suspected of or known to have affiliations with malicious gangs. High-security prisons house large populations of violent offenders. Violations include drug trafficking, domestic violence, manslaughter, and homicide. Designed to hold violent prisoners securely, high-security prisons are fortified with multiple barriers of barbed wire fences and have gun towers operated by armed officers 24 hours a day. Depending on the inmate's level of custody, as aforementioned, inmates can be housed alone in individual cells and kept in lockdown, often longer than 23 hours per day, or allowed 1 hour of outdoor exercise per day, alone. Meals are served through small holes in cell doors. Normally, inmates are not permitted any contact with other inmates and are under constant surveillance via closed-circuit television cameras. Such

stringent constraints on social interaction could easily create short- and long-term impacts on prisoners who may need ongoing health care and on prisoners who did not need mental health care before incarceration.

Typically, when prisoners are received into a particular prison system, their physical and mental health condition is carefully evaluated, after which they are placed in their designated prison custody level of classification. The placement security level is indirectly correlated with the inmate's quality of life: The lower the classification level of the inmate, the higher the quality of life. In other words, quality of prison life is inversely related to sentencing because the quality of life tends to decrease as the length of confinement increases. Thus, quality of life plays a major role in the welfare of each prisoner, as well as for their health. As a result, each prisoner's classification has an enormous impact on their everyday existence. The next part broadly portrays the realities of incarceration.

Life Inside Prison

This section depicts life behind bars. Life inside a prison is being forced to fit into an environment where inmates are dehumanized to control them, receive no compassion, encounter little to no privacy, and are not allowed to touch other people or even to show feelings.

Control is paramount. Each prison has its own set of laws and procedures that must be followed. Prison rules dictate how inmates are expected to think, behave, and communicate with one another. When a person enters prison, they are put under scrutiny, the intensity of scrutiny and monitoring increases with the security level of the prison. Inmates must conform their thoughts and behaviors to the prison's regulations to stay out

of trouble and perhaps cut time from their sentence for good behavior. Alternatively, if a person who is incarcerated violates prison rules and regulations, they are punished according to protocols, but still required to conform to the regulations of the judicial system. Prison rules dictate how to act and think for the length of a prison sentence. The environment created by prison rules could exert short- and long-term impacts on prisoners who may need ongoing health care and on prisoners who did not initially need it.

Many prisoners adjust. That is, many prisoners show a shift in compliance to strict (written) prison rules and (unwritten) prison expectations in a process called *institutionalization*, which is the shift in behavior and development that an inmate undergoes in prison (Wymore & Raber, 2021). The longer a person is incarcerated, the more profoundly they change their ways and thinking. Prisoners are often said to have institutionalized themselves. Thus, this could happen gradually or after a string of arguments or reprimands. Both scenarios are possible.

Prison inmates have more freedom than jail inmates, taking the security level into account (Wymore & Raber, 2021). The range of access to activities varies depending upon the prison (Chadick et al., 2018). A person who is incarcerated in prison can further their education by getting a general education diploma (GED), expand any professional aspirations with access to a limited number of jobs, and are allotted time outdoors (Cislo & Trestman, 2013; FBOP, n.d.-b).

Whether institutionalization, the reliable daily reality of life behind bars, or other psychological features of imprisonment explain why so many prisoners complete their

sentences only to return to prison again remains to be established. However, recidivism is likely.

Recidivism Statistics

Recidivism is defined as a criminal act that leads to a person being rearrested, found guilty, and sentenced again (Vito & Maahs, 2021). Reoffenders are often confined locally rather than returned to prison (Farabee et al., 2019). Recidivism rates are key indicators of how well the country's criminal justice system is operating and how well inmates respond to prison programs designed to reduce recidivism. Table 4 shows key findings from a recent (Durose et al., 2014) study released in July 2010 indicating that over time, recidivism increased.

Table 4

Reconviction and Reimprisonment Rates 2005–2010

Time frame	Reconviction	Reimprisonment
6 months	13%	10%
1 year	23%	17%
2 years	36%	29%
3 years	45%	36%
4 years	51%	41%
5 years	55%	45%

An individual's chances of recidivating are related to numerous variables. This includes a person's pre-incarceration situation, events that occurred while they were incarcerated, their social environment, and the nature of their community (D. Wallace & Wang, 2020). Recidivism is also related in a person's capacity to reintegrate into society, the inability of which, arguably, has the most influence. Many recently released ex-

offenders struggle to obtain employment, reestablish relationships with loved ones, and resume normal daily activities that do not involve criminal behavior (D. Wallace & Wang, 2020). Additional problems arise after being sent to prison. The most common experiences are feeling judged and treated unfairly because of having a criminal record. People who were previously in prison are often seen as dangerous and untrustworthy. Discrimination can make it harder for them to get a job and earn enough money. This can lead to problems like not having a safe place to live and might make them turn to crime and drugs again (Baćak et al., 2019).

Recidivism impacts everyone, including the criminal, crime victims, the police, the community at large, and taxpayers. Recidivism plays a significant role in countless discussions about crime rates by nation, the severity of jail sentences, and whether social programs that teach and help instead of punishing offenders are better long-term solutions than prisons. Societies with greater rates of recidivism frequently have more people incarcerated as a result, which increases the tax burden on the local governments and taxpayers. Recidivism rates are claimed to be as high as 50% globally and do not appear to have decreased in recent years, despite wide variations in these rates (D. Wallace & Wang, 2020). One of the many questions behind high rates of recidivism is why offenders choose to go back to jail when the connections between mental illness and incarceration are so strong.

Connections Between Mental Illness and Prison

Prison is big business. In 2020, there were more than 1.2 million people in prison. That same year, state governments spent a combined $55 billion on corrections, most of which went to operating state-run prisons, including correctional officers' salaries and

benefits. Although the annual average of $37,499 spent per adult in federal custody must be multiplied by the number of years of their sentence, annual housing costs per prisoner vary considerably per state. The minimum was $18,000 per prisoner in Mississippi, while the maximum was $135,978 per prisoner in Wyoming. The number of prisoners per 100,000 residents of a state is the prison's incarceration rate. Alaska has the highest incarceration rate at 625 per 100,000 residents. Mississippi has the second highest prisoner incarceration rate at 594 prisoners per 100,000 residents. As a region, the South has the highest incarceration rate at 424 prisoners per 100,000 residents. In contrast, the region with the lowest prison incarceration rate was the Northeast, at 185 prisoners per 100,000 residents.

This section on the connections between mental illnesses and prison is presented in four parts. The first part provides statistics on the percentage of incarcerated people with mental illnesses. The second part describes living conditions in prison that could create mental illnesses and that could exacerbate existing mental illnesses. The third part describes prison mental illness services. The fourth and final part provides statistics on the availability of therapists and counselors.

Statistics on the Percentage of Incarcerated People with Mental Illnesses

Researchers have repeatedly examined the link between incarceration and mental health. Despite this fact, there is more misunderstanding of the relationship between mental illness and criminality than understanding (Alarid & Rubin, 2018).

When two out of three inmates could use help, the relationship between mental illness and criminality is undeniable. According to the APA (n.d.-b), 64% of incarcerated individuals suffer from various mental disorders. Although there are estimates of 10–25%

of incarcerated individuals suffering from an SMI such as schizophrenia, many inmates suffer from lesser psychological health disorders. Prisoners with SMIs are disproportionally represented in prison with around 1 in 4 likely to have an SMI (Hedden et al., 2021). Many inmates suffer from a mental condition between the least and most severe of mental illnesses: PTSD. More than half of the people in prison have a mental disability, while only 11% of the general population do. Furthermore, it was shown that the United States. State and county prisons have 10 times more people with mental illnesses as compared to state mental hospitals (Baloch & Jennings, 2018).

To place the statistics into perspective, an estimated 22% of American adults suffer from a mental illness (NIMH, n.d.). Comparatively, an estimated quarter to half of prisoners had a history with mental illness that they could conceivably bring to their life in prison. The NAMI (n.d.-b) estimated that between a third and a half of incarcerated persons in America's jails and prisons have a history of mental illness (37% in state or federal prisons and 44% in in local jails). An intensive review of 18,185 records of incarcerated persons showed that of quarter of them (26%) were diagnosed with a mental health condition at some point before incarceration (Reingle Gonzalez & Connell, 2014). Such studies provide strong evidence of the connection between criminality and mental illness (Carr et al., 2021).

Problems with one's mental health and drug abuse frequently go hand in hand (Morin, 2021). Drug abuse and alcohol abuse are prevalent among incarcerated individuals in the United States (Henry, 2020). Drug abuse, although not a form of mental illness, is common among those who are incarcerated. Among persons who are incarcerated in the United States, about a third (32.6%) exhibited alcohol abuse and

nearly half (43.6%) exhibited substance abuse the year before their incarceration (Henry, 2020). While there is no single cause of mental illness, numerous factors, such as childhood trauma, chronic medical conditions, biological factors, isolation, or the use of narcotics and alcohol can contribute to mental illness (Centers for Disease Control and Prevention [CDC], 2021).

Given men's higher tolerance for risky behaviors, the fact that the connection between criminal behavior, incarceration, and mental illness is more frequent among women than among men spotlights the role of mental illness. In the United States, problems with mental health affect a higher proportion of incarcerated women than incarcerated men (FBOP, n.d.-b). Compared to the general population and the proportion by gender among the incarcerated population, the percentage of incarcerated women suffering from mental health conditions comorbid with drug addiction is also significantly higher than it is among incarcerated men (Henry, 2020). In addition, women prisoners experience not only many more negative experiences than men, but also experience many more prison-inflicted traumas than do men (Henry, 2020; NAMI, n.d.-b). Nearly half (46.7%) of incarcerated women reported being victims of physical assault compared to just (12.6%) incarcerated men. About a quarter (27%) of incarcerated women reported having experienced multiple sexual assaults compared to a fraction (3.7%) of incarcerated men (Henry, 2020).

Moreover, Henry (2020) substantiated the hypothesis that a "pipeline" leads from abuse to incarceration: Women incarcerated in the United States are more likely to have been abuse victims or experienced some other form of traumatic event in their lives before incarceration. A sample of 183 incarcerated women, who filled out a questionnaire

regarding their experiences with trauma and its impact their mental condition, reported that they had a high rate of juvenile poly-victimization, which was strongly associated with nervousness, PTSD, misery, and suicidal thoughts. This earlier experience with trauma puts such women at a higher risk of developing mental illnesses, and possibility making them more susceptible to criminal behavior (Henry, 2020). The study provided further evidence that traumatic experiences and mental illnesses are more prevalent in women, which reinforces the proposal that women are at a higher risk of developing further mental illnesses and possibility making them more susceptible to criminal behavior. These statistics establish America's jails and prisons as de-facto mental healthcare providers (NAMI, n.d.-b). The question, addressed in the next part, is whether America's jails and prisons are up to the task.

Living Conditions in Prison That Could Cause Mental Illness or Exacerbate Existing Mental Illness

This section addresses the prison living conditions that could cause mental illness to develop or serve to exacerbate existing mental illness. Little is understood about how incarceration itself and its commensurate exposure to shocking events could or does contribute to mental illness. This part is not intended to provide a complete treatise, which is beyond the scope of this chapter, but instead serves as an attempt to draw important connections between possibilities of prison as cause and mental illness as effect.

For all prison inmates, prison is monotonous captivity that eventually stretches from weeks to years of unstimulating confinement. According to participants in a 2003

study of convicts in England, a lack of physical and mental stimulation caused frustration that developed into extreme stress and wrath (Hall et al., 2019).

People who enter prison with preexisting mental health issues may appear to react normally when they are placed in a correctional institution, making it difficult for prison staff to recognize the problems and inadvertently forcing the afflicted individuals to suffer in silence (Morin, 2021). People who enter prison with preexisting mental health issues may face additional challenges to navigating life in a jail or prison (NAMI, n.d.-b). Behaviors related to their symptoms can put them at risk for suffering the consequences of violating facility rules; such consequences range from being barred from participating in prison programs to solitary confinement. In solitary confinement, one may be isolated for 22–24 hours a day which can lead to sensory deprivation and physical idleness. Prisons use isolation as a means of punishment; however, isolation is also used as a way of keeping general population prisoners safe from those who may cause harm to other prisoners (Brinkley-Rubinstein et al., 2019). Though there are minimal psychological affects resulting from solitary confinement to prisoners confined in general, it is clear that prisoners should be monitored for mental health decomposition (Chadick et al., 2018).

Several realities of prison life could exacerbate existing mental illness or cause mental illness to develop. Many are related to inmates' patent lack of power and control over their environment (Cislo & Trestman, 2013). There is the lack of privacy, cramped quarters, and continual surveillance as well as frequent exposure to violence and overcrowding alternated with isolation (Hall et al., 2019). Necessarily, there is restriction of physical movement and personal choices. Inmates are housed in a confined space with closely circumscribed opportunities to exercise. There can be constant exposure to

hostility, both from other inmates and prison staff, creating great risk of becoming a victim of crime and violent assault inside prison. Incarcerated people are at risk of developing post incarceration syndrome (PICS), especially those subject to lengthy isolation and abuse (Lund, 2021).

There is isolation from society as one knew society before going to prison. Social relationships with family members and other loved ones usually erode during incarceration. Separation from friends and relatives is a significant source of stress for prisoners. Many interviewed inmates said that separation is the hardest part of being imprisoned (Quandt & Jones, 2021). The jail setting makes it more difficult for inmates to bond, even when family members visit them. The interaction between prisoners, their families, and children is necessarily impacted by the fact that security is the top priority when planning and operating correctional facilities. Evaluating the association between mental diseases and conditions in all prisons, those imprisoned more than 50 miles from home were even more likely to experience despair.

Even if they successfully institutionalize by shifting their behavior to adjust to prison life (Wymore & Raber, 2021), individuals who are incarcerated respond to the restrictions and powerlessness of incarceration in many ways, few of which are optimistic or healthy. Persons who are incarcerated have little to no influence over their daily routines, unable to choose when they wake up, when and what they eat, which occupations fill their days, and whether they have access to exercise and recreation (Lamb & Weinberger, 2020). Loss of autonomy and control in the absence of what is perceived as adequate compensation is detrimental to a person’s mental health because it compounds feelings of powerlessness. For countless inmates, life loses meaning and

purpose. Not only does a lack of meaning and purpose increase negative emotions such as anxiety and melancholy; it also gives rise to the far greater darkness of hopelessness (Lamb & Weinberger, 2020).

On top of powerlessness, many inmates develop feelings of isolation and shame in response to the provocations of living forcibly in stressful environments. Compared to members of the public at large, many incarcerated individuals become deeply dissatisfied with life, which often leads to mood disorders such as severe depression or suicide ideation (Quandt & Jones, 2021). Incarceration is linked to an increased number of deaths by overdose (Pearl & Perez, 2018), perhaps prompting the FBOP webmaster to prominently display suicide prevention text on its page on mental health services. When one learns that there are three times as many persons with extreme psychological conditions incarcerated in the United States as there are in psychiatric facilities, one is not particularly surprised.

Whether or not an inmate is mentally fit or mentally ill, many have experienced traumatic abuse before incarceration. These abusive experiences may lower the threshold of sensitivity to trauma and create a greater susceptibility to the harrowing challenges of prison. Traumatic events could be physical, mental, psychological, sexual, spiritual, verbal, or even financial in nature. Evidence suggests many older adults in prison have suffered more traumatic experiences prior to imprisonment (Maschi et al., 2015), which can be categorized as stress, grief, and trauma. At the core of these, the one inherent aspect which overlaps with each is the loss of control and power. The traumatized individual not only lost their control and power over the traumatic event; they also lost control of their emotions about it. This strikes a chord for the many incarcerated

individuals who have seen or experienced traumatic events firsthand that were so overwhelming that they have caused them to either give up total control or give power to something or someone, greatly affecting their life negatively.

In counterpoint, a traumatic occurrence does not significantly contribute to the diagnosis of PTSD. Instead, the reappearance of symptoms would ultimately lead to a diagnosis, claiming that the aftereffects of a traumatic event can only be identified when an individual is completely overcome by an experience. There is a high probability that various persons will interpret a single occurrence otherwise (Follette & Vijay, 2009). Following release among the previously imprisoned, the traumatic experience of incarceration is expected to have both positive and negative psychological effects, similar to the understanding that military captives have upon returning home. There is a high risk of death after incarceration (Brinkley-Rubinstein et al., 2019).

Finally, even after serving their sentences, many people continue to experience the emotional impacts of incarceration. The emotional impact does not end with the prisoner, the collateral effects of mass incarceration also effect individual families and entire communities (Bowleg, 2020). This could cause PICS, a mental sickness similar to PTSD (Hall et al., 2019).

Mental Health Care in Prisons

The connections between mental illness and prison suggest that it is financially sound and ethically important to give prisoners with unique medical and mental health care issues the special care they need. The presence of the help they need could affect their long-term health positively. while the absence of the help they need is likely to impact their long-term health negatively.

The NAMI (n.d.-b) recommended that prisoners with mental illness have access to appropriate mental health treatment, which includes regular and timely screenings, regular and timely access to mental health providers, and access to medications and programs that support their recovery. Some prisons have gone as far as creating mental health units to treat prisoners who suffer with severe mental illness (Cohen et al., 2020). The classifications of prisoners by medical and mental healthcare provide prisoners with additional care to support their health care needs, but do not provide definitions. Table 5 lists the numbers and percentages of male and female inmates at each level of mental healthcare (with the 1 being less severe to 4 as most severe) as of January 2023 (FBOP, n.d.-a).

Table 5

Numbers and Percentages of Inmates in Mental Health Care in 2023

Mental healthcare level	Men	Women	Total
1	100,856 (65%)	6,721 (4%)	107,577 (69%)
2	40,616 (26%)	3,629 (2%)	44,245 (28%)
3	2,658 (2%)	307 (0.2%)	2,965 (2%)
4	1,236 (1%)	108 (0.07%)	1,344 (0.9%)

The provision of care depends on inmate needs, a prison's willingness to provide for inmate needs, its ability to financially provide for inmate needs, and ultimately on its stakeholders' political will. Many prisons' healthcare systems have long been criticized as being insufficient, underfunded, and understaffed, and many inmates have suffered abuse and neglect at the hands of the prison medical staff who are responsible for providing for them. A decade ago, medical facilities in prisons varied on the extent to which they

provided primary care, dental care, substance abuse treatment, and mental health services (Cislo & Trestman, 2013). Whereas the level of security in which the inmate is housed correlates directly with prisoner behavior, there are not enough resources available to ensure that inmates with mental illnesses receive treatment while incarcerated. For example, the NAMI (n.d.-b) estimated that almost two thirds (63%) of persons with a history of mental illness incarcerated in state and federal prisons do not receive treatment for their mental illnesses while incarcerated. Over a decade ago, in the United States, a million incarcerated people suffered from mental illness without any assistance or treatment for their conditions. It is also challenging for incarcerated persons with a history of mental illness to remain on any pre-incarceration pharmaceutical regimens. Half of the persons who were taking medication for mental health conditions upon incarceration failed to receive their medication once in prison. The suffering of people who have mental illnesses and the suffering of their families is made much worse when mental health care is inadequate.

About one in five (18%) inmates who had been diagnosed with a mental health condition were taking medication for it on admission to prison (Reingle Gonzalez & Connell, 2014). Once in prison, more than 50% of them did not receive the previous medical treatment by means of drugs (pharmacotherapy). Inmates with SMIs such as schizophrenia were more likely to receive pharmacotherapy, as compared with those presenting with less overt AMI conditions such as depression. Lack of treatment continuity was partially explained by screening procedures that did not result in treatment by a medical professional in prison.

Health services inside prison have ramifications for life outside of prison. Whereas inmates with the most serious mental disorders re-offend or recidivate at unusually high rates when compared to the unafflicted prison population, recidivism rates among offenders with mental illness who received treatment were lower than among offenders who did not. Persons with mental illnesses who are arrested for criminal activity alternate between criminal justice and mental health systems at disproportionately high rates. Moreover, separate criminal justice and mental health databases create challenges in tracking recidivism. However, compared the recidivism outcomes of 102 inmates diagnosed with mental illness and found that some prison programs reduce recidivism. One group had a diagnosed mental illness (n = 58). The other group was diagnosed with comorbidity mental illness and substance abuse (n = 44). Both groups voluntarily stabilized on medication, engaged in a diversion program, and reported to their assigned community-based outpatient mental health clinic. Although mental illness, alcohol abuse, and substance abuse put individuals who are recently released from prison at a 129% greater chance of death than the general population (Pearl & Perez, 2018), the follow-up regime reduced recidivism in both groups, with fewer rearrests and fewer days in jail in the following year.

Treatment for mental illness such as utilization of outpatient mental health services reduces recidivism. Treatment for mental illness while incarcerated is financially and ethically reasonable. Yet, treatment for prisoners with mental illnesses also depends on the availability of therapists and counselors.

Statistics on the Availability of Therapists and Counselors

This section presents dichotomous statistics on the availability of therapists and counselors serving prison populations to address the availability of professional assistance with mental health issues. One view is that help is plentiful and available, while the other view is that help is inadequate.

The view that help is plentiful and available comes from the prison system, which claims that all is well. For example, the FBOP (n.d.-a) website contains the following reassurances:

> The Bureau provides a full range of mental health treatment through staff psychologists and psychiatrists. The Bureau also provides forensic services to the courts, including a range of evaluative mental health studies outlined in federal statutes. Psychologists are available for formal counseling and treatment on an individual or group basis. In addition, staff in an inmate's housing unit are available for informal counseling. Services available through the institution are enhanced by contract services from the community.
>
> The Bureau's professional staff provides essential medical, dental, and mental health (psychiatric) services in a manner consistent with accepted community standards for a correctional environment. The Bureau uses licensed and credentialed health care providers in its ambulatory care units, which are supported by community consultants and specialists. For inmates with chronic or acute medical conditions, the Bureau operates several medical referral centers providing advanced care. (FBOP, n.d.-a, para.1)

However, the primary follow-through information on the above quote pertains to suicide prevention. No more information could be located on the four levels of mental health care provided to inmates.

The view that help is inadequate comes from other sources. For example, inmates often complete simple screening questionnaires upon admission without concurrent evaluation by a mental health professional. Correspondingly, another suggestion of inadequacy stems from claims that the mental health needs of incarcerated persons are frequently ignored (NAMI, n.d.-b). In most prisons, specialized medical care is rare, and related to efforts to conserve prison financial resources. Inmates' medications are frequently denied because of the high cost of medications (Kira et al., 2014). Some conditions may not be treatable by using generic services or support groups. The necessary mental health services may exist only outside of the facility, which calls for transportation and treatment fees for the inmates who would need this specialized care. In addition, most prisons lack adequate access to professionals who can assist with treatment (Kira et al., 2014).

Despite demonstrative statistics on the greater need for mental illness services for incarcerated women, there has been an inadequate supply of services and resources available to female inmates with a history of mental illness or traumatic experiences. Traumatic experience and likelihood of mental illness is prevalent among female inmates (Segal et al., 2018). Female needs for existing mental health problems are treated inadequately (Segal et al., 2018). This strongly suggests that availability and training for mental health professionals to assist incarcerated individuals is also inadequate (Segal et al., 2018).

If a mentally disturbed criminal is not given the treatment they need, chances are good that the person will reoffend. Lack of adequate treatment of mental illness creates a vicious cycle: As mental health conditions worsen, one's behavior and ability to manage worsens (Venable, 2021). While in prison, this vicious cycle decreases the chances of reducing one's sentence on the premise of good behavior and often leads to punishments that cause the afflicted individual to suffer even more from their mental illness. Lack of adequate support for mental illness in prison makes it more difficult for inmates to readjust to their new lives behind bars and upon release. Once released from prison, it increases the chances of recidivism. Extended sentences and recidivism both cost local governments and taxpayers more money because more prison time is needed. Recall that there were more than 1.2 million people in prison in 2020 and each inmate cost an average of $37,000 a year multiplied by the number of years of their sentence. This is why the need for proper care and treatment within institutions and the community is pertinent in saving and rebuilding the lives of those incarcerated or vulnerable to incarceration.

Summary

The purpose of this research was to understand the connections between mental illness and prison. This literature review was divided into three main sections. The first section identified the theoretical framework as Agnew's (2001, 2015) GST. The second section presented the related literature in three main sections: "Mental Illness," "Prison Life," and the "Connections Between Mental Illness and Prison Life." The section, "Mental Illness," was presented in six parts (definitions of mental illness, statistics on percentages of mental illness, gender differences, main types, etiology due to trauma, and

treatment). The section, “Prison Life,” was presented in five parts (types of crimes, definitions of detention centers, jails, and prisons; security levels, life inside prison, and recidivism statistics). The section, “Connections Between Mental Illness and Prison Life,” was presented in four parts (statistics, prison living conditions that create or exacerbate mental illness, prison mental illness services, and availability of therapists and counselors).

CHAPTER THREE: METHODS

Overview

The purpose of this research was to understand the connections between mental illness and prison. The criminal justice system and mental health are undeniably interlinked (Fraser et al., 2009). Two interrelated general problems initiated this research. One is the exponentially increasing number of prisoners with mental illness across recent decades (NIMH, n.d.). According to the APA (n.d.-b), 64%, or two out of every three incarcerated individuals suffer from various mental disorders. The other problem is the lack of adequate mental healthcare in prisons. Widespread inadequacy is underscored by the increasing number of calls for improved mental health services on humane as well as moral grounds (NAMI, n.d-b; NIMH, n.d.; Vera Institute of Justice, n.d.). There is currently an urgent need to improve the quality of mental health care in prisons to address the mental health needs of prisoners adequately (Prison Reform Trust, 2021).

These two problems—the staggering prevalence of mental illness among prisoners and inadequate mental healthcare for them—mean that prison stakeholders face increasingly critical challenges in their two-fold task. They must not only address the high prevalence of mental illnesses and disorders among prisoners as it impacts daily prison operations, but also provide and manage adequate mental healthcare in prisons. Prison stakeholders, including the criminal justice system itself, need to develop effective strategies. Without such strategies, the prison system risks becoming a 21st-century asylum for the mentally ill who obtain little or no treatment. However, the necessary data to guide the development of those strategies are lacking, a gap that this study was designed to address. Hereafter, individuals with mental illness incarcerated for crimes in

U.S. prisons, ranging from minimum to maximum security, are called prisoners.

Chapter Three presents the details of data collection and analysis for this study. This chapter contains 11 subsections, including “Design,” “Research Questions,” “Setting,” “Participants,” “Procedures,” “The Researcher’s Role,” “Data Collection,” “Data Analysis,” “Trustworthiness,” “Ethical Considerations,” and “Summary.”

Design

The general design of this study was the qualitative approach. This was appropriate because the researcher sought to understand the experiences of prisoners with mental illness through the eyes of those with the most direct access to the illnesses besides the prisoners themselves: prison counselors and therapists. The specific research design was an ontological phenomenology. This was appropriate because phenomenology enables understanding of the lived experience, which is a person’s interpretation or analysis of what they have experienced (Dudovskiy, 2022). In this study, the realm of the lived experience of interest was that of prison therapists’ views of mental health among prisoners. The lived experience relates, in turn, to ontology, which is the science of being that examines what exists, based on the assumption that reality is real and therefore measurable after terms are defined (Dudovskiy, 2022). Based on the idea that reality is a demonstrable fact, reality can be investigated through an examination of its components and the relationships among them yet still reflect the eye of the beholder. This is why the qualitative design was specifically selected.

To understand the impacts of mental illness on prison and vice versa, the design was implemented by collecting three phenomenological components of prison therapists’ lived experiences. One was their knowledge of the nature and prevalence of mental

illness among prisoners. The second was their knowledge of prison characteristics that exacerbate or create a prisoner's mental illness. The third was their knowledge of the relative adequacy of prison mental health care. The analysis emphasized the importance of subjective interpretation and meaning-making in the research process. This paradigm was particularly relevant for this study, as the experiences and perspectives of prisoners with mental health conditions are central to understanding the impact of incarceration on mental health outcomes.

Research Questions

The RQs addressed in this qualitative study include the following five questions:

RQ1: What is the nature and prevalence of mental illness among U.S. prisoners?

RQ2: What prison factors exacerbate existing mental illness among U.S. prisoners?

RQ3: What prison factors create mental illness among U.S. prisoners?

RQ4: What is the availability of mental health services in U.S. prisons?

RQ5: What is the effectiveness of mental health services in U.S. prisons?

Setting

The technical setting for this study was a prison, as the research was conducted through Zoom interviews rather than on prison grounds due to the high security level of the prisons where the prison therapists worked and the time it would take secure access could potentially cause a delay. The prisons where the prison therapists worked were in a tri-state area in the Southeast region of the United States. The security level was prison versus detention centers or jails. Counselors and therapists who work with prisoners in a U.S. prison have experience with the broad topic. The study was focused on

understanding mental health in prisoners; specifically examining three crucial aspects: the nature and prevalence of mental illness among prisoners, identifying prison features that exacerbate or create mental health issues, and assessing the adequacy of the level of mental health care offered inside prisons. The researcher aimed to illuminate these factors in order to inform potential advancements in mental health care and prison conditions, as well as to shed light on the mental health difficulties faced by those who are incarcerated.

Participants

The theoretical or target population was composed of all participants of theoretical interest to the researcher (O'Sullivan et al., 2017). The theoretical or target population for this study was composed of certified or licensed counselors and therapists who were currently working or had worked in American prisons with prisoners who have mental health issues in the context of counseling. Hereafter called prison therapists, this population was appropriate for this study's problem and purpose because certified and licensed prison therapists are the individuals who provide the interface between prisoners and the prison mental health services provided to them. In addition, they have the professional training to discuss mental illness on a clinical level.

Sampling is the process of selecting part of the target population for study (O'Sullivan et al., 2017). The sample drawn from the target population is a subset of it (O'Sullivan et al., 2017). Specifically, the individual members of the target population to which a researcher has sufficient access to collect a sample is called the accessible population or sampling frame (O'Sullivan et al., 2017). In this study, the accessible sample comprised mental health professionals in the researcher's professional network who have worked as prison therapists. The inclusion criteria for participating in this

research were adults who held counseling certifications or licensure and had a minimum of 3 years of experience counseling prisoners.

The potential participants who met the inclusion criteria and were solicited by the researcher to participate in the study constituted the selected sample (O'Sullivan et al., 2017). Because the sample of participants was also composed of individuals who are familiar with the experience under investigation (i.e., mental health among prisoners), participating prison therapists also constituted a purposive sample. Purposive sampling is a strategy in which the researcher accesses experts who are knowledgeable about a specific culture, domain, or profession under investigation.

Procedures

This section outlines the steps taken to conduct this study, which are also elaborated in various sections of this chapter. The interview questions were developed so that two to five of them addressed each of the five research questions. After writing the interview guide, the researcher retained two experts in the field to review the content validity of the interview questions. Both verified the content validity of the interview questions. To ensure clarity of questions and wording, a pilot interview was conducted with an individual who met the inclusion criteria, but who was not invited to participate in the study itself. The pilot interview was conducted after receipt of the Liberty University Institutional Review Board (IRB) approval to collect data (Appendix A). Anchoring the interview questions in the literature and expert review were accomplished before the proposal defense. The interview questions are listed and justified in the "Data Collection" section later in this chapter.

Liberty University IRB approval was sought prior to data collection. After the

IRB granted this researcher permission to collect data, the recruitment or selection strategy involved two steps of soliciting participants. The aim of the two-pronged approach to soliciting and interviewing participants was triangulation. In the first step, one set of prison therapists was interviewed and their narratives were examined for themes. In the second step, a second set of prison therapists were interviewed and their narratives examined for themes. Then, the two sets of results were triangulated to see if the same themes emerged, which they did.

To collect participants for both sets of interviews, all of the colleagues in the researcher's network who met the criteria were solicited for participation. The original intention of this data collection schema was to solicit six prison therapists per interview set to produce a data set based on a dozen prison therapists. Because five were available for the first set of interviews, seven were solicited for the second set of interviews. Solicitation was via an invitational email (Appendix B). Counselors and therapists who volunteered to participate were asked to indicate their willingness to participate by signing and returning the informed consent form (Appendix C). The researcher then contacted them and scheduled the interviews via Zoom. The narrative data were recorded and transcribed using real-time Zoom transcription software.

The Researcher's Role

There was no relationship other than professional interests between each of the participants. The researcher's role was to gather information on the mental state of prisoners through interviews with prison therapists. By speaking with them, the researcher acquired a better understanding of how mental health has affected prisoners and used this information in the dissertation.

When choosing the appropriate population for generating a purposive sample, researchers must rely on their own knowledge, expertise, and judgment. In this study, the researcher's knowledge and judgment was based on firsthand experience. As the child of an active-duty military police (MP) officer, this researcher underestimated her father's fragile emotional state, his struggles through endless deployments, and overnight brig (prison) duty, leaving the researcher's mother to deal with four children. However, as an adult, this researcher ultimately observed how her father's mental illness led to the unraveling of a 21-year marriage. Seeing a childhood friend's brother struggle with mental illness during his incarceration piqued the researcher's interest further. Interviewing counselors and therapists was appropriate because it provided insights on mental health in the prison system.

The researcher's bias is that mental health treatment is not fully adequate. This view is the result of direct observations of family members who were imprisoned without the provision of adequate mental health care. An assumption was that prison therapists would have similar impressions that prison therapeutic methods of recovery could be improved. The researcher's role was not to prove these biases or assumptions, but to use awareness of them to minimize or properly categorize them during data collection, and analysis.

Data Collection

In this study, the phenomenological data collection approach was to interview 12 prison therapists who volunteered to be interviewed. The researcher emailed each potential participant and invited them to participate by engaging in an interview about their experiences as a prison therapist (Appendix B). Attached to this invitational email

was a blank copy of the informed consent form (Appendix C). Individual prison therapists who volunteered to be interviewed were asked to respond to the invitational email in the affirmative and to sign and return the informed consent form. Following this, the researcher scheduled and conducted the interview. Because the participants were anticipated to be busy professionals with limited time, each participant was emailed the interview guide beforehand to respect their limited time and to conduct the interviews efficiently. Each interview participant was labeled with a "T" for therapist and a case number (i.e., pseudonyms were identified as T1–T12).

Interviews were conducted via Zoom, recorded, and transcribed. Although the gold standard is the face-to-face interview, Zoom meetings are viable alternatives to face-to-face interviews. For one reason, the reliability and validity of face-to-face interviews over remote meeting software like Zoom has been well established by methodologists (Creswell & Creswell, 2018). They are nearly as effective as interviews conducted between persons in the same physical space because the Zoom context creates an atmosphere of connectedness (Creswell & Creswell, 2018). Using Zoom was also a viable alternative because the participants were scattered across a tri-state area in the Southeast, and thus not economically accessible to the researcher.

For their interview, each participant was asked to find a secure location where they would not be overheard. Interviews began with a standard introduction. The researcher thanked each participant for their valuable help with the research, emphasized that their well-being during the interview was paramount, and encouraged each participant to ask to take a break at any point during the interview. Further, the researcher reminded each participant that they could refuse to answer any question or end the

interview at any time if they felt any discomfort, and that the interview would be recorded. They were asked if they had any questions (no one did), after which the interview commenced.

For consistency in delivery, content, and inflection, the researcher read each interview question to each participant. The researcher planned ahead of time on probing, an interview technique in which prompts are understanding, encouraging, or ad lib remarks to solicit more remarks. The researcher also planned on making liberal use of paraphrasing to ensure that she had a clear idea of the meaning of a participant's perspective.

Interviews

The data collection strategy involved interviews, defined in the context of qualitative inquiry as the solicitation of narrative material though the direct (verbal) or indirect (written) discourse of answering questions (Creswell & Creswell, 2018). Interviews were appropriate to this research because the aim of the study was to solicit the world view of prison therapists on mental illness among prisoners through details of their lived experiences as prison therapists. The interview questions were generated from and grounded in the literature on mental health issues in the prison system, as presented in Chapters One and Two. The interview questions were developed to be strongly focused on the content of the question and were few in number to respect the busy schedules of the participants (the researcher is familiar with the busy schedules of prison therapists and accordingly wrote a short interview guide; in fact, four prison therapists who were invited to participate declined because their schedule was too busy). The relationship between the interview guide and research questions is discussed in the text

that follows the interview guide below.

Prison Mental Health Interview Questions

The researcher began with the following opening statement:

Thank you for agreeing to participate in this study of mental illness among incarcerated prisoners. I asked you to participate in this interview because you are a certified or licensed counselor or therapist who has at least 3 years of experience counseling incarcerated adults while they serve their sentences. For brevity, I refer to the "incarcerated individuals with mental illness" as "prisoners." In this study, prisoners are individuals who are or were currently serving sentences for crimes in prison (not jail) when you counseled them. Please remember that this interview will be recorded. If any question makes you uncomfortable, let me know and we will move onto the next question. You can take a break if you need one. The interview ought to take about 20 minutes, but please take the time you need to answer the questions.

The following questions were asked of every participant:

1. Please describe your credentials for discussing mental illness among prisoners today. (Prompts: years of experience working with the prison population in the capacity of […], security levels of those prisons).
2. In your experience, what is an estimate of the number of prisoners who have a mental illness?
3. Please describe two types of mental illness you have witnessed among male prisoners. What was the basic treatment plan for these issues in men?

4. Please describe two types of mental illness you have witnessed among female prisoners. What was the basic treatment plan for these mental illness issues in women?
5. What is your view of the role of trauma in the development of mental illness? [Prompts: Have prisoners you have counseled talked about early trauma? If so, did they relate it to their mental health issues?]
6. We assume prisoners are under strain from incarceration. In your view, what are the three worst strains or traumas prisoners must endure while in prison? [Prompt: Does it differ across prisoners or do most of the prisoners suffer from the same strains?]
7. In your experience, what are some of the conditions of prison life that might worsen existing mental illness or create it? What changes might improve these conditions?
8. Do you think that exposure to other prisoners with mental illness is or can be traumatic for a prisoner? Do you think that one source of trauma in prison is inescapable exposure to a mentally ill prisoner?
9. Are there enough available resources to ensure that mentally ill prisoners receive proper treatment while incarcerated? If so, what are they? If not, what is missing?
10. What role, if any, do you think mental illness plays in recidivism?

The following section shows that although the interview guide was intentionally short, pilot testing underscored its validity and the guide itself was concentrated and highly efficient. Below, the purpose of each interview question listed above is discussed

to establish its validity and relationship to the research questions. The interview questions were developed so that material to answer the five research questions could be based on responses to two to five interview questions. Interview Question 1 established the extent of the participant's professional experience, which contributed to the study's trustworthiness. Narrative materials to RQ1, which was on the prevalence of mental illness among prisoners, were incorporated in Interview Questions 2, 3, and 4. Answers were used for comparisons with published estimates of prevalence. For example, some estimates suggest as many as 64% of prisoners are suffering from various mental disorders with 10–25% suffering from schizophrenia (APA, n.d.-b). Interview Questions 3 and 4 were also used to compare the types of mental illness among prisoners with published estimates, as well as to address gender differences in mental illness. In the United States, the 2020 statistics showed the greater prevalence of AMIs among women (25.9%) as compared to men (15.9%); as well as of SMIs among women (7.0%) as compared to men (4.0%; NIMH, n.d.). Similarly, the 2021 statistics showed the greater prevalence of AMIs among women (27.2%) as compared to men (18.1%; NIMH, n.d.). Finally, these questions also began the probe into the adequacy of available care.

Narrative materials for RQ2, which was prison factors that exacerbate mental illness among prisoners, were incorporated in Interview Questions 5, 6, 7, and 10. Responses to Interview Question 5 were compared to published estimates of the role of trauma in exacerbating mental illness among prisoners and used to showcase the participants' worldview of trauma. Trauma is defined as the emotional reaction to a shocking experience (APA, n.d.-b) and as an occurrence involving bodily violence, self-injury, or damage to the person (DeVeaux, 2013). There are countless events that

traumatize, but the *DSM-5* recognizes two main categories. Type I trauma stems from damage, pain, or shock caused by an unusual or unexpected incident. Type II trauma stems from injury, pain, or shock induced by shocking events that are anticipated, continuing, or occur many times over a period of time.

Interview Question 6 was used to solicit prison therapists' views of the main conditions that might establish or exacerbate mental illness among prisoners in terms of the strains of prison life. This was used to determine if the predictions from Agnew's (2001, 2015) GST are supported by the participants' views. Interview Question 6 was also expected to reveal more information about the participants' worldview of the role of trauma in mental illness. Interview Question 7 was used to solicit prison therapists' views of the main conditions that possibly antagonize prisoners to the point of creating mental illness. This element was not found in the search of the prison and mental illness literature and may constitute a unique contribution to that literature. Interview Question 8 was specifically intended to solicit prison therapists' views on whether exposure to prisoners with mental illness, against the background context of many years of unavoidable exposure, constitutes a significant strain on other prisoners. For example, does unavoidable exposure to mental illness in another person constitute an unforeseen type of prison trauma?

Narrative materials for RQ3, which inquired about factors that could create mental illness among prisoners, were collected from responses to Interview Questions 5, 6, 7, 8, and 10. Explanations of the above roles in addressing RQ2 held for addressing RQ3.

Narrative materials for RQ4, which was on the availability of mental health services for prisoners, were incorporated in Interview Questions 3 and 4. Prison health care has been soundly criticized as inadequate, underfunded, and understaffed. Like pneumonia or arthritis, mental illness is a disease that can worsen if not identified and treated, particularly among those who have SMIs. About one in five prisoners (18%) were taking medication for mental illness when admitted to prison, but more than 50% of them did not receive the previous pharmacotherapy once incarcerated (Reingle Gonzalez & Connell, 2014). These realities reinforce the need for adequate treatment.

Finally, narrative materials for RQ5, which was on the effectiveness of mental health services for prisoners, were incorporated in Interview Questions 7, 9, and 10. Interview Question 7 solicited prison therapists' views of the main conditions that possibly antagonize prisoners to the point of creating mental illness, which is diametrically opposed to treatment effectiveness. Interview Question 9 addressed issues of inadequacy directly. Interview Question 10 addressed the roles of mental health in recidivism. Recidivism is defined as a criminal act that leads to a person being arrested and sentenced again (Vito & Maahs, 2020). In addition, recidivism is related to a person's ability or inability to reintegrate into society. Many recently released ex-offenders struggle to obtain employment, reestablish relationships with loved ones, and resume normal daily activities that do not involve criminal behavior (D. Wallace & Wang, 2020). Ultimately, recidivism impacts everyone, including the criminal, crime victims, the police, the community at large, and taxpayers.

Data Analysis

The data analysis process involved reviewing each transcription for accuracy. The researcher read each transcription while listening to the interview recording and corrected any transcription errors. Assignment of case numbers (i.e., T1–T12) was done to protect the confidentiality of the participants.

Before interviews and analysis began, the researcher attempted to identify and reduce or remove the influence of potentially harmful personal biases or preconceptions that may taint the analytical process by bracketing. Bracketing was crucial for this study's quality because of the researcher's past involvement with prisoners with mental illness. This involvement made it critical for the researcher to suspend all prejudgments to neutralize personal bias as much as possible, as previously discussed in the section titled "The Researcher's Role" (pp. 84–85).

Thorough bracketing is fundamental to epoché. Epoché is the emotional-cognitive process in which the qualitative researcher makes judgments during qualitative analysis. Husserl, the founder of phenomenology, described epoché as the researcher suspending their personal beliefs to focus on what the participants said. Before and during interviews and analysis, epoché was employed as the researcher suspended judgment to grasp the experiential essence of the phenomenon under investigation which, in this study, was what prison therapists know about mental illness among prisoners. This uninvolved neutral interpretive stance was an essential part of the qualitative analysis in this study.

Phenomenological Data Analysis

Data analysis involved seeking evidence of similar and dissimilar attitudes or perspectives between, but also within, participants. The transcribed narrative data were

coded manually in multiple iterative steps to ensure that every element of participants' perspectives was identified, coded, sorted, and attributed to a theme. With open coding, the researcher searched repeatedly (iteratively) for significant words, phrases, and statements; and labeled them until no new information was revealed during the collection process. Iterative open and axial coding were employed to draw connections between open codes to create axial clusters (of confirming or disconfirming codes) and between axial clusters to identify larger connections in the search for that theme. Selective coding was used to identify pertinent passages to site as evidence.

Trustworthiness

To magnify the trustworthiness of this study, the researcher employed creditability, dependability and confirmability, and transferability.

Credibility

As a dimension of qualitative research, credibility is the extent to which the findings describe reality accurately. Credibility depends on the richness of the information gathered and on the analytical abilities of the researcher. The researcher upheld credibility by deliberating on this study's processes with her doctoral committee and by piloting the interview with a colleague familiar with prison mental health, but who was not invited to participate in this study to elicit honest feedback regarding the appropriateness of the interview. The researcher further upheld creditability with purposeful sampling and employing bracketing and epoché during analysis.

Dependability and Confirmability

Dependability and confirmability in qualitative research were addressed through the provision of rich details about the setting and context of the study as well as details

about the participants' perspectives. The researcher upheld dependability by intentionally writing each interview question so that they clearly related to the core focus of the phenomenon under investigation, which was the lived experience of prison therapists with mental illness in prisoners. To add transparency, the researcher upheld confirmability by writing a reflexive journal to record evidence that she did not set out to find what she expected to find, but instead the findings were based on careful data collection and honest analysis.

Transferability

Transferability is a final aspect of qualitative research. The results of this study of prison therapists on the topics of mental illness among prisoners or on the adequacy of prison mental illness healthcare may or may not transfer to another context. The researcher achieved transferability by writing rich, detailed contextual descriptions of the prison therapists' perspectives.

Ethical Considerations

Participants in narrative research are more likely to be candid and accurate when they believe that their responses will remain confidential and untraceable to them (O'Sullivan et al., 2017). This study involved a dangerous and even incendiary topic: untreated mental illness among prisoners. Any information that became public could have serious ramifications for prison personnel, especially in the current atmosphere of accusations of racism aimed at the criminal justice system. For example, public perceptions that prison leadership perceive mental health services as out of their purview could encourage further accusations of unfairness or racial bias.

Therefore, in this study, confidentiality was a priority and maintained by removing any identifying information during any Zoom interviews (e.g., blocking the prison therapist's face) and from interview transcripts. Efforts to preserve the anonymity of the participants' personal identity precluded studies of body language during the interviews. However, this was not seen as an issue because therapists are professionals who have been trained to maintain a neutral stance when dealing with clients, and the same neutrality was anticipated to occur during the interviews and also anticipated to obviate body language. Identification of participants was by case number only (pseudonym: T#). Participants were assured that all potentially identifying information would be kept confidential. Moreover, obvious identifiers such as names were solicited only for the purpose of informed consent. Further steps to protect confidentiality included housing data in the researcher's password-protected computer, reporting the results in anonymized form, and destroying the data 5 years after completion of the study.

The invitational email (Appendix B) included the informed consent form (Appendix C) which participants were required to sign before proceeding. The consent form used understandable language to set forth the research purpose, voluntary participation, procedures to safeguard confidentiality, participants' rights to decline to answer questions or to complete the interview, and the researcher's contact information and official status with Liberty University.

Summary

Currently, two out of every three prisoners in U.S. prisons suffer from mental illness. The purpose of this research was to understand the connections between mental illness and prison.

The general design of this study was qualitative. The specific research design was an ontological phenomenology, which was appropriate because phenomenology serves to understand the lived experience which, in this study, included the realm of experience or lived experiences of prison therapists treating prisoners for mental health issues. There were five research questions:

RQ1: What is the nature and prevalence of mental illness among U.S. prisoners?

RQ2: What prison factors exacerbate existing mental illness among U.S. prisoners?

RQ3: What prison factors create mental illness among U.S. prisoners?

RQ4: What is the availability of mental health services in U.S. prisons?

RQ5: What is the effectiveness of mental health services in U.S. prisons?

The study's setting is prison although in name only, as the research was conducted through Zoom interviews rather than on prison grounds. The sample was composed of 12 certified or licensed prison therapists. The inclusion criteria for participating were adults with counseling certifications or licensure and a minimum of 3 years of experience counseling prisoners.

Procedures involved obtaining IRB approval, pilot testing the interview questions, soliciting two sets of participants for triangulation via an invitation email sent to the researcher's professional network, and scheduling and conducting interviews. The phenomenological data were collected from interviews with 12 prison therapists who volunteered to be interviewed; the first set was composed of 5 prison therapists and the second set was composed of 7 prison therapists. Each interview participant was labeled with a "T" for therapist and a case number (i.e., T1–T12). Interviews were conducted in

Zoom and recorded. Participants were asked to find a secure location for their interview where they would not be overheard. For consistency in delivery, content, and inflection, the researcher read each interview question to each participant and manually transcribed each recording. There were 10 interview questions. Before interviews and analysis began, the researcher identified and reduced or removed the influence of any potentially harmful personal biases with the processes of bracketing and epoché. The researcher coded each set of transcribed interviews manually, coded each in multiple iterative steps of open, axial, and selective coding, generated the emergent themes, and compared the results of each set of interviews to increase the study's rigor by triangulation. Confidentiality was given the highest priority.

CHAPTER FOUR: FINDINGS

Overview

The overall purpose of this research was to understand the connections between mental illness and prison. Two interrelated general problems initiated this research. One problem is the exponential increase in the number of prisoners with mental illness in American prisons (NIMH, n.d.). The other problem is the lack of adequate mental health care for prisoners. Improvements in the quality of mental health care that adequately address the mental health needs of prisoners are urgently needed (Prison Reform Trust, 2021). Delays in urgently needed improvements magnify the transformation of the American prison system into a "21st century asylum for the mentally ill" (WHO, 1999).

Addressing these two problems means the prison stakeholders who are responsible for providing and managing adequate mental health care in prisons face escalating critical challenges. To offset these critical challenges, prison stakeholders need effective strategies. However, the data needed to guide the development of effective strategies are largely unavailable, which is a gap in knowledge about mental illness among prisoners. This study was designed to address that gap.

The aims of this study were to learn about the prevalence of mental health disorders, the overall conditions that exacerbate or perhaps create mental illnesses in prison, including the role of traumatic events; and the estimated adequacy of prison-provided mental health care. Its primary goal was to illustrate the manifestation of mental illness among prisoners and secondarily to suggest concrete solutions for a more compassionate and effective mental health treatment in correctional systems.

Hereafter in this chapter, individuals incarcerated for crimes in U.S. prisons are

called prisoners regardless of their mental health status. Individuals who served as participants because they counsel prisoners are called prison therapists. Gender information was not collected, so all of the prison therapists are referred to primarily by assigned pseudonyms or the generic “he.”

This chapter is presented in three main sections. The first section lists the research questions. The second section describes the participants’ professional credentials. The third section presents the results.

Research Questions

The research questions addressed in this qualitative study were as follows:

RQ1: What is the nature and prevalence of mental illness among U.S. prisoners?

RQ2: What prison factors exacerbate existing mental illness among U.S. prisoners?

RQ3: What prison factors create mental illness among U.S. prisoners?

RQ4: What is the availability of mental health services in U.S. prisons?

RQ5: What is the effectiveness of mental health services in U.S. prisons?

Participants’ Professional Credentials

A total of 12 prison therapists were available to be interviewed. Each therapist was labeled with “T” for therapist and a case number (i.e., T1–T12) to protect their anonymity. The prison therapists reported a breadth of licensure and certifications. Licensure included licensed counselors, licensed professional counselors, social workers, social work master’s level, licensed clinical social workers, marriage and family therapists, healthcare administration master’s level, and health care administrators. Years of experience in counseling and the prison system ranged from 8–31 years and averaged

25 years. For example, T1 had 30+ years with incarcerated populations and T3 had 10 years with incarcerated populations.

Results

Results are presented in seven parts. The first part explains theme development and thematic schematic. The second part describes reflexivity and bracketing. The third part explains data collection. The fourth part is a discussion of the trustworthiness of the data. The fifth parts described data analysis. The sixth part presents the results in five subsections, one each for RQs 1, 2, 3, 4, and 5, respectively. The seventh part includes some recommendations for improvements.

Theme Development and Thematic Schematic

This first part is a condensed explanation of the main and overarching schematic presentation of the themes. The condensed explanation is confirmed by brief yet broad examples of evidence from the data. The bulk of the specific evidence that supports the overarching and main themes is presented in the sections titled, Results for RQs 1, 2, 3, 4, and 5.

Stark and dark, prison is a form of punishment through deprivation. Incarceration penalizes people by eliminating creature comforts. The overarching theme that emerged from the prison therapists' commentaries was parallel strains (see Figure 1). The parallel strain theme represents the idea that life in prison for prisoners is a dynamic kaleidoscope of pressures from their past that are antagonized by the ubiquitous pressures of their present. Pressures from the past are from two major sources: unmet basic needs pertaining to Maslow's (1998) hierarchy of needs theory when the prisoners were children and the strains of social inequities pertaining to Agnew's (1992) GST when the

prisoners were adults that led, at least in part, to their criminal behavior. The parallel strain theme is the idea that current pressures experienced in prison are the same as the two past pressures, mainly composed of unmet basic needs and societal strains. Ubiquitous in prison, these pressures are familiar from prisoners' past experiences and are matched by current and recurrent experiences with them in prison. Moreover, past pressures aggravate present pressures all the while prisoners serve their sentences. This study's overarching theme of parallel strains predicts that life in prison exacerbates or even creates mental illness, a prediction that was largely supported by the data.

Figure 1

Interrelationships between the Three Sources of Parallel Strains

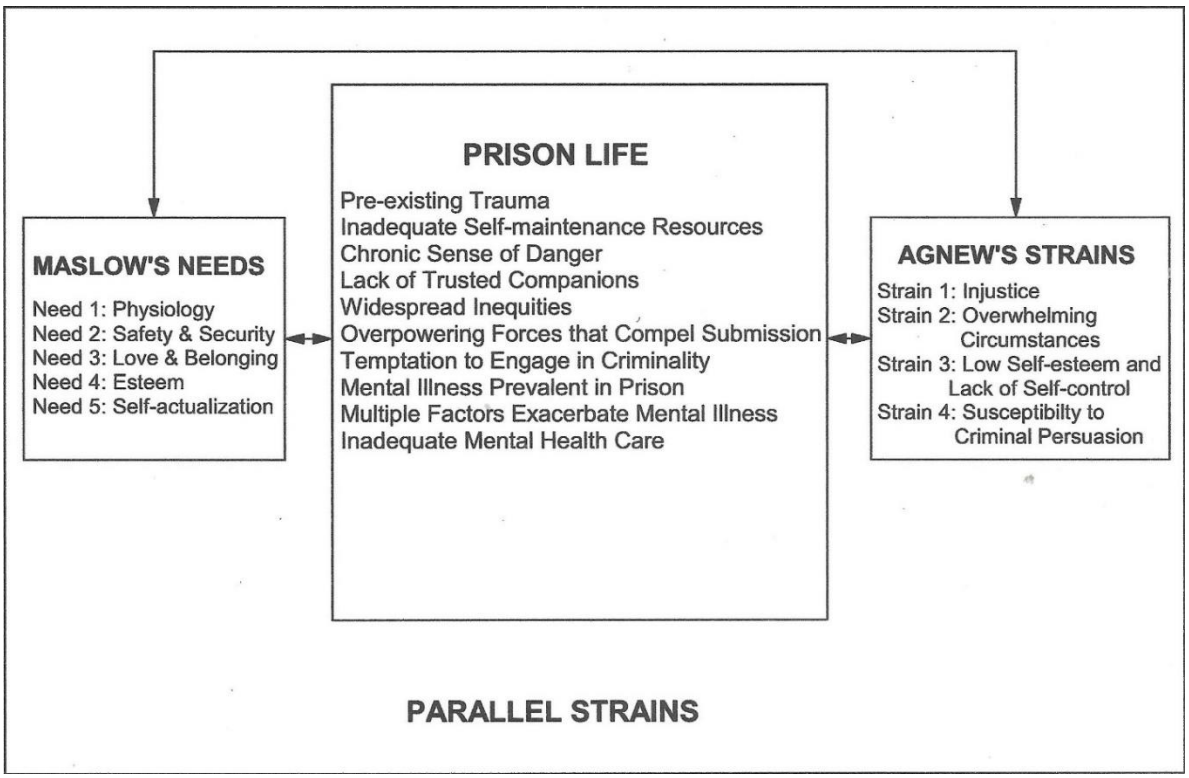

Figure 1 illustrates the three sources of parallel strain as three main themes: Maslow's (1998) needs, prison life, and Agnew's (1992) strains. One main theme is prison life. The main theme of "prison life" is the compendium of the violations of basic

needs and source of strains of the other two main themes. Evidence that the prison therapists perceived the pressures of prison life as linkages between the other two main themes is reported throughout the rest of this chapter.

The main theme of Maslow's needs in Figure 1 arises from Maslow's (1998) theory of the hierarchy of human needs. Maslow's theory predicts that people have basic needs, and that the fulfilment of their basic needs is central because fulfillment opens the gateway to later accomplishments whereas unmet needs open the gateway to personal frustration and potential vexation with society. For the rest of the text, Maslow's five needs are numbered and capitalized for ease of recognition.

The evidence summarized for Maslow's needs in Figure 1 and presented in detail in this chapter's sections covering the results for RQs 1–5 is based on prison therapists' disclosures that most prisoners suffered from unmet needs as children. Moreover, in most cases, the impacts of unmet needs were intensified by experiences of trauma.

The pyramidal base or Maslow's Need 1 is composed of physiological needs that are the essentials of survival: adequate food, water, warmth, and rest. Evidence in this chapter shows that Need 1 (physiology, see Figure 1) is violated in prison in various ways (prison life, see Figure 1). Prisoners who cannot access elementary services like adequate food and basic cleanliness suffer from unmet physiological needs. Several prison therapists claimed that prisoners may receive inadequate food and often lack self-maintenance resources, such as being able to take a shower or being provided with cleaning supplies to clean their cells.

Moving up the pyramid, Maslow's Need 2 (safety and security, see Figure 1) relies on adequate money, reliable resources, and stable shelter. Evidence in this chapter

shows that Need 2 is unmet in prison because prison is a desperately unsafe and unstable place to live, and thus traumatic in its own right (prison life, see Figure 1). Prisoners who feel vulnerable to harm from fellow inmates and guards suffer from unmet safety needs. According to prison therapists, prisoners dread contact with fellow prisoners and respond somewhere between apprehension and panic about the physical, mental, and sexual abuse fellow prisoners wreak. Prisoners also dread contact with the inequities wielded by prison guards (prison life, see Figure 1), which spills onto Strain 1 (injustice) and Strain 2 (overwhelming circumstances). Abuses by fellow prisoners and guards may be experienced even more excessively by prisoners whose childhood traumas made them more sensitive (i.e., sensitized) to the emotional drains of being abused as an adult or made them more vulnerable to the feelings of helplessness they experienced as traumatized children. Rather than fulfilling the basic needs of safety and security, prison life engenders a profound sense of chronic danger. This reduces or cancels the basic needs of rest (Need 1) and feelings of sanctuary (Need 2).

Maslow's Need 3 is composed of love and a sense of belonging: These are fulfilled by available and supportive family, friends, and community members. According to the prison therapists, Need 3 (love & belonging, see Figure 1) is rarely fulfilled in prison (prison life, see Figure 1). Prisoners often lack contact with family members. Prisoners who cannot access family and friends suffer from unmet needs for friendship, love, and the warm haven of feeling like a valued part of a community of equals. Prisoners may have fewer fellow prisoners whom they can trust compared to the many that they had best mistrust.

Prison fulfills Maslow's three basic needs of physiology, safety and security, and love and belonging unpredictably at best. The next two needs on Maslow's hierarchy are probably completely out of reach for prisoners. Maslow's Need 4 pertains to self-esteem: This is fulfilled by self-confidence, respecting others, being respected, and achieving excellence. The opposite of Need 4 (esteem, see Figure 1) is being made to feel chronically worthless or subservient. In prison, the inescapable demand for total compliance eventually becomes overwhelming and, as it is designed to do, intensifies low self-esteem to compel submission (prison life, see Figure 1). Evidence in this chapter shows that prison therapists had few reassuring lived experiences that confirmed any positive developments of prisoner self-esteem.

Maslow's final Need 5 is self-actualization: the fulfillment of a person's full potential. Most people have fleeting peak experiences but few probably reach self-actualization (Maslow, 1998). Indirect evidence in this chapter indicates that self-actualization (Maslow's Need 5, see Figure 1) is likely to be an unreachable status in prison (prison life, see Figure 1). It is difficult to visualize how Maslow's Need 4, self-esteem, and Need 5, self-actualization, ever grow and flourish in prison.

In short, the prison therapists' evidence suggests that prison is the antithesis of the ascent to self-actualization in Maslow's hierarchy of needs. The brief synopsis of the parallel strains theme shows that violations of Maslow's hierarchy of needs are present in every unmet need in prison. This totality of unmet Maslowian needs in prison creates profound strain.

In complement, the second main theme is the many faces of tension and struggle encapsulated as Agnew's strains shown in Figure 1. Agnew's (1992) General Strain

Theory (GST) predicts that strain emanates from four main elements, which the data from the prison therapists in this study showed are omnipresent in prison. One, Agnew argued that strain is produced by exposure to injustice (Strain 1). In prison, injustice is rife because of the multiple inequities inherent in prison life and therefore exposure to it is unavoidable. Two, strain is produced by exposure to overwhelming circumstances (Strain 2). Prison is replete with overpowering forces initially stemming from the lack of personal control. It is further expressed in a myriad of ways, including the obvious inequities between guards and prisoners and less conspicuous inequities among the prisoners themselves. Prison life is hard to visualize as anything but the crushing absence of freedom. Three, strain is produced by low self-esteem and little self-control (Strain 3). Even for prisoners with reasonably well-developed feelings of self-worth and self-control, prison life will consistently confront them with constant pressure. Four, strain comes from pressure to commit a crime (Strain 4). Pressure to commit crimes is present in a variety of forms in prison. The evidence summarized for Agnew's strains in Figure 1 and presented in the results for RQs 1–5 is based on published linkages between early unmet needs and subsequent feelings of strain against society. There is a strong correlation between the trauma of childhood abuse, neglect, and household dysfunction with increased risks for substance abuse and mental health issues later in life (Chapman et al., 2004). As another related set of parallel strains, childhood traumas often manifest as increasing struggles against society and later risks for a life of crime.

Reflexivity and Bracketing

This study was prompted by a personal discovery of the dramatic and systematic inadequacies in America's prison system pertaining to mental health care for prisoners.

During incarceration, prisoners with mental health issues struggle because their mental health treatment is either inadequate or absent. Inadequacy and absence of help compounds their problems. This research was further inspired by a literature search that revealed crucial gaps in knowledge about the consequences of imprisonment on prisoners with mental illness, with or without the exacerbation of inadequate care. This study's goal was to highlight the challenges faced by the affected stakeholders (prisoners, prison staff, and prison therapists); however, the data were only collected on the perspectives of prison therapists.

To collect reliable data, the researcher interviewed prison therapists who have extensive work experience counseling prisoners. To collect accurate data, bracketing was crucial. Bracketing is when a qualitative researcher engages in the emotional-cognitive process of identifying their biases about any results they expect to find. The way to eliminate biases is to suspend judgements during data collection and analysis. This is the qualitative analytical process known as epoché (Saldaña, 2013). Specifically, to the extent possible, the researcher bracketed by disengaging her beliefs about mental illness among prisoners and mental health care for the incarcerated to focus upon the literal appearance of the interview contents without believing or disbelieving them (Saldaña, 2013). Bracketing enabled her to imbue thematic analysis with a neutral interpretive stance.

Because the researcher has a history of involvement with mental illness among incarcerated individuals, bracketing was key to interviewing the participants reliably and analyzing their data accurately without introducing any of her own potential biases. Therefore, before interviews began and until analysis ended, she employed continual

efforts to identify and remove any personal preconceptions. The researcher's personal discovery made it critical for her to suspend all prejudgments and assume a neutral interpretive stance in order to circumvent any tainting of the analytical process. The next section describes the steps in ensuring the collection of valid and reliable data.

Data Collection

After the IRB granted this researcher permission to collect data, the recruitment or selection strategy involved a two-pronged approach to soliciting participants in order to triangulate the data. The first prong involved collecting data from a set of five prison therapists and analyzing their narrative data for themes. Once this step was completed. the second prong was launched. It involved collecting data from a fresh set of seven prison therapists, analyzing their narrative data for themes, and then comparing the two sets of data for evidence of parallel themes. The difference in the number of prison therapists per interview set was due to sampling constraints. The original data collection schema was to solicit six prison therapists in the two sets of prison therapists to produce a rigorous data set based on a dozen prison therapists. However, only five prison therapists were available for the first set of interviews. Therefore, seven prison therapists were solicited for the second set of interviews. When both sets of thematic data were in hand, the themes and evidence were cross-referenced. The result of cross-referencing was that the same three themes emerged as shown in Figure 1. Very strong evidence of parallel themes emerged (see Figure 1), which was one of many expressions of parallelism; in this case, the strong parallels between the two sets of prison therapists interviewed for this study. The rest of the results below present representative commentary as evidence of themes.

This study was an ontological phenomenology. Ontology is the "science of being" that rests on the tenet that reality is a demonstrable fact and therefore measurable by an examination of its components and of the relationships among components (Dudovskiy, 2022). Phenomenology addresses lived experiences (Dudovskiy, 2022). In this study, the lived experiences of interest were the prison therapists' interpretations of their experiences with prisoner mental illness and therapy in the prison setting. The prison therapists discussed the prisoners. Prisoners were not interviewed for this study.

Data were collected from interviews with prison therapists conducted by recorded Zoom meetings. The first set of five interviews was conducted between 8-16 January 2024. The second set of seven interviews was conducted between March 23–26, 2024. For both sets, prisoner therapists were part of the researcher's professional network and approached based on the extent of their experience with prison therapy. For the interview, prisoner therapist participants found a secure location where they could not be overheard. The researcher conducted each interview from her office, which is a secure space where conversations cannot be overheard. Each interview began with a standard introduction in which the researcher thanked the prison therapists for their valuable participation, restated the definition of prisoners that the prison therapist should consider when responding to interview questions, and emphasized that prison therapist well-being during the interview was paramount. The researcher also reminded each prison therapist that they could refuse to answer any question without penalty and that the interview would be recorded. The researcher then asked if they had any final questions. No one in either set of interviews did as they had had a chance to review the interview questions

ahead of time to expedite data collection. The interview began after each prison therapist signed the informed consent.

As a counselor, this researcher is comfortable with interviewing and felt that she made each participant feel comfortable before the interview began. In turn, the prison therapists seemed eager to share their insights. The researcher read each interview question verbatim to pose every question to every participant using the same emotional neutrality. Each interview lasted 20–30 minutes and yielded a large amount of valuable data. Their remarks showed a genuine interest in prisoner physical and psychological well-being with earnest statements.

The researcher transcribed each set of interviews. Transcription was followed by member-checking wherein participants were sent copies of their interview transcripts to review it for accuracy. All 12 prison therapists reviewed and confirmed the accuracy of their transcripts without revisions. The next section describes the steps taken to ensure robust research.

Trustworthiness of the Data

The robustness of this research was based on the study's validity and reliability through evidence of trustworthiness (Creswell & Creswell, 2018). Specifically, trustworthiness describes strategies that were used to establish the credibility, dependability, transferability, and confirmability of this study's results. Nonjudgment was utilized throughout.

Credibility

Credibility is the accuracy of the results, mainly established by a clear portrayal of the manner in which the data were collected and analyzed (Alase, 2017). This study's

credibility was established in six steps. One, credibility was established with purposive sampling. The inclusion criteria for participation were counseling certification or licensure and a minimum of 3 years of experience counseling prisoners. Purposive sampling was conducted for licensed prison therapists who were employed at a prison as a therapist and had several years of experience counseling prisoners. These criteria ensured that prison therapists had a significant understanding of mental illness among prisoners in American prisons. Two, data were collected using the time-tested qualitative tool of one-on-one interviews (Eatough & Smith, 2017). Interviews allowed the researcher to capture as many aspects of prisoner mental health as possible while identifying convergent as well as divergent data (Sullivan & Forester, 2019). Credibility was further established with the approved qualitative research procedures outlined in Chapter Three of this dissertation. Three, the researcher-generated a 10-question prison mental health interview guide that was reviewed by two experts in the field who verified its content validity. Four, to further establish data accuracy, the approved procedures of developing the interview guide, recording interviews, and transcribing interviews verbatim were followed (Saldaña, 2013). Five, university-approved procedures (see Chapter Three) were followed by analyzing the data as an ontological phenomenology. Six, the credibility of this study was established on the basis of the researcher's professional connection to the prison community, which includes 20 years of experience in the field of mental illness counseling.

Dependability

Dependability refers to the stability of the results from qualitative study. It includes acknowledgement of any change in the phenomenon under study and/or the

study's methodology or design as applicable (Alase, 2017). In this study, the researcher was unaware of any pertinent changes in the treatment of mental illness among prisoners. Dependability was further established by utilizing the approved procedures outlined in Chapter Three. The researcher also employed member checking by asking each prison therapist to review the transcript of their interview to solicit corrections and gain their approval of the transcription's accuracy.

Transferability

Transferability is the fit of the qualitative study's findings with similar circumstances outside the study itself (Eatough & Smith, 2017). Evidence of transferability lies in the robustness and richness of the data, as well as making sure that the findings have some applicability to other contexts (Eatough & Smith, 2017). In this study, transferability was established by sampling prison therapists from a diverse set of prisons because the combination of seasoned professionals and relatively new counselors brought a broad range of experiences in prison counseling to the study. Transferability was further certified by candid perspectives of the topics posed in each interview question by the participants. Through thematic analyses of transcripts, descriptions of strained parallelism were generated in robust language that accurately depicted the findings in a non-judgmental way.

Confirmability

Confirmability is established with converging evidence that the findings of a qualitative study are credible, dependable, and transferable (Saldaña, 2013). Further, confirmability is based on a detailed description of the research processes (Saldaña, 2013). During the interviews, neutral language was used. The researcher read each

question without emotion. Member-checking was employed to ensure that the transcriptions were accurate and complete.

Data Analysis

Data analysis began with a thorough review of each transcription for accuracy before member checking. After member-checking, analysis followed Saldaña's (2013) guide to qualitative coding and mainly involved seeking evidence of similar and dissimilar attitudes within and between the prison therapists. Narrative transcriptions were perused repeatedly and coded manually in multiple iterative steps to identify, code, sort, and relate to a theme. With open coding, the researcher searched repeatedly for significant words, phrases, and statements until every text was labeled (i.e., saturated). Repeated coding was used to link related open codes into axial clusters and to link axial clusters into themes. Unexpected codes and/or themes that do not correlate to specific research questions were also incorporated into the results.

Results for RQs

The next sections include answers to the RQs showing the extent to which the narrative data confirm or disconfirm the themes presented in Figure 1. Select participant quotes are provided as support of the research questions and as evidence of emergent themes.

Results for RQ1

What is the nature and prevalence of mental illness among U.S. prisoners? The answer to RQ1 is three-fold. One, estimates of prevalence ranged 75–100% depending on whether or not the prison therapists cited clinical diagnoses in their estimates. Two, the most common types of mental illness were depression, schizophrenia,

and anxiety. Three, mental health treatment plans were comparable across male and female prisoners.

The evidence in this section provides three examples of parallel strains (see Figure 1). The first parallel strain is that common mental health issues between the men and women prisoners are comparable in their emphasis on depression, schizophrenia, and anxiety. That is, men and women suffer homologous issues. The second parallel strain is that treatment plans between the male and female prisoners are the same. Whatever the outcome of therapy might be, men and women presumably suffer similarly, sustaining parallel challenges in embracing treatment. The third parallel strain is that treatment plans occur in parallel: One is developed by the prison therapists. The other is developed by the prisoner. Given that, as per this study's participants, most prisoners do not recognize links between their childhood traumas, criminal behavior, or current mental health status (discussed below), one questions the efficacy of the prisoner's personal plan for recovery.

RQ1: Prevalence

The prison therapists' estimates of the prevalence of mental illness among prisoners generally agreed, ranging from 75–90%. T4 gave the highest estimate at 100%: "Everyone residing in prison is affected by mental health to some level." It should be noted that use of the phrase "is affected by" leaves plenty of room for interpretation and speculation. The other quotes for prevalence was similar to one another. For example, T5 and T3 gave percentages that were close in value, ranging from 80–90%. T3 stated, "I would say between 80% and 90% are suffering with mental illness." T5 quoted a similar statistic: "About 85% of individuals are or have suffered from mental illness." The lower ends of the estimates of prevalence were with estimates of 75%, but that is still three out

of four prisoners. As T1 said, “We have possibly only 75% of our prison population who is diagnosed with a diagnosis of mental health illness and maybe about another 10% who is not diagnosed with mental health illness but suffers with it.” The similarity of estimates across the prison therapists was another example of the overarching theme of parallel strains (see Figure 1) because it suggested that the challenges that prison personnel and prisoners experience as a result of mental illness are equivalent across prisons.

When estimating the prevalence of mental illness, the prison therapists were divided on specifying a diagnosis. For example, T1, T2, and T4 distinguished diagnosed from nondiagnosed prisoners. T1 characterized their percentage estimate oddly as “only 75%.” Use of the qualifier “only” was odd because it insinuated that 75% is a small percentage of a group when, in fact, it is the majority of the group. This odd reference was potentially related to T1’s differentiation of diagnosed and nondiagnosed prisoners. Perhaps they meant that 75% was an underestimate because the other 25% should be diagnosed. An important research question that should be addressed in the future is the time frame of when a prisoner receives a diagnosis; that is, before or during their incarceration.

T4 declared without equivocation that every prisoner is affected by mental health at some level. However, by clarifying “everyone *residing* [emphasis added] in prison,” T4 stopped short of including prison staff. T4 also did not specify whether he meant that every prisoner had a mental illness or every prisoner was affected by exposure to a mental illness, either their own or someone else’s. In addition, T4’s estimates were the highest, and included everyone who had volunteered to participate in a prison program

for mental illness counseling. Among the prisoners who had not volunteered for counseling, the majority appeared to be afflicted in some way. According to T4:

> The severity of their mental health concerns varies. If I had to put a percentage number on who has been diagnosed with a serious mental illness [SMI], 100% of the voluntary participants in the prison and jail reentry programs have a mental health diagnosis. Eighty percent of the "other" population not assigned to a mental health program have verbalized symptoms of mental illness.

In contrast, T3 and T5 both provided the percentages of prisoners who suffered from mental illness but did not mention diagnosis.

About half of the prison therapists took care to differentiate prisoners by diagnosis; that is, those who were diagnosed versus those who were not diagnosed with mental illness. Diagnosis is challenging when it cannot be easily established as to when diagnosis took place or how much mental illness was present before incarceration as compared to the amount created or exacerbated by the challenge of prison life.

RQ1: Nature of Common Mental Illness Types and Treatment

Common mental illness types in males. During the interviews, the prison therapists were asked to name the two most common mental health issues among the male and the female prisoners. The goal of asking them to name two issues was to identify the two that came immediately to mind; the aim here was to gauge occurrence broadly as the most memorable. T2 pointed out that a range of mental disorders are possible "depending on what happened, [such as] the trauma of going in or [what] happened to them when they get in."

For the men, the prison therapists named a total of 16 issues. Depression was the most common, mentioned by 31% of the prison therapists. Second was schizophrenia, mentioned by 25% of the prison therapists. Tied for third were anxiety (12%) and PTSD (12%). The remaining issues (borderline, bipolar, PTSD, substance abuse, and psychosis) were each mentioned by one prison therapist.

According to T2 and seconded by numerous other prison therapists, the main issues regarding mental illness among male prisoners were depression and anxiety. About treatment, he went on to say, “We allow them to come up with their own treatment plan, while we assist them with their plan. We also come up with a plan for them. We allow them to make goals.” Most of the prison therapists cited parallel treatment plans developed by the prisoner and the therapist. Like most of the prison therapists, T5 identified depression, but unlike the others, T5 also identified psychosis induced by substance abuse. The treatment plan included a drug treatment program for identifying triggers and coping skills, performing one’s assigned working job, ensuring compliance with psych meds, participating in regular doctor visits, practicing abstinence, eliminating self-injury, and implementing a relapse prevention plan. T4 identified major depressive disorder as well as borderline personality disorder, Bipolar 1 and 2, generalized anxiety, and PTSD. No treatment was suggested.

Common mental illness types in females. For the women, the prison therapists named a total of 13 issues. For T4, common issues included borderline personality disorder, major depressive disorder, Bipolar 1 and 2, generalized anxiety, and PTSD. Among the women, depression was the most common, mentioned by 33% of the prison therapists. Second was anxiety, mentioned by 25% of the prison therapists. Third was

bipolar, mentioned by 17%. The remaining issues (borderline, schizophrenia, and PTSD) were each mentioned by one prison therapist (6%).

There were few gender differences in the mental health issues identified by the prison therapists. T1 cited bipolar, depression, and anxiety, noting that these conditions were "very similar" to men's treatment, emphasizing "CBT [cognitive behavior therapy], mindfulness, and motivational interviewing." T2 said that they use the same treatment plan for depression and anxiety among the women as they do with men. This was echoed by T3: "The [women's] treatment plan is the same as the males."

Treatment plans. T1, T2, and T3 explicitly mentioned parallelism (see Figure 1) in treatments in that the prisoner develops one plan and the prison therapist develops another plan. T3 explained the rationale: "By allowing [prisoners] to come up with their own treatment plan, it shows them that we trust them to make decisions and they have a little control." T5 provided the greatest detail on treatments for one man suffering from depression and another man suffering from substance-induced psychosis:

> I have witnessed an individual suffering from major depression disorder. The treatment plan consists of eliminating any form of self-injurious behavior, suicidal threats, and impulsive behavior, identifying triggers for depression and trauma, implementing positive coping skills, developing, and implementing a relapse prevention plan, and working in the assigned job.
>
> I have witnessed an individual [who] suffered from psychosis with induced substance abuse. The treatment plan consists of participating and graduating a drug treatment program, identifying triggers for substance use, identifying, and implementing positive coping skills, working in an assigned job,

being compliant with psych meds along with seeing a psychiatric doctor every month or 90 days, and refraining from drug usage and passing a drug test. However, the prison therapists were divided on gender differences in treatment. T1, T2, and T3 used the same treatments for men and women, which provided an example of the overarching theme of parallel strains (see Figure 1) because, whether or not treatment is construed as a strain to undertake, the majority of prison therapists generally used equivalent or parallel approaches when designing treatments by gender. For example, T4 noted, "In females I have witnessed the same [types of mental health treatment] as for males." However, T3 was the only prison therapist who noted that they treat women prisoners with mental health issues "a little" differently than they treat the men. T3's comments elaborated about women prisoners' greater needs for outlets to express their more heightened emotions during treatment: "Women want that more loving feeling than men. They want to be able to cry it out. So, we have to turn on the extra 'teddy bear' phase with them." Important questions for future research are how prison therapists view gender differences in types of mental health issues and in treatment protocols among the incarcerated populations.

Results for RQ2

What prison factors exacerbate existing mental illness among U.S. prisoners?

The answer to RQ2 was two-fold. One, preexisting trauma was a given in mental illness; for most of the prisoners, mental illness followed trauma and the trauma of prison life exacerbated mental illness. Two, the three worst strains on prisoners in the eyes of prison therapists are violations of Maslow's (1998) Need 2 (safety & security, see Figure 1) and Need 3 (love & belonging, see Figure 1) along with frequent exposure to Agnew's

(1992) Strain 2 (overwhelming circumstances, Figure 1). These too exacerbated mental illness.

RQ2: Preexisting Trauma as a Given

The impact of trauma was central to this research so the prison therapists were asked to discuss their views of the role of trauma in the development of mental illness. The consensus was striking. All of the prison therapists acknowledged unequivocally that previous trauma is central to mental illness, at least among the prisoners with whom they had worked. T3 remarked, "Trauma plays a *major role* [emphasis added] in mental illness." T4 provided the metaphor that trauma taints a victim's window to the world and corresponding development, or lack thereof, of positive coping skills:

> Adverse childhood experiences [ACE] scores are fairly high for most persons incarcerated within the prison system. Their exposure to previous trauma, vicarious trauma, and chronic-ongoing trauma severely impacts the lenses through which they are able to see the world. Trauma can also skew a person's ability to develop healthy coping skills of mental illness [MI] symptoms.

In the prison therapists' lived experience, trauma is mostly traced to unresolved childhood issues, of which there are many different types. Whereas trauma has been taking place for centuries, recent decades have changed how children exposed to traumatic experiences respond. The following commentary by T2 raised further questions about the role of grandparents versus parents raising the children in creating parallel strains by violating Maslow's (1998) Need 2 (safety & security) and Need 3 (love & belonging):

> Trauma is how they were raised. There is a lot of trauma; PTSD in particular, especially if it's dealing with the unresolved issues of childhood sexual abuse, other unresolved childhood traumas, domestic violence, or even what we might call a "whipping" in previous times.
>
> Children are experiencing trauma differently today. What we might call a whipping in previous times, today they say, "You're killing me." You know, they got a serious beating. Parents didn't know about trauma or how they were impacting their children. All those children didn't take that very well, and it did something to a lot of them.
>
> A lot of trauma [also] depends on the age of their parents [and] whether the grandparents had to come in and take over and raise them. For instance, one client I know was traumatized because her mother experienced the trauma of grief over the loss of somebody real close. [The mother] checked out for a while. She started using drugs, substances. This client described it as terribly unstable for her.
>
> Some of [trauma] could be trafficking as well. Some of it could be sexual abuse as an adult as well as domestic violence. Women partners experience a higher rate of trauma due to domestic violence.
>
> There is a lot going on out there. So, trauma does play a big part.

Most of the therapists segued from the role of preexisting trauma in mental illness directly into treatment implications, because, as T5 noted, "Focusing on trauma is essential to identify mental illness." T1, who had the most experience among this study's participants, pointed out that many prisoners do not realize the linkage between early

trauma they sustained and their subsequent mental health issues and criminal behavior. Soliciting this realization takes clinical acumen, according to T1:

> My view is that in order to treat the illness, you have to treat the trauma and go back to where the trauma started. Sometimes the prisoner may not know that they have trauma, so it takes really good interviewing questions and an assessment to find out where this trauma began and start to seek the help [develop the treatment plan] for them.
>
> In general, they do not think earlier trauma is linked to any mental health issues. I would say they don't relate it to their mental health issues, but in treatment, we will get to the bottom of it to find out where it started. And then we try to draw them to see where the depression really started years ago and help them identify it.
>
> Some prisoners talk about early trauma they have had. So that's why I began to talk about where the trauma may have begun with physical abuse or sexual abuse as a child. They have been carrying this trauma with them. And they may think that they have forgotten it, but they really are still dealing with it.

T3 also described his view of the role of addressing trauma in treatment. Like T1, T3 emphasized that many prisoners do not realize the linkage between their early unresolved trauma, subsequent mental health issues, and criminal behavior:

> I explain to the prisoners that we have to get to the root of the problem of what got them here. Why did they do the crime? I try to go back to childhood to see if their trauma is from childhood. Over half of them do not believe that they suffer from any trauma until I sit down with them, and we go over their life.

Once a prisoner reviews the traumas of their previous life with a counselor, an important question for future research is how many prisoners are persuaded that trauma is linked to their mental health issues and both are linked to the need for counseling and behavior change.

RQ2: Three Worst Strains of Incarceration

There was no absence of opinions about prison strains that exacerbate mental illness. T2 found it hard to pinpoint the major sources of strain because they are too numerous:

> There's a lot that a lot goes on in there. One, they have to get adjusted to prison life, which includes sexual abuse. Two, they have racism and gangs. You have all kinds of gangs [and corresponding activities] in there as well. You have the Blacks against one group. The Hispanics [are] against the Jamaicans. Three, drugs.

Prison therapists mentioned several sources of strain from prison life that may be inflamed by previous trauma. In keeping with the indirect linkage between Maslow's (1998) needs and Agnew's (1992) strains mediated through prison life (see Figure 1), their comments provided ample evidence of the overarching theme of parallel strains (see Figure 1). These included several homologous conditions of unmet Maslowian needs and Agnew's strains. With respect to Maslow's unmet needs, one expression of the theme of parallelism (see Figure 1) is that the worst prison strains are based on familiarity: Strains such as sexual abuse, sexual violence, drugs, drug abuse, gang activities, racism, fear for one's safety, and direct and indirect exposure to trauma are likely to be more familiar than unfamiliar. According to the prison therapists, the prisoners probably experienced

these conditions as children and adolescents, and as adults outside prison as well. According to Agnew's GST, these conditions may have also initially contributed to the crime that led to the prison sentence.

The prison therapists were divided on the question of what the three worst strains of prison life actually are. They identified 11 strains altogether. About one in four (27%) cited separation anxiety; this constitutes the unmet Need 2 (safety & security) and unmet Need 3 (love & belonging), which is evidence of two parallel strains. About one in five (18%) cited the process of acclimating to prison life which, in keeping with the linkages between Maslow's needs, prison life, and Agnew's strains shown in Figure 1, is evidence of layers or tiers of parallel strains. Another 18% cited lack of safety; this is evidence of direct parallel strains from unmet Need 2 (safety & security), Strain 1 (injustice), and Strain 2 (overwhelming circumstances), as shown in Figure 1. T3 cited the loss of emotional attachments: "I would say the number one strain would be adjust to the life now in prison, separation anxiety from the world, and admitting that they do suffer from mental illness." T4 had a similar view to T3: "The most strains or traumas prisoner must endure while in prison are potential lack of safety, potential lack of security, potential for emotional and physical abuse, and loss of identity, loss of freedom, isolation from 'normalized' outlets."

Other strains were mentioned by one therapist each and collectively provided evidence of a variety of parallel strains. For example, admitting mental illness could violate Need 2 (safety & security), Need 4 (self-esteem), and signify Strain 2 (overwhelming circumstances), according to T3. T2 mentioned gangs, racism, and sexual abuse. T5's references to drugs and undiagnosed substance abuse in other prisoners are

examples violations of Need 2 (safety & security) at a minimum. According to T1 and T2, lockdown and prison authorities, respectively, could potentially constitute all four of Agnew's strains, including Strain 1 (injustice), Strain 2 (overwhelming circumstances), Strain 3 (low self-esteem), and Strain 4 (susceptibility to criminal persuasion). As per T1, lockdown was the greatest source of strain, although the prisoner brought the conditions onto themselves: "Caveat: The only way that you're in a lockdown cell is if you have done something that caused you to go to lockdown. But that's not a normal situation." T2 added a cryptic suggestion, calling the interactions between prison authorities and prisoners a strain, leaving many unanswered questions about how prisoners in understaffed prisons make the rich richer: "Then it [also] depends on their interaction with the powers that be because it's known that basically they are there to provide a source of cheap income for outside businesses to make the rich richer." Finally, T4 mentioned the loss of identity and freedom due to isolation from "normalized" outlets that epitomizes prison life are violations of Maslow's Need 2 (safety & security) and Need 3 (love & belonging), Strain 3 (low self-esteem), and possibly also Strain 2 (overwhelming circumstances), again at a minimum.

T5 was the most precise: "The three worst strains or traumas individuals have endured in prison are having an unidentified substance abuse, separation anxiety, and safety issues." T5's reference to undiagnosed substance abuse is intriguing because one might suspect that many prisoners have unidentified substance abuse issues. Questions for future research about unidentified substance abuse issues might be important to pursue.

Results for RQ3

What prison factors create mental illness among U.S. prisoners?

The answer to RQ3 was two-fold. One, the top four parallel strains that create mental illness in prison are Strain 1 (injustice), Need 2 (safety & security), Need 3 (love & belonging), and Strain 2 (overwhelming circumstances). This was additional evidence of the overarching theme of parallelism (see Figure 1) in that strains that created mental health issues were parallel to strains that exacerbated them. Two, the prison therapists were divided on whether exposure to other prisoners with mental illness is or can be traumatic for a prisoner and therefore create mental health issues. All of the prison therapists' sources of strain from life in prison could create mental illness among prisoners. As evidence of the linkages between Maslow's needs, prison life, and Agnew's strains shown in Figure 1, all of these suggestions are examples of parallel strains.

The prison therapist with the most experience was T1. He cited separation anxiety as fundamental to creating mental illness among prisoners. In the following comments about the lack of social support in prison, T1 provided strong evidence of parallel strains via the unmet Maslow Need 3 (love & belonging) and Strain 3 (low self-esteem) even as he struggled to describe his views:

> I would say [the major strain is] being so far away from their family, not having family visit, not having family contact [or] support system, not able to really be engaged with them. I think it makes the person more depressed. Although we teach coping skills, being away from people and your [familiar social] surroundings can depress you more and create more feelings of separation.

> Some prisoners never see their family because they are so far away and the visitation hours are not always accommodating family members or support system to come in town, get a hotel to be able to see them just for 2 hours within that setting and take a plane back to where they're going.

T2 brought up a horrifying condition in "the way they're handled when they go in there." He gave the example of restraining prisoners in chairs. "In fact, they had a person with mental health issues who died in a Georgia prison. When they found him, he was infested with bed bugs. He basically was eaten alive." Physical restraint violates all of Maslow's needs and is a potent source of three of Agnew's four sources of strain (injustice, overwhelming circumstances, and low self-esteem), thus providing multiple types of parallel strains.

T3 cited conditions of prison life. "Things that might worsen create mental illness are lack of care such as food and showers. A big one would be not giving them enough recreation time." Inadequate food and self-maintenance resources, also cited by several other prison therapists, are examples of unmet Need 1 (physiology). Inadequate recreation time could be construed as an example of unmet Need 2 (safety & security) because a person cannot play in the truest sense of the word unless they feel safe to do so. Inadequate recreation time could be construed as an expression of the unmet Need 3 (love & belonging) because a person cannot play in the truest sense of the word unless they feel that they are among trusted companions. These provide multiple layers of parallel strains.

Table 6 lists the 11 conditions cited by T4 that exacerbate mental illness among prisoners. The majority of these were also cited by the other prison therapists. Just T4's comments alone provided tremendous evidence of parallel strains. All of the conditions

T4 named are examples of parallel strains of Strain 1 (injustice). Six conditions (54%) violated Need 2 (safety & security). Five conditions (45%) violated Need 3 (love & belonging). Four conditions (36%) were examples of Strain 2 (overwhelming circumstances). Two conditions (18%) were examples of Strain 4 (low self-esteem) and one (9%) was an example of Strain 4 (susceptibility to criminal persuasion).

Table 6

Prison Conditions That Create Mental Illness and Corresponding Parallel Strains

Prison therapist	Prison condition that exacerbates mental illness (violates Maslow's needs and/or amplifies Agnew's strains)
T4	Poor environment (Need 2, safety & security)
	Lack of privacy (Need 2, safety & security)
	Lack of health and mental health providers (Need 2, safety & security)
	Disregard for need for therapy (Need 2, safety & security; Need 3, love & belonging)
	Restricted access to medication, medical, and psychiatric services (Need 2, safety & security; Need 3, love & belonging)
	Harsh redirection (Need 2, safety & security; Strain 3, low self-esteem)
	Restricted access to prosocial environments (Need 3, love & belonging)
	Underfunded programs dedicated to addressing mental health providing psychoeducation to inmates (Need 3, love & belonging; Strain 2, overwhelming circumstances)
	Potential isolation practices to punish instead of teaching (Need 3, love & belonging; Need 4, esteem; Strain 2, overwhelming circumstances; and Strain 3, low-self-esteem)
	Unbalanced scale of justice (Strain 2, overwhelming circumstances)
	Corruption within prison hierarchy (Strain 2 overwhelming circumstances; Strain 4 susceptibility to criminal persuasion)

RQ3: Exposure to Other Prisoners With Mental Illness as Traumatic

As previously stated, trauma is a precursor to mental illness and mental illness is prevalent in prison. This led to the question of whether exposure to mentally ill prisoners constituted a renewed traumatic experience for a prisoner and could create mental illness. The prison therapists were divided.

T5 was the only therapist who declared incontrovertibly that exposure to mental illness was traumatic: "Having other incarcerated individuals exposed to unidentified trauma is very traumatic and can exacerbate mental illness." On the other hand, T1 was the only prison therapist who unequivocally disagreed that exposure constituted a traumatic experience for a prisoner. T1 argued that all prisoners should be exposed to one another because it helps normalize the situation for everyone. This is a possible candidate for parallel strains involving exposure to Strain 2 (overwhelming circumstances) because, in real life, it is possible to avoid a person with mental illness. In contrast, in prison, exposure may be unavoidable as well as chronic, according to T1:

> Out in the real world, we're exposed to mentally ill people all the time and we learn to adapt okay. I don't think that being exposed to a mentally ill prisoner would create a trauma. I don't think it's traumatic for a prisoner [because] being exposed to [mental illness] really helps them to understand mental illness.
>
> I think that sometimes it's a stigma to separate mentally ill people from the general population, which really creates more mental illness for the individual. Where if they're in the general population, they're able to learn how to adapt to regular lifestyle living.

The remaining prison therapists were equivocal about exposure creating mental illness. T2 did not say exposure was traumatic per se, but argued instead that segregating prisoners on the basis of their mental illness statuses was necessary to circumvent potential dangers to the prisoners:

> It depends if they know that this person has mental illness. First of all, they should separate them. Some people [are] claustrophobic, [reacting poorly when] they know they can't get out. People with mental illness are going to act out. If they have mental illness, they don't belong in with the regular people. You don't know. It could be a danger to the other person and a danger to that other person. It all depends.

For persons who are unable to ignore or accept the mental illness for what it is, a possible source of parallel strains is exposure to Strain 2 (overwhelming circumstances). Whether this is traumatic depends on the circumstances, according to T3:

> I think its 50-50. Some prisoners allow what others are going through to affect them. The ones that do allow mental illness of others get to them are worst off because they are dealing with their problems and everyone else's problems. Some are strong enough to walk away and do their own thing by staying on track. Most don't want to fall in a rabbit hole, and they would do whatever that can to get out.

Results for RQ4

What is the availability of mental health services in U.S. prisons?

The prison therapists showed complete consensus: Resources are inadequate, limited in both availability and effectiveness. T5 said that care was inadequate because of a general dearth of "better qualified and trained staff." T3 was blunt and succinct, "There

is not enough resources to help inmates that deal with mental illness. We don't have enough staff compared to the inmates with mental illness." Like T3, T1 conceded that there are some resources "but they're never enough. For mentally ill prisoners, you need a lot of individuals and you know that is limited. We have a waitlist for individual therapy."

Results for RQ5

What is the effectiveness of mental health services in U.S. prisons?

Though it could be construed as quite a damning commentary on his years as a therapist, T4 simply said "No" when asked if prison mental health services were effective. Despite consensus on the general inadequacy of mental health care in prison (see Figure 1), therapists had diverging perspectives on which resources were lacking. T1 pointed out how prison therapy is "inherently limited" because the social systems in which the prisoner will operate once released from prison, especially the family system, is not available for the therapist to work with:

> It's limited in what we can do with the prisoners that are incarcerated. For example, giving prisoners information one-on-one is not always enough because you need to work with the family and the dynamics of when they return back to their population, how they're going to deal with it. Teaching family members how to deal with them, how to discuss them.

T2 argued that a substantial source of ineffectiveness is the lack of training for guards to understand mental illness. In T2's experience, most guards were ill-equipped or poorly-equipped because they lacked the rudiments of understanding mental illness.

According to T2, this was an example of another parallel strain, this time between guard and prisoner:

> I don't think so at all. Training the guards how to deal with mentally ill people and all that . . . a lot of that is missing. Just because [a prisoner has] a mental illness don't mean that they can't function. You know, they process things differently. But if you're not training the people that you hired to understand this, then they're treating them like regular prisoners. [Guards] feel like these people are insulting them or not obeying them. That's how they get hurt. [Guards] don't know they need better training. [Guards] think [a mental ill prisoner is] faking it . . . maybe some of them are. But how do you know? How do you? You know, you don't. They should have a section for mental illness and put them in. That's what they need. Don't put them in [with the] general population.

RQ5: Roles of Mental Illness in Recidivism

To further explore the lines of counseling effectiveness for RQ5, prison therapists were asked for their views on the role of mental illness in recidivism. Recidivism is re-arrestment after serving one's sentence and is released from jail. It is the tendency to reoffend and leads to the former prisoner being arrested and sentenced again (Vito & Maahs, 2021). The idea here was that effective mental health services ought to reduce recidivism because recidivism is related to a person's ability or inability to reintegrate into society. The prison therapists shared the common lived experience of a strong linkage between mental illness and recidivism. Most of the prison therapists thought that mental illness is the leading cause of recidivism. According to T4: "Large role. Due to untreated mental illness or undertreated mental illness, persons are more likely to

reoffend if not set up proper follow up, continuity of care." Similarly, T5 asserted that, "Mental illness has a vital role in recidivism. [Needed are] more support systems, properly identify mental illness disorder, treatment as well as gainful employment." According to T3, "many prisoners are not provided the necessary resources, care, or knowledge to deal with mental illness" and thus become embroiled in "a negative cycle of continued reoffending." T3:

> I believe mental illness is the leading cause of recidivism. Many prisoners are not provided the necessary resources and care to deal with mental illness. Becomes a negative cycle of continued reoffending again due to either lack of care or knowledge of how to deal with their particular mental illness."

According to several therapists, many mentally ill prisoners lack the wherewithal to manage basic self-maintenance duties once they have served their sentence and been released to life outside of prison. While the prisoner is still serving their prison sentence, the prison therapist is hamstrung because they cannot feasibly anticipate the prisoner's needs once they have been released. Moreover, many prisoners lack the general skills of making a living and setting up a household. T1 noted, "That's a very tough question because their basic needs are met at prison," so indications that a prisoner may lack the ability to take care of themself once outside of prison are invisible and probably inaccessible to the prison therapist. T1:

> That's a tough question for me to answer because I believe everybody [does] their best to bring the individual up to the point they need to. But a mental illness continues to fluctuate, especially in prison. You don't know how this person is really going to do. . . . They're in confinement. You don't really know when

> they're back in the world setting and all the things that is in the world that they have to deal with. They don't have to deal with paying rent. They don't have to deal with being homeless. They don't have to deal with purchasing their own food. Their basic needs are met at prison. So when they get back, it's tough because these people are going back into [reality] all over the world.

T2 cited the specific example of military vets becoming homeless and returning to prison "simply" to have a place to live. T2 said that the lack of the skills of establishing and maintaining a stable household is crucial to recidivism. "Basically, I think it's a big role. Look at the vets. They're on the street. They become homeless. They're coming back because they need a place to sleep. They try to steal, and it may not be a lot, but that's what they do." T2:

> Some of them do have mental illness. That's what they do. OK. And a lot of the vets who've gone over and fought for this country come back with mental illnesses and they end up in [prison]. So, no matter what, it's training these people to recognize it and training the public to understand that sometimes these guards have to do what they have to do because the mentally ill can kill too. That's true.

Recommendations for Improvement

The prison therapists were not explicitly questioned on their recommendations for improving the situation. However, a few recommendations emerged. T5 had a short list of what is lacking: more qualified and trained staff members, competent assessment tools, more space, and improved locations of buildings. T4 also had a short list of improvements, including having appropriate and available programs, more engaged staff

members, serving enough food, providing access to cleaning supplies, letting the prisoners have enough showers and recreational time, and access to a law library.

This chapter presented evidence of many parallel strains pertaining to separation anxiety and violations of Maslow's (1998) Need 2 (safety & security) and Need 3 (love & belonging). One important recommendation pertained to the provision of family and friends. Because prisoners cannot request to be moved to a prison closer to their family and many family members are financially unable to visit incarcerated relatives, T1 thought that, "Changes that might improve conditions are related to available finances that enable the prisoner to reach out to family." That might enable a prisoner's family "to come visit even if only once a month or once a quarter."

T2 suggested revisiting the reasons for incarceration to eliminate or find other venues for people who commit minor crimes:

> Prisons and jails would not be overpopulated if they get rid of the nickel and dime bags that they put in there, yeah, and [people they incarcerate without] enough evidence. If you go back and pull up some of those old cases, people are getting out now with the Innocence Project. Yes, a lot of [unnecessary imprisonment] is going on. Sad.

T2 went further to point out that the lack of staff training created more parallel strains. T2 recommended more guard training: "They need more education on how to treat mentally ill people anyway." T2 saw several dimensions to the need for more training:

> It depends on who they bring in, whether these guards are trained properly, whether they pay properly, whether they take in whatever goes on. First of all, all of the people that are in jail don't need to be in there. Number one. What do you

need to be in jail for? It depends on if you have marijuana or an edible. A ticket would do. It's what it is. They're not going to stop [petty incarceration].

The sad part is that they are mixing them. Some of these children, bound over for some of the stupid stuff that they do, are put in with grown men. I don't know if they put just anybody in with the hard core. But we know what happened to them. You see where I'm coming from?

It's [also] personal, because when I was a police officer, I didn't take that person. I had to become hardcore though. And I would tell them, I'm going home at the end of the night. You have a choice. You can go the easy way or the hard way, but you are going down to that prison.

It starts from the top down. It has to start at the top. Because they're hiring people who are afraid to be in there. I don't know how they do it. Imagine you are [a police officer or guard] in a new jail. The bottom line is that you are outnumbered. You can be taken over any time.

OK, it's just a certain amount of fear [the guards] put in [prisoners] to keep them in their place, but they're outnumbered. That's scary. So, I think it starts at the top treating people the way you might want to be treated if you were incarcerated. Let's face it, federal jail is a party. Right? Right. So, what's stopping them from treating the other? The federal jails, they're good. It starts at the top training.

Summary

The overall purpose of this research was to understand the connections between mental illness and prison. The qualitative design was an ontological phenomenology, in

which 12 prison therapists were interviewed in two separate waves in order to triangulate the results. The participants brought to the study a breadth of professional licensures and 8–30+ years of experience counseling prisoners with mental health issues. Results began with a condensed explanation of the main and overarching themes, illustrated in a thematic schematic (see Figure 1). Evidence from the prison therapists' lived experiences revealed on overarching theme of parallel strains resulting from the combination of a prisoner's past with their present life of incarceration. Pressures from the past and the present were from two major sources: the unmet basic needs of Maslow's (1998) hierarchy of needs theory and strains experienced as adults that led, at least in part, to their criminal behavior listed in Agnew's (1992) GST. Prison life continues to exert these pressures. This study's overarching theme of parallel strains predicts that prison life exacerbates and at times even creates the factors that contribute to mental illness, for which supporting evidence was also forthcoming.

The researcher took several steps to ensure that the data were valid and reliable. These included reflexivity and bracketing, careful selection of participants with the appropriate credentials, systematic data collection with remote face-to-face interviews, much paraphrasing during the interviews, member checking, and triangulation between two separate sets of interviews to ensure the validity, reliability, and trustworthiness of the data and analysis.

There were five research questions. RQ1 was, "What is the nature and prevalence of mental illness among U.S. prisoners?" The answer to RQ1 is three-fold. One, estimates of prevalence ranged from 75–100%. Two, the most common types of mental illness

were depression, schizophrenia, and anxiety. Three, mental health treatment plans were comparable across male and female prisoners.

RQ2 was, “What prison factors exacerbate existing mental illness among U.S. prisoners?” The answer to RQ2 was two-fold. One, preexisting trauma was a given in subsequent mental illness. Two, the three worst strains on prisoners in the eyes of prison therapists are violations of Maslow’s (1998) Need 2 (safety & security) and Need 3 (love & belonging), along with demonstrations of Agnew’s (1992) Strain 2 (overwhelming circumstances), as shown in Figure 1.

RQ3 was, What prison factors create mental illness among U.S. prisoners? The answer to RQ3 was two-fold. One, the top four parallel strains that create mental illness in prison are Strain 1 (injustice), unmet Need 2 (safety & security), unmet Need 3 (love & belonging), and Strain 2 (overwhelming circumstances). Two, the prison therapists were divided on whether exposure to other prisoners with mental illness is or can be traumatic for a prisoner.

RQ4 was, “What is the availability of mental health services in U.S. prisons? The answer was based on complete consensus among the prison therapists: Resources are inadequate and limited in availability.

RQ5 was, “What is the effectiveness of mental health services in U.S. prisons? The answer was also based on complete consensus among the prison therapists: Resources are of limited effectiveness.

This study served to examine the complex relationship of mental illness and incarceration with special emphasis on the high prevalence of mental health issues among the prisoners and inadequacy of mental health care services in U.S. prisons. By using

qualitative methods and thematic analysis, findings showed how prisoners in the prison population are affected by diverse mental health conditions and often deteriorate further in the abusive prison environment. The prison therapists reported that the prison system is experiencing critical challenges in their attempts to provide adequate mental health care for inmates; therefore, major deficiencies that are systemic in addressing the needs of mentally ill inmates in this system are revealed. The main lesson from this research is that mental healthcare inadequacy in prisons is of tremendous significance and also leads to the mental state of the inmates being worsened when they do not receive treatment.

This study showed that there is an urgent need to review the mental health services in U.S. prisons and champion the transition from the traditional mental healthcare service that addresses the individual to the comprehensive, accessible, and effective mental healthcare solutions that must be integrated into the correctional system. Such a transition means adopting evidence-based practices as well as policies which, in turn, place a significant weight on mental health rehabilitation and prisoner reintegration as societal process. Along with these findings, there is a significant insight stemming from the research surrounding the problem of tackling the root causes of criminality, particularly with mental health problems. The findings suggest that provision of mental health care through a combination of both prison and nonprison channels may provide a way of not only reducing self-harming behaviors among incarcerated individuals, but also of preventing recidivism.

CHAPTER FIVE: CONCLUSION

Overview

Chapter Five is a summary of the research itinerary, which condenses the exploration of the complex connection between mental health conditions and the prison environment. This chapter revisits the study's purpose, which was to uncover the spread of mental health issues among incarcerated people, explore the factors within prison institutions that aggravate these circumstances, and assess the suitability and efficiency of the mental health services offered. This chapter then highlights the main conclusions and proceeds to a detailed analysis of them, relating to the existing research and theories. The chapter discussion is closely focused on the methodological and practical implications of the study, which are beyond the academia and are helpful for policy makers and practitioners in the correctional mental health care.

Moreover, the chapter addresses the obstacles faced during the research and gives some suggestions for the future investigations, which highlight this study as a part of the ongoing discussion on criminal justice and mental health. This chapter was designed to help readers better comprehend the hurdles as well as opportunities for improving mental health support in prisons, and help them advocate for enlightened and compassionate changes.

Summary of Findings

The research uncovered critical data on the mental health status within the prison system, which answered the questions posed. It proved that mental health problems were very common among the prisoners as the therapists continuously pointed to the high number of cases of depression, anxiety, and schizophrenia. This dominance indicates the

urgent need of the comprehensive mental healthcare within correctional facilities. The investigation of the prison environment also showed that overcrowding, isolation, and absence of privacy aggravates the mental health problems. These environmental stressors play an important role in the degeneration of inmates' mental health, underlining the prison as a vital intervention spot. It was observed that the number of mental health services was insufficient, and there was a considerable discrepancy between the services needed and the services provided. The therapists discussed the lack of resources, inadequate staffing, and systemic factors including stigma and insufficient training as the major impediments to high-quality care.

This information gives an indication of the resources that are still undiscovered for coping mechanisms and peer support that can be introduced into the formal support system. Together, these findings cover a broad picture of the current state of mental healthcare in prisons, highlighting that reforms are required immediately. The research also highlights the crisis that mental health issues have become in the U.S. prison system, where not only are they widespread but deeply ingrained in the culture of the correctional setting. The fact that mental health disorders among inmates, as revealed by the prison therapists, are prevalent indicates a problem that needs immediate and holistic actions. The result is not only a reflection of the mental health problems in society but also an aggravation of the poor and often tricky conditions within jails.

Overcrowding, isolation, and a severe lack of privacy have been mentioned as the significant aggravators of mental health problems, and the grim picture of inmates' day-to-day reality is that these issues are their daily companions. Such causes create a situation that is not only not conducive to mental health recovery but exacerbates the

current conditions. The austere nature of prisons, with the continuous presence of these stressors, highlights the necessity to see the prison system as the center point of care for mental health problems. Unfortunately, I discovered a significant discrepancy between the mental health services needed and those provided. Therapists mentioned that the lack of resources, inadequate training of personnel, and systemic issues such as stigma and insufficient training were the major obstacles to providing quality care.

Such components as resilience and mutual help among prisoners are the unrecognized sources and methods of survival that, if officially acknowledged and included in the mental health care system, could significantly improve the overall well-being of incarcerated persons. This result indicates the possibilities for positive peer influence and support that can be taken advantage of to improve inmates' mental health. The study has critical findings that make a holistic picture of the current situation of mental health care in prisons, convincingly proving the urgent requirement for reform. The numbers illustrate how the systemic and environmental factors further aggravate mental health problems in prisons and that this requires a root-and-branch overhaul of the mental health care system inside these establishments. The findings bring to the forefront a paradigm shift that is centered on a more comprehensive approach to mental health care in prisons, one that takes into account the intricate interaction between environmental factors, mental health challenges, and the possibility of peer support and resilience.

Discussion

Empirical Literature

The research uncovered critical data on the mental health status within the prison system, which answered the interview questions. In addition, the study provides that

mental health problems were very common among the prisoners, and the therapists continuously pointed to the high number of cases of depression, anxiety, and schizophrenia. This dominance indicates the urgent need for comprehensive mental health care within the correctional facilities. The investigation of the prison environment also showed that overcrowding, isolation, and absence of privacy aggravates the mental health problems. These environmental stressors play an important role in the degeneration of inmates' mental health, which underlines the prison as a vital intervention spot (Papagathonikou, 2021). Participants observed that the number of mental health services was insufficient, and there was a considerable discrepancy between the services needed and the services provided. The therapists discussed the lack of resources, inadequate staffing, and systemic factors including stigma and insufficient training as the major impediments to high-quality care. According to Knaak et al. (2017),

> Inadequate skills and training seem to be associated with stigmatization in two ways. First, it is believed to lead to feelings of anxiety or fear and a desire for avoidance and social/clinical distance among practitioners, which can negatively impact patient–provider interactions and quality of care. Second, it can lead to less effective treatment and poorer outcomes. (p. 2)

While the prison environment presents a number of difficulties, the emergence of unexpected themes of resilience and the formation of informal support networks among prisoners were identified. This information gives an indication of the resources that are still undiscovered for coping mechanisms and peer support that can be introduced into the formal support system. Together, these findings cover a broad picture of the current state of mental health care in prisons, highlighting that reforms are required immediately.

Theoretical Literature

The GST (Agnew, 1992) was presented in Chapter Two to give a new perspective on the role of specific strains, such as prison life, in the mental health problems of the inmates. The GST was applied to assess the connection between social pressures and criminal behavior (Celik, 2022). However, this study went further by delving into the microlevel strains that occur in prisons. The study emphasized that particular strains such as loneliness, privacy deprivation and exposure to violence can directly lead to deterioration of mental health problems, which may provide evidence for the GST use in the correctional setting. In addition, this research provided fresh perspectives on the role of the GST in inmates as it looks into the coping mechanisms that the inmates use to deal with these strains and the effects of these mechanisms on mental health outcomes. The GST presents institutional coping strategies as a very important factor that may either help to reduce or exacerbate mental health issues in prisons. This expansion of the GST, however, does not only make one's understanding of the complex relationship between strain, coping mechanisms, and mental health among inmates deeper but, in fact, reveals the multifaceted nature of this relationship.

Novel Contributions

This research resulted in some new ideas that are important for the discussion. First, it enabled an in-depth exploration of the occurrence of mental health disorders within different security levels of prisons, in order to understand the environmental factors that might have an effect on the development of such disorders among inmates. Moreover, with the help of the GST and empirical findings regarding institutional coping mechanisms, this study served to develop a new theoretical approach for the investigation

of mental health in prisons. The approach put forward can be used as a basis for future research and intervention programs which will, in turn, reduce the problems of mental health in the incarcerated population.

Implications

Theoretical Implications

The results of this study have huge theoretical implications for the mental health of prison residents as they are being seen through the lens of the GST. This research expands the GST further by isolating the particular strains that are present in prison settings and pinpointing how the mental health of the inmates can be affected by the nuances of such strains in a highly structured and potentially stressful environment like a prison. The study findings imply that the GST can be a good basis to explore the relationship between social pressures and criminal behavior as well as the mental health of prisoners in jails. The GST thus points to the importance of theoretical models which consider the specific stresses of different institutional environments, as well as the psychological impact, as the foundations for future psychological and criminological theorization and development.

Empirical Implications

Empirically, this study enriches the knowledge about mental health disorders in prisons, by providing detailed information on how different security levels and institutional pressures affect the occurrence and spectrum of mental health problems. The implications of these findings for the research methodologies of criminal justice and psychology are in the development of more detailed, context-based approaches to studying mental health in the prison environment. This investigation has highlighted the

need for the consideration of the environmental and security-related factors that aggravate mental health problems, thus future empirical studies should be conducted to find more differentiated and contextualized perspectives when investigating mental health in prisons. In addition, this study emphasizes the need for longitudinal research in order to understand the long-term effects of incarceration on mental health which calls for empirical studies that trail individuals throughout their incarceration..

Practical Implications

The study findings from a practical perspective have meaningful implications for policymakers, prison administrators, mental health specialists, and reform advocates who aim to change the prison system and improve the mental health of inmates. Identifying the unique strains based on specific strains of mental health within different prison environments is a prerequisite to designing appropriate interventions that will help to alleviate these challenges. For example, approaches involving measures to reduce isolation, increase privacy, and manage violence exposure will be the most significant steps in dealing with mental health in prisons. It is important for policymakers and prison authorities to take note of these findings and use them in the development of policies and programs aimed to improve mental health care in prisons. This could be done through allocating resources for intake mental health screenings and mental health services throughout the period of incarceration, with the goal of ensuring that the treatment is tailored to the specific needs and security levels of inmates.

Such research reinforces the fact that mental health professionals working in carceral settings must grasp the peculiar environmental stressors faced by inmates and take these into consideration in their therapeutic plans. Skill development for prison

employees on the mental health consequences of incarceration and methods for inmate mental health support can be of great value. In addition, the study's results call for reforms that address the basic causes of mental health problems in prisons including overcrowding, lack of meaningful involvement in activities, and insufficient mental health resources. Advocates and reformers will be able to use this research to make the case for changes that ensure that inmates with mental health issues are given more attention and support, including the development of alternative sentencing programs for mentally ill offenders and the expansion of reentry support services to facilitate their successful return to the community.

Delimitations and Limitations

Delimitations

The study had several purposeful decisions which were aimed at defining the scope and focus, therefore increasing the feasibility and appropriateness to the research objectives. First, the restriction of participants to those who are over 18 years old was made to correspond with ethical standards and to concentrate on adult prison populations where mental health issues are more prominent. Furthermore, the research applied a qualitative methodology, but more specifically an ethnographic approach instead of a phenomenological one. This decision was an attempt to dig deeply into the lived experiences of prison therapists and get their perspectives on mental health care in prison settings, which would later be used to create a more detailed picture of the complex interactions between prison environments and inmate mental health. This approach ensured a deeper comprehension of the institutional and systemic obstacles that hinder mental health care provision in carceral settings.

Limitations

The study's limitations are a result of its design, sample selection, and methods of analysis. The qualitative nature of the research, though it provided depth, is limited in its generalizability that is it unable to be applied across all prison populations and settings (Baffour et al., 2022). The attention to prison therapists as the main actors did not include the inmates' viewpoints, therefore there can be a possible bias in the perception of the efficiency of mental health services in prisons. Besides, the sample size of the study consisted of prisons located in the Southeast region of the United States which limits the applicability of the findings to other regions with different prison systems and policies. Factors including gender, age, ethnicity, and geographical location of participants were not uniform, which could have affected the study outcomes and their interpretations. These shortcomings, however, point out the need for further research which will help to clarify the conclusions and address the identified gaps.

Recommendations for Future Research

The next step for future research is to go beyond the boundaries of the current study, in order to enrich and expand knowledge about the mental health problems existing in the prison system. Firstly, research should be designed to be more inclusive and incorporate participants from different demographic groups, such as male and female, young and old, various ethnicities, and geographic locations (Robertson et al., 2020). Such diversity would strengthen the applicability of the results across different prison populations and settings. Secondly, the future researchers should consider a mixed-methods design which would combine the depth of qualitative data with the breadth of quantitative data (Hemming, 2021). This method can provide a broader

perspective on the occurrence and the influence of mental health problems among prisoners and the efficiency of interventions. Furthermore, researchers must conduct longitudinal studies to see the long-term results of mental health interventions in the prisons. These studies could help in assessing the longevity of treatment effects and in determining the prospects of reducing recidivism rates among individuals with mental health problems. Lastly, future researchers should examine the influence of particular prison rules and procedures on mental health, such as the application of solitary confinement and access to mental health services. Research into such areas might uncover evidence-based suggestions for policy changes that are meant to improve the mental health status of incarcerated persons.

Summary

This study was an examination of the complex relationship of mental illness and incarceration with special emphasis on the high prevalence of mental health issues among the prisoners and adequacy of mental health care service in U.S. prisons. By using qualitative methods and thematic analysis, findings showed how many of the prison population affected by diverse mental health conditions can deteriorate with the abusive prison environment. The study indicated how the prison system is experiencing critical challenges with providing mental health care for inmates; therefore, major systemic deficiencies in addressing the needs of mentally ill inmates in this system were revealed. The main lesson from this research is that the inadequacy of mental care in prisons is of tremendous significance and also leads to the mental state of the inmates being worsened when they do not get treatment. This study showed that there was an urgent need to review the mental health services in the prisons and champion for the transition from the

traditional mental health care service that seeks to address the individual to the comprehensive, accessible, and effective mental health care solutions that are integrated into the correctional system. The study also highlighted the importance of adopting evidence-informed practices as well as policies which, in turn, place a significant weight on mental health rehabilitation and prisoner reintegration as societal process.

Along with these findings, the study provided a significant insight stemming from the research surrounding the problem of tackling the root causes of criminality, particularly with mental health problems. The results suggest that provision of mental health care through a combination of both prison and nonprison channels may provide a way of not only reducing.

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APPENDIX A: IRB APPROVAL

January 12, 2024

Ingria Haywood

Sharon Mullane

Re: IRB Exemption - IRB-FY23-24-928 EFFECT OF INCARCERATION ON PRISONERS DIAGNOSED WITH MENTAL HEALTH CONDITIONS: TRAUMA, TREATMENT, AND TRANSITIONING

Dear Ingria Haywood, Sharon Mullane,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may

report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, PhD, CIP

Administrative Chair

Research Ethics Office

APPENDIX B: INVITATIONAL FLYER

Hello Potential Research Study Participant:

> As a student in the Helms School of Government at Liberty University. I am conducting research as part of the requirements for my PhD. The purpose of my research is to interview licensed therapists or counselors to get an understanding from an inside point of view about Effect of incarceration on prisoners diagnosed with mental health conditions: Trauma, Treatment, and Transition. If you meet my participant criteria and are interested, I would like to invite you to join my study.

To participate, you must be a licensed therapist or counselor, and willing to discuss mental health treatment and services provided to male/female inmates. If you agree to be in this study, I will ask you to participate in a 30–60-minute interview. After the interview, participants will be asked to participate in member checking, which is the process of checking your interview transcripts for accuracy. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

> Would you like to participate? [Yes.] Great, could I get your email so I can send you a zoom request with the date and time of the interview? Once we received zoom request just accepted the time and date. We will complete the interview on the time and date. [No.] I understand. Thank you for your time.
>
> A consent document will be given to you via email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me via email before the interview.
>
> Thank you for your time. Do you have any questions?
>
> Sincerely,
>
> Ingria Haywood,
> Doctoral Candidate-Liberty University

APPENDIX C: INFORMED CONSENT FORM

Title of the Project: Effect of incarceration on prisoners diagnosed with mental health conditions: Trauma, Treatment, and Transition.
Principal Investigator: Ingria Haywood, Ph.D. student at Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be a licensed therapist or counselor, and willing to discuss mental health treatment and services provided to male/female inmates. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to address inmates' mental health diagnose treatment while incarceration.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in a 30–60-minute interview.
2. Validate your transcribed interview responses.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include understanding mental health condition and the treatment they receive while they are incarceration.

What risks might you experience from being in this study?

The risks involved in this study include are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms.
- Interviews will be conducted in a private location where others will not easily overhear the conversation.
- Data collected from you may be shared for use in future research studies of with other researchers. If data collected from you is shared, and information that could identify you, if applicable, will be removed before the data is shared.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be audio-recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer and question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Ingria Haywood. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] You may also contact the researcher's faculty sponsor, Sharon Mullane at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researchers will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.