SECONDARY TRAUMATIC STRESS, COMPASSION FATIGUE, AND BURNOUT:

HOW WORKING IN CORRECTIONAL SETTINGS

AFFECTS MENTAL HEALTH PROVIDERS

A Dissertation

Presented to the Faculty of

Antioch University Seattle

Seattle, WA

In Partial Fulfillment

of the Requirements of the Degree

Doctor of Psychology

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September 2016

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DOCTOR OF PSYCHOLOGY

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ABSTRACT

SECONDARY TRAUMATIC STRESS, COMPASSION FATIGUE, AND BURNOUT:

HOW WORKING IN CORRECTIONAL SETTINGS

AFFECTS MENTAL HEALTH PROVIDERS

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Over the last three decades, there has been a sharp increase in the number of people incarcerated within the United States. A significant number of those incarcerated have been diagnosed with a mental health disorder. Subsequently, as the incarceration rate rises, so does the need for qualified mental health professionals who are able to treat mentally ill prisoners. Correctional mental health providers work in very dangerous, oppressive, and often chaotic settings, with very little control over their environment. They must address daily episodes of violence and threats from inmates with histories of murder, rape, and assault, while still maintaining their ability to engage in a therapeutic relationship. They must be able to address a wide array of psychiatric and behavioral issues exhibited by the inmates, including acute psychosis, chronic depression, bipolar disorder, and various personality disorders, while simultaneously developing a constructive treatment plan. Additionally, many inmates have experienced extreme cases of trauma, often sharing vivid descriptions of abuse and suffering. These combined factors can eventually contribute to the development of secondary traumatic stress, compassion fatigue, and burnout amongst correctional mental health providers. This research will examine how correctional mental health providers cope with the effects of working with the prisoner population and how it affects their own mental health. This research is specifically interested in

how trauma exposure manifests in the form of Secondary Traumatic Stress amongst correctional

mental health staff. The electronic version of this dissertation is at AURA: Antioch University

Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center,

https://etd.ohiolink.edu

Dedication

This paper is dedicated to my late parents, Rosie and Biscayne Johnson, whose love and support I will cherish forever.

Acknowledgments

I am grateful to so many people who have traveled with me through this journey that I hardly know where to begin. I would like to thank my family and friends, for their continuous words of encouragement, and unyielding confidence in my abilities, with a special recognition to my aunt Ardella, who has been my biggest cheerleader and inspiration. I would also like to express gratitude to my friends, colleagues, and professors at Antioch University Seattle, and particularly, my dissertation committee, whose wisdom and experience guided me through this process. I would also like to convey a special thanks to my committee chair, Mark Russell, and my academic advisor, Mary Wieneke, without whom I could not have completed this process. Lastly, I cannot express how grateful I am to the volunteers and participants of this study. I have been truly touched by their compassion, generosity, and their willingness to share their stories and experiences..

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Chapter I: Introduction

Overview

Secondary traumatic stress (STS), *compassion fatigue* (CF), and *vicarious traumatization* (VT) are just a few of the terms used to describe the potentially deleterious effects of treating trauma victims and those struggling with emotional and psychological distress. (Devilly, Wright, & Varker, 2009). Although there is much debate regarding the specific definitions of these terms, Devilly et al. (2009) and Figley (1995) all agree that the effects can be financially, emotionally, and physically damaging to individuals, their families, patients, and organizations. Those who develop these conditions exhibit an array of symptoms including anxiety, depression, insomnia, and intrusive imagery (Figley, 1995). Those struggling with STS experience symptoms identical to post-traumatic stress disorder (PTSD), differing only by secondary nature of the traumatic material.

Although studies exploring rates of suicide amongst psychologists have yielded mixed results (Kleespies et al., 2011; Mahoney, 1997; Phillips, 1999), there is evidence to support heightened levels of depression and suicidality amongst psychologists. In one national study of 800 psychologists, Pope and Tabachnick (1994) discovered that the majority of participants had been in therapy and 61% of those individuals reportedly experienced at least one episode of clinical depression. Furthermore, 29% of these individuals acknowledged suicidal ideation, with 4% having made at least one suicide attempt. These findings were validated by Gilroy, Carroll, and Murra (2002). In a study of 1,000 randomly selected counseling psychologists, 62% identified as depressed, of which, 42% admitted suicidal ideation and/or behaviors. In addition to the emotional and psychologically devastating aspects of depression and suicide, many practitioners express disruption in their professional abilities due to anxiety, burnout, and

depression (APA, 2010). Therapists may exhibit decreased energy and motivation, fatigue, and memory deficits, which can also lead to ethical violations and malpractice (Gilroy et al., 2002; Moursund, 1993; Sherman, 1996). Often organizations and community mental health agencies suffer an economic loss due to increased absenteeism, higher turnover, and lower productivity (Maslach & Leiter, 1997).

Several factors contribute to the development of STS, including environmental factors (work setting, perceived organizational support, caseload size, client needs, and collegial relationships), as well as individual factors, such as the level of education, level of experience, and coping styles (Dagan, Itzhaky, & Ben-Porat, 2015; Figley, 2002; Walsh & Walsh, 2002). Furthermore, Salston and Figley (2003) found that individuals with a personal history of trauma may be more vulnerable to developing STS. Subsequently, STS does not impact everyone exposed to traumatic material. Nonetheless, correctional mental health providers are presented with an exceptionally high risk due to their clientele (McCann & Pearlman, 1990). Incarcerated men and women tend to have particularly high levels of chronic and childhood trauma, depression, and repeated exposure to violence (Wolff, Blitz, Shi, Siegel, & Bachman, 2007). The primary component of the therapeutic relationship involves developing an empathic, and even intimate relationship with another individual. Subsequently, mental health professionals, such as psychologists, social workers, and counselors, face a high risk of developing STS because of the nature of their work.

As correctional mental health providers are constantly exposed to a tremendous amount of trauma and suffering, it is reasonable to believe that they, too, would experience high rates of primary and secondary traumatic stress, resulting in loss of income and productivity. The purpose of this study is to explore how mental health providers working within correctional

facilities are affected by constant exposure to trauma and to better understand their experience of STS.

Incarceration of the Mentally Ill

The practice of punishing and imprisoning people with mental illness is not a new phenomenon. Throughout history, those suffering from severe and persistent mental illness have often been isolated and marginalized from mainstream society (American Experience, 2002). Nevertheless, what has changed is the volume of mentally ill people who are presently being criminalized and incarcerated within the United States. Furthermore, the experience of being incarcerated can create or exacerbate mental health issues amongst inmates (Bradley, 2009; Goomany & Dickinson, 2015). These factors have given rise to the field of Correctional Psychology, which focuses on clinicians who practice within various correctional facilities and institutions. As of March 2009, the Federal Bureau of Prisons employed over 450 psychologists to work in federal correctional facilities throughout the country (Gross & Magaletta, 2009).

The deinstitutionalization movement of the 1970s led to a dramatic decrease in access to mental health care in the United States (Prins, 2011). One of the latent consequences of deinstitutionalization (also known as transinstitutionalization) was the shift of those with mental health issues from hospitals and treatment centers to the correctional system (Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984). Add to this the rapid increase in incarceration rates in the United States for a variety of offenses, including non-violent drug offenses, and the correctional system has become a major location for mental health care in the United States (Steadman, Osher, Robbins, Case, & Samuels, 2009). A 2013 review conducted by the International Centre for Prison Studies (ICPS) noted that the incarceration rate within the United States is greater than any other nation in the world (Walmsley, 2014). According to the U.S.

Bureau of Justice Statistics, by the end of 2013, there were 1,574,700 individuals incarcerated in

state and federal institutions (Carson, 2014). This figure rises to nearly 6.9 million when local,

city, and county inmates are included, as well as those under community supervision, in the form

of probation, parole, and electronic home monitoring. During the last two decades of the 20th

century, the number of individuals sentenced to federal and state jails and prisons increased by

350%.

Many incarcerated individuals come from diverse backgrounds fraught with poverty,

violence, underemployment, poor education, substance abuse, and mental illness (Wolff et al.,

2007). According to the most recent study released by the Bureau of Justice, by midyear 2005,

nearly half (1,264,300) of incarcerated men and women had a mental health problem—defined

as "a recent history or symptoms of a mental health problem—as defined by the DSM-IV-

occurring 12 months prior to the interview" (James & Glaze, 2006, n.p.). Of these 1,264,300, the

following was revealed:

- Jail inmates who had a mental health problem (24%) were three times more likely than jail inmates without (8%) to report being physically or sexually abused in the past.
- State prisoners who had a mental health problem were twice as likely as state prisoners without to have been injured in a fight since admission (20% compared to 10%).
- Female inmates had higher rates of mental health problems than male inmates (state prisons: 73% of females and 55% of males; local jails: 75% of females and 63% of males).
- About 74% of state prisoners and 76% of local jail inmates who had a mental health problem met criteria for substance dependence or abuse.
- Nearly a quarter of both State prisoners and jail inmates who had a mental health problem, compared to a fifth of those without, had served three or more prior incarcerations.
- Over one in three state prisoners and one in six jail inmates who had a mental health problem had received treatment since admission. (p. 1)

Many jails and prisons are severely overcrowded, with an overabundance of people with

antisocial personality traits, gang-involvement, and poor coping skills (Toch, 1985; Travis et al.,

2014). Correctional facilities also possess high concentrations of individuals with severe mental illness and those who have both suffered and inflicted trauma. In a study of trauma-exposure and posttraumatic stress disorder (PTSD) amongst 592 incarcerated men, researchers found that as many as seven out of ten incarcerated men reported episodes of childhood physical and/or sexual abuse or neglect (Wolff, Huening, Shi, Frueh, & Hoover, 2014). Similar findings have occurred in studies of female inmates, with as many as 80% reporting a past or present psychiatric diagnosis and 34% meeting the diagnostic criteria for posttraumatic stress disorder (James & Glaze, 2006). Subsequently, correctional mental health providers engaged in a therapeutic relationship with these individuals risk exposure to an inordinate amount of traumatic material.

Correctional System Definitions

According to the Washington State Penal Code, the term *correctional institution* refers to

any place designated by law for the keeping of persons held in custody under process of law, or under lawful arrest, including state prisons, county and local jails, and other facilities operated by the department of corrections or local governmental units primarily for the purposes of punishment, correction, or rehabilitation following conviction of a criminal offense. (Revised Code of Washington 9.94.049)

These facilities may include prisons, jails, federal detention centers, and psychiatric institutions. Although these terms are often used interchangeably, these facilities actually serve different functions, and each present a series of unique challenges for psychologists.

Jails and Detention Centers

The United States Bureau of Justice Statistics defines jails and detention centers as generally short-term facilities operated by county or city governance. (Carson, 2014). These facilities are typically used to house men, women, and adolescents who are awaiting trial, sentencing, and transfer to another facility, as well as those who have been convicted of misdemeanor offenses. Following arrest, most individuals are initially taken to jail or a detention

center to undergo processing, including fingerprinting, photographing, intake, and a medical exam. After the initial process (also known as booking), the individual will await an arraignment hearing, which is typically held within forty-eight hours. During the arraignment hearing, where individuals go before a judge or local magistrate and receive a formal reading of the charges by the state prosecutor. During this hearing the accused may request release from custody, often by posting bail (Drapalski, Youman, Stuewig, & Tangney, 2009). If bail is denied, an individual must remain in jail until the case reaches a resolution. Subsequently, an individual may remain in one of these facilities for as little as a few hours, to as much as several years while awaiting trial. (Drapalski et al., 2009).

Prisons

The U.S. Bureau of Justice Statistics defines prisons as longer-term facilities operated by state or federal governments, and more recently, by private corporations (Carson, 2014). These institutions confine individuals who have been convicted of felony offenses and sentenced to one year or more of confinement. Many state psychiatric hospitals have a prison unit, which houses people who are awaiting forensic evaluations prior to trial and/or sentencing and those declared mentally incompetent.

Mental Health Providers

The Revised Code of Washington defines psychotherapy and psychology as follows:

"Psychotherapy" means the practice of counseling using diagnosis of mental disorders according to the fourth edition of the diagnostic and statistical manual of mental disorders, published in 1994, and the development of treatment plans for counseling based on diagnosis of mental disorders in accordance with established practice standards. (Revised Code of Washington 18.19.020(11))

The "practice of psychology" means the observation, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures for the purposes of preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health. It includes, but is not limited to,

providing the following services to individuals, families, groups, organizations, and the public, whether or not payment is received for services rendered. (Revised Code of Washington 18.83.010(1))

For the purpose of the study, the terms *correctional mental health provider* (CMHP) and *correctional mental health staff* (CMHS) will be used to describe licensed clinical social workers, licensed clinical psychologists, psychiatrists, and forensic psychiatric nurses who provide mental health treatment to inmates in various correctional facilities.

Mental Health Treatment

The phrase *mental health treatment* is the current overarching term used to describe a vast number of therapeutic treatments and interventions. These include dozens of treatments, many of which have been empirically validated through rigorous studies, such as cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT). In Washington State, the Revised Code of Washington 18.19.020(6) defines counseling as follows:

> Counseling means employing any therapeutic techniques, including but not limited to social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential.

For the purpose of this project, the term *mental health treatment* is broadened to include the above definition, as well as the administration of individual and group therapy, intake assessments, management of psychotropic medication, and forensic evaluations, for the purpose of "preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health" (Revised Code of Washington 18.83.010).

Defining Mental Illness and Mental Health Disorders

Definitions of mental illness and mental health disorders vary and are often vague. In addition to state, federal, and local regulations, psychologists are largely governed by the

American Psychological Association (APA). This organization provides education, oversight, advocacy, and guidelines for those studying and practicing psychology (APA.org). The most frequently used diagnostic tool for American psychologists is *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5;* American Psychiatric Association [APA], 2013). According to the American Psychiatric Association, a mental health disorder is defined as follows:

> A mental disorder is 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 or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA, 2013, p. 20)

The Centers for Disease Control (CDC) defines mental illness as the "dysregulation of mood, thought, and/or behavior, as recognized by the DSM-IV" (Centers for Disease Control and Prevention, 2016, p.1). Additionally, a mental health diagnosis should have "clinical utility," as it aids the clinician in determining a prognosis, treatment plans and potential treatment outcomes for patients (APA. 2013, p. 20).

Serious Mental Illness

The phrase serious mental illness (SMI; sometimes called severe or significant mental illness) is frequently used to describe a condition in a subset of individuals who have been diagnosed with a mental health disorder. However, it is important to note that there is no single, universal definition of what constitutes a serious mental illness. A study by Schinnar, Rothbard, Kanter, and Jung (1990) reviewed 17 definitions of serious mental illness that were used by various mental health professionals. Subsequently, definitions varied so widely that in a

representative sample of 222 patients receiving care from a local clinic, the designation of

serious mental illness was used to describe anywhere from 4% to 88% of patients, depending

upon the operational definition used by the provider (Schinnar et al., 1990).

According to the Department of Health and Human Services: Substance Abuse and

Mental Health Services Administration (SAMHSA), the term *serious mental illness* originated

with the 1992 Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act.

Since the law required states to include prevalence rates of serious mental illness in their

application for federal funding, SAMHSA created the following definition of seriously mentally

ill (SMI):

> Persons aged 18 or older who currently or at any time in the past year have had a
> diagnosable mental, behavioral, or emotional disorder (excluding developmental and
> substance use disorders) of sufficient duration to meet diagnostic criteria specified within
> DSM-IV (APA, 1994) that has resulted in serious functional impairment, which
> substantially interferes with or limits one or more major life activities. (Department of
> Health and Human Services: Substance Abuse and Mental Health Services
> Administration, 1991, n.p.)

Based upon this definition, nearly all mental health diagnoses could be categorized as serious,

depending upon the extent to which they impact an individual's daily functioning. Nonetheless,

many organizations, including the National Institute of Mental Health (NIMH) and the Centers

for Disease Control, use similarly vague definitions.

For the purpose of this study, serious mental illness is used to include the definition

outlined by the American Psychological Association (2009):

> SMI refers to mental disorders that carry certain diagnoses, such as schizophrenia, bipolar
> disorder, and major depression; that are relatively persistent (e.g., lasting at least a year);
> and that result in comparatively severe impairment in major areas of functioning, such as
> cognitive capabilities; disruption of normal developmental processes, especially in late
> adolescence; vocational capacity and social relationships (Federal Register, 1993). (p. 5)

Incarceration and Mental Illness

In 1998, the United States Department of Justice (DOJ) estimated that 283,800 mentally ill offenders—those who experienced and/or had been treated for mental health symptoms in the twelve months before this study—were held in state and federal prisons and local jails. An additional 547,800 mentally ill individuals were under community supervision. By mid-year of 2005, that figure increased to 1,263,300, including 705,600 in state prisons, 78,800 in federal prisons, and 479,900 in local jails (James & Glaze, 2006).

The practice of incarcerating the mentally ill has given rise to a new type of treatment facility, the correctional system. In July 2014, one of the largest mental facilities in the United States was a wing of a Los Angeles County Jail, known as the Twin Towers, which houses an average daily population of 1,400 mentally ill patients (Cooper, 2013). In New York City, the average daily number of inmates at Riker's Island is typically 11,400, with a maximum of 15,000. Of those 11,400, nearly 4,000 suffer from some type of mental illness based upon intake assessments (Winerip & Schwirtz, 2014). Similarly, the Cook County Jail in Chicago, Illinois is also considered one of the largest mental health facilities in the country, with approximately 60% of inmates reporting a prior mental health diagnosis at the time of their intake (Muhkerjee, 2013).

Mental Health Providers in the Department of Corrections

Mental health providers working within correctional facilities face daily exposure to much of the same violence and trauma experienced by the inmates. They are tasked with treating individuals who are often hostile, have co-occurring substance abuse issues with frequent relapses, and may lack the skills or motivation to change (Garland, 2004). Additionally, correctional mental health staff must operate within a highly bureaucratic system, surrounded by

non-clinical staff, where treatment is not the primary focus (Varghese, Magletta, Fitzgerald, & McLearen, 2015). These factors can create dangerous working conditions and contribute to feelings of job frustration, burnout, and secondary traumatic stress for mental health providers.

Challenges of Providing Mental Health Services in Correctional Systems

Correctional mental health providers (CMHP) often encounter specific challenges that differ from those in community mental health and private practice. They tend to interact with more clinically complex populations as inmates often have exceptionally high rates of homelessness, severe mental illness, and substance abuse (Perkins & Oser, 2014). Correctional mental health providers also spend several hours each day locked inside facilities with violent offenders, including rapists, murderers, and gang-members. Furthermore, CMHPs must be able to provide treatment to ethnically, culturally, and socially diverse populations who are often marginalized by society (Shoptaw, Stein, & Rosin, 2000). Clinicians are required to perform thorough assessments for suicide risk, physical and sexual violence, and gang activities, often after only a single, brief encounter with the inmate (International Association for Correctional and Forensic Psychology, 2010). These factors can (and often do) hinder client progress, which can contribute to feelings of job frustration and burnout amongst providers.

Secondary Traumatic Stress

Secondary traumatic stress (STS) has been defined as "the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). In recent decades, STS has been studied across a wide array of fields, including first-responders of natural disasters (Argentero & Setti, 2009), child welfare social workers (Salloum, Kondrat, Johnco, & Olson, 2015), clinicians treating survivors of

terrorist attacks (Adams, Figley, & Boscarino, 2008), doctors and nurses working in emergency rooms (Beck, 2011), and therapists working with trauma-exposed individuals (Jenkins & Baird, 2002; Robinson-Keilig, 2014). STS is seen as almost identical to PTSD except that exposure to the traumatic event is indirect. The effects of STS can be detrimental to the individual and to the client. Mental health providers coping with STS tend to have higher rates of illness and depression, higher rates of absenteeism and turnover, and decreased satisfaction in other areas of their lives (Figley, 1995).

As correctional mental health providers are constantly exposed to a tremendous amount of trauma and suffering, it is reasonable to believe that they, too, would experience high rates of primary and secondary traumatic stress. However, little research has been conducted in this area. Subsequently, this research study will explore how mental health providers working within correctional facilities are affected by the constant exposure to trauma.

Research Questions

The purpose of this study is to acquire knowledge about the experience of mental health providers working in correctional facilities. The researcher hypothesizes that due to the conditions of correctional facilities and repeated exposure to trauma, those working in these settings are likely to experience symptoms of primary or secondary traumatic stress disorder. This study focuses only on the secondary traumatic stress experienced. The following questions will be used to test this theory:

- Research Question #1: What is the experience of mental health providers working with incarcerated mentally ill?

- Research Question #2: What experiences, if any, have correctional mental health providers had with secondary traumatic stress?

Significance of Study

There is a surprising lack of research regarding the prevalence and manifestation of secondary traumatic stress amongst correctional mental health staff. Although the field of correctional psychology has grown exponentially over the last few decades, most studies of correctional staff have focused on correctional officers, who are charged with maintaining the safety and security of inmates and employees (Saxon et al., 2001). Medical and mental health professionals in these settings are often exposed to high levels of physical and emotional threats (Hawk, 1997). Nonetheless, in a study of STS amongst juvenile detention employees, the authors noted, "There has been limited research evaluating the impact of STS among service professionals in adult and juvenile correctional settings" (Hatcher, Bride, Oh, King, & Catrett, 2011, p. 209).

Furthermore, Garland (2004) noted, "To this author's knowledge, the only treatment staff in prisons who have been examined in connection with burnout are correctional teachers and a group of counselors, vocational counselors and educators that comprised half of a sample of correctional personnel" (p. 452). Additionally, Lent and Schwartz (2012) found that "a review of burnout-related literature between 1974 and 2012, completed using PsycInfo, yielded over 4,000 results. However, few publications specifically address causes of burnout among mental health professionals" (p. 356). Similarly, after performing an exhaustive search of several social science and criminology databases, this author discovered very few articles addressing compassion fatigue and secondary traumatic stress disorder amongst correctional staff. Furthermore, with the exception of a dissertation written by a doctoral candidate (Francis, 2013), the articles that did address this issue tended to focus on correctional substance abuse counselors and corrections officers. While there is a growing amount of research regarding the prevalence of

mental illness within corrections, most of it focuses on the experiences of the inmates; there is very little research exploring how working within correctional facilities affects mental health practitioners.

The purpose of this study is to explore the experiences of mental health workers in correctional populations and their experience of STS. Since this issue has scarcely been explored, this study will provide greater insight and understanding of the challenges encountered by correctional mental health providers and how these challenges may contribute to secondary traumatic stress. By using a phenomenological case study format, correctional mental health providers will have an opportunity to discuss and describe their experiences working with mentally ill inmates. This format will also provide an opportunity to examine how providers cope with this issue and, subsequently, offer guidance for the treatment and prevention of STS.

The consequences of STS are potentially hazardous to mental health workers, their families, recipients of services, and the public. While those ramifications are beyond the scope of this inquiry, it is expected that this study may help give direction to other areas STS of workers has impact.

Chapter II: Literature Review

History and Policy Changes in Treating the Mentally Ill

The United States underwent a series of social, political, and cultural movements during the 1960s and 1970s. Amongst those most commonly discussed are the Civil Rights, Feminist, Anti-War, and Gay-Rights Movements. Another lesser-known movement occurring during that period was that of deinstitutionalization. This movement sought to deinstitutionalize the severely mentally ill by moving people out of psychiatric hospitals and asylums and returning them to their communities (Prins, 2011). Between 1955 and 1995, the number of available psychiatric beds throughout the United States decreased from 558,239 to 71,619, leaving over 486,000 individuals without treatment. By the end of 2013, the number of beds had dwindled even further to approximately 35,000 (Torrey et al., 2014).

Before the deinstitutionalization movement, many people with severe mental illness were typically treated in the home by their family physician, in psychiatric hospitals, in asylums, or by religious organizations (Koyanagi & Bazelon, 2007). Unfortunately, many of the interventions used were often ineffective and even cruel. Individuals were often subjected to painful and humiliating treatments, including, but not limited to lobotomies, electroshock treatment, and isolation for weeks and even years (Foerschner, 2010). The deinstitutionalization movement sought to end these practices by shutting down facilities (Kreig, 2001; Yoon & Bruckner, 2009). As societal views of mental illness changed, tolerance for these practices waned (Lamb & Bachrach, 2001). Additionally, the introduction of more effective psychotropic medications (most notably lithium) led to the release of hundreds, and eventually thousands, of patients (Torrey, 1997), with the expectation that people would be treated by therapists, counselors, and social workers within their communities, rather than inside of asylums.

As stated by President Carter's 1977 Commission on Mental Health, the objective of deinstitutionalization "is to maintain the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services" (American Presidency Project, 1977, n.p.). Unfortunately, this goal did not come to fruition. Because of poor funding, and a lack of outreach to communities, many people in the general public developed a growing fear of those with mental illness (Lamb & Bachrach, 2001). While proponents of deinstitutionalization touted the benefits of community treatment for those with severe mental illness, the reality has been quite grim. Instead of seeing mentally ill individuals treated in community clinics and hospitals, there has been a tremendous increase in the incarceration rates of the mentally ill (Sabol, Couture, & Harrison, 2007).

There were two other policies born of the 1960s and 1970s that contributed to the increase of incarceration rates: the War on Crime and the War on Drugs. While the intent of these laws was to decrease violent crimes and drug offenses, these federal policies dramatically increased the arrest and incarceration rates of non-violent offenders, including those with serious mental illness (Foerschener, 2010). These programs required mandatory, determinate sentencing for non-violent and drug-related offenses; they reduced prison alternative programs that were once used to treat and rehabilitate offenders; they demanded lengthy prison sentences for first time and repeat offenders, thereby eliminating the opportunity for individuals to obtain substance abuse and mental health treatment in the community (U.S. Sentencing Commission).

Mental Illness Among Incarcerated and Non-Incarcerated Populations

When compared to the general population, there is a disproportionately high percentage of mentally ill people among correctional populations (Torrey, Kennard, Eslinger, Lamb, &

Pavle, 2010). Understanding the prevalence of mental illness within the broader societal context helps to provide a better understanding of the vastness of this issue in correctional settings. In 2012 the U.S. Department of Health and Human Services conducted a national survey of mental health and substance abuse amongst American adults. The study included screenings of 214,274 people, whose addresses were gathered from U.S. census data, comprised of a random sample of 68,309 non-institutionalized adults (ages 12 and above) of varying races, ages, and socio-economic levels. Based upon the results, the researchers extrapolated that "an estimated 43.7 million adults aged 18 or older had experienced some type of mental illness in the past year. This represented 18.6 percent of all U.S. adults" (U. S. Department of Health and Human Services [DHHS], 2012, n.p.).

The National Institute of Mental Health (NIMH) defines *serious mental illness* (SMI) as follows:

- a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) diagnosable currently or within the past year;
- of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV);
- resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. (2014, n.p.)

The DHHS (2012) estimated 9.6 million adults aged 18 or older had experienced serious mental illness within the past year. This figure represented 4.1 % of all U.S. adults (DHHS, 2012). However, according to the National GAINS Center (1997), the rate of serious mental illnesses among prisoners is three to five times the rate found in the general community.

Correctional inmates encounter numerous physical and emotional challenges that can exacerbate existing mental health issues or create new issues in those who were not mentally ill at intake (Goomany & Dickinson, 2015). Inmates have very limited control over their sleeping quarters, dietary habits, or general surroundings; some are isolated within their cells for 23 hours

every day for a period of months or even years (Amnesty International, 2012), and their access to the outside world is restricted. Additionally, there is the constant threat of violence from other inmates and fear of punishment from correctional officers (Goomany & Dickinson, 2015)

These factors may also contribute to the high rates of suicide and other self-injurious behaviors within correctional facilities. For example, a study of the King County Correctional Facility in Seattle Washington revealed that 124 people attempted suicide within a 33-month period (Washington State Department of Corrections, 2010). These figures are commensurate with other facilities of similar size and population (Goss, Peterson, Smith, Kalb, & Brodey, 2002). Furthermore, while the CDC identified intentional self-harm as the tenth leading cause of death in the United States (CDC, 2016), the U.S. Bureau of Justice Statistics identified suicide as the leading cause of death within correctional facilities (Carson, 2014).

Individuals who arrive in prison with serious mental illnesses are often subjected to even more hardship than non-mentally ill inmates. A study by Steadman et al. (2009) examined 822 inmates who were recently admitted to two jails in Maryland and three jails in New York during 2003 and 2005. The researchers reviewed the admissions records of inmates to determine how many individuals identified a mental health condition during their intake screening to determine which inmates to interview for additional data. They concluded that 14.5% of males and 31.0% of females met the criteria for having a current serious mental illness, including schizophrenia spectrum disorders, bipolar disorder, and brief psychotic disorder. Most of these individuals did not have access to mental health resources within the community; consequently, they would be released from jail without treatment or resources.

Post-Traumatic Stress Disorder

The field of traumatology endeavors to study and treat those exposed to traumatic events. This area of study encompasses all conditions associated with trauma, including post-traumatic stress disorder (PTSD) and secondary traumatic stress (STS).

In order to acquire a comprehensive understanding of STS, one must first possess basic knowledge of the condition from which it stems. The phrase *post-traumatic stress disorder* (PTSD) is a relatively new term. It was first introduced in the 1980 Diagnostic and Statistical Manual, Third Edition (DSM-III). The condition referred to a series of maladaptive thoughts, behaviors, and emotions in response to a catastrophic event, such as war, torture, bombings, earthquakes, and airplane crashes. Over the last three decades, both the definition and criteria for PTSD have been expanded to include additional types of traumatic events and symptomology.

The most recent Diagnostic and Statistical Manual (the DSM-5) lists the basic criteria required for a diagnosis of PTSD (APA, 2013). The first criterion relates to the actual event or stressor that caused the trauma. This includes "direct or indirect exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (APA, 2013, p. 271). Once the traumatic event has been identified, an individual must present with at least one to two symptoms in each of the following categories before meeting the DSM-5 criteria for a diagnosis of PTSD:

- intrusive symptoms: flashbacks, nightmares, and/or recurrent, distressing thoughts of the traumatic event (p. 271);
- avoidance: persistent attempts to avoid memories and external stimuli (people, places, activities and objects) that may trigger or remind a person of the traumatic event (p. 271);
- negative alterations in cognitions or mood: persistent feelings of fear, shame, and anger directed towards oneself, others, or even the world at large (p. 271); and
- arousal symptoms: persistent feelings of anxiety, hypervigilance, difficulty concentrating, and sleep disturbances (p. 272).

The American Psychiatric Association (APA) estimates that PTSD affects approximately 3.5% of U.S. adults; a lifetime risk for PTSD is estimated at 8.7% (APA, 2015).

Posttraumatic Stress Disorder Amongst Inmates

Incidents of PTSD are higher amongst inmates (James & Glaze, 2006). This has been attributed to the high risk factors that tend to appear in criminal populations, specifically, poverty, minority status, childhood abuse and neglect, and drug-seeking behaviors (Kubiak, 2004). Additionally, there has been a link between repeated trauma exposure and later criminal involvement (Scott, 2010). Lifetime trauma exposure rates for incarcerated men can vary from 62% to 100%, depending upon the size of the population, the type of facility, and the diagnostic criteria used (Wolff et al., 2014). Statistics for female inmates are equally high, with PTSD rates often twice as high as their male counterparts (Drapalski et al., 2009).

Ruzich, Reichert, and Lurigio (2014) examined 117 male jail detainees awaiting entry into substance abuse treatment programs They found that nearly 25% of participants reported prior psychiatric hospitalizations, and almost 10% were taking psychotropic medication. Additionally, 21% met the DSM-IV criteria for a diagnosis of PTSD (Ruzich et al., 2014). Qualitative data from six of the study participants indicated that many individuals had experienced chronic exposure to trauma, repeated episodes of family and community violence, and substance abuse. Approximately 10% of inmates are veterans of the United States Armed Forces, and many were combat veterans (Mumola, 2007). In 2007, the U.S. Bureau of Justice Statistics (BJS) estimated 703,0000 veterans were under correctional supervision (Blue-Howells, Clark, van den Berk-Clark, & McGuire, 2013; Noonan & Mumola, 2007). A significant number of these individuals struggle with numerous co-morbidities, including mental illness, substance abuse, homelessness,

and PTSD (Noonan & Mumola, 2007). In fact, some studies of incarcerated veterans have reported rates of PTSD ranging from 17% to 39% (White, Mulvey, Fox, & Choate, 2011).

Correctional Mental Health Providers

Mental Health Providers practicing inside of correctional facilities perform many of the same tasks as community providers (Haag, 2006). They complete intake assessments for new inmates, facilitate individual and group psychotherapy sessions, and make diagnoses and recommendations based upon clinical observations and collateral data (Gannon & Ward, 2014; Haag, 2006). Correctional providers must also comprehend the fundamentals of the judicial and correctional systems (Watkins, 1992). They are often required to perform forensic functions, such as evaluations, which may be used to determine a persons' level of competency or sanity (i.e., whether a person was coherent at the time the crime was committed and/or whether the person is presently lucid enough to participate in the criminal proceedings) (Haag, 2006; Watkins, 1992). Psychologists are expected to understand the legal definitions of terms, such as *sanity*, *legally insane*, and *competency,* and may be required to testify in court about their evaluations and clinical observations (Mackain, Myers, Ostapiej, & Newman, 2008).

Correctional psychologists may also provide recommendations to judges and parole boards (Haag, 2006). These reports generally include an overview of the individual's past and current behaviors, which are used to assess the individual's level of risk to the community upon release from custody (Haag, 2006).

Ethical Challenges and Lack of Privacy

Some of the tasks performed by correctional mental health staff may result in ethical and moral conflicts (Gannon & Ward, 2014; Haag, 2006). One such conflict often arises in the form of dual role conflict (Ward, 2013). While correctional providers may view their primary role

through the lens of a therapeutic model, correctional officers and custody staff often expect providers to focus on inmate risk-assessments and uphold security protocols (Gannon et al., 2014; Rohleder, Miller, & Smith, 2006; Ward, 2013). This often places providers in an ethical quandary, as they are asked to choose between professional guidelines and institutional policies.

Additionally, a cornerstone of the therapeutic relationship is confidentiality. In community mental health and private practice, psychologists are expected, and even legally required, to protect the anonymity and privacy of their clients. Unless there is a clear and compelling reason to disclose information revealed in session, such as reports or suspicion of harm to one's self or others, clients are safe to disclose any information without fear of retribution or punishment.

However, this level of privacy and discretion does not exist in correctional mental health (Haag, 2006; Weinberger & Sreenivasan, 1994). For those living and working within correctional facilities, traditional concepts of privacy, such as confidentiality and privilege, are non-existent. (Haag, 2006; Kitchener & Anderson, 2000). There are video and audio cameras throughout the facilities, and interview space is often scarce. Both inmates and providers often require an escort by correctional officers, who, for safety purposes, may be required to remain present during interviews and assessments (Haag, 2006; Weinberger & Sreenivasan, 1994). Additionally, therapeutic notes, evaluations, and psychometric test results are available to various members of the correctional and judicial system. (Haag, 2006) In fact, inmates are informed that their telephone calls and correspondence are often monitored, and all information gathered from or about the inmate can be disclosed to the courts without the inmate's consent (Olley, Nicholls, & Brink, 2009).

Understaffing of correctional mental health providers. Despite the growth in the field of Correctional Psychology, the number of correctional psychologists and mental health practitioners has not increased as rapidly as facility population (Bronson, Maruschak, & Berzofsky, 2015). This has resulted in psychologists becoming overwhelmed by the seemingly infinite number of patients in need of services (Holloway, 2005). At a 2005 convention of the American Psychological Association (APA), correctional psychologists identified insufficient staffing and resources as the primary challenge to providing services within correctional facilities (Holloway, 2005). As one psychologist noted, there were 182,000 inmates in federal prisons across the United States. However, there were only 400 doctoral level psychologists providing services to those individuals (Holloway, 2005).

Other Obstacles of Working in Corrections

Research in the field of social work has indicated that job frustration tends to increase when organizational factors impede the delivery of services to clients (Garner & Hunter, 2012). Employee perceptions of managerial support, high caseloads, role conflict, role ambiguity, and increased regulations contribute to frustration and burnout (Lewandowski, 2003). These issues are particularly salient for those working in correctional settings, where providers may have very little control over their environment. Correctional mental health providers often have restricted access to clients, limited movement within a facility, and constant monitoring by correctional officers. (Haag, 2006; Kitchener & Anderson, 2000). While these precautions are necessary to ensure the safety of staff and inmates, it presents logistical and confidentiality problems for the providers. It is often difficult for therapists to establish routine appointment schedules with patients because interactions with inmates are completely at the discretion of the correctional staff. (Gannon & Ward, 2014; Haag, 2006). This can create a rift between officers, whose

primary role is safety and security, and mental health staff, who focus on treatment and rehabilitation (Varghese et al., 2015).

Psychologists and other mental health providers working within jails may encounter hundreds, or even thousands of people, each year as many larger jails require a mental health intake or full evaluation of all inmates, especially for those with a known history of mental illness and those presenting with acute signs of mental illness (Boothby & Clements, 2000). Since the length of stay can vary from a few hours to several months, psychologists provide intake assessments, forensic evaluations, and brief interventions, but intense, long-term, engagement is often not feasible (Mackain, Myers, Ostapiej, & Newman, 2010; Schwartz, 2003). Mental health providers working in these settings encounter a tremendous amount of suffering as they are exposed to countless individuals who have experienced or inflicted trauma (Mackain et al., 2010).

Exposure to violence. Violence within correctional facilities manifests in different ways. There is inmate-on-inmate violence, which includes forced sexual assault, fistfights, stabbings, and gang activity. There is self-inflicted violence, in which inmates harm themselves (often by cutting or swallowing inanimate objects), and there is staff-to-inmate violence in which an inmate might assault a correctional officer or in which an officer may physically restrain or otherwise incapacitate an inmate (Goomany & Dickinson, 2015).

One study of prison violence surveyed 7,785 inmates across 14 adult prisons (13 male and one female) (Wolff et al., 2007). Using a modified version of the National Violence against Women and Men Survey, they inquired about various types of violence the inmates experienced during their current incarceration. The results indicated that 25% of male and 20% of female inmates reported being physically assaulted by another inmate. Also, 29.2% of men and 8.2% of

women reported having had physical contact with correctional staff. The rates for physical assault for male inmates was 18 times higher than victimization rates in the general public and 27 times higher for women. Furthermore, even when weighted for race/ethnicity, sex, and income, the adjusted rates of victimization were still 10 times lower than those for people inside prison.

These issues are not unique to American prisons. A study of 240 correctional officers in French prisons explored the prevalence of primary and secondary trauma exposure amongst correctional providers. The study revealed that over 93% of the officers had been exposed to at least one incident of verbal abuse, threats of violence, or actual physical violence (Boudoukha, Altintas, Rusinek, Fantini-Hauwel, & Hautekeete, 2013). In all instances CMHPs are expected to address these issues as they arise while simultaneously protecting themselves to avoid victimization (Garland, 2004).

Exposure to extreme cases. While all mental health practitioners encounter challenging clients throughout their careers, those working in corrections are tasked with treating a disproportionate number of people with antisocial personality disorders, borderline personality disorder, PTSD, depression, and psychotic disorders (James & Glaze, 2006). Those working with sex-offenders, for example, are often exposed to their clients' stories of perpetration, violence, and deviant fantasies (Ennis & Horne, 2003). In these instances, clinicians must manage their own personal response, such as anger and revulsion, while still maintaining empathy and professionalism (Bengis, 1997).

Secondary Traumatic Stress (STS)

Freud was amongst the earliest to explore the concept of compassion fatigue and STS, with his theory of counter-transference (Freud, 1910; Tehrani, 2007). This term was originally used to describe the ways in which a therapist allows his/her own personal thoughts, feelings,

and experiences to interfere with how he/she conceptualizes a client. The therapist begins to transfer his/her past experiences onto the client (Freud, 1910;Tehrani, 2007). This theory was expanded upon by Carl Jung in 1946, when he posited that the "sufferings of the client are sometimes taken-up and shared by the therapist" (Tehrani, 2007, p. 327).

As researchers learned more about the effects of trauma exposure, they began to recognize similar symptoms in those who were indirectly exposed to traumatic events (Figley, 1993). Most notable were symptoms of burnout, intrusive thoughts, and avoidance.

Charles Figley has spent the last three decades researching and educating the public about STS, compassion fatigue, and vicarious traumatization. STS is the present term used to describe the emotional, physical, and cognitive effects of trauma on the therapist (Severson & Pettus-Davis, 2012). First described by Figley (1993), it is the cost of caring for those who are suffering. Secondary traumatic stress disorder is often used synonymously with compassion fatigue (CF), vicarious traumatization (VT), and burnout (Dagan et al., 2015; Newell & MacNeil, 2010). However, some researchers in the field of traumatology have outlined distinctions among these terms (Devilly et al., 2009; Figley, 1995, 2002; Rzeszutek, Partyka, & Golab, 2015).

McCann and Pearlman (1990) first described the concept of vicarious traumatization as a "transformation in the therapists' inner experience resulting from empathetic engagement with clients' trauma material" (p. 560). In essence, vicarious traumatization negatively affects the cognitive process of therapists who are repeatedly exposed to their clients' trauma (Rzeszutek et al., 2015).

This is often contrasted with the concept of compassion fatigue, which refers to the emotional exhaustion resulting from job demands and countertransference issues that arise within the provider-client relationship (Figley, 1995). The symptoms associated with

compassion fatigue most closely mirror those of STS. However, some researchers (Devilly et al., 2009; Figley, 1995, 2005) have transitioned towards using the term compassion fatigue, as they define it as encompassing both the PTSD symptoms of STS, as well as the changes in cognitive schemas as they relate to social and interpersonal perceptions of the world (Figley, 1995, p. 3). It should be noted that that there is no definitive data supporting the use of one construct over another (Craig & Sprang, 2010).

As with STS, CF, and VT, individuals suffering from burnout may also experience physiologic and behavior symptoms similar, such as headaches, insomnia, exhaustion, and anxiety (Newell & MacNeil, 2010). Burnout is often described as a "three-dimensional syndrome, comprising of emotional exhaustion, depersonalization, and the perception that one has failed to accomplish one's goals" (Maslach et al., 2001, p. 403). However, unlike the aforementioned conditions, burnout is not specific to those working with trauma victims; anyone in any field can experience burnout. Over the last few decades, there have been numerous attempts to study, define, and quantify these symptoms. Several psychometric measures have also been developed, including the Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004), the Compassion Fatigue Scale (Figley, 1993), and the Compassion Fatigue Self-Test for Psychotherapists (Figley, 1995).

Despite their subtle differences, these conditions share several common factors, each having deleterious effects on the caregiver, most commonly in the form of psychological distress, somatic symptoms, such as headaches, gastrointestinal issues, and chronic fatigue, and disruption to interpersonal relationships.

Effects of Secondary Traumatic Stress

The effects of STS can be all encompassing as they impact every area of an individual's life (Devilly et al., 2009; Figley, 1995). Just as those suffering from PTSD, people with STS tend to struggle with intrusive thoughts of the traumatic event, avoidance, sleep disturbances, arousal/hypervigilence, and disruptions to interpersonal relationships (Senter, Morgan, Serna-McDonald, & Bewley, 2010). Those struggling with STS often show marked decrease in work productivity, use more sick days, have higher turnover, and experience higher levels of conflict with colleagues (Figley, 1995).

Robinson-Keilig (2014) examined the effects of STS in relation to interpersonal functioning. The Secondary Traumatic Stress Scale (STSS) was used to survey 320 licensed, master's and doctoral level mental health therapists to determine the presence of STS and to what extent their relationships had been affected by STS. The study revealed that those with higher levels of STS tended to have lower levels of relationship satisfaction, social intimacy, and less constructive communication within their personal relationships. These findings were consistent with other studies in which clinicians stated that STS had negatively affected their personal and professional lives (Ting, Jacobson, Sanders, Bride, & Harrington, 2005).

Frequent exposure to secondary trauma can alter an individual's worldview. Tehrani (2007) examined the impact of secondary trauma on the assumptions, values, and beliefs of various caregivers using a variation of the Trauma Belief Inventory and the Post Traumatic Growth Inventory. This study examined the 319 responses from psychologists, psychiatrists, counselors, therapists, nurses, doctors, lawyers, religious leaders, teachers, police officers, and others. They discovered that 60% of those surveyed had feelings of being overwhelmed, and 64% experienced negative changes regarding their view of the world as a dangerous place. They

also found that support in the work place was lacking in many environments; this seemed to play a great factor in increased negative thoughts and beliefs.

Prevalence of Secondary Traumatic Stress

The prevalence and scope of compassion fatigue in mental health practitioners has not yet been defined. Over the last decade, several research studies have been conducted in an attempt to quantify the prevalence of secondary traumatic stress and compassion fatigue amongst various groups, including law enforcement, nurses, parole officers, and social workers (Abendroth & Flannery, 2006; Devilly et al., 2009; Newell & McNeil, 2010). Variables, such as age, sex, education level, years of experience, and frequency of exposure, have all been used to determine who is most affected by these disorders (Dagan et al., 2015).

A study of Oklahoma City trauma workers found that 65% of respondents reported symptoms of PTSD following their work with victims of the Oklahoma City bombings in 1995 (Wee & Meyers, 2002). The Shah, Garland, and Katz (2007) study of 76 humanitarian aid workers found that all of the participants reported compassion fatigue as a hazard of their work.

Conversely, in a random, national sample of 520 self-identified trauma treatment specialists, the researchers discovered that only 5% of the participants were at high risk for compassion fatigue and burnout (Craig & Sprang, 2010). Additionally, those with few years of clinical experience and less trauma-related training were at higher risk. Furthermore, those working in community mental health settings and those with higher percentages of PTSD clients showed heightened levels of burnout and compassion fatigue (Craig & Sprang, 2010). Nonetheless, the prevalence and scope of compassion fatigue in mental health practitioners remains undetermined (Craig & Sprang, 2010).

STS Amongst Correctional Workers

As discussed earlier, the risk for STS can be particularly high for correctional mental health staff as they work in an often-hostile environment with severely mentally ill, traumatized, and violent offenders, and with little organizational support (Gannon & Ward, 2014).

Although few studies specifically explore STS and correctional mental health providers, there has been research on the effects of job frustration and burnout amongst correctional officers and general correctional staff, including administrators, counselors, and managers (Boudoukha et al., 2013; Lewis, Lewis, & Garby, 2012; Perkins & Oser, 2014;). Keinan and Malach-Pines (2007) examined factors related to stress and burnout amongst Israeli Prison Services (IPS). They discovered significantly high levels of stress, especially for those with lower-ranking positions in the facility. Males had higher stress rates than females (M = 6.2 vs. M = 5.35), and those with higher levels of education exhibited fewer stress-related symptoms.

Perkins and Oser (2014) discovered that the counselors working in community settings reporting higher levels of organizational support had less job frustration, which is often a precursor to burnout (Lewandowski, 2003).

Similarly, a study of correctional officers in French prisons, conducted by Boudoukha et al. (2013), noted a significant positive correlation between posttraumatic stress symptoms (as measured by the Impact of Events Scale-Revised (IES-R) and Emotional Exhaustion and Depersonalization, as measured by the Maslach Burnout Inventory (MBI).

These studies indicate that those working in correctional settings are at high risk for developing STS and burnout. These results are largely attributed to the perceived "depressive nature of prisons," the lack of resources for rehabilitative programs, high caseloads, low salary, and minimal organizational support (Resig & Lovrich, 1998, p. 215).

Secondary Traumatic Stress Research Studies

      Hatcher et al. (2011). The researchers of this study sought to understand the experiences of juvenile justice staff in relation to STS. A 2006 report by the U.S. Department of Justice noted that 2.1 million juveniles were arrested in 2005. Studies have indicated that juvenile offenders tend to have exceptionally high rates of trauma exposure, including community violence, sexual assault, child abuse, familial loss, and death of peers (Buka, Stichick, Birdthistle, & Earls, 2001; Osofsky, 1995). In fact, some studies have indicated rates of trauma exposure as high as 90% amongst juvenile offenders (Abram, Teplin, Longworth, McClelland, & Dulcan, 2004; Costello, Erkanli, Fairbank, & Angold, 2002). Furthermore, other studies have revealed reports of multiple traumas from over 82% of juvenile offenders, compared to 4.5% amongst non-offenders (Costello et al., 2002; Ruchkin, Schwab-Stone, Koposov, Vermeiren, & Steiner, 2002). Consequently, the researchers hypothesized that there would be high rates of STS amongst correctional providers working with this population.

    Participants were recruited during an annual self-care retreat, sponsored by the Georgia Department of Juvenile Justice (DJJ). A total of 118 teachers and staff completed a demographic questionnaire, which included information about their job responsibilities, educational level, professional organizational affiliations, as well as age, gender, and race/ethnicity. Additionally, participants completed the Secondary Traumatic Stress Scale (STSS), which is a 17-item, Likert-type scale, measuring levels of intrusion, avoidance, and arousal (Bride et al., 2004).

      Approximately 95% of the participants reported that their work involved addressing traumatic events experienced by the children and adolescents. Of the general juvenile justice workers, 81.4% met at least one diagnostic criterion for PTSD based on the STSS, 55.1% met two, and 39.0% met all three. However, of those who identified as social workers, 55% met at

least one diagnostic criterion, 25% met two, and 15.2% met all three. This could indicate that those with higher levels of education and training are less prone to STS, a finding which is consistent with several other studies (Baird & Jenkins, 2003; Dagan et al., 2015).

The authors noted several limitations with this study. For example, the participants were recruited from a self-care conference, which may have attracted those already experiencing STS and burnout, thereby skewing the results. Also, participants included more managerial staff, as opposed to entry-level staff, who may have different experiences and viewpoints. Despite these limitations, the findings do highlight a need for more research into the experiences of correctional providers and a need to increase awareness of the signs and symptoms of STS amongst organizational and supervisory-level staff.

Smith (2007). In an effort to understand the impact of compassion fatigue amongst those working with people living with HIV/AIDS, Smith conducted a qualitative study of graduate students working with this population at a community clinic. Presented as a series of vignettes, Smith examined the development and manifestation of symptoms amongst a group of graduate students working with this population. As the majority of the clients at this clinic tended to struggle with a multitude of psychosocial and behavioral issues, the therapists were frequently presented with cases involving physical, psychological, and sexual abuse and trauma. In each case, the clinicians experienced numerous STS symptoms, including recurring thoughts of the trauma, alterations in sleeping and eating patterns, anxiety, and avoidance. Most prevalent amongst the group was a sense of helplessness, anger, and frustration as they attempted to treat their clients. Although this study is limited by the methodology (i.e., subjective experiences of four individuals working at a community mental health clinic), it does illustrate the challenges encountered by those working with traumatized individuals.

Bride (2007). The goal of this study was to explore the prevalence of STS amongst social workers. Researchers contacted 600 master's level social workers licensed in a U.S. southern state. The initial responses totaled 294. However, after excluding for incomplete surveys, the result was a total of 283 surveys. In addition to demographic data, researchers used the Secondary Traumatic Stress Scale (STSS). This 17-item, self-report test uses a 5-point Likert scale with responses ranging from never to very often. It is used to assess frequency of intrusive thoughts, avoidance, and arousal symptoms. The majority of respondents (56.6%) were mental health or substance abuse providers. Forty-one percent reported that their clients were moderately traumatized, while 34.5% reported working with severely traumatized clients. Subsequently, 55% of respondents met at least one criterion for PTSD. Responses for psychological or physiological distress when reminded of working with traumatized clients were 19.1% and 12.5% respectively. These results suggest that mental health social workers are exposed to a significant amount of trauma. Moreover, this exposure is positively correlated with symptoms of STS.

As with all research, this study also had its limitations. With only a 47% response rate, it is possible that those suffering with STS were more likely to complete the survey, thus skewing the results. Furthermore, only licensed social workers from a single state were chosen from the study, thus limiting generalizability to non-licensed social workers and those practicing in other areas of the country. Nonetheless, this study does provide data supporting the relationship between exposure to trauma and STS.

Lent and Schwartz (2012). In a study of the impact on work setting and STS, this article conducted a survey of 340 licensed professional counselors, members of the American Counseling Association, and members of a Midwestern state licensing association. The

researchers sent a national online survey to 800 potential participants and ultimately received a total of 340 responses. Demographic data collected for the study yielded the following results: 85% White, 11% Black, 2% Native American, and 2% Latino. Additionally, 77% (261) were master's level clinicians, and 34% (79) were doctoral level clinicians.

By using the Maslach Burnout Inventory-Human Services Survey and the International Personality Item Pool (IPIP), researchers discovered that the respondents employed as community mental health providers exhibited higher levels of burnout than those in private practice. The community mental health providers also scored lower on having a sense of personal accomplishment and higher on emotional exhaustion and depersonalization. The researchers also noted that those who scored higher on the neuroticism scale tended to exhibit higher levels of distress.

Although this study supports the concept of STS amongst mental health providers, it does have some limitations. Only online surveys were used to collect data, which eliminated the opportunity to observe clients and discuss their responses. Also, as noted by the authors, responses from the midwestern state were overrepresented in their sample, reducing generalizability.

MacKain, Myers, Ostapiej, and Newman (2010). In an effort to explain the high-vacancy rate of correctional psychology positions throughout North Carolina—rates as high as 46% in some areas—MacKain et al. (2010) surveyed correctional psychologists across 79 facilities to ascertain their level of job satisfaction. The researchers used a slightly modified version of the job satisfaction scale created by Boothby and Clements in 2000. The survey uses a 5-point Likert-type scale to measure job satisfaction across eighteen facets, including autonomy, safety, relationships with supervisors, relationships with inmates, and job security. The

researchers were particularly interested in assessing how four facets correlated with overall satisfaction: economic issues, management issues, satisfaction with work relationships, and perceived organizational support.

Surveys were sent to 93 correctional psychologists who were all identified by the North Carolina Department of Corrections (DOC). Seventy-two psychologists (77%) returned the completed surveys. Forty-seven percent of respondents were women, and 73% were master's-level clinicians, with the designation of licensed psychological associates. Employment with DOC ranged from 6 months to 36 years, with a median of 7 years, and 63% worked in rural areas.

The areas that were not significantly correlated with job satisfaction were safety, salary, relationships with coworkers, and relationships with inmates. The survey results were consistent with those identified by Boothby and Clements' (2002) national survey of correctional psychologists. Additionally, the survey included a qualitative component, which allowed participants to provide written comments. Sixty-one percent of the respondents provided comments that addressed areas of dissatisfaction. The following six themes emerged from these comments, in order from most to least frequently cited: 1. salary/benefits, 2. organizational support, 3. advancement opportunities, 4. workload, 5. training, and 6. other.

The researchers identified several limitations with their study. Despite salary being identified as the primary area of dissatisfaction, it was not highly correlated with overall satisfaction. This indicated that other related factors might have influenced the assessment of salary, such as benefits and job security. Once these factors were taken into consideration, economic issues became a significant predictor of overall satisfaction. Similarly, questions relating to satisfaction with supervision might have been ambiguous, given that these

psychologists are under the supervision of clinical and non-clinical staff. Lastly, the researchers used theoretical rather than empirical grounds to identify the four underlying facets related to job satisfaction. While there are certainly benefits to this approach, they risk excluding some important components, while over relying on others that are less significant.

Chapter III: Methodology

Framework and Foundation

This is a mixed-method project with a predominately qualitative focus. According to Trickett (1996), "by emphasizing detailed, first-hand descriptions of people and settings, qualitative methods are thought to enhance the study of behavior embedded in a larger social world" (p. 21). Since the experience of correctional mental health providers has scarcely been explored, this researcher determined that a qualitative case study would be the best approach, as it will provide participants with an opportunity to discuss their experiences of working with challenging populations within a correctional setting. Furthermore, unlike quantitative data, which focuses more on statistical analysis, qualitative methods provide the researcher with an opportunity to delve deeply into this particular area of study.

A qualitative inquiry provides an opportunity for the researcher to engage with the participants on four levels: asking, witnessing, interpreting, and knowing (Stein & Mankowski, 2004). It empowers people to share their stories. By witnessing what the participant discloses, the researcher affirms the experience. By interpreting the data, the researcher clarifies, organizes, and unites information gathered from participants.

The benefits of qualitative methods have long been accepted in community and social psychology (Creswell, 2006). A prominent feature of qualitative methodology is that it gives voice to populations and illuminates cultural narratives (Mankowski & Rappaport, 2000). Furthermore, some researchers have suggested that participation in qualitative studies can have therapeutic effects on traumatized populations (Berger & Malkinson, 2000; Dyregrov, Dyregrov, & Raudalen, 2000). This is particularly relevant in this study as this may be the first time the CMHP have had an opportunity to discuss work-related issues of stress and trauma.

Case Study Method

One method of qualitative research used to illuminate a particular phenomenon is the case study. Merriam (1998) defined case studies as detailed descriptions of a setting and its participants, accompanied by an analysis of the data for themes, patterns, and issues. Creswell (2006) elaborated on this concept by distinguishing among three variations of case studies: the single, instrumental case study, which uses one case to focus on an issue or concern; the collective/multiple case study, which uses multiple cases to explore an issue; and the intrinsic case study, which focuses on a specific case, deemed to be particularly unique.

A collective case study was deemed most appropriate for this project, as it will provide an opportunity to explore the individual and collective experience of CMHPs and their experiences with STS. Gathering data from multiple participants will allow the researcher to examine common themes that may arise within and across interviews.

Case study limitations. Case studies are often criticized for their small sample size, lack of generalizability, and inability to be replicated. Unlike a quantitative study, which may include thousands of participants, a case study can have as little as one participant. Staunch proponents of quantitative methods often criticize qualitative methodology for its lack of vigor in the collection and analysis of empirical data (Flyvbjerg, 2006). However, supporters of qualitative methods assert that the flexibility and fluidity of case methods is what makes it ideal. As stated by Shields (2007), "It is precisely because case study includes paradoxes and acknowledges that there are no simple answers, that it can and should qualify as the gold standard" (as cited in Merriam, 2009, p. 12).

Limitations of quantitative approach. While conducting a series of surveys would provide a larger sample size, it does not provide an opportunity to understand the overall

experience of participants. Strictly quantitative methods often rely heavily upon statistics and do not provide for an open dialogue or a deeper exploration of ideas that might spontaneously arise during a case study interview.

Advantages of case study method. Searle (1999) listed the following advantages to using the case study method:

- Stimulating new research: Case studies can illuminate unknown or under-explored phenomena. Case studies can highlight issues for further research.
- Contradicting established theory: Case studies can challenge or dispute established theories and hypothesis by providing compelling, contradictory data.
- Giving new insight into phenomena or experience: Case studies provide detailed depictions of various issues, which can provide invaluable information about previously unknown subjects.
- Permitting investigation of otherwise inaccessible situations: Case studies provide researchers with a chance to investigate cases and issues that occur organically within our society. In these instances, case studies allow deeper insight into the process and mechanisms associated with a phenomenon. (p. 5)

Research Procedures

Search for keywords. In order to ensure a thorough search of all databases, numerous keywords and phrases were used to gather data. This list includes, but is not limited to, the following: compassion fatigue, secondary traumatic stress, post-traumatic stress disorder, post-traumatic stress disorder and inmates, secondary traumatic stress and prisons; vicarious trauma, vicarious traumatization and corrections, inmate violence, correctional mental health, secondary traumatic stress and jails, burnout and correctional mental health, secondary trauma and corrections, and mental illness and incarceration.

The researcher also utilized various academic databases to acquire peer-reviewed, scientific journal articles. This list includes, but is not limited to, PsychInfo, OhioLink, and ProQuest. Federal, state and county websites were also used to gather statistical data regarding incarceration rates, treatment protocols, and policies regarding the incarceration of mentally ill.

Procedures for collecting data.

Recruitment. Participants for this study were initially recruited using a snowball sampling method, whereby those who were already recruited for the study referred others whom they knew on a personal or professional level. Direct requests were made to known correctional mental health providers at various facilities throughout Washington State. These individuals were asked to relay the researcher's contact information to their colleagues and potential candidates for participation. Additionally, the researcher provided a descriptive overview of the study and the recruitment parameters, which was circulated via email by and to prospective participants. All recruitment procedures were conducted in accordance with the ethical standards and guidelines provided by Antioch University Seattle and its Institutional Review Board.

For purposes of this research, the ideal length of employment in a correctional facility was anticipated to be at least two years. However, since a major component of secondary traumatic stress is burnout and decreased job satisfaction, it was surmised that many individuals who previously worked in these facilities may have left their jobs to seek alternative employment. Therefore, if the initial response rate was low, the researcher was willing to accept participants who had worked within a correctional setting for at least six months within the previous three years rather than the more ideal two years. Fortunately, this alternative criterion was not needed as there was a tremendous response to the initial recruitment request.

The researcher initially expected to interview three to five correctional mental health providers. However, twelve people responded to the recruitment email within the first two weeks. Although all of these individuals met the participation criteria, the researcher was able to meet with a total of eight participants due to scheduling and logistical issues and time constraints (on behalf of the researcher and the participants).

Screening. Once initial contact was made, primarily via email, eligibility was assessed based upon the following criteria: (a) Participants were required to be current, full-time, mental health employees of a correctional institution. (b) Participants were required to have a minimum of one year of full-time employment in correctional mental health. (c) Participants were required to possess advanced degrees, with a minimum of a master's degree. (d) Participants were expected to be at least 21 years of age. Additional demographic information, such as race, religion, and ethnicity were not considered as part of the inclusion or exclusion criteria.

Participants. This study consisted of eight mental health providers, who were presently employed at three different correctional facilities located in a Pacific northwest state. Individual, face-to-face interviews were conducted with each individual at a location chosen by the participants. The participants identified as Caucasian (n = 6), Hispanic (n = 1), and African-American (n = 1). This composition is consistent with the demographics of the area. All participants identified as either married or involved in long-term relationships. Additionally, all but one participant had children. Each participant possessed advanced degrees, including masters-level clinicians (n = 6), a psychiatrist (n = 1), and a clinical psychologist (n = 1). Participant ages ranged from 29 to 65 years old, with a mean age of 48 years. Participant experience in correctional mental health ranged from 1 year to 34 years, with a mean of 6.6 years (median = 3.25 years). The participants' total years of mental health experience ranged from 4.5 years to over 35 years, with a mean of 14 years.

Informed consent. In accordance with the terms outlined within the Antioch University Seattle Institutional Review Board application, informed consent was discussed with each participant, and each was given an opportunity to ask questions before the commencement of each interview (see Appendix A). Participants received oral and written notice of the study

purpose and procedures, the risks and benefits associated with the study, and the voluntary nature of the study, which included the right to withdraw without penalty. Participants were also informed of their rights concerning anonymity and confidentiality, as well as the legal limitations and exceptions to confidentiality. Each participant agreed to be audio-recorded during the interview. Participants were informed that the information would be used as part of a dissertation defense and that the results could eventually be published in scientific journals and presented at meetings and seminars. Participants were provided with the contact information for the primary researcher and the dissertation chairperson, and a copy of the signed consent form was offered to each participant (only one participant opted to take a copy).

Interview questions. A semi-structured format was used for each interview. Although this format is not as directive as a structured interview, there are many benefits to this style. It permits the researcher to guide the conversation towards a particular subject while still allowing participants the opportunity to express and expound upon ideas and even explore topics that were not anticipated by the interviewer (Whiting, 2008). According to DiCicco-Bloom and Crabtree (2006), "Semi-structured, in-depth interviews should be personal and intimate encounters in which open, direct, verbal questions are used to elicit detailed narratives and stories" (p. 317).

Each participant was asked to describe academic training, employment experience, and current responsibilities as a correctional mental health provider. Additional questions included the following: How would you describe your average client in corrections? What has your experience been in regards to working with trauma in a correctional setting? What have you found to be most rewarding/most challenging in regards to your work in corrections? How does your experience in corrections differ from your experience with trauma in a community setting?

Has working in correctional mental health altered your worldview? If yes, please explain in detail.

Participant Risks

Confidentiality. All participants were advised of the risks and limitations pertaining to confidentiality. Although participants were recruited from various facilities across the Pacific northwest, they derived from a relatively small professional community. Subsequently, participants were advised that it may be possible for colleagues to identify one another based upon certain details (should they choose to read the final report). Nonetheless, every effort was (and will be) made to maintain confidentiality.

Discussion of difficult topics. This study explored several sensitive topics relating to mental illness, child abuse, and exposure to trauma and violence. Subsequently, participants risked emotional discomfort while discussing these topics. This risk was possibly mitigated by the fact that all study participants are mental health professionals with access to mental health treatment and services (which many reportedly accessed throughout various points in their career). Furthermore, participants were encouraged to discuss and explore various coping mechanisms that they have utilized to address and resolve symptoms associated with STS.

Interview Tools

The researcher used digital audio recordings of each interview, as well as various note-taking devices, including a laptop and pen/paper. Written and verbal consent to audio record was obtained before each interview. Since privacy and confidentiality are of the utmost importance, the participants were each given an opportunity to suggest a location where he or she would feel most comfortable. Subsequently, three interviews were conducted in interview rooms located within the correctional facility, four were conducted in local coffee shops, and one interview

took place in a private room on the Antioch University campus. All data has been securely

maintained in a locked cabinet and on a password-encrypted computer. Additionally, any

personally identifying information has been stored in a separate, secure location, and all

recordings will be destroyed upon completion of the study.

Psychometric instruments. Although the researcher plans to use a primarily qualitative

method of inquiry, two psychometric tools were administered to each participant to assess the

level of job satisfaction and the presence of STS. STSS is a 17-item, self-report instrument

designed to measure intrusion, avoidance, and arousal symptoms within their professional roles

(Bride et al., 2004). The questionnaire uses a 5-point Likert-type scale for responses ranging

from 1 (never) to 5 (very often). The participants are asked to respond to statements based upon

their feelings in the past seven days. These include statements such as "I avoided people, places

or things that reminded me of my work with clients," "I expected something bad to happen," and

"Reminders of my work with clients upset me."

The STSS and its subscales have been measured for reliability and validity, and all values

are within acceptable standard of ranges (Devillis, 1991). Coefficient alpha scales range from .80

(intrusion) to .93 (full-scale STSS). The test is scored based upon percentiles, with scoring as

follows: Below 50% = little or no STS, 51% - 75% = mild STS, 76%-90% = moderate STS,

91– 95% = high STS, and 96% and above = severe STS. Bride (2007) suggested that a score at

the lower end of the moderate range serves as a cut-off point for determining PTSD due to STS.

The Professional Quality of Life Scale (ProQOL) (Stamm, 2009) is most commonly used

to determine the quality of life of various types of caregivers and helpers (counselors,

psychologists, and psychiatrists) (Stamm, 2009). The survey relies upon three subscales:

compassion fatigue, compassion satisfaction, and burnout. The alpha reliability scores for each

scale are as follows: compassion satisfaction = .88; trauma/compassion fatigue = .81; and burnout = .75 (Stamm, 2009).

 Data analysis. Data was analyzed by reviewing audio recordings and notes taken during the interviews. In Chapter IV The researcher will describe and discuss the experiences of the participants, both individually and as they relate to each other, as well as discuss any common themes that may arise within the data. The psychometric instruments used were also scored and measured in accordance with their respective interpretation manuals and guidelines.

Chapter IV: Results

The primary goal of this study is to explore the experiences of correctional mental health providers and the effects of secondary traumatic stress upon the providers. Two questions were posed in pursuit of attaining this goal: Research Question #1: What is the experience of mental health providers working with incarcerated mentally ill? Research Question #2: What experiences, if any, have correctional mental health providers had with secondary traumatic stress?

The following chapter will review data collected from interviews with eight correctional mental health providers. This section will include an overview of providers' daily tasks and responsibilities, a description of the clients they serve, including common behaviors and diagnoses, and the providers' personal experiences with STS.

In addition to developing an understanding of a particular phenomenon, qualitative inquiry also demands that the researcher be willing and able to explore factors that may influence the researcher's perspective. This includes the identification of thoughts and feelings, personal reflection, and documention of any personal or ethical dilemmas involving the subject being studied (Saldana, 2016). This goal is largely accomplished through the use of note-taking, bracketing, and memoing.

Analytic memos serve many functions in the coding process. They help the researcher accomplish the following goals:

1. Reflect on and write about how [she] personally relates to the participants and/or the phenomenon;
2. Reflect on and write about the participants' routines, rituals, rules, roles and relationships;
3. Reflect on and write about the code choices and their operational definitions;
4. Reflect on and write about emergent patterns, categories, themes, concepts and assertions; and

5. Reflect on and write about any problems, personal or ethical dilemmas with the study. (Saldana, 2016, p. 46)

As the primary researcher, my personal interest and experience regarding correctional mental health is particularly relevant to the subject. I have spent nearly two decades working in social services. After several years as a foster care case manager, I returned to graduate school to obtain a master's degree in criminal justice. I spent the next few years as a street outreach case manager, providing services to homeless individuals struggling with mental illness, addiction, and HIV/AIDS. I eventually returned to my current graduate school program to pursue a doctorate in psychology. It was during this time that I became employed as a social work release planner at a correctional facility, and it was there that I began to experience symptoms of compassion fatigue and burnout. There were times when I found myself saddened and disheartened by the seemingly endless stream of individuals entering (and reentering) the facility. Each day I listened to stories of childhood physical and sexual abuse, chronic substance abuse, and intimate partner violence. I began to experience chronic headaches, insomnia, and depression. Furthermore, I observed identical symptoms in peers (many of whom had left their correctional jobs for a return to community service programs). Moreover, I was particularly dismayed by the lack of empathy on behalf of administrators and managers and the lack of infrastructure to address these issues.

As a result of my own experiences, it was especially important for me (as the researcher) to ensure that I did not impose my own experiences onto the participants. Subsequently, in addition to audio-recording each meeting, I took studious notes during each interview, during which I used memos to notate my own thoughts and emotions at that particular moment.

Participant Overview

This study was composed of eight participants. Individuals were recruited from three prisons throughout the Pacific northwest. Individual, face-to-face interviews were conducted with each participant. The participants primarily identified as Caucasian (n = 6), followed by Hispanic (n = 1), and African-American (n = 1). This composition is consistent with the demographics of the area. All participants identified as either married or involved in a long-term relationship. Additionally, all but one participant had children. Each participant possessed advanced degrees, including master's-level clinicians (n = 6), a psychiatrist (n = 1), and a clinical psychologist (n =1). Participant ages ranged from 29 to 65 years old, with a mean age of 48 years. Participant experience in correctional mental health ranged from 1 year to 34 years, with a mean of 6.6 years (median = 3.25 years). The participants' total years of mental health experience ranged from 4.5 years to over 35 years, with a mean of 14 years (see Table 1).

Table 1

Participant Age and Experience

Age	Education	Number of Years of Employed in Correctional Mental Health	Total Years of Experience in Mental Health
57	M.D.	5 years	25+ years
35	M.A. (Psychology)	3.5 years	8 years
65	M.A. (Counseling)	30+ years	35+ years
56	M.A. (Counseling)	2 years	17 years
29	MSW, LSWAIC	3 years	5 years
42	M.S., LMFTA	2 years	4.5 Years
64	M.S., LMHC	7 years	14 years
38	PhD, LCP	1 year	6 years

Research Question #1: **What is the experience of mental health providers working with incarcerated mentally ill?**

  Theme one: most common diagnoses. Correctional facilities contain individuals with a wide array of mental health diagnoses, ranging from mild adjustment disorder to chronic psychosis with violent tendencies (Goomany & Dickinson, 2015). Substance use disorders and PTSD are amongst the most common Axis-I diagnoses for incarcerated individuals. (Butler & Kariminia, 2005; Saxon et al., 2001; Sindicich et al., 2014; Wolff et al., 2014). Participants were asked to define the most common diagnoses encountered within their facilities. All providers identified substance abuse, depression, anxiety, ADHD, and PTSD amongst the most common diagnoses, which is consistent with the above-mentioned studies. Other conditions included various personality disorders, such as Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (APD). However, most providers noted that DOC policies preclude direct treatment of personality disorders; most treatment is focused on addressing mood disorders. Below are examples of some of the provider responses:

> D4: So a lot of drug addiction, a lot of depression, possibly a lot of ADHD. Psychotic disorders like schizophrenia, seems fairly equivalent to the prevalence as it is in the normal population. And only a handful of people have severe schizophrenia disorder. So, anxiety, depression, drug addiction [are the most common disorders I treat].

> B2: I see a lot of depression, a lot of drug induced [disorders], and a lot of PTSD. I would say most of them do have a history of mental health either being inpatient at different psychiatric hospitals or having had treatment in the community. Probably at least 90-95% of them have a history of mental health problems.

> A1: Most common diagnosis is substance use, PTSD, usually ADHD, a lot of ADHD, and depression. Sometimes, very rare, but psychotic patients with schizophrenia.

> D6: I think that the typical diagnosis is depression and anxiety of some kind. . . . we see a lot of depression, a lot of anxiety, and PTSD . . . and definitely high level of meth abuse, heroine, opiates, and pain killers.

F7: Probably, the most common one we work with of course is major depressive disorder, recurrent. We do have several people who actually have a true diagnosis of schizophrenia or a psychotic disorder or something. We have a lot of borderline personality disorder, and of course, you have the antisocial personality disorder, but I think I'm not quick always to give that because it distracts you away from what else might be going on where they would've been acting out this way. Then we do have some true bipolar disorder folks, but a lot of the guys that come in with a bipolar disorder diagnosis are really borderline personality disorder.

Then a lot of anxiety disorders. We have a great deal of PTSD as you can imagine. We have a lot of vets. We have veterans who have PTSD but then just being in the prison system itself can cause PTSD. Of course then we have a lot of complex trauma from childhood. I would say the majority of our guys have complex trauma from childhood. Definitely high level of meth abuse, heroine, and opiates, painkillers, alcohol. Then of course you have the whole plethora of people that are really poly substance abusers who'll use anything they can get their hands on.

G8: There's certainly a lot of adjustment disorder with mixed depression and anxiety. You've got PTSD - It's very rare that I meet an offender who has not experienced neglect and abuse as a child. There's dysthymia. There's major depressive disorder. Borderline personality disorder, anti-social personality disorder and all the drug addiction. There are so many drug addicts there.

Theme two: changes in worldview. In their theory of Assumptive Worldview, Janoff and Bulman (1989), assert that people generally maintain three assumptions about the world: 1. The world is benevolent. 2. The world is meaningful, and 3. The self is worthy. Based upon these assumptions, people tend to view the world through a positive lens; they believe most people are good and that there is a certain order to the world, i.e., if I am a good person, then good things will happen to me. However, this positive worldview often changes (even temporarily) after a traumatic event (Feldman & Kaal, 2007). Alterations to one's worldview following exposure to trauma are often explained as follows:

In the process providing services to survivors, the caregiver is exposed to traumatic material that begins to affect one's worldview, emotional and psychological needs, the belief system, and cognitions, which develop over time. (Figley, 1995)

Participants were asked whether their work in corrections has influenced their worldview. The following responses represent how their worldview has changed since working in corrections:

A1: Now when I see children outside, I want to protect them. I feel now every child I see with any parent, I don't trust the parents. I developed [these feelings] because of the repeated, repeated, repeated information I get from them [inmates]. Now, I can't trust some people, some parents. That's my problem now. I'm very hesitant . . . because I hear it over and over and over and over the same trauma so it affects me, it really affects me.

D4: My worldview, so I'll say this about it. Number one, it was striking to me how many men have been abused as children. The other parts of my worldview, is I feel like there's this public perception that all of the offenders are locked up in prison somewhere so we don't have to worry that much about them, but really they're cycling in and out all the time. They do time, and then they're released. And they do time, and then they're released, which really brings up the necessity to treat and rehabilitate as much as possible while people are in… so that when people get out, they're somewhat rehabilitated so they don't fall back into the same pattern and do the same stuff over again.

Theme three: challenges of working in corrections. Psychologists who work in dangerous settings are described as working in extremis (Johnson et al., 2011). These settings, which include correctional facilities, disaster areas, and military conflict zones, are categorized as such because they present a persistent threat to the psychologist's mental and physical well-being (Johnson et al., 2011). The participants of this study identified several major challenges of working in correctional settings. From these responses emerged five basic categories: staff issues/conflict, client issues, caseload sizes, systemic issues, institutional issues, and exposure to trauma.

Staff Issues/Conflict

Adapting to prison culture can be one of the most difficult challenges of working in corrections (Rohleder et al., 2006). According to Dershimer (1990), employer support is one of the most critical aspects of working with individuals who have been affected by high levels of trauma. He goes on to state, "Staff support is not a luxury but a necessity. Without it clinicians can become dehumanized, causing them to distance themselves in relationships, experience fewer feelings, and become more mechanical and less caring in both their and personal and professional lives" (Dershimer, 1990, p. 119). Six of the eight participants in this study identified

lack of support and staff conflict as a major area of concern and a huge obstacle to successfully

performing daily tasks. Providers employed at three different facilities and in varying stages of

their careers made the statements below:

> D6: [My experience has] really been mixed. There's been quite a bit of turmoil in our department and a lot of that turmoil has to do with in-house bickering, backbiting. There's been a lot of unhappiness by the majority of us with our supervisors…One, because they didn't have the experience and they didn't have the managerial skills that they probably needed. Plus, there were some ethical things that were happening and there were some... Just poor judgment, poor decision making things, at least from my perspective…Again, I wish I could describe the negativity here. It can be pretty profound. And, again, when I say negativity, I'm specifically referring to the foul and vulgar language, the disparaging remarks, the sexist remarks, the. . . . There's just a lot of inappropriateness here.

> I've been very discouraged at the types of personalities I've worked within the Medical Building. Well, not just the Medical Building, I guess throughout [the facility]. I would... I've longed for there to be more respect, less back-biting, less gossip. I've longed for there to be less demeaning language. For instance, my last two supervisors were female and it wasn't just the men making sexist remarks, but it was also females making sexist remarks, such as "bitch," calling "bitches" and a whole of other awful things that I'm not gonna put on that record. It's just a very negative environment where inappropriate language is used, and it's just widely acceptable here in the Department of Corrections. And I don't know that that's professional. I don't know that... In fact I know it's not, I don't even think it's ethical. I think that we're here to treat patients. Yes, they did horrific crimes and they're in prison for it. That doesn't mean they need to be disrespected. That's what I think is the way it should be on the offender level on how we treat offenders. As far as other staff, what is it that they're afraid of? Why do we need to disparage other people? Why do we need to say very vulgar and rude things about them, what does that accomplish? It's just an interesting environment

> C3: All the politics is ridiculous and just nonproductive. You get people that are making decisions and have no idea what they're making a decision about let alone what the right decision is. So that's been my frustration through probably most of my career. I'd much rather deal with the inmates.

> D5: I would say more than working with the offenders, I think it's just the environment in corrections that wears on you. I don't know if you've heard that before or not but it is. It's just the people you work around sometimes are more draining than the offenders you work with. I'm able to set really good boundaries with [inmates], but when it's your co-workers, you're just kinda like, "Whoa, I'm maxed out." Sometimes you'll hear corrections call us "Hug-a-thugs", or sometimes you'll hear, "Oh Mental Health will just get [inmates] out of anything." It's actually not true, we don't have the power to get them out of anything. So, I would say it does wear on you.

Honestly, I think that sometimes, it could just be state employment . . . but in our facility at least, you have a lot of individuals who are above you that are difficult to deal with, or that don't understand what you're doing, and so it's difficult to accomplish anything. So I would almost say, management and the hierarchy is really difficult, and then just knowing that you don't have a lot of support as an employee. So that and then you have a lot of people. I do sound like I have so many blanket statements, but you just have individuals that are able to get away with not performing their duties a lot, and so you do find yourself filling in a lot, and I think it just kinda gets exhausting. And you do become pretty negative about it because you're just like, "I shouldn't have to be doing this. You had an hour and half lunch today, why am I seeing your patients?" Or just people that kinda bicker or . . . I would say more the problems are more with the environment than the offenders. I don't know. Sounds pretty terrible.

G8: Everyday I'm just shocked at how the employees' behaviors and interactions do parallel in some way what happens between the offender population. A lot of splitting, backbiting, gossiping. The power-movers, climbing the social ladders, but almost like subtly, doing it subtly. I've never been in a job where I was micromanaged, secretly and more passive aggressively. I don't want to be micromanaged. I don't want to work in that type of environment, and I know those environments are everywhere in every company, but again, I feel like the culture - There's this tension and fear that I've never experienced in any other job, and I've worked in hospitals and community health and food service and law offices, but there's a tension here that I feel like it makes it- It just has a real negative effect on the culture.

Client Issues

Correctional psychologists have very little autonomy pertaining to the types of clients they treat (Clements et al., 2007). Additionally, they encounter a large number of people who may be less enthusiastic about engaging in treatment and those who are difficult to treat based upon DOC parameters, such as those with APD and BPD. Below are some of the client issues discussed by the participants:

A1: The biggest challenge is when the patient is not manageable, when the patient is really mentally unstable and very difficult to manage him, very difficult to make him safe to himself and safe to others, when patients, or inmates are really persistently suicidal, suicidal ideation, intention and when they are noncompliant with their medication. They are aggressive to our officers, they are aggressive to the inmates, when they are aggressive to themselves, when they are aggressive to staff, that is a challenging situation, a difficult situation. We have to make sure, this guy is safe to himself, safe to others and we have to make sure we have to give them the right medication, we have to make sure, we give the right diagnosis.

B2: I think the hardest thing is finding out if they're lying or what their secondary gain is. It's hard to diagnosis anyways. We're not like medical. We don't have the labs and x-rays to find out what it is. We rely on what they're telling us. So, in corrections you always have to wonder are they're just trying to get that sleeping pill. Are they trying to sleep their time away? Are they trying to sell it? Are they trying to get SSI when they get out and use this assessment to do it? I mean, sometimes you get people that are just like, "Well, I want to get SSI. Can I have this assessment so I can do that?" Or they'll come in and they'll tell you the DSM, if you ask like "What are your symptoms?". They'll tell you the DSM. People don't come in and say they're hypervigilant. We don't use that terminology day to day.

C3: So I don't think I have compassion fatigue. But there are times when I'm real tired of dealing with personality disorders. And that's really the problem for me is the personality disorder stuff. I don't get tired of dealing with a brain damaged guy that can't control his emotions or that . . . I know what's going on with him. And he will respond if I... Because I know how to deal with him, and we can get by this. But personality disorder guys are just so demanding at all times, and so blaming, and so unwilling to look at their part in any of that, that they get very tiring.

D4: LWOP is the term for Life Without Parole. And some of those guys are . . . That's really hard for them. Their life is over basically. Now, they have to try and create some life in prison. I always think to myself, from a clinician perspective, what do you tell them? What do you say to a life without parole person to give them any kind of hope or any kind of, I don't know, confidence that they could have any gratification from their lives moving forward when it's all gonna be spent in a little, tiny box? And that's a difficult conversation to have with people.

Caseload size. As most mental health providers can attest, an average caseload can vary among agencies and treatment populations. Studies by the Case Management Society of America (CMSA) and the National Association of Social Workers (NASW) have identified caseload sizes ranging from two to 365 (Stricker, 2014). Several studies have indicated a positive correlation between STS and caseload size, especially when the caseload contains a high proportion of trauma survivors. (Brady, Guy, Poelstra, & Brokaw, 1999; Hatcher et al., 2011; Kassam-Adams, 1994). In a study of caseload factors amongst mental health professionals, including psychologists, community counselors, psychiatrists, and social workers, Walsh and Walsh (2002) examined how caseload affects the mental health of providers. Of the 79 participants, they determined that the proportion of male clients, the level of client need, and the proportion of

clients with depression significantly predicted staff mental health. The participants of this study

were each asked to provide an overview of their typical caseload. In addition to the high levels of

traumatic experiences and severe mental illness noted above, nearly all participants noted high

caseloads as an impediment to providing optimal services. Their responses were as follows:

> C3: Intensive Management Status, maximum custody. The Washington State term is "IMS," Intensive Management Status. So a day, I see anywhere from two to 20. I try and see everyone that walks in the gate to just check with them, "How you doing mental health-wise? Are you on medication? Are you suicidal?"

> Lots of those guys come over upset . . . so there's a lot of that emotional stuff coming in the door. And then we do hearings almost everyday . . . I do a brief mental health check-in in the hearing. Like how are they doing, are they suicidal, are they on medication, are they adjusting to medication, do they need something different. So that's anywhere from zero hearings in a day depending on who came in when to sometimes 15 hearings.

> D6: So I have a caseload of about 90, it hovers around 90, and I think that's a pretty fair caseload given the type of population we serve where we see a lot of depression, a lot of anxiety, and PTSD. We can manage those cases on a month-to-month basis. There was a particular supervisor who came in and immediately demanded that we begin going to these different types of custody level meetings. These are meetings over at segregation, these were meetings over in the units, and we were supposed to do all of that while trying to maintain our caseloads. And it just became very impractical and very difficult to do. Very stressful.

> F7: [My caseload] is at 112. It's crazy! We have 450 mental health clients. Two years ago, we had 300 . . . it's risen that much in the last two years. We also each do one group [with about 10-15 inmates] and it meets once a week because we have caseloads of over a hundred people and so that's about the max we can do.

> I think one thing is that we're pretty overwhelmed. DOC is pretty overwhelmed with mental health clients anyway because they're coming to prison rather than getting help in the community. Number two, we are considered a safe haven facility, so for people that want to drop out of the gangs. We have a large sex offender population because we're one of the only two sex offender treatment sites in the state. I think we get a lot more clients with mental health issues but because we're a safe haven, I think we get sent a lot of the more vulnerable people.

> G8: Everybody has these huge caseloads. My caseload's smaller but I've seen a handful of people leave. I have a few people on my caseload that won't be getting out till like 2030 something too. It just ranges; I have someone leaving in two days to someone getting out in 2033.

I've been saying that since I started the numbers have only been increasing. Just in a year, it increased from people having a 80-size caseload to a 120-size caseload, and I'm saying, "That's not okay, right?" Then I feel like I don't get much validation for that. It's like living in a Bizarro world because I thought a 30-size caseload with Community Mental Health was- That's tops. Forty-five, my goodness. Now I'm at 120, and I'm like, "Maybe we can manage that," because you're constantly told you can manage it. "That's all we've got. We don't have any more resources. We have no more money. We have no more space." I think they'll get there. Unfortunately, the sacrifices that are happening along the way- We just have to ignore it. I don't know.

Conversely, one participant noted the positive effects of a high caseload. He described it as a protective factor, which prevented him from spending too much time ruminating on a single case.

D4: Also, one thing that's interesting about our job is the pace of it is fairly rapid. We're doing these mental health appraisals and we're seeing guys on kite [inmate request] appointments, so we're pretty much going from guy to guy. That seems to have some sort of built-in [defense]; you can't get too stuck on one story for very long. You gotta see a guy, finish up a report, and boom, you got your next appointment waiting in the lobby.

Systemic Issues

Many providers discussed the ways in which their work is impacted by larger, societal and systemic problems. Issues pertaining to the lack of community resources for inmates upon release from custody, including the shortage of housing, substance abuse treatment, employment, and counseling, increased arrests of individuals with mental illness and a general lack of infrastructure to support the vast number of people cycling in and out of the criminal justice system. While some of these issues may not directly cause the manifestation of STS, most of the participants believe these issues contribute to burnout and general frustration.

G8: It's definitely opened my eyes to how institutions can live in a stagnant state, and then those people who have been in this system, the longer you're in it, the more you become complacent, really. That's just how the brain works. You know, it's like desensitized. . . . . I don't know why there's no one lobbying or trying to petition the upper [Department of Corrections] leadership for more mental health support. I don't know why no one's doing that. Maybe that kind of mentality doesn't work there. That's one of the bigger, ground level [problems]. They need more therapists! They're spending so much money on auditing, organizational, business stuff at the tippy, tippy top, and I'm thinking,

"You need to hire way more mental health therapists." 120-size caseload? And those people are getting treatment? No. It's space management and crisis management. It may contribute to recidivism, but I don't think it's a very efficient use of time, personally. I'm not getting to talk to the people who are truly mentally ill. Does that make sense? If we had more workers, I think it would be more organized and eventually, we'd get to the point where we could be a lot more efficient with what we do.

D5: I think I especially get . . . I feel bad about the older guys because we have programs for housing vouchers for individuals that have supervision. It pays for three months of their housing, but we have no transition programs for geriatrics. And you're talking about these vulnerable adults, these feeble old men sometimes that have dementia, and if the policy says that they don't have supervision and they're maxing out and released homeless, and we're supposed to be okay with that? I think that's where I get really worked up and I'll go to the medical providers and be like, "We can't do this." So we've started a group trying to get something in place but it's just so hard. So yeah, I would say it definitely kind of affects you.

D4: There's no infrastructure. I don't know how many guys I have that come in to my office for, they're coming to prison for the third, or fourth, or fifth, or sixth time and they tell me, "Well, God, when my sentence is up, I just get released and it's like, what am I gonna do now? I got nowhere to go, no support structure, I'm not plugged into anything. I'm just adrift." And the easiest thing to do is to do what they were doing to survive when they got caught. They just fall back into it.

C3: Well, over the years that I've been here, there are more and more mentally ill guys coming into the system. And that's due to a number of factors. The state mental health system has shrunk significantly, but that's only one factor. The other factors are the increase in drug use, especially methamphetamine, which is a real wrecker of humans and a wrecker of mental health. And then the changes in society too have really hurt people's mental health . . . I mean, there are a lot of factors, and they're more and more mentally ill people coming in.

Institutional Issues

Many clinicians discussed the ways in which they have been affected by the *prison environment*. While some seemed to struggle to specify exactly what was meant by that term, most identified a general sense of hostility and malaise. A master's level clinician, who has worked in corrections for several years, provided the following statement,

F7: Really, I think one of the biggest challenges is dealing with the Department of Correction rules. It's a whole culture that you have to try to help these guys deal with. Sometimes things that [correctional officers] thinks are helpful aren't helpful in terms of mental health. You have to help the offenders not only deal with their own issues and

being appropriate but also how do you operate in a culture that may not always be conducive to being supportive.

This provider went on to provide an example of the ways in which she believes DOC staff negatively interacts with inmates:

> There are some COs that are really not appropriate. For instance, I have a guy on my caseload who's gay. In this case because he's gay, they're sure he's predatory sexually and he's not. They're always on him, watching him. Of course, he suffers from depression and struggled. This just adds to that and it's created problems for him. That's frustrating. I had another guy who's very, very unstable in terms of his depression and we have one officer who can be just nasty. He was supposed to go to his follow-up to present for a program he's in. It's a very important day for him, but when he goes to leave the unit and the officer purposely closes the doors on him, won't let him go. He's says, "Too late." It wasn't too late. The officer was being inappropriate but guess who got the infraction? See, it's that kind of harassment in a sense that can really be deleterious to their mental health and we have no power to do anything about those things other than try to help advocate for them as much as we can.
>
> There's the attitude with a lot of custody that we're just tree huggers and we let these guys get away with everything. We have that, too. That's not everybody because we have a lot of custody really respect mental health and work really well with us. It doesn't take too many of those attitudes to really create very non-supportive environment. Then that's when I think you have these officers that really respond in these passive-aggressive ways with offenders as a result or aggressive. It can be just full on aggressive.

Another clinician echoed these sentiments while describing how the environment even affects mental health and medical providers:

> D6: And then as far as an institution, there's a lot of different types of systems. There's family systems, there's institutional systems, and each of these systems can be highly chaotic, highly disruptive, and dysfunctional. And I've been really shocked at how dysfunctional a facility can be, and I'm not talking about management per se right here, I'm talking about the fellow mental health staff, fellow medical staff, fellow nursing staff. And dysfunction is just on all levels.

Exposure to Traumatic Material

Although not all participants have experienced STS, they all reported being exposed to traumatic material on a near daily basis. Most of the providers discussed the childhood abuse experienced by many inmates as the most painful and traumatic material they encounter.

A1: I have never heard about so many children being sexually abused until I came here . . . it's hard to believe over and over again. I believe I was sad a lot of times. I want to protect children now. I can't tolerate it if I see somebody shouting at a child or parents mishandling their children, I feel an urge, I feel angry, really irritable because I can't take it . . . what they [the inmates] have went through, what they have experienced as a child. It affects me. It made me very sensitive to children.

C3: Well, I think that probably the rise of gangs [has changed the prison dynamic]. We have the whole Sureno/Norteno feud, which has brought lots of violence with it. We had some Blood/Crip troubles, but not much. It's nothing like the scope of the Norteno/Sureno who we've ended up having to separate and keep separate 'cause they fight on sight. I've never been attacked. But yeah, I ran [special units] for years . . . So there are lots of fights, suicide attempts, a few attacks of slashings and that sort of thing.

It's incredible some and that's part of my problem with thinking about the new, next generation is I've heard so many stories of just unbelievable childhoods. Unbelievable stuff that people could be that cruel and that uncaring. So yeah, there's a lot of the childhood trauma stuff, sexual abuse, physical abuse, neglect. Ugh. It doesn't have me hopeful for humanity much…the real, the trauma that really effects people is mostly childhood trauma here. At varying degrees, I'd say 60-75% have had pretty rough childhoods. Some of them just. . . . Their parents didn't care and they got running the streets at age 11 or something like that, which was fun, but then usually got some. . . . They were usually vulnerable kids in bad situation: Sexual abuse, or stuff like that. But 60-75% of really nasty childhood trauma from caretakers I'd say.

D4: One of the most shocking things to me about this job is how many males have been sexually abused as children. I would have never even imagined… It's not something you hear a lot about. It's not something that's talked about, and it's pretty shocking to me.

D5: 17:09 S2: Yeah. A lot of these kids. . . . A lot of these guys, especially the ones that are in their 20s and 30s right now, they are products of foster care. I mean, some of the stories that they tell you is just... It's baffling. And, of course, you have no way to verify it. But some of it, you can tell when somebody is being genuine, most often. And some of it, you'll find history in like their childhood record, and stuff like that. But yeah, I mean just emotional, or the things that they were expected to do. . . . To be a child of a drug home and then to be expected to go deal and put yourself in danger time and time again. So yeah, I would say a lot of them were just products of unhealthy households.

Some of them you find you just feel so terribly for the things they've been through and why they're here. Or not even why they're here because a lot of them will own it and say, "I just did it", but then you start deconstructing their backgrounds and you think, "Well of course you're here, of course you didn't know where else to go, of course you didn't know what else to do." And so I think sometimes at the end of the day, I do kinda debrief a colleague and I carpool together. So it is easy to debrief with somebody that you can discuss it with that's familiar. But it's definitely difficult to talk about it I think with your friends and family at home, because they don't really get it. Everybody always just says,

"I don't know how you do that all day, I would just. . . . I couldn't. I couldn't listen to that." Or, "How are you around child molesters all day?" And it does tax on you because you will have individuals that just come in, and it's like they're telling you their story not because they're trying to process it but because they like hearing it. And that's the hard stuff for me because you can't say, "You're a pervert, stop." You have to try and change their thought patterns, and I think those ones are the hard ones, the guys that will come in and tell you how their children wanted it, and how they expected it, and how that's why it happened and they did nothing wrong and you just. . . . It's so hard.

D6: It's so surprising how often [traumatic issues] comes up, that I'm now seeking out additional training to deal with it. Yeah, it's the sad part of my job, and it's touching in the sense that you get a sense, really quick, why some of these men are where they are at today. When you just sit down and you really listen to their stories, and what happened to them, beginning in early childhood on up through adolescence and adulthood, it makes a lot of sense to me that they're at where they're at, where they are where they're at today. And some of them have lingering PTSD and chronic PTSD, not so much acute PTSD, but chronic, and we... As a fairly new clinician, I've struggled treating that, and so I'm now looking into doing EMDR, or what they call Lifespan Integration, to help them work through that.

F7: We do a lot of crisis intervention like we're the ones that see if somebody was sexually harassed or sexually assaulted [within the facility] We provide mental health services for them. We see people if they've had a death in their family but we're doing a lot of supportive therapy and crisis intervention and then we do ongoing individual therapy as much as you can with only seeing somebody every four to six weeks.

Research Question #2: **What experiences, if any, have correctional mental health providers**

had with secondary traumatic stress?

  Theme one: secondary trauma and compassion fatigue. As with PTSD, a primary

component of STS is the exposure to a traumatic event and the negative affect on the mental,

physical, and emotional health of providers. The following discussion with one of the

participants discusses some of the traumatic material to which he is subjected each day:

  A1: Interviewee: Most of them, the sad part of it that makes me always really sad is how these inmates, most of them they have childhood trauma, emotional trauma, physical trauma and sexual trauma. This is what makes me really very sad; they were really treated in such a way they have anger, anger toward any person they think, they may think [is] similar to [their] abuser as a child…They feel anger so you have to be careful when you take the interview, make sure you show them sympathy, make sure they trust you first. I don't directly ask them about their childhood but [I] make sure I'm safe; I

make sure they trust me then after that, slowly when I ask them, they can [describe] details about how they were traumatized. It stressed me out. Makes me stressful.

Interviewer: In what way?

Interviewee: I feel sad. Sometimes when I hear such repeated, repeated complaints of childhood abuse. I developed. . . . I feel depressed really sometimes, I feel sad [about] how many children are really suffering… and the antisocial activities they do, how they try to harm themselves, how they use drugs, it's because of their childhood mismanagement of the parents, they abuse them so I feel sad. I [have] sympathy, I really [feel] empathy to[wards] them. I don't focus more on their crimes. I focus on their problems and try to help them really to remove mental conflict, the emotional trauma they have. I try to help them. Everyday I hear about that just really … I feel depressed sometimes. It makes me depressed.

Interviewer: Because you're hearing about these stories?

Interviewee: Over and over. Over and over I hear it. Oh my God. Sometimes I tend to cry. Sometimes I tend to cry. I feel sad I feel really depressed. I carry their pain… I just really experience myself how painful their childhood abuse was. I experience it myself even. I take it from them.

Interviewer: So is it a form of secondary traumatic stress or something else?

Interviewee: No question about that. I have that. I developed because …when they tell me [about their abuse], oh my God. I become overwhelmed. I become overwhelmed. . . . Sometimes I come home and think over and over, oh these children, how they suffer.

The following discussion was with a clinician, who had been working at the current facility for over one year. The participant discussed the emotional impact of working in corrections:

Interviewer: Do you think that doing this work has affected you in regards secondary compassion fatigue? Have you experienced that?

G8: Yeah probably for a few different reasons. Reading all of the crazy stories, that can be pretty extreme. . . . I need to understand this person, I need to understand my safety, I need to understand where this person is coming from, and a police report provides the information about what this person does outside of prison and what they're remembering everyday. Then, a couple of weeks ago I listened to two stories in a row of people who had murdered their babies. The hospital's descriptions of the injuries…

Interviewer: How have you been able to cope with that?

G8 : Probably not very well.

The interview was briefly paused at the participant's request after she became visibly

upset. The following statements were made immediately after the recording resumed.

G8: I would say, part of [why I get upset] is because I have kids, so that's kind of hard. You read stories all the time of people being abused and . . . Yeah, we talk about it a lot as a department and we'll talk about it with one another, and I think you get desensitized to it to a certain degree. I try to approach it as much as I can from a clinical standpoint because that really is my goal to unpack this person's brain and their approach and why they did what they did, and were they inebriated, do they identify as a child more than an adult? Anything that that kind of story could give you.

Then also just being there [at the facility]; it's a different world where people aren't necessarily being treated in a natural way. There's a reason for that, I know they're there because they've done bad things. I don't think I've been traumatized, but it is kind of -- You see a lot of brutal events here and there. Or even just being in the segregation areas, that's hard. People telling their stories of how they've been treated in prison, that can also create secondary trauma, it's anxiety causing, as well as their own stories of abuse and neglect as children. Yeah, it's everywhere. You can't get away from it.

One of the most harmful aspects of STS is its insidious nature. Despite being highly

educated, well-trained, mental health professionals, all of the participants who have experienced

symptoms of STS (either currently or in the past) noted a divide between their symptoms and the

recognition that they were being affected by their work. In the following excerpts, each

participant notes that he or she did not notice behavioral changes or symptoms until it was

identified by a spouse or peer.

D6: It was a breaking point. . . . I felt like everyone was like, "Are you okay?" "Are you okay?" "Are you okay?" It's like, "Okay. They're obviously seeing something here," and yeah, I am stressed out, and yeah, I'm not happy, and whatnot; I had to take a look at that. It's two parts, though. I wanna say, it's been more so around the negative work environment here in Corrections that has caused that. But then there is that piece of the stories that you hear, the trauma that you hear, the dealing with those things that does definitely move me.

At the time there was just a lot of the problems here at work, that a lot of the negativity going on and it had gotten so bad that I had started dreading coming to work. And I

remember feeling very anxious and I remember even having what I think was probably panic-like symptoms from time to time.

And it's interesting that I can relate on a whole new level with people who are experiencing those symptoms, what that might be like. And then, I think I had some depression going on. I sought help at one time.

Another provider discussed intermittent feelings of compassion fatigue throughout his career.

Interviewer: Okay. And is compassion fatigue or secondary trauma something that you've witnessed or observed in yourself? Have you noticed any of the symptoms in yourself in the time that you've worked here?

C3: Yeah, yeah. My wife would say, "Definitely." She thinks I've gotten more callous, which is probably true. That's probably true. I would think so. But the compassion fatigue, there are some symptoms, but to me, they come and go.

Similarly, the clinician below also discussed how others have commented on changes in her demeanor that she had not previously noticed:

D5: I definitely think it does wear on you, as much as I would like to say, "No, it doesn't," It does. And even my boyfriend has said, "You've just gotten more negative since you started working there, you're more negative." And I always try and check back in with where I started . . . and then I'll have people that just say, "You care too much," Or, "You're working too hard." . . . So, I wouldn't say that it necessarily... Maybe it has changed my worldview, I mean, I've never actually really thought of it, but yeah, I guess you become a little more pessimistic.

Theme two: coping with STS. Once one has identified the presence of STS signs, it is important to determine how to address and ameliorate the symptoms. Environmental, organizational, and peer support are among the many factors that can influence how well a person copes with STS (Dagan, Itzhaky, Ben-Porat, 2015; Ennis & Horne, 2003; Thoits, 1995). When asked how they have coped with the effects of STS, most of the participants identified peer support (particularly in the workplace) as their primary resource.

B2: We have team meetings every week, not really to talk about cases though. We talk about them amongst each other though, or with my supervisor. We're always really good. We have a really good mental health team. We're lucky. Everyone gets along and is open. We rely on each other a lot.

D4: 0:33:39 S2: We have a pretty collegial team. I guess we do a little bit of case consultation with each other, supervision, just talking about those cases that seem like real hardships. Sometimes, we'll sneak off into each other's offices and say, "God, I just saw this guy and his life sucks. I feel terrible about it."

F7: Team support, peer support is very important. . . . This one therapist and I, the two oldest ones that have been working together for a while, we said, "We're going to write a book someday and it's going to be titled 'I Have This Guy'," because we'll go in and say, "Okay, I have this guy." We do supportive therapy for each other. We do a lot of supportive stuff for each other as a team.

G8: I think talking to my coworkers about it [helps]. Talking to my supervisor has been helpful, occasionally. Again, he's busy, everyone's really busy.

Additionally, three participants identified external supports, particularly family, professional

counseling, and extracurricular activities, to be the most helpful in addressing symptoms.

D5: I also have a per diem job and it helps me to be less cynical. It helps me remember why I love my profession and the fun parts of it, and that it's different in the community. It's a little toxic here. but its what you let get to you...I live with my partner and my dog. . . . And then, I do a lot of volunteer work. I do a lot of animal rescue stuff and so that helps keep me sustained. I really enjoy that. And then like I said, my job at the hospital is a reminder of the good that social work does.

D6: I've done everything. I've done it the wrong way and I'm trying to do it the right way. In terms of culpability, there've been days where I think I took on a little bit too much of their pain. And that's what makes me so grateful for [flexible] hours to kind of detox from that… I went to a doctor, told him about what was going on. Let him know that I was a mental health therapist and I thought that maybe some type of anti-depressant would help and he gave it to me, but it just... I didn't like the side effects. I didn't like the. . . . How it made me feel. And after a few months I went off of that and then, in time, I talked to [a colleague] about self care, about taking care of myself and how I could do that better and he said, "Look, I know exactly where you are. By the way, several years ago I was exactly where you're at. I had all these problems going on. I wasn't eating healthy. I was overweight. I wasn't taking care of myself. I wasn't exercising. If you'll do this, this, and this, I think you'll feel a lot better." So I did. I've been doing all the steps that he's shared with me and that's helped a lot.

Overall, family, faith, exercise, dieting, those types of things. Not dieting per se but lifestyle choices. When I was deep in the despair of the trenches, I was ready to abandon [my faith] but as I'm coming out of it, my faith informs my decision in the fact that I need to be a force for positive change, where patience, kindness, gentleness, and respectfulness win the day.

C3: It has helped to know that home. . . . The life on the streets is far different than life in here. But then, my daughter went to college at Seattle Pacific, and I'd go up there and I'd be looking at all these kids that were the same age as the kids I deal with here and going, "Oh, look at these people. They speak well, they're opening doors for me." It was just such a breath of fresh air to realize and I got thinking, "Well, I kind of have a pessimistic view of that age of people because of who I work with." And so it was gratifying to me to see this whole... That some of my daughter's generation was doing just fine, thanks. And there really is hope for the future.

Rewards of Working in Correctional Mental Health

Considering the emotional, physical, and psychological dangers of working in corrections, one might wonder why mental health providers choose employment in that setting. Many of the providers expressed a genuine passion about their work and the population. Although most never expected to work in corrections, many described it as a good intervention point. Since many of the inmates they treat tend to have co-occurring disorders with poly-substance abuse, incarceration is often their only period of sobriety and the only time they are able to stabilize on medications and fully engage in therapy. Most providers found this especially rewarding as it allowed them to interact with clients who were eager to obtain treatment. Below are statements made by the providers when asked about the rewards of working in correctional mental health:

A1: Yes and I love it because I love patients. Really I love patient health. When you work with mentally ill patients and you are the one to understand them. You are the one who won't judge them because of their mental illness. If you really understand the mental illness, what kind of behavior manifests, if you understand it then the number of conflicts, disagreements, anger, violence will be decreased depending on you, your approach, the rapport you do. So I love mental health. I love it.

B2: We also get guys in there who really do want to change. They've come from a horribly abusive background or neglectful background. They've used a lot of drugs. They don't always see prison as a bad thing. They see it like a new start. They really do want the help and to get sober and to learn coping techniques and to get stabilized with their mental health and medications. You do have the other ones who really want the help as well and who have already been at their rock bottom. They want to go up.

C3: The most rewarding is when inmates are really working on change and then. . . . So I learn a lot from them that I can use down the line with other guys.

D5: I think that it's the ones that you feel like you make really good breakthroughs with. I've had a couple guys, and I think these are my favorite ones to work with because at the beginning they are more labor intensive, so I end up with them 'cause they have the time, but the ones that really are just rigid and don't want to talk. And I think that, at the end, when you have finally gotten them to discuss their symptoms and the way they're feeling and wanting to move forward or identify goals, or will say, "Thank you, I've never felt like anybody took the time." I think those are the big ones for me. I have about three that I just will think about when I'm having a really tough day, I'm like, "No, but it's okay, because you made a difference and this guy's still out, and he pursued his art degree or whatever it is. So it's kinda cool those ones. Like, the one I told you I'm working with who's really gang related. He just keeps to himself, but after the 4th or 5th, he goes, "I just wanna thank you. I can tell that you're trying to help me and so I appreciate it, but I'm gonna need more time." And I was like, "Oh, that's fine," But I also try and relate with them like on a... I guess I just try to build rapport really quick.

G8: The clinical work. Any clinical work that we do with these clients, even the most annoying ones is absolutely interesting and you can learn so much and for the most part they are interested to take part in treatment interventions. I would say it's rare that someone doesn't want to come and meet with you and work on their mental illness. It is rare. So that's wonderful. Just getting to know the people and hearing their stories. It's my favorite.

D6: It really has affected me. It's turned up my compassion. I get a little troubled now when I hear people make disparaging remarks about offenders because they're judging them without knowledge. And I don't know how you can get into those stories and not come out changed.

F7: I've always wanted to help people that were disadvantaged in a way who had a lot of trauma in their early lives, and that was why I [entered corrections] in the first place. . . . I like the mental health side. I like to do groups and I like to do therapy and I'm used to this population and so I thought it'd be a good opportunity. I love it.

One of, and this isn't always a hundred percent, but one of the things is we're getting to see these guys clean and sober. Also, they don't have all of the stressors going on necessarily that they've had outside. They don't have to figure out how they're going to pay their rent or if they have place to live. They don't have to figure out if they're getting food. They have meals. Most often, they have jobs.

Within the facility, they're getting education and some of them are discovering that they're actually pretty smart and capable. We don't have all of those types of things that they're dealing with out in the community that are ongoing stressors. Having those basic needs met helps them be able to focus on improving their mental health. Their overall physical health is better because they're eating, they're not using, they're getting sleep,

they have a schedule, and they've got a lot of support and structured environment helps them with a lot of things that otherwise, they'll just be spiraling out of control.

I love this work because they really. . . . Most of the guys I meet would really want help. They really would like to do things better. I was just meeting with a kid before I came to see you. Young kid, he's only twenty. He really struggles with depression, a lot of anxiety, really low self-esteem and just a lot of shame and guilt about the things he's done that have brought him into prison. He told me this morning, he says, "I want to learn how to do this without medications. I want to get better. I want to know how to be better without medications. I made a promise to myself a week ago that I was going to figure this out."

It's just gratifying to get somebody like that and be able to show them compassion and allow that opening for them to start to work on things and here's the thing, to give them hope. To see them start to become hopeful because when I told him, I said, "Oh, we can do that. We can work on this." I said, "Look, we have this time period," and I said, "You will not believe the changes that you can make within this period. When you leave here, you're going to be very different from the person you're sitting here as today. In other words, you're going to think very differently about yourself."

You could see him. He just sits up and he goes, "Really?" He says, "Okay." Before that, he was just like this beaten down, sad, very depressed kid. I think the thing that for me is being to instill hope and then follow it up with the practical things that really help this happen and show them that this is what you do, these are the possibilities, now what do you want to do to get there because I'll help you. Just being able to inspire hope and to help them actually take the steps and accomplish the things that get them to that place they want to be is the best thing in the world. It's wonderful. That's why I don't get burnt out because it's really a spiritual experience when you think about it. For me, it is. It's pretty cool. I like it.

Psychometric Tests

Professional Quality of Life Scale: Version 5. Each participant in this study completed the Professional Quality of Life Scale: Version 5 (ProQOL-V). This Likert-type scale includes three subscales: compassion satisfaction (e.g., "My work makes me feel satisfied"), burnout (e.g., "I feel worn-out because of my work as a helper"), and secondary traumatic Satress (e.g., "I find it difficult to separate my personal life from my life as a helper"). Each subscale includes ten items, which ask the participants to describe how often they have experienced a particular item within the last 30 days, ranging from never to very often (one to five).

Scoring the ProQOL-V requires reverse coding for items 1, 4, 15, 17, and 29 (see

conversion chart below). Next, each subscale is totaled as follows: compassion satisfaction

(items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30); burnout (items 1, 4, 8, 10, 15, 17, 19, 21, 26, and

29); and the Secondary Traumatic Stress Scale (items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28).

Table 2

ProQOL-V Reverse Scoring Chart

Original Response	Conversion
1	5
2	4
3	3
4	2
5	1

Participant responses indicate high levels of compassion satisfaction and average levels

of burnout and STST (see Table 3).

Table 3

ProQOL-V: Participant Scores

Participant	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
A1	35 (average)	25 (average)	35 (average)
B2	37 (average)	20 (low)	15 (low)
C3	46 (high)	20 (low)	12 (low)
D4	38 (average)	20 (low)	14 (low)
D5	27 (average)	20 (low)	14 (low)
D6	34 (average	27 (average)	33 (average)
F7	46 (high)	17 (low)	15 (low)
G8	34 (average)	32 (average)	27 (average)

Secondary Traumatic Stress Scale. The Secondary Traumatic Stress Scale (STSS) (Bride et

al., 2004) was administered to each participant. This17-item, self-report instrument is designed to

measure intrusion, avoidance, and arousal symptoms of direct service providers. The survey uses

a 5-point Likert-type scale, with responses ranging from 1 (never) to 5 (very often). The participants are asked to respond to statements based upon their feelings within the past seven days. The scale includes statements such as "I thought about my work with clients when I didn't intend to" and "I felt discouraged about the future."

Bride (2007) suggested that individuals with a score of 38 or higher on the STSS Total Score are likely struggling with PTSD due to STS. Based upon their responses, two of the participants scored in the high range, indicating the presence of STS.

Table 4

Secondary Traumatic Stress Scale (STSS)

Participant	Intrusion	Avoidance	Arousal	Total
A1	14	15	14	43 (high)
B2	11	12	10	33 (average)
C3	6	10	07	23 (low)
D4	12	14	11	37 (average)
D5	07	13	11	31 (average)
D6	13	21	12	46 (high)
F7	05	07	06	18 (low)
G8	12	24	16	52 (high)

Chapter V: Discussion

Summary of Findings

This study explored the experience of correctional mental health providers and the presence of secondary traumatic stress disorder. The goal was to explore the ways in which correctional environments affect the emotional and psychological well-being of providers. Two research questions were posed at the beginning of the study. Research Question #1: What is the experience of mental health providers working with incarcerated mentally ill? And Research Question #2: What experiences, if any, have correctional mental health providers had with secondary traumatic stress?

Limitations of Study

Sampling methods. As with many qualitative studies, small sample size is often a concern as it limits the generalizability of the findings (Griffin, 2004). Since a snowball sampling method was used, only individuals identified by peers and colleagues were aware of the study. Subsequently, there might have been other eligible individuals who were not aware of the study. Similarly, given the nature of the topic, the study might have attracted more individuals who have experienced symptoms of STS and burnout, thereby skewing the results. Additionally, there is always a greater risk of bias affecting the results of qualitative studies as the researchers are required to make subjective decisions regarding the acquisition and interpretation of information. Nonetheless, this particular limitation was likely mitigated by the quantitative methods utilized in the study. Lastly, although the participants were recruited from several facilities, they were all employed under the auspices of the Department of Corrections in one Pacific northwestern state. Subsequently, it is possible that the systemic and organizational issues discussed are unique to this particular area of the country.

Explaining discrepancies between qualitative and quantitative results. Nearly all participants discussed having experienced symptoms of STS, burnout, and/or compassion fatigue. They discussed feelings of depression, anxiety, and fear, as well as somatic symptoms, such as headaches and panic attacks. Nonetheless, none of the participants met the criteria for the conditions based upon the results of the STSS and ProQol. There are several possible reasons for this discrepancy. The STSS and ProQol measure symptoms occurring within seven and 30 days respectively, prior to the date of the survey. Since three of the participants who discussed struggles with STS had since sought treatment for the condition, their symptoms have dissipated, and, therefore, did not register on the survey. For example, one participant discussed having such intense feelings of sadness and despair earlier in her career that the feelings prompted her to leave the field entirely for several years. She explains her decision below:

> F7: I had twelve years before doing probation and during my first. . . . Usually when you're going to have that problem, it's about four to five years in, you start to think the whole world's going to hell in a hand-basket. Everybody's awful. There are no good parents, there are no good families, and you start to really go into this horrible state where you're depressed and angry.
>
> I used to have to go to the middle school and the high school and stand in the hallway and go, "Okay, I don't know all these kids." Obviously, there's a lot of really good kids and families out there. I've already dealt with that and when I left [corrections] that was why, because I wanted to get my head back into what's really normal, what's really going on out here, not what's just going on in this microcosm. It really made a difference. When I came back into this [field], I already had my head in a good space."

Discussion of Themes

Saakvitne and Pearlman (1996) identified several factors that may contribute to the development of STS. For mental health providers, this includes insufficient training and education, particularly in the field of traumatology; unrealistic expectations of one's abilities; personal trauma history; negative personal coping strategies; lack of supervision; stressful personal life events; and inadequate vacation time. Additionally, there are client characteristics

that may increase or activate a traumatic response within the provider. These include the intensity of the client's pain and suffering, experiences of abuse and trauma, prolonged feelings of hopelessness, and self-destructive behaviors.

In a literature review of the influence of prison culture on the mental health of prisoners, Goomany and Dickinson (2015) identified four themes that influenced a prisoner's mental health: social, emotional, organizational, and physical. Those who are deprived of social interaction, such as individuals kept in isolation or confined to their cells for up to 23 hours per day, were more likely to express feelings of anger and frustration. Emotional aspects of confinement were largely defined by separation from family, particularly by incarcerated women who were separated from their children. The organizational structure of prisons can also be deleterious to a person's mental health. Many inmates describe a profound loss of autonomy as they must obtain approval to perform even the most mundane tasks. Furthermore, many inmates found the enforcement of certain rules to be arbitrary and pernicious, which increased feelings of anger, resentment, and depression. Lastly, in addition to being physically confined within an unnatural setting, overcrowding within facilities was identified as a major area of concern as it increased tension, altercations, and even the transmission of communicable diseases.

Interestingly, these four themes emerged throughout interviews with the participants of this study. Issues regarding social interaction, emotional support, organizational support (or lack thereof), and limited physical space were discussed by each of the participants in this study. For example, although the mental health providers are not permanently confined to the facility, they each discussed the ways in which simply being in that environment affects how they view the world and how they interact with each other. Five clinicians discussed the anger and frustration

expressed by some of their peers (both mental health and correctional staff) due to the lack of resources and services.

Furthermore, regarding physical space, nearly all of the participants noted the increasingly large caseloads and occasional overcrowding. Prison overcrowding has been described as the "cancer" of the incarceration system (Criminal Justice Alliance, 2012, p. 3). For inmates, it results in more time spent within their cells due to security concerns, lack of mental stimulation, and fewer opportunities for education and work within the facilities due to increased demand (Goomany & Dickinson, 2015). For correctional staff, overcrowding results in higher caseloads, greater incidents of violence, and increased demands for services (Goomany & Dickinson, 2015). One participant of the current study described the issue as follows:

> Sometimes [the inmate census] gets up to 1500, but usually it's around 1200 or 1300. When we get too much higher than that, we're triple bunking and we're having guys sleeping on floors which is never a good thing to have three guys in a small cell like we have.

Additionally, at least four providers discussed their frustration with what they viewed as the capricious and harmful nature of many DOC regulations. This could indicate that the very issues that influence the mental health of inmates also influence the mental health of correctional employees. Similarly, while the inmates experience a physical separation from their families, several providers discussed an emotional barrier between themselves and their loved ones as they attempt to shield their friends and family from the details of their work. As one participant stated:

> I take some of the funny stories home. Sometimes I'll tell my husband, but when I started my first practicum I think I came to him once with a story about a woman who had been raped and the product of that was her son, and she kept her son. I remember just going home and telling my husband that story and he was like, "I don't know if I can listen to stories like that." He's in a very different field and so. . . . I didn't resent him for that, to be honest.

Another provider discussed fears of judgment from those who don't understand the value or benefits of working in corrections,

> It's definitely difficult to talk about [my work] with friends and family at home, because they don't really get it. Everybody always just says, "I don't know how you do that all day, I would just. . . . I couldn't. I couldn't listen to that." Or, "How are you around child molesters all day?"

A third participant discussed the "gallows humor" that he and his peers have developed over the years, which does not translate well when shared with others outside of the field. He discussed looks of horror on the faces of individuals after sharing stories of events that occurred within the facility. Subsequently, these individuals sometimes experience an increased sense of isolation as they become less able and willing to discuss their experiences outside of work. Social support was identified as a strong, positive resource by most of the providers. Even though official policies regarding STS were not prominent in any of these facilities, participants recognized the importance of having someone with whom they could discuss difficult or traumatic material. The lack of social support can be especially detrimental for those who feel unsupported by peers and management.

Unanticipated Research Outcomes

Incarcerated individuals are often highly marginalized and stigmatized throughout our society (Agozino, 2000). Whether an individual was incarcerated for a minor, non-violent crime, or a heinous, violent attack, society often views them with the same level of disdain (Hagan, 1993; Moore, 1996). Even upon release, many individuals find it difficult to locate housing and employment because of the stigma attached to their previous crimes (Apel & Sweeten, 2010). Therefore, it was particularly rewarding to hear the compassion and dedication of the correctional mental health providers. Despite the challenges they encounter working in corrections, every participant expressed deep concern regarding the wellbeing of the client.

They were all able to convey sympathy for their clients, not for the pain they have inflicted, but for the pain they have endured.

> D4: There's a high prevalence of mental health problems among incarcerated populations and that does contribute significantly to their criminal history and criminal behavior. There's no question about it. I think that's often overlooked among custody staff and probably among the general population on the outside who believe all criminals are bad people and it's not the truth, right? All criminals are not bad people. A lot of criminals had really bad lives and really bad things happened to them, which has contributed to their criminal behavior. That's one of the most striking things I've seen in working [at this facility].

> D5: Some of them you find you just feel so terribly for the things they've been through and why they're here. Or not even why they're here because a lot of them will own it and say, "I just did it", but then you start deconstructing their backgrounds and you think, "Well of course you're here, of course you didn't know where else to go, of course you didn't know what else to do."

Why STS Goes Unnoticed/Untreated

Although the participants in this study were employed at different facilities across the state, there are a limited number of correctional mental health providers (particularly psychiatrists and doctoral-level psychologists). Subsequently, some providers admitted a reluctance to criticize peers or management, fearing that they might later be identified and possibly penalized. Therefore, some providers were only willing to share certain details of their experience off the record, once the recording ended. This mentality is consistent with findings in other research. A 2011 study by Johnson et al. identified the most prevalent reasons psychologists fail to report concerns about their peers:

- a desire to respect the professional judgment, privacy, and autonomy of colleagues;

- concern that one has insufficient evidence to support competence concerns;

- fear that the intervention will harm the collegial relationship;

- lack of clarity regarding one's ethical obligations to intervene; and

- fear that one's reputation will be harmed in the larger community of psychologists (Johnson et al, 2008).

Additionally, researchers suggest that psychologists may also feel fear and shame over their perceived lack of competence (Johnson et al., 2011; O'Connor, 2001). This phenomenon exemplifies the need for employers to establish a platform for employees to express their thoughts and feelings about themselves and their peers. If employees do not feel safe and supported (particularly by their employers), then both the therapists and clients suffer.

Preventing /Treating STS

Although the effects of STS can be devastating, the condition can be treated and even avoided. In a study of the effects of working with female incest survivors, Hollingsworth (1993) identified several strategies that were helpful for therapists working with this population. These included the following:

- peer support,

- supervision and consultation,

- level of training,

- personal therapy,

- maintaining a professional/personal life balance, and

- establishing boundaries with clients.

Similarly, other studies have identified the need for organizations to establish guidelines pertaining to the importance of self-care (Carroll, Gilroy, & Murra, 1999). This would include encouraging employees to participate in personal therapy, increased peer supervision, and continuing education courses aimed at learning self-care techniques (Gilroy et al., 2002).

How STS and Burnout Affect Organizations

Several studies have explored the ways in which work stress affects job performance (Arshadi & Dimiri, 2013; Gilboa, Shirom, Fried, & Cooper, 2013; Khamisa, Oldenburg, Peltzer, & Ilic, 2015). A 2013 study conducted by the APA surveyed 1,501 employees about their work experiences. Sixty-five percent of respondents identified work as a significant source of stress. Furthermore, only 36% of employees believed their companies provided sufficient resources to help them manage work-related stress (APA, 2013). These findings are consistent with studies conducted by the CDC (2015) and the U.S. Department of Labor (2016), which identified numerous individual and organizational consequences of work-related stress. Employees frequently identified work-stress as a contributing factor to their emotional exhaustion, depression, and physical health, with the development of medical conditions, such as ulcers, headaches, and musculoskeletal ailments. Many employers have also noticed the affects of workplace stress on employee productivity, including missed deadlines, increased errors, conflict with co-workers/supervisors, increased absenteeism, and chronic lateness, as well as increases in disability claims and healthcare costs. Furthermore, the CDC has also estimated that absenteeism related to employee illness and injury costs employers approximately $225.8 billion annually in lost revenue and medical expenses (CDC, 2015).

Fortunately, as awareness of this issue has increased, there has been greater research regarding treatment and prevention. Many studies have indicated that practicing self-care can improve employee satisfaction and productivity (Figley, 2002; Stamm, 1999), which includes developing and utilizing strategies to maintain a balance between one's personal and professional life. Furthermore, reliance upon professional support from peers and supervisors, as well as social support systems from family and friends, has been indicated to prevent and reduce

symptoms associated with STS and compassion fatigue (Figley & Barnes, 2005; Maslach, 2003;

Newell & MacNeil, 2010; Stamm, 1999). Likewise, many of the participants in the current study

identified peer support and team meetings as helpful tools in combating emotional stress and

fatigue.

Similarly, employers can also implement policies and programs to reduce employee

stress, fatigue, and burnout. The American Psychological Association suggests the following

organizational improvements based upon employee suggestions:

- Ensure that the workload is in line with workers' capabilities and resources.
- Design jobs to provide meaning, stimulation, and opportunities for workers to use their skills.
- Clearly define workers' roles and responsibilities.
- Give workers opportunities to participate in decisions and actions affecting their jobs.
- Improve communications—reduce uncertainty about career development and future employment prospects.
- Provide opportunities for social interaction among workers.
  Establish work schedules that are compatible with demands and responsibilities outside the job. (U.S. Department of Health and Human Services, 2013, p. 15)

Lastly, individual psychotherapy may be helpful for those who are experiencing extreme

levels of stress and compassion fatigue, especially for those with a personal history of trauma

(Gardell & Harris, 2003; Stamm, 1999). This can aid individuals in developing positive coping

techniques, realistic professional and personal goals, which, consequently, improves emotional

and physical health outcomes (Figley, 2002; Maslach, 2003; Pearlman, 1999).

Trauma Treatment Model

Several studies have indicated a positive correlation between therapists' personal history

of trauma and the manifestation of STS (Dagan et al., 2015; Jenkins & Baird, 2002; Salston &

Figley, 2003). The constructivist view of trauma examines the individual's history and life

experience in an attempt to understand how one may adapt to a traumatic event. Constructivist

self-development theory (CSDT) explores the interaction among an individual's personality

traits, biological and psychological resources, and interpersonal experiences, within the larger social and cultural context (Devilly et al., 2009; Saakvitne, Tennen, & Affleck, 1998). By combining components of social learning theory, cognitive behavioral theory, constructivist theory, and psychoanalytic theory, CSDT studies how the individual processes the traumatic event; what meaning is assigned to the event; and how these interpretations affect the individuals' cognitive schemas, personal beliefs, and expectations about the self and others, particularly as it pertains to safety, trust, intimacy, self-esteem, and power (McCann & Pearlman, 1990).

Posttraumatic growth occurs when an individual begins to heal following a traumatic event. CSDT aids in this process by helping individuals integrate the event into their personal narrative (Saakvitne et al., 1998). It has been used to treat traumatized college students (McCann & Pearlman, 1992), survivors of domestic violence (McCann & Pearlman, 1990), and therapists suffering from vicarious traumatization (Figley, 1995; Pearlman & Saakvitne, 1995). Subsequently, this multi-disciplinary approach may be effective in treating correctional providers suffering from STS as it explores several aspects of the individual's functioning (personally and professionally), including a person's capacity to "maintain a coherent and consistent sense of self," (Trippany, Kress, & Wilcoxon, 2004, p. 33) develop ego-resources to meet emotional needs, and establish healthier coping mechanisms (McCann & Pearlman, 1990;). Dagan et al. (2015), suggest that therapists develop a "tolerance for ambiguity," (Trippany, Kress, & Wilcoxon, 2004, p. 595) which will aid therapists in becoming less rigid when working with trauma victims. For correctional mental health providers, who utilize this model to treat their symptoms, this includes adjusting their expectations for client outcomes, and recognizing their own limitations as clinicians.

Recommendations and Implications

As the need for correctional mental health professionals continues to grow, greater efforts should be made to understand the tremendous strain placed upon these practitioners. Although most state and non-profit agencies operate with limited funds, it is imperative that they offer continuing education courses. Several providers discussed the need for additional training, specifically as it relates to trauma and co-occurring disorders. Future studies could explore the ways in which increased training directly affects correctional mental health providers struggling with STS and whether it reduces the manifestation of the condition in novice counselors.

Additionally, since all participants were employed by one agency, future studies should include clinicians from different states and federal jurisdictions to increase generalizability. Additionally, many participants of this study noted the absence of any official forums or policies pertaining to STS and self-care. Increased awareness of prevention and treatment for STS could aid providers in recognizing signs and improving symptoms.

Lastly, while all participants noted a generally positive relationship with many correctional officers, most also felt that the officers often misunderstood their role as mental health practitioners. This sometimes resulted in strained relations and occasional hostility between the two groups, each of whom, view the other as a hindrance to performing daily tasks. Correctional psychologists have described similar experiences in other research studies (Haag, 2006; Rohleder et al., 2006; Watkins, 1992). Future studies should explore ways to bridge the divide between mental health providers and the Department of Corrections staff, which could include establishing training manuals and protocols to improve communication.

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Appendix A:

Informed Consent for Participants

Research Study Participation

Informed Consent and Notice of Confidentiality

Research Purpose: My name is Nykia Johnson, and I am a doctoral candidate in the psychology program at Antioch University Seattle. I am conducting research about the experiences of correctional mental health providers, particularly as it relates to compassion fatigue and secondary traumatic stress disorder.

Participation Requirements: If you agree to participate, it would involve a 60-90 minute interview with the researcher, during which, you will be asked to complete two brief questionnaires. Interviews will be audio-recorded for accuracy, and later transcribed by the researcher.

Freedom to Withdraw: You are under no obligation to enroll in this study. If you do enroll, you can refuse to respond to any and all questions, and you have the right to withdraw from the study at any time, without penalty.

Risk/Benefits: As this study will entail an exploration of sensitive topics pertaining to trauma and mental illness, there is the potential for emotional discomfort. Nonetheless, this study will also provide a unique opportunity for participants to discuss their experiences in a safe and secure setting, without fear of penalty or reproach. Furthermore, the information obtained from the study may assist other providers who have had similar experiences.

Confidentiality: During the interview, you will be assigned a pseudonym to protect your identity. The pseudonym will be used with all handwritten notes, questionnaires, transcripts, and audio-recordings. Information obtained during this study will be presented at a dissertation defense. It may also be published in scientific journals, and presented at scientific meetings. Nonetheless, your identity will remain confidential.

The researcher has explained this project to me, and I agree to take part in this study. I have been given an opportunity to ask questions about the study. I understand that my statements will be de-identified, and that my identity will not be disclosed. I also understand that my participation is completely voluntary, and I may withdraw from the study at any time. I also attest that I am over 21 years of age, and I am legally able to provide consent.

Exceptions to Confidentiality: Although strenuous efforts will be made to protect your privacy and confidentiality, there may be exceptions, as required by state and federal law. For example, the researcher is mandated to disclose any reports of plans to harm yourself or others, or if you disclose the abuse of a child or vulnerable adult. Please note that any potential exceptions to confidentiality will be discussed with the dissertation chairperson, and appropriate authorities.

Signatures:

_____   _____

Participant Signature   Date

_____   _____

Researcher Signature   Date

Researcher Contact Information:

Nykia Johnson, MA
AUS PsyD Student
Email: NJohnson1@antioch.edu
Cell: XXXXXXXXX

Mark Russell, PhD
AUS Core Faculty/Dissertation Chairperson
2326 Sixth Avenue, Seattle WA 98121
Email: MRussell@antioch.edu
Office: (206) 268-4837

Appendix B:

Advertisements

Participant Recruitment Notice

My name is Nykia Johnson, and I am a doctoral student at Antioch University Seattle. I am currently working on my dissertation, and my professor suggested that I contact you about participating in my study.

My research revolves around the experience of correctional mental health providers, and the prevalence of secondary traumatic stress disorder. I have already passed my first two committee meetings, and I received IRB approval to conduct my study. Subsequently, I am looking for individuals who are willing to meet with me to discuss their experience of working in correctional settings. This would not require much of your time, and there is a small reward for your participation (in the form of a gift-card). Participants must meet the following basic criteria:

- Master and doctoral level correctional mental health staff (including, but not limited to, psychologists, psychiatrists, forensic nurse practitioners, and social workers).

- Participants must be current, or recent, full-time correctional mental health providers, who have worked in a correctional setting for at least six consecutive months.

- Participants must be direct care providers (thereby excluding administrative and managerial staff).

Please note that your participation will be confidential and anonymous. Neither the participants, nor the facilities will be identified in the final paper. Also, my schedule is completely flexible, and I will meet with you at the time and place of your choosing.

Please forward this notice to any providers at other facilities who may be interested in participating. Furthermore, please feel free to contact me with any additional questions about this study. I may be reached daily via email at njohnson1@antioch.edu, or via telephone at (206) XXX-XXXX.

Sincerely,

Nykia Johnson, MA
AUS PsyD Student

Appendix C:

IRB Application

ANTIOCH UNIVERSITY SEATTLE
IRB APPLICATION

1. **Name and mailing address of Principal Investigator(s):**

   Nykia Johnson

2. **Academic Department:**

   Psychology

3. **Departmental Status:**

   Doctoral Student

4. **Phone Number:**

   (206) xxx-xxxx

5. **Name of research advisor:**

   Mark Russell, Ph.D.

6. **Name & email address(es) of other researcher(s) involved in this project:**

   N/A

7. **Project Title:**

   Mass Incarceration of Mentally Ill and its Affect on Correctional Staff: The

   Prevalence of Secondary Traumatic Stress Amongst Correctional Mental Health

8. **Is this project federally funded:**

   No

   Source of funding for this project (if applicable):

   N/A

9. **Expected starting date for data collection:**

   December 14, 2015

10. Expected completion date for data collection:

March 14, 2016

11. Project Purpose(s):

The purpose of this study is to examine the experiences of correctional mental health providers, particularly as it relates to secondary traumatic stress disorder. There has been a sharp increase in the U.S. incarceration rate over the last three decades (Carson, 2014). Many of those incarcerated have been diagnosed with a mental health disorder, most commonly, substance use disorders, major depression, psychotic disorders, and posttraumatic stress disorder (James and Glaze, 2006).

In addition to the systemic issues that plague the criminal justice system – underfunding, overcrowding, and lack of resources - the increased number of mentally ill inmates frequently overburdens correctional mental health providers. These providers are tasked with performing psychiatric evaluations, suicide risk assessments, violence risk assessments (for victimization and perpetration), and identifying treatment needs (Ax, Fagan, Magaletta, Morgan, Nussbaum, and White, 2007). Furthermore, they must perform individual and/or group therapy to address issues relating to sex offenses, gang violence, childhood abuse, depression, anger, and anxiety (Boothby and Clements, 2000). Correctional mental health providers are exposed to horrific stories of trauma (both those inflicted and sustained by the inmates), and they work in extremely dangerous settings, where the threat of violence and victimization are ever-present (Wolff, Blitz, Shi, Siegel, Bachman, 2007). These factors place correctional mental health providers at high risk for

developing secondary traumatic stress disorder, compassion fatigue, and burnout. Additionally, correctional facilities are non-clinical settings, where the primary goals are to detain and punish, rather than treat and rehabilitate. Subsequently, there is often little organizational support, and few resources available to prevent and treat secondary traumatic stress and burnout amongst mental health providers.

This research study will explore the experience of mental health practitioners working within correctional settings. Several studies have found that repeated exposure to trauma can increase ones' susceptibility to developing secondary traumatic stress disorder and compassion fatigue (Scott, 2010). Given the tremendous amount of trauma exposure encountered by correctional mental health providers, this researcher is interested in discovering how providers address and cope with this exposure, particularly whether it manifests in the form of secondary traumatic stress.

12. **Describe the proposed participants- age, number, sex, race, or other special characteristics. Describe criteria for inclusion and exclusion of participants. Please provide brief justification for these criteria. (Up to 500 words):**

Three to five participants will be interviewed for this study. All participants will be over 21 years of age. Race, religion, ethnicity and other demographic information will not be considered for exclusion or inclusion. Since the participants will be professional mental health counselors, they are expected to possess a master's or doctoral-level education.

Given the environmental and emotional stressors involved with correctional mental health services, and vast understaffing, there is a fairly high staff-turnover rate. Subsequently, it may be difficult to locate current employees who meet the criteria. Therefore, participants must have worked full-time within a correctional facility for at least six consecutive months within the last three years.

Describe how the participants are to be selected and recruited. (Up to 500 words)

A multi-faceted recruitment approach will be used for this study. Individuals will be recruited through snowball sampling, word-of-mouth, emails, and flyers. Participants will be recruited from local and state correctional facilities throughout Washington State and New York State. The researcher will contact the clinical, medical, and mental health departments at the King County Department of Adult and Juvenile Detention (DAJD), Washington State Department of Corrections, City of New York Department of Corrections, and the New York State Department of Corrections.

Once potential participants have been identified, they will undergo a brief telephone screening, to ensure their qualifications. This would include 2-5 questions regarding their employment history, current job position, and an overview of their daily responsibilities. Participant acceptance into the study will be based upon their current or recent employment as a full-time, correctional mental health professional, with at least six consecutive months of experience in said position.

Describe the proposed procedures, (e.g., interview surveys, questionnaires, experiments, etc) in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described. USE SIMPLE LANGUAGE, AVOID JARGON, AND IDENTIFY ACRONYMS. Please do not insert a copy of your methodology section from your proposal. State briefly and concisely the procedures for the project. (500 words)

This will be a mixed-method study, with a strong qualitative focus. A case study format will be used to acquire information from participants regarding their experience with mentally ill inmates, and Secondary Traumatic Stress. It will also provide an opportunity to explore individual experiences, and examine how providers cope with exposure to trauma.

After participants have been accepted into the study, they will be provided with written and verbal informed consent. The interviews will be approximately 90-minutes in length. In addition to the attached interview questions, psychometric instruments will also be used to assess the presence of STS. These include the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, Figley, 2003), and the Professional Quality of Life Scale (ProQL; Stamm 2010). By using a combined approach, the researcher will have an opportunity to delve into the experiences of the participants.

Each interview will be audio-recorded, and later transcribed. Although follow-up interviews are not required, it may be necessary if post-interview

questions arise. Additionally, participants will be advised of their right to review and obtain a copy of their transcribed interviews, and the final study.

13. **Participants in research may be exposed to the possibility of harm - physiological, psychological, and/or social - please provide the following information: (Up to 500 words)**

   a. **Identify and describe potential risks of harm to participants (including physical, emotional, financial, or social harm).**

      Participants will have the right to refuse or terminate the interview. Participants will not be placed in any physical or financial danger. Nonetheless, there is still the possibility of emotional pain, as they will be asked to discuss issues relating to trauma, abuse and suffering.

   b. **Identify and describe the anticipated benefits of this research (including direct benefits to participants and to society-at-large or others)**

      Despite the plethora of research pertaining to Secondary Traumatic Stress Disorder and Compassion Fatigue, there is very little information available regarding the experiences of correctional mental health providers.

      Participants of the study will have the benefit of sharing their stories and their experiences with the researcher. Since these providers work in often rigid, non-therapeutic environments, these interviews may provide a rare opportunity to discuss their emotional and psychological experiences with a peer. Additionally, by sharing their stories, the participants will help

others who have had similar experiences. The study will also raise awareness of the issues encountered by correctional mental health professionals, and potentially reveal methods to address and reduce instances of STS, and educate providers about recognizing symptoms.

c. **Explain why you believe the risks are so outweighed by the benefits described above as to warrant asking participants to accept these risks. Include a discussion of why the research method you propose is superior to alternative methods that may entail less risk.**

Secondary Traumatic Stress and Compassion Fatigue amongst correctional mental health providers have been vastly underexplored. Moreover, it remains highly stigmatizing, and is often overlooked by employers and employees. Participating in this project may help to familiarize providers with the signs and symptoms of STS, and provide them with a forum to discuss some of the challenges they have faced, without judgment or fear of repercussions. Given the tremendous emotional and physical consequences associated with STS (including depression, anxiety, fatigue, and headaches), the researcher believes that the benefits of this study outweigh the possible consequences. Participants will be fully-informed of their rights; they may refuse to respond to any questions, and they may terminate interviews at any time.

d. Explain fully how the rights and welfare of participants at risk will be protected (e.g., screening out particularly vulnerable participants, follow-up contact with participants, list of referrals, etc.) and what provisions will be made for the case of an adverse incident occurring during the study.

Participants will be asked to share personal information, including their experience with trauma and severe mental illness, which can be emotionally stressful. However, participants in the study will have the advantage of being trained mental health professionals, with access to resources and increased knowledge of protective factors, and a greater familiarity with research study procedures and safeguards. Additionally, due to their advanced levels of education and extensive employment histories, they are not categorized as a "vulnerable population". Nonetheless, participants will be provided with a list of local mental health providers should they desire professional counseling.

14. **Explain how participants' privacy is addressed by your proposed research. Specify any steps taken to safeguard the anonymity of participants and/or confidentiality of their responses. Indicate what personal identifying information will be kept, and procedures for storage and ultimate disposal of personal information. Describe how you will de-identify the data or attach the signed confidentiality agreement on the attachments tab (scan, if necessary). (Up to 500 words)**

This study necessitates the collection of personal, demographic information from each participant (including job title, current and past employment, and education). Furthermore, names will be gathered as part of the recruitment and informed consent process. However, once accepted into the study, participants will be assigned an alpha-numeric code. Additionally, specific job titles and locations will be omitted from the final results, using instead phrases such as 'a social worker employed at a correctional facility in Washington State', or, 'a former mental health counselor previously employed in a New York State correctional facility'. Additionally, each participant will be assigned an alias for the final report, such as 'Jane Smith, a mental health counselor at a correctional facility in Washington State'.

Furthermore, the master list of real names and aliases will be maintained in a word document on a personal laptop, which will be secured by the researcher at all times. Additionally, consent forms and confidentiality agreements will be secured in a separate location.

15. **Will electrical, mechanical (electroencephalogram, biofeedback, etc.) be applied to participants, or will audio-visual devices be used for recording participants?**

The researcher will use an audio-recording device during each interview. Recordings will later be transcribed into written documents. All materials will be de-identified, assigned an alpha-numeric code, and stored in a locked drawer at the researcher's residence, on a removable hard drive.

16. **Type of Review:**

Non-expedited review

17. **Informed consent and/or assent statements, if any are used, are to be included with this application. If information other than that provided on the informed consent form is provided (e.g. a cover letter), attach a copy of such information. If a consent form is not used, or if consent is to be presented orally, state your reason for this modification below. *Oral consent is not allowed when participants are under age 18.**

> Please see attached informed consent statement.

18. **If questionnaires, tests, or related research instruments are to be used, then you must attach a copy of the instrument at the bottom of this form (unless the instrument is copyrighted material), or submit a detailed description (with examples of items) of the research instruments, questionnaires, or tests that are to be used in the project. Copies will be retained in the permanent IRB files. If you intend to use a copyrighted instrument, please consult with your research advisor and your IRB chair. Please clearly name and identify all attached documents when you add them on the attachments tab.**

> Attached is the proposed script, including a list of semi-structured questions that will be used during the interview. Also attached are copies of the Secondary Traumatic Stress Scale, and the Compassion Fatigue Scale, which will be administered to each participant.

Appendix D:

Interview Questions for Correctional Mental Health Providers

Mass Incarceration of Mentally Ill and its Affect on Correctional Staff: The Prevalence of Secondary Traumatic Stress Amongst Correctional Mental Health

Thank you for agreeing to participate in this interview. My name is Nykia Johnson and I am a graduate student in the Department of Psychology at Antioch University Seattle. I am completing my dissertation as required by the doctoral program. I am interested in learning about the experiences of correctional mental health providers, specifically as it relates to secondary traumatic stress disorder and compassion fatigue.

I would like to ask you a series of questions pertaining to your experiences as a correctional mental health provider. Your participation is completely voluntary, and you are not required to respond to these questions. You also have the right to terminate the interview at any time. With your permission, I would like to record this interview. Please note that all identifying information will be removed, to protect your anonymity. Feel free to ask for clarification if any of the questions are unclear.

Let's begin with some demographic information

1. Age: _____
2. Sex: _____
3. Marital Status: Single _____ Married _____ Living with partner_____,
   Widowed_____
4. Number of children _____
5. Race/Ethnicity _____
6. Education Level _____
7. Vocation/Training _____
8. Current Employment Position _____
9. Number of years employed as a social worker/psychologist _____
10. Number of years in your current position _____

Now, I would like to discuss the details of your work experience

- What led you to the field of social work/psychology?
- Do you provide direct services to clients/inmates at this facility?
- Approximately how many hours per day/week do you spend working directly with clients?
- Please describe your counseling style? Do you use any specific theoretical model?
- How many clients do you see each day/week?
- How did you become involved in correctional mental health?
- Please describe your duties and responsibilities?
- What percentage of your clients have a history of trauma?
- How often do your clients discuss episodes of trauma and/or symptoms of PTSD?

- Are you familiar with the symptoms of compassion fatigue and secondary traumatic stress disorder?
- Have you experienced CF/STS symptoms throughout your career?
- Have you experienced CF/STS symptoms while in your current position?
- How does your experience with trauma, CF and STS in corrections differ from your experience with these issues in the community?
- Could you describe what you experienced in regard to CF/STS?
- Does your employer provide resources or a forum to discuss, prevent, or address issues related to STS/CF?
- Do you feel comfortable discussing your experience of CF/STS with your employer?
- How have you coped with your experiences regarding STS/CF?
- Would you like to add anything that we haven't discussed?

Thank you for your time and for your patience and honesty. Your participation has been very helpful. Please feel free to pass along my contact information to any other providers who might be willing to discuss their experiences with CF/STS.

Appendix E:

Secondary Traumatic Stress Scale

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary
Traumatic Stress Scale. Research on Social Work Practice, 14, 27-35.

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized
clients. Read each statement then indicate how frequently the statement was true for you in the past seven (7)
days by circling the corresponding number next to the statement.
NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship.
You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

Never Rarely Occasionally Often Very Often

1. I felt emotionally numb………………………………. 1 2 3 4 5
2. My heart started pounding when I thought about
my work with clients……………………………… 1 2 3 4 5
3. It seemed as if I was reliving the trauma(s) experienced
by my client(s)………………………………………... 1 2 3 4 5
4. I had trouble sleeping………………………………... 1 2 3 4 5
5. I felt discouraged about the future……………………. 1 2 3 4 5
6. Reminders of my work with clients upset me…………….. 1 2 3 4 5
7. I had little interest in being around others………………. 1 2 3 4 5
8. I felt jumpy……………………………………….… 1 2 3 4 5
9. I was less active than usual……………………………. 1 2 3 4 5
10. I thought about my work with clients when I didn't
intend to……………………………………………………1 2 3 4 5
11. I had trouble concentrating…………………………….. 1 2 3 4 5
12. I avoided people, places, or things that reminded me
of my work with clients……………………………… 1 2 3 4 5
13. I had disturbing dreams about my work with clients……... 1 2 3 4 5
14. I wanted to avoid working with some clients…………….. 1 2 3 4 5
15. I was easily annoyed……………………………….... 1 2 3 4 5
16. I expected something bad to happen…………………….... 1 2 3 4 5
17. I noticed gaps in my memory about client sessions………. 1 2 3 4 5

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Intrusion Subscale (add items 2, 3, 6, 10, 13) Intrusion Score _____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17) Avoidance Score _____
Arousal Subscale (add items 4, 8, 11, 15, 16) Arousal Score _____
TOTAL (add Intrusion, Arousal, and Avoidance Scores) Total Score _____

Appendix F:

Professional Quality of Life Scale (ProQOL)

Professional Quality of Life Scale (ProQOL)
Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences
of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening
experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

PROQOL SELF SCORING WORKSHEET
This worksheet helps you to get an estimate of your score on the ProQOL. To make it easy for you to use on your own, scores are grouped into high, average and low. If your score falls close to the border between

categories, you may find that you fit into one group better than the other. The scores are estimates of your compassion satisfaction and fatigue. It is important that you use this information to assist you in understanding how your professional quality of life is, not to set you into one category or the other. The ProQOL is not a medical test and should not be used for diagnosis.

What is my score and what does it mean?

In this section, you will score your test and then you can compare your score to the interpretation below.

Scoring

1. Be certain you respond to all items.

2. Go to items 1, 4, 15, 17 and 29 and reverse your score. For example, if you scored the item 1, write a 5 beside it. We ask you to reverse these scores because we have learned that the test works better if you reverse these scores.

You Wrote Change to

1 5
2 4
3 3
4 2
5 1

To find your score on Compassion Satisfaction, add your scores on questions 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.

The sum of my Compassion
Satisfaction questions was _____
So My Score Equals My Level of Compassion Satisfaction
22 or less
43 or less Low
Between 23 and 41 Around 50 Average
42 or more 57 or more High

To find your score on Burnout, add your scores questions 1, 4, 8, 10, 15, 17, 19, 21, 26 and 29. Find your score on the table below.

The sum of my Burnout questions
So My Score Equals My Level of Burnout
22 or less 43 or less Low
Between 23 and 41 Around 50 Average
42 or more 57 or more High

To find your score on Secondary Traumatic Stress, add your scores on questions 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.
Find your score on the table below.

The sum of my Secondary
Traumatic Stress questions
So My Score Equals My Level of Secondary
Traumatic Stress
22 or less 43 or less Low
Between 23 and 41 Around 50 Average
42 or more 57 or more High

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCALE

Based on your responses, your personal scores are below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of compassion fatigue. It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a nonsupportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work-related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. You may see or provide treatment to people who have experienced horrific events. If your work puts you directly in the path of danger, for example due to your work as a emergency medical personnel, a disaster responder or as a medicine personnel, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, such as providing care to people who have sustained emotional or physical injuries, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

Appendix G:

Permissions

From: **Nykia Johnson** <njohnson1@antioch.edu>
To: bbride@gsu.edu
cc: Nicky Johnson <nykiaj@hotmail.com>
Date: Fri, Oct 21, 2016 at 10:18 PM
Subject: STSS Copyright Permission
Mailed-by: antioch.edu
: Important according to our magic sauce.

Greetings Dr. Bride,

I am a doctoral candidate at Antioch University Seattle, and I am in the process of completing my dissertation. The paper is a study of secondary trauma, compassion fatigue, and burnout amongst correctional mental health staff. The STSS was administered to each participant, and I would like to include a copy of the questionnaire in my appendix. Since you were listed as the copyright holder, I am requesting permission to use this document in my final dissertation. The paper will be electronically published at the sites listed below.

- ProQuest Dissertations and Theses Database, a print on demand publisher, http://www.proquest.com/products-services/pqdt.html
- OhioLINK Electronic Theses and Dissertations center, an open access archive, https://etd.ohiolink.edu
- AURA: Antioch University Repository and Archive, an open access archive, http://aura.antioch.edu

Could you please approve my request at your earliest convenience. If you have any further questions, I may be reached via email, or at 206-696-0200. I look forward to hearing from you.

Sincerely,

Nykia Johnson, MA
AUS Doctoral Candidate

_____

From: **Brian Edward Bride** <bbride@gsu.edu>
To: Nykia Johnson <njohnson1@antioch.edu>
cc: Nicky Johnson <nykiaj@hotmail.com>
Date: Fri, Oct 21, 2016 at 10:40 PM
Subject: Re: STSS Copyright Permission
Mailed-by: gsu.edu
Signed-by: mygsu.onmicrosoft.com
: Important mainly because it was sent directly to you.

Permission granted.

Brian E. Bride, Ph.D., M.S.W., M.P.H.
Distinguished University Professor
Director, School of Social Work
Georgia State University
1243 Urban Life Building
Atlanta, GA 30302

_____

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Title:
Development and Validation of the Secondary Traumatic Stress Scale:
Author:
Brian E. Bride, Margaret M. Robinson, Bonnie Yegidis, Charles R. Figley
Publication:
Research on Social Work Practice
Publisher:
SAGE Publications
Date:
01/01/2004

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