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The Cultural Construction of Mental Illness in Prison: A Perfect Storm of Pathology

Joseph D. Galanek

Brown School of Social Work, Washington University in St Louis, St. Louis, MO, USA

Joseph D. Galanek: jgalanek@brownschool.wustl.edu

Abstract

Large numbers of individuals in U.S. prisons meet DSM criteria for severe psychiatric disorder. These individuals also have co-occurring personality and substance abuse disorders, medical conditions, and histories of exposure to social pathologies. Based on nine months of ethnographic fieldwork in a U.S. prison, focusing on staff narratives, I utilize interpretivist and constructivist perspectives to analyze how mental health clinicians construct psychiatric disorder among inmates. Discrete categorization of disorders may be confounded by the clinical co-morbidities of inmates and the prison context. Incarcerated individuals' responses to the institutional context substantially inform mental health staffs' illness construction and the prison itself is identified as an etiological agent for disordered behaviors. In addition, diagnostic processes are found to be indeterminate, contested, and shaped by interactions with staff. Analysis of illness construction reveals that what is at stake for clinicians is not only provision of appropriate treatment, but also mandates for the safety and security of the institution. Enmeshed in these mandates, prison mental health becomes a particular local form of psychiatric knowledge. This paper contributes to anthropological approaches to mental disorder by demonstrating how local contexts mediate psychiatric knowledge and contribute to the limited ethnographic record of prisons.

Keywords

Prison; Mental illness; Medical anthropology; Illness construction; Co-occurring disorders

Introduction: Institutional Clinical Complexities and the Incarcerated Mentally Ill

The nature of this environment is so drastically different from the community, and the complexity of the clients we work with. Part of what makes them so complicated is that there is no one dimensional clear cut kind of mental illness or problem, particularly with this population. There's layers of psychopathology. All that co-morbidity converges and comes together in a perfect storm. Mental Health Staff, Pacific Northwest Penitentiary

The United States currently leads the world in incarceration, with a little over two million individuals housed in jails and prisons (Glaze 2011; Walmsley 2007). Among this society of captives are large numbers of individuals who meet criteria for psychiatric illness according to the Diagnostic and Statistical Manual of the American Psychiatric Association (American Psychiatric Association 2000; Ditton 1999; James and Glaze 2006). Fifteen to twenty

percent of U.S. inmates¹ have a severe psychiatric disorder such as schizophrenia, bipolar disorder, or major depression (Torrey et al. 2010).² In addition to serious mental illness (Axis I disorders), a substantial portion of this psychiatric population has co-occurring substance abuse disorders and/or personality disorders (Axis II), and co-morbid medical conditions (Adams and Ferrandino 2008; Black et al. 2010; Coid et al. 2009; Cuddeback et al. 2010; Farrell and Hedges 2011; Morgan et al. 2010; Teplin 1994). Little is known of their lives other than the difficulties they have adjusting to and coping in prison and the challenges in providing them treatment (Adams and Ferrandino 2008; Holton 2003).

These mentally ill offenders often have histories of enmeshment in numerous social pathologies consistent with the general community population of the severely mentally ill in the U.S. These include histories of homelessness and residence in contexts of high crime (Draine et al. 2002; Greenberg and Rosenheck 2008; Newman 1994). In addition, family histories of incarceration and substance abuse, and histories of physical and sexual abuse while incarcerated or in community settings have also been reported within the incarcerated psychiatric population (James and Glaze 2006; Blitz et al. 2008). Embedded in institutional contexts of substance abuse (Inciardi et al. 1993), violence (Hunt et al. 1993) and overcrowding (Gibbons and de Katzenbach 2006), these inmates are also subject to the “pains of imprisonment,” which include deprivation of security and autonomy (Sykes 1958) and mortification of the self, in which inmates are forced into social relationships with others (Goffman 1961, p. 28). These strictures such are among the dehumanizing effects of total institutions.

Based on this epidemiologic profile, this psychiatric population may be constituted as different from the prototypical cases that inform U.S. biomedical psychiatric categories, for which the underlying presumption is that symptoms of severe psychiatric illness are solely outward manifestations of neuropsychiatric insults (Gaines 1992b; Kleinman 1988; Luhrmann 2000). Byron Good, in his discussion of biological reductionism in U.S. psychiatry and its Neo-Kraepelin focus on the “typical” cases which inform DSM diagnostic categories, states that this perspective constitutes mental illness as “suddenly erupting in the life of an otherwise healthy and secure individual” (1993, p. 436). For the incarcerated mentally ill, this interpretive framework for disordered behavior is of limited utility, as their enmeshment in contexts radically different from the middle-class Anglo prototype assumed in the DSM’s model of illness (Gaines 1992b; Good 1993, p. 437) and the convergence of co-occurring disorders and pathological developmental histories creates a substantially different prototypical *case* than those presumed in the DSM’s categories. Diagnostic practices in professional biomedical psychiatry are interpretative acts, and examination of these practices reveals their limitations, particularly when similar interpretations are applied to varying social and cultural contexts (Kleinman 1988; Gaines 1992a, b; Hopper 1991). Analysis of these diagnostic practices also reveals how local contexts mediate the use of this professional knowledge (Lester 2009; Rhodes 2000, 2004).

The examination, or diagnostic assessment, is one of the primary disciplinary processes of prisons enacted by the psy disciplines’ technologies (Rose 1996, p. 54). In these processes, subjects are fixed as objects, and the examination “manifests the subjection of those who are perceived as objects and the objectification of those who are subject” (Foucault 1977, pp. 184–185). The examination “constitutes the individual as a describable, analyzable object”

¹I use the term “inmate” rather than “prisoner” in this paper as it is the word used to refer to men serving sentences at this ethnographic site, and throughout the state system of this department of corrections. This usage reflects a host of other managerial terminology which substitutes “institution” for “prison”, “superintendent” for “warden”, and “officer” for “guard”, among others. Mental health staff refer to the men they work with as “inmates”, or “mentally ill inmates”, and following from this, I use this emic term throughout the paper.

²Throughout this paper I utilize the term severe psychiatric disorder or severe mental illness to refer to these DSM categories.

that can be “corrected [and] normalized” through the disciplinary apparatus of the prison (Foucault 1977, pp. 191–192). The problematic nature of the carceral examination is revealed within the ethnographic record of prison mental health systems’ practices, as institutional contexts are sites of contested knowledge among staff and inmates (Rhodes 2000, 2004; Waldram 2012). For example, it has been demonstrated that diagnostic practices and categories are contested, indeterminate and intertwined in custodial (security) concerns within prisons, and not solely a corrective to disordered subjectivities (Garland 1990, pp. 145, 162; Rhodes 2000, 2004, p. 152). Thick accounts of the examination reveal significant aspects of how these diagnostic acts are embedded within institutional contexts. In attending to such processes, I draw attention to the indeterminacy of inmate subjectivities and behaviors which prison mental health clinicians attempt to “objectify” and how these clinical complexities create diagnostic uncertainties and thus problematize psychiatric knowledge.

Mental health services in the U.S. state prison system have become part of the carceral institutional landscape (Rhodes 2000, 2004), and display considerable heterogeneity in their implementation and the services rendered (Beck and Maruschak 2001, Hoge et al. 2007). Prison mental health systems, accordingly, should be constructed as particular systems of professional psychiatric knowledge which are constituted by local social and cultural processes (Gaines 1992a, pp. 23–24; Rhodes 2004; Waldram 2012). An interpretive, constructivist perspective on diagnosis and the problematic nature of psychiatric knowledge raises the question of how prison mental health providers sort through the co-morbid conditions of inmate populations in attempts to provide assessment and treatment. This perspective also raises several other compelling questions. How does a particular prison context mediate diagnostic practices grounded in professional biomedical psychiatric practices? Are inmates’ behaviors de-contextualized or reduced to neurobiological pathologies (Lurhmann 2000; Waldram 2012)? How are diagnostic distinctions between Axis I *states*, representative of biologically based illnesses and Axis II *traits*, indicative of an immutable personality (Lurhmann 2000, pp. 46–47; Rhodes 2004, p. 42) constituted within a population presumed to have both Axis I and Axis II conditions? In a context in which most all individuals are presumed to meet criteria for Axis II anti-social personality disorder (ASPD), or “criminality” (Lurhmann 2000: 115), is there more emphasis on treating the “mad” over the “bad”? How do clinicians take co-morbidities into account in the professional constructions of illness? Finally, what is at stake for clinicians as they constitute illness in an institutional context (Kleinman 1992)? That is, what is the set of “moral priorities”, or meanings attached to their diagnostic practices, and how are these priorities embedded, constrained and enabled within the institutional context (Kleinman 1992, p. 130)?

To answer these questions, this paper examines how prison mental health clinicians construct psychiatric disorder among a population of inmates. I focus substantially on provider perspectives in order to examine how severe psychiatric disorder is professionally constituted using biomedical psychiatric and psy disciplinary knowledge, and how co-morbid conditions are accounted for within the context of a prison and its corresponding mental health system. I do not focus on the actual treatment processes of the therapeutic intervention (Waldram 2012, p. 235), but rather attend to how clinicians grapple with assessments and classifications of mental disorder (Rhodes 2000, 2004). What occurs when the psy disciplines, and their knowledge of disordered subjectivity attempts to constitute discrete entities or bounded “things” (Good 1994, p. 53; Lurhmann 2000, p. 45), and are enacted in an environment that potentially confounds the use of its methods (Rhodes 2004, pp. 150–154)?

Analysis of how professional psychiatric systems' practitioners construct illness reveals how it is embedded in the local moral world of the prison, and accesses "what is at stake", and "how that which matters is to be sought and gained" in the enactment of this knowledge (Kleinman 1992; Lewis-Fernandez and Kleinman 1995, p. 434; Waldram 2012, p. 99). Kleinman (1992, p. 130) discusses that in order to grasp what is at stake within a moral world, it is crucial to ascertain categories that reveal local conceptions of illnesses and their corresponding treatments. Through explication of how diagnostic processes construct these local illness categories within a prison context, I examine the purpose and processes of carceral subjectification, and how the institutional context structures these processes (Foucault 1977, p. 190; Kleinman 1992, pp. 129–130; Rose 1996, p. 171). Analysis of these professional constitutive acts uncovers significant aspects of what is at stake for these mental health professionals; what they "most aspire to" and what they jointly take to be the purpose of their work while enmeshed within a correctional institution (Kleinman 1992, p. 129).

The following review of prison ethnography reveals how little is known of the heterogeneous expressions of "prison mental health", including how professional knowledge is enacted within these local contexts. This paper contributes to the limited prison ethnographic record by analyzing illness construction with a particular prison environment and how local contexts mediate professional psychiatric knowledge.

The Rarity of Prison Ethnography

Ethnographic research in U.S. prisons is rare, and noteworthy for its paucity (Rhodes 2001). Rhodes's (2001) review of anthropological explorations of the prison environment is noteworthy for its thinness. Both Simon (2000) and Wacquant (2002a, p. 384) have suggested the lack of thick ethnographic prison research is the result of the United States' correctional system jettisoning rehabilitative goals and the related necessity of research on the processes of institutional life to achieve this end. Simon (2000) also notes a convergence of hyper-incarceration policies in the U.S. over the past 30 years and a shift to research agendas focused less on the institutional interactional processes (Fleisher 1989; Sykes 1958), and more on professional prison managerial practices (DiIulio 1987) and rates of incarceration (Simon 2000, p. 291). Other factors which have contributed to the dearth of prison ethnography include ethnographers being considered "risks" within the tightly controlled institutional context (Rhodes 2009; Waldram 2009a, b, 2012). In aiming to govern institutions effectively, managerial practices have taken less account of institutional social and cultural processes and diminished the importance of understanding these processes (DiIulio 1987; Simon 2000).

Prison research in the U.S. and globally has provided a small but substantial corpus of work³ that has conceptualized the prison as its own society, with its own unique hierarchical social structures (Clemmer 1945; Davidson 1974; Owen 1998; Sykes 1958), social roles (Irwin 1970; Owen 1998), language and cultural meanings (Cardozo-Freeman 1984; Goifman 2002; Reed 2003) and how social relationships among staff and inmates create moral worlds and maintain social order (Fleisher 1989; Liebling 2004; Sparks, Bottoms and Hay 1996). These seminal projects did not explore the presence of the mentally ill in prison or the role of mental health professionals. Recent ethnographic work has focused on institutional rehabilitative treatments aimed to decrease recidivism and increase inmates' institutional functioning, while addressing personality disorders, sexual offending behaviors, and

³Here, I focus specifically on prison ethnographies that seek to uncover the social and cultural processes within the institution, rather than on research which examines the nexus of communities and carceral institutions, for example Wacquant (2002b).

psychiatric disorders (Genders and Players 1995; Rhodes 2000, 2002, 2004; Waldram 1997, 2007, 2008, 2009a, b, 2010a, b, 2012).

Although research in Canada and Britain has occasionally focused on individuals with severe mental illness (Waldram 1997, pp. 178–185), this research has purposely not examined incarcerated individuals with serious psychiatric disorders and treatment staffs' perspectives on this population. For example, Grendon Prison in the UK, deemed a therapeutic institution due to its rehabilitative efforts based in therapeutic communities and psychotherapy, focused on individuals' inability to function in the prison, as well as aims of decreased recidivism (Genders and Players 1995, pp. 47, 52). The inmates admitted to this therapeutic prison, however, were not diagnosed with severe mental illness, as inmates suffering from severe psychiatric disorders were considered unsuitable for its psychotherapeutic orientation (Genders and Players 1995, p. 47). Waldram's (1997) study of symbolic healing among Aboriginal inmates in Canadian prisons highlighted that biomedical psychiatric constructions of mental disorder de-contextualized and obscured the traumatic experiences of these individuals in their communities (pp. 46–47). This constitution of the individual as the locus of mental disorder is indicative of professional biomedical psychiatry (Gaines 1992b; Lurhmann 2000). This raises the question of how mental health professionals in diverse correctional environments constitute psychiatric disorder. Is there a strict use of DSM categories to differentiate "behavior" from "illness" within all prison environments, and thus an intense focus on individual pathology divorced from developmental and contextual processes? Constituting prison mental health systems as local systems, embedded and enmeshed in institutions, may reveal the variability in how illness is constructed "in an environment where everyone is defined as deviant" (Rhodes 2004, p. 115).

Rhodes (2000, 2004) and Waldram (2012) have conducted the most substantial ethnographic research on how diagnostic and treatment practices are enacted and embedded within correctional institutions. This research was conducted within two highly controlled prison units, with the psychiatric inpatient unit's goal of differentiating psychiatric illness from volitional behavior (Rhodes 2004), and a prison therapeutic community's aim to treat convicted sexual offenders (Waldram 2012). Inmates diagnosed with severe psychiatric disorder and living in the general prison population, outside of the confines of these units, have not been a focus of ethnographic work. Waldram indicates that the men he interviewed and observed in his study of sex offender treatment were primarily constituted as Axis II, ASPD with some co-morbid affective disorders, but not individuals diagnosed with severe mental illness (2012, p. 57). Waldram's (2008, 2012) research in the Canadian prison system demonstrates how therapeutic interventions delimit inmates' abilities to confer personal meaning to their life narratives as the paradigmatic narrative of correctional environments is privileged in constitution of the "sexual offender". As was the case in Grendon Prison (Genders and Players 1995), the aim of treatment was to reduce offending behaviors, either in communities or in institutions. For institutional mental health staff, however, the goals of treatment may not be directly linked to management of risk, i.e., risk of re-offense (Bewley and Morgan 2011; Rose 2002, pp. 19–20; Waldram 2012, p. 19). Psychiatric illness construction is linked to legal mandates to provide appropriate psychiatric treatment, but the benefits of treatment provision may also be "aimed at the prison system itself rather than society" (Bewley and Morgan 2011; Simon 2000, p. 301). Appropriate assessment of whether an inmate has mental illness may be linked also to maintaining safety and security of the prison, rather than solely to treat mental illness (Rhodes 2004, p. 153). These mandates to treat and maintain safety and security of the prison carry implications of how prison mental health systems are enmeshed in correctional environments and are entry points into understanding the local moral world of the prison.

Rhodes demonstrated that the primary goal of the prison's inpatient psychiatric unit (IPU) was to determine if an inmate was mentally ill (Axis I) or "behavioral" (Axis II). She identified psychiatric diagnosis as a "primary mechanism through which mental health workers negotiate the acceptance or rejection of those referred to them", and ascribe culpability to inmate behavior (2004, pp. 140–143). Although Rhodes reveals that co-morbidity and its complexities are accepted by mental health staff, she did not explicitly address whether these co-occurring disorders and pathological developmental histories (or contextual factors) converge in professional illness construction (2000, p. 351, 2004, pp. 117, 118, 121).⁴ The work of the prison IPU indicates that staff must "settle on one side or the other" on the issue of whether inmates are Axis I or Axis II (even when an inmate may be displaying signs of both disorders) in order to assure appropriate use of resources, or maintain safety and security on the unit (Rhodes 2004, pp. 107, 151–152). Rhodes (2004, p. 142) further discusses that psychiatrists in the mental health unit have a "highly nuanced view" of the uses and limitations of the Axis I/Axis II categories, and descriptions of staff meetings suggest that mental health professionals question whether an inmate's mental health issues are "tied into his anti-social stuff" (p. 150). It is this "nuanced view" of local psychiatric knowledge, embedded in carceral institutional processes, that I attempt to access in staff narratives of illness construction. Contextualizing how institutional diagnostic practices grapple with the co-morbidities of the prison population also reveals the enmeshment of institutional and professional mandates for mental health clinicians as they attempt to constitute psychiatric disorder.

The Research Context: Pacific Northwest Penitentiary and Its Mental Health Treatment System

Pacific Northwest Penitentiary (PNP)⁵ is a 2,000 bed male state prison that houses individuals designated medium to maximum custody. Located in the western United States, it has been in operation for over 100 years. PNP houses 500 inmates in large cell blocks, with four to five correctional officers managing each cell block. The prison is an institution of mass movement, in which inmates move freely through the prison on their way to work, the dining hall, medical and mental health appointments, the recreation yard, and education programs. There is a high level of staff-inmate interaction due to this mass movement, as well as the result of institutional mandates for staff to interact with inmates in a pro-social manner, modeling behaviors and maintaining communication with the inmate population (see for e.g., Fleisher 1989; Liebling 2004). Mentally ill inmates are not segregated from the general prison population, and live within these large cell blocks, intermingling with other inmates and staff. A thick description of this prison environment is beyond the scope of this paper. However, PNP's social context is reflective of recent trends in U.S. prisons, in that large numbers of young inmates affiliated with gangs are present (Hunt et al. 1993) and hierarchical social structures place "old school convicts", (e.g., murderers, drug dealers or "lifers") at the top and sex offenders at the bottom of the inmate pecking order (Waldram 2012). There is a shared ethos among inmates and staff of communication, mutual respect, and "only being as good as your word" that contributes to the orderly functioning of the institution (Fleisher 1989, p. 179; Liebling 2004; Sparks et al. 1996, p. 194). The orderliness of the prison is embedded within discourses centering on "the safety and security of the institution", a phrase that both staff and inmates use to discuss the primary mandate of all institutional conduct. A convict code (for e.g., Liebling 2004, p. 359) is adhered to by many inmates that prohibit intensive interactions with staff, but there is considerable variability in

⁴Rhodes does state that mental health professionals do take into account developmental histories (e.g. 2004, p. 147), but gathering these histories into a unified narrative and subsequently using that narrative to focus treatment (Waldram 2012) are not explicitly identified as part of the work on the inpatient unit's mental health staff.

⁵Pacific Northwest Penitentiary is a pseudonym for the ethnographic site.

how inmates respond to these behavioral proscriptions. These ideal cultural values are contested, shared, or disregarded among staff and inmates as they attempt to live and work in this environment. Inmates diagnosed with mental illness were observed to belong to any number of inmate social roles within the institution, such as gang member, old school convict, or sex offender (see for e.g., Irwin 1970).

In 2009, a point prevalence of psychiatric disorder from PNP indicated that a total of 457 inmates were currently receiving some form of mental health treatment, or a little under 20% of the total inmate population. Of these 457 inmates, 214, or 10% of the inmate population met DSM criteria for receipt of the highest level of mental health services in the institution. This high-need category included diagnoses of schizophrenia, schizo-affective disorder, bipolar disorder, and major depression (recurrent). These disorders are a focus of the treatment system due to the severity of untreated symptoms of these disorders (e.g., suicide attempts or psychosis). In the mid 1990s, an outpatient mental health system was established to provide intensive services to the general inmate population. An IPU located within the prison had been part of institution-based services prior to that time. Based on a community mental health center model of care, services are provided within the prison context primarily through the work of mental health case managers. Mental health staffs' treatment is not focused on diminishing criminal behaviors (Genders and Players 1995) or sexual offending behaviors (Waldram 2012), and rehabilitative efforts are focused solely on interventions for individuals with severe psychiatric disorder or less acute disorders that warrant treatment.

A team of 11 clinical staff, who are full-time state employees embedded within the institution, operate as the "front line staff" for mental health services. As state employees, they also have a concurrent mandate to ensure a safe and orderly working environment. Their work consists of psychiatric evaluations to determine need for services (diagnosis and assessment); case management services such as monitoring inmate psychiatric treatment and linking inmates to appropriate services. They are involved in crisis management, such as responding to officers' calls regarding inmate behaviors (e.g., suicidal or bizarre behaviors); and providing limited short term therapeutic interventions. These case managers are all Master's level professionals, but have a wide range of credentials from counseling and social work to psychology. There are intensive interactions with the prison environment, and working relations with security officers and other prison staff such as medical staff are enacted to ensure appropriate care of inmates. These interactions contribute collaterally to clinicians' assessments and interpretations of inmates' behaviors. Clinical work is primarily conducted in private offices as in any community mental health center, and mental health staff offices are located with other non-uniformed professional staff. These front line staff also assess inmates "cell-side" or on the cell blocks, "checking in" with men on their caseload. This facilitates the working relationships with corrections officers and medical staff. In addition to the mental health case managers, Master's level contract mental health staff work part time in the penitentiary. These staff are not state employees, and do not have interactions with the general prison staff; their work does not address criminality or sex offenses. Rather, it consists largely in individual counseling sessions and group therapy focused on psychotherapeutic interventions for mental illness. These contractors provide the bulk of clinical services to the inmates in the prison. The final group of mental health professionals are the medical staff, or "prescribers"—the psychiatrists and psychiatric nurse practitioner—who evaluate need for psychopharmacological treatment. All of these services are provided in general population, i.e., the inmates seen by these practitioners are not in specialized treatment units, they are living in the general prison population in either one or two man cells. An IPU within the prison treats inmates in need of intensive services, and is similar to the one described by Rhodes (2004). It was staffed in the same manner as the therapeutic communities described by Waldram (2012) and Genders and Players (1995, p. 94): security officers, mental health staff, and inmates intermingle within the confines of a

treatment unit very similar to a closed psychiatric ward. This clinical team, including the mental health staff of the IPU, frequently collaborates and interacts informally and in staff meetings in order to determine need for services, or assess for presence of severe psychiatric disorder among members of the inmate population.

Methods

This research is based on nine months of ethnographic research within PNP. The goal of the larger project was to examine how social and cultural processes within a state prison mediate the course and outcomes of psychiatric disorder for inmates with severe mental illness. Participants in the larger ethnographic research project included inmates diagnosed with severe psychiatric disorder, mental health staff, security staff, and other prison staff who self-identified as having experience working with inmates diagnosed with severe psychiatric disorder. Written informed consent was obtained for all participants, and ongoing informed consent was obtained for all inmate participants. Research was conducted March through November, 2009, and incorporated open-ended qualitative interviews and direct observation of the prison environment.

As an observer, I had official status as a “volunteer” and an ID badge that granted unescorted access throughout the institution. I was given permission to observe cell block work routines and staff interactions with inmates on the cell blocks and in common areas within the prison. Attendance at several formal administrative meetings with institutional mental health, medical and security staff facilitated open lines of communication regarding the research and recruitment of staff.⁶ I utilized the freedom of mobility granted me quite readily within the prison, and that visibility within the institution helped establish me as a consistent and credible presence among the inmates and staff of the penitentiary. Approximately, 430 h of direct observation were undertaken. These included observations of: cell block activities and interactions between officers and inmates; observations of common areas such as the dining hall, inmate and staff work areas (such as laundry and security gates) and institutional spaces where frequent and informal contact occurs between staff and inmates, such as areas leading to and connecting cell blocks; education, mental health and medical wing waiting areas.⁷ No direct observation of private clinical interviews between mental health staff and inmates in treatment were conducted due to ethical concerns of privacy, confidentiality, and risk of treatment disruption. Although plain-clothed staff are observed walking through all areas of the institution and occasionally on cell blocks, inmates would approach me as I observed cell block routines or “hung out” in common areas, asking me what my role was in the institution. These encounters allowed me to “get the word out” that I was a researcher, specifically communicate to inmates the goals of the research and clearly demarcate my role from that of a full-time employee of the prison.⁸ I noted that inmates on the cell blocks observed my interactions within the institution, and after a month of consistently observing institutional activities, most inmates either acknowledged my presence with small talk or simply ignored me as I conducted observations. Security staff were informed of my presence and purpose, but I still engaged with officers each week, informing them of my research, answering their questions, and

⁶More substantial examination of the processes of entry into the prison and conducting ethnographic fieldwork within an institution will be the subject of a future paper. Given the scarcity of prison ethnography, primarily due to the complexities surrounding entry into this context (Rhodes 2009; Waldram 1997, p. xiii, 2009, b, 2012), a significant discussion on the issues of conducting such research are necessary, but beyond the scope of this paper.

⁷These areas are common areas of the prison in which staff and inmates “hang out”, and do not breach confidentiality of inmates waiting for appointments. Staff were frequently observed in conversations with inmates or among themselves in these common areas, facilitating informal communications in the prison. For example, staff walk through waiting areas for appointments and stop and engage with inmates in small talk or to follow-up on inmate requests or questions. Staff also use these informal spaces to engage in conversation, or to simply take a break from their work, sharing a cup of coffee, or reading newspapers.

generally keeping lines of communication open. Similar to the inmates, officers as well as mental health staff who saw me in the prison either engaged in conversation or merely acknowledged my presence briefly. Once established as a researcher who was making observations in the institution, inmates and staff accepted my presence, and no concerns were raised by administration, line staff, professional staff or inmates regarding my role or activities. All research protocols were approved by the university's institutional review board as well as the research office of the state department of corrections which oversees management of the institution.

For this paper, I primarily utilize interview data from mental health staff participants at PNP, and focus my analysis on their experiences working with individuals with severe psychiatric disorders. These severe disorders include individuals with diagnoses that warrant the highest level of treatment available: schizophrenia and psychotic disorders, schizo-affective disorder, bipolar disorder, or major depression (recurrent and severe). Interviews concerned understanding how institutional mental health professionals worked with and assessed inmates within the prison who were in this high need category.

Seven of the eleven mental health staff assigned to PNP were recruited for the study. All mental health staff were interviewed at least three times in a private office at PNP; interviews ranged from 40 to 50 min in length. All but two mental health staff participants for this research were general population mental health staff, i.e., they worked in the larger prison environment and had caseloads of inmates with severe illness. Of the two with differing responsibilities, one worked solely in one of the disciplinary segregation units, and the other had previously worked in general population and now held an administrative position in the prison. The mental health staff members interviewed were either case managers (Master's level psychologist, social work, counselor), psychiatrists, psychiatric nurse practitioners or doctoral-level psychologists. Of the mental health staff interviewed, two had 10 or more years of experience working at this penitentiary, one had more than 5 years' experience, and four had 2 years' or fewer experience providing mental health services in the institution.

The interviews consisted of only two prepared questions: (1) Can you describe for me how you conceptualize mental illness in prison; and (2) Can you describe what it is like to interact and work with inmates with mental illness? These open-ended questions were augmented with exploration, in particular, of how prison mental health staff perceive and understand the relationship between DSM Axis I and Axis II disorders, as well as how clinicians go about "doing mental health", or assessments and diagnostic practices, and how

⁸No inmate or staff interviews were conducted in public spaces, to preserve confidentiality and privacy of participants. Initially, I was informed by inmate participants that several inmates that they knew were questioning who I was, and were suspicious of my presence. After interviewing several inmates (and with no breaches of confidentiality—either perceived or real), and "getting the word out" through informal and formal lines of communication, my role was definitively established within PNP for the duration of the research. Once established as a researcher within the institution, I would "make the rounds" during observation periods, stopping by the cell block where most observations were conducted, going to the dining hall during meals, engaging with staff and inmates in small talk and conversation in common areas, and then return to my assigned office for interviews (Bernard 2011, p. 277). This set a routine up for observation periods and interview times, and I was able to keep a highly visible profile in the institution as a researcher or "participating observer" (Bernard 2011: 259). This participating observer role was similar to activities described by Waldram (2012, pp. 34–45), in which a high degree of observation was conducted within the institution. For a contrast in methods, compare Davidson (1974) and Fleisher (1989). At the conclusion of the ethnographic research, I assessed this strategy as useful in making my role known to both inmates and staff, so as not to obscure my behaviors and activities and to emphasize my role as a researcher. It also allowed staff and inmates to become accustomed to my presence (Bernard 2011, p. 269). It should not be discounted that I was in a unique position, and thus a curiosity to staff and inmates; interacting with me could have been opportunities to relieve the tedium of institutional routines. My mobility within the institution was facilitated by institutional administrative mandates which expected a high level of staff-inmate interactions to ensure communication, for staff to model pro-social behaviors and for staff to problem-solve with inmates to decrease tensions inherent in institutional life. So, although a plain-clothed volunteer staff, mobile and active in the institution is somewhat unusual, high levels of interaction and communication with inmates or security staff is not. It is part of PNP's institutional cultural expectations for staff and volunteer behavior.

this informs treatment. All interviews were digitally recorded and transcribed verbatim. Atlas.ti version 5.5, a qualitative analysis software program, was used to code interview data for themes. I primarily used a priori codes such as “etiology of mental illness” or “treatment” to broadly code segments of interview data. Reduction of interview data to manageable coded sorts occurred after interviews were completed and allowed for review of all coded interview segments (Ulin et al. 2005, pp. 144–145). After compiling coded sorts of all interview themes, the large blocks of coded interview data were then compiled into files generated by Atlas.ti. These files were then reviewed for discrepancies and generalizations, with data and conclusions being generated through an iterative review of interview segments.

Developmental Histories: “Bad Brain, Bad Environment, and It Went Downhill From There”

One aspect of mental health clinicians’ work is gathering developmental histories on the inmates who come to their attention. Many individuals with mental illness in prison have substantial histories of sexual and physical abuse, homelessness, multiple institutionalizations, and histories of unstable and chaotic family structures (Waldrum 1997, pp. 47–56; Rhodes 2004, p. 125). Although, as one mental health staff noted, “There are many inmates here with no psychopathology”, an incarcerated individual with mental illness has a stronger likelihood of being exposed to some of these social pathologies at some point in his past. When attempting to access constructions of mental illness in prison, I initially asked for composite clinical sketches of severely mentally ill inmates. One mental health staff member provided a composite of inmates that are encountered by mental health professionals which reflected the social pathologies discussed above:

Some of these guys have had just crap lives from the get-go. They never had a chance - bad brain, bad environment, and it went downhill from there. You’ve got Mom doing drugs and drinking while pregnant. Dad doing drugs and beating on Mom while she’s pregnant...the baby’s born premature, low birth weight. In the home it’s too many kids, not enough money, not enough space ... very distracted, substance-abusing parents. It’s a chaotic environment. Kids grow up not knowing whether the parents are going to stroke them or hit them. The kid will usually be an average intelligence or below average kid. By middle school, they’re using drugs... by high school, a fair amount of drugs, then a little crime, petty thefts, shoplifting. By middle teens, they’re probably dropped out of high school and solidly in the drug culture, maybe just working and doing some drinking. They end up doing some crimes, for which they get busted, with controlled substances. They’ve been in fights, car wrecks, head injuries and then they end up in prison, early to mid 20’s. This is not unusual. And sometimes it [*mental illness*] comes out when they’re in prison, and other times, it’s simply that they can’t get away from where they are, and they can’t blame it on a meth run. They really truly are delusionally paranoid, but they can’t just move to the next town, or the next street, when it gets in their way.

This clinical picture of inmates diagnosed with severe mental illness provides insight into the complexities encountered by mental health staff. Mental health staff construct this psychiatric population as individuals who have been exposed to some of the more egregious social pathologies. These factors are presumed to be etiological agents of Axis I psychiatric disorder, or contribute to the levels of maladaptive behavior observed among some of the more dysfunctional inmates in their care. Of note here is that medical issues, including head injuries (Farrell and Hedges 2011), are a substantial clinical factor for incarcerated

populations, and if staff-confirmed, these issues may contribute to clinical presentations, affecting cognition and affect.

One mental health staff member who had worked both in community and psychiatric inpatient settings discussed how he perceived the inmates in mental health care as different from community mental health consumers:

These guys in prison are way more complicated than what we see in the community. You're aren't going to see these guys in a private office—they're never going to show up. They won't have a *felt need to*. Even in community county clinics, who treat the bulk of the most severely mentally ill...even there, the bulk of the guys we see in prison don't show up there. Not because they shouldn't, it's because they're non-compliant. Here, they're in a captive environment.

This quote reflects clinicians' perspectives that the inmates who come to the attention of the treatment system are substantially different from mental health consumers in the community, based on their developmental histories. Once within the prison, however, during professional assessment processes, the inmates' disorganized behaviors, their thoughts, their affect, are constituted as mentally ill, and not just a "bad meth run". Here, the psychiatric assessment is reflective of disciplinary processes "pinning down of each individual in his own particularity" (Foucault 1977, p. 192). Of note within this clinical sketch is the interweaving of biological etiological agents, such as pre-natal exposure to alcohol, with social histories outlining marginal existences in community settings, and biologically based etiologies of mental disorder such as head injuries or pre-natal neurological insults. The clinical sketch portrays individuals as being subjected to pathological social contexts and injurious physical circumstances throughout their pre-incarceration life course. However, once in prison, the individual, who to that point may be seen as living a chaotic *life*, undergoes a transformation to a "mentally ill inmate". Captive, and with symptoms that cannot be ascribed to an unregulated environment, the individual is constituted as mentally ill, or a *case* (Foucault 1977, p. 191).

Substance Abuse Among the Incarcerated Mentally Ill: "Garbage Can Addiction"

Mental health staff offered yet another clinical consideration in attempting to grasp the complexities encountered in the penitentiary in the profound histories of substance abuse encountered among inmates:

The hard ones are the ones that combine substance abuse disorders, personality disorders, and Axis I disorders. Substance abuse is in excess of 70 % in the inmate population here. You see people abusing a variety of different classes of drugs - heavy drinkers, heavy meth [*methamphetamines*] users, barbiturates, heroin. People have tried a little bit of everything. They will identify a drug of choice, but it's panoramic. It's so difficult to do a drug and alcohol history for these guys, because it's so extensive, and you've got different drugs overlapping. Their consumption overlaps with another as it tapers off, then it rises at another point in time. It's so extensive. Sometimes you can't separate it out, the mental illness and substance abuse. Sometimes all you can say is we have this mixed up quiche of clinical presentation, but after everything's baked together you really can't separate it out.

Mental health staff characterized this substance abuse as "garbage can addiction"; there was no clear "drug of choice", and inmates' substance abuse histories followed an erratic and unpredictable trajectory. Moreover, the "mixed up quiche" may mimic "true" Axis I symptoms (Osher and Hensley 2010). For example, mental health staff noted that inmates abusing methamphetamines in the community (or in the prison) can present with disordered

thinking, sleep disturbances, paranoia, or anxious affect. Extensive polysubstance abuse “baked in” with the presence of Axis I and possibly Axis II psychiatric disorders can confound the work of mental health clinicians. In particular, psychotic disorder (NOS), or *not otherwise specified* is a diagnosis that clinicians see frequently within the penitentiary, as detoxification from street drugs, prescription drugs, alcohol or a combination of the three are presumed to still be affecting clinical presentation. A mental health staff described how this substance abuse is an etiological agent for psychiatric symptoms among inmates:

Psychotic disorder (NOS) is pretty common in here. I can't tell you how many inmates come through the intake center with psychosis (NOS) and you get a history on them and it's like, '*Oh, they've been using meth, an eight ball a day, for 10 years*'. I suspect what we're seeing is a fallout from methamphetamines. So you have to tease it apart.

Because drugs are available in correctional facilities, both in jail and state prisons, clinicians have to be conscious that inmates on their caseload may continue to abuse drugs while incarcerated and engaged in treatment. Attempting to assess whether a “true” Axis I is present may be a matter of consultation with other mental health staff, as well as a “wait and see” approach to determine how the inmate is functioning within the institution, and use of urinalysis testing. In these narratives, the construction of mental illness becomes increasingly opaque, although it continues to be grounded in biological etiological theories. Inmates present with co-occurring Axis I psychiatric disorders and presumably Axis II personality disorders, and due to the profound substance abuse prevalent in the prison population, neurophysiological insults from drug and alcohol use may further complicate the clinical picture. This focus on biologically based etiologies of symptom presentation substantially informs how prison clinicians constitute psychiatric disorder, as it is congruent with biomedical psychiatric accounts of mental illness. Biomedical psychiatric accounts of behavior opened up pathways to providing treatment and constituted formerly “behavioral” inmates as having psychiatric disorders amenable to treatment.

Axis I Disorders in Prison: “Clear Cut”

Individuals with severe psychiatric disorders were discussed by mental health clinicians as being present and identifiable within the prison setting and responding positively to the treatments provided by the mental health team. These individuals were discussed by staff as being “easier” to treat than inmates with complex co-morbidities, due to the “clear cut” presence of severe psychiatric symptoms, such as disorganized thinking. Mental health staff discussed how the gross presence of psychiatric symptoms, such as psychosis, facilitated identification, assessment and treatment of these individuals in the general population.

Mental health staff confirmed that individuals assessed as having a severe mental illness “cleared up” with appropriate psychiatric treatments. These treatments were primarily pharmacological; for individuals with severe psychiatric symptoms such as auditory hallucinations, disorganized thinking or paranoia, medications were discussed as being the “first line” of treatment to diminish the severity of these symptoms. All mental health staff discussed how the use of medications (primarily atypical anti-psychotic medications) allowed inmates to function in the penitentiary. Psychiatric medications were part of the cultural fabric of the institution; large numbers of inmates received medications for not only severe disorders, but also less severe affective disorders and adjustment disorders. The utilization of psychiatric medications may not be a novel finding given the prevalence of the biomedical psychiatric model in the United States. However, historical narratives of the penitentiary provided by other staff revealed that prior to the implementation of the mental health system, inmates displaying bizarre behaviors were not always constituted as “mentally ill” and amenable to pharmacological interventions. Rather, they were seen as

“acting out”, or “behavioral” (Rhodes 2004, pp. 154–155). A security officer noted that many front line corrections officers observed profound behavioral changes in inmates who were formerly aggressive, acting out or “unmanageable”:

Before we started doing a lot of psych meds, a lot of these individuals had chemical imbalances, aggression...and we were constantly combating these individuals. Once they got on the medications, we noticed that these individuals were able to exist and live in the general prison population. Years before they were never able to live in general population. They’re able to function a lot better than in the past. These were the inmates who acted like gorillas in the past, and now they can interact and you can have a conversation with them.

Security officers discussed that psychiatric medications were an accepted treatment strategy among staff, as they were observed to work and enabled inmates with severe behavioral histories in the institution to cope and function within the penitentiary. The efficacy of psychopharmacological treatments among these formerly “behavioral” inmates was evidence to staff that psychiatric disorder was present among many of these incarcerated men (Lurhmann 2000, p. 49). The connection between biologically based Axis I conditions and medications was also viewed critically by mental health staff, and some discussed an over-reliance on pharmacological treatments. One mental health staff member expressed the view that medications were one aspect of treatment, not the end point of the treatment process. This perspective suggests a tension within an environment that demands an expedient solution to aberrant behaviors through medications and purports to effectively address mental illness in that mental health staff also recognized that mentally ill inmates had treatment needs beyond alleviating disruptive symptoms. Contexts of behavior and the presence of personality disorders among the inmate population also substantially informed the constitution of illness within PNP.

Co-occurring Axis I and Axis II Disorders: “Spicing It Up”

One of the clinical complexities noted by the mental health staff was that individuals with severe Axis I psychiatric disorders could also have the presence of an Axis II or personality disorder. Mental health staff acknowledged the sole presence of an Axis I disorder may be rare within the prison population. If the hallmark of prison populations is the presence of personality disorders, or “longstanding problems of character” (Lurhmann 2000, pp. 47, 114–115; Moran 1999), then how do clinicians perceive the relationship between Axis I and Axis II disorders? One mental health staff member specifically discussed how the co-morbidity of these conditions can diminish clinical certainty.

We have very few inmates on my caseload that are only Axis I. I can have guys that have an Axis I of schizophrenia, but they can also have an Axis II of borderline personality disorder. What makes things complicated is that they have a significant mental illness, but they have some personality disorder symptoms that come out and spice things up. So maybe if they’re cutting [*i.e. self-mutilation*] and they’re saying it’s because the voices are telling them to do it, you don’t know if there’s secondary gain there. It’s difficult to separate the two. The bottom line is you’re dealing with inmates, so you have to be prepared that they’re a little Axis II every now and then.

Within this quote, the clinician reveals that by virtue of working with incarcerated men, there is an expectation that personality disorders will be present among this population, and come out “every now and then”. This quote also reveals some of the difficulties clinicians experience in their interpretations of inmate behavior, and their work in constituting severe mental illness. In particular, the self-mutilation, or cutting, may be indicative of a suicide attempt (and command auditory hallucinations), it may be characteristic of manipulative

behavior (seeking secondary gain, such as transfer to the IPU), or it may be symptoms indicative of the professional construction of borderline personality disorder with no secondary gain or manipulation (the inmate is in distress).

These attempts at manipulation are constituted by staff as Axis II behaviors, or indicative of borderline or anti-social traits or disorders. Correctional officers may discuss these behaviors as indicative of “criminality” or simply “manipulation”, but mental health staff aligned these behaviors with their constructions of personality disorders, as well as an assumption that personality disorders were prevalent among inmates at PNP. Illness construction among general population mental health staff, then, is not an either/or proposition, in which the mad and bad are demarcated. Rather, the bad may become mad, or individuals who engaged in manipulative or “behavioral” actions may also develop Axis I symptoms that warrant treatment. One mental health staff member’s comments reflected an appreciation of this complexity, stating, “I can’t run the risk of someone I saw for behavioral issues six months ago would not have Axis I psychiatric symptoms at some point”. This perspective is reflected in Rhodes’ ethnography (2004, pp. 157–158), in which there is a mixing and matching of behavioral interpretations, and an acknowledgement that the severely mentally ill also engage in manipulation, or volitional “behavioral” acts.

Given this clinical perspective, mental health staff also discussed how individuals with “clear cut” cases of psychosis could “clear up” through pharmacological interventions and an individual’s “true” personality could emerge from the disordered thinking, hallucinations, and delusions. One mental health staff member discussed how this process may unfold during the course of treatment:

We treat the biological symptoms through pharmacology to get those under control, get the brain repaired, and the person’s thinking is now more linear, clear, organized. The Axis I symptoms are being controlled, the symptoms are being treated. Then the personality disorder becomes more apparent, often in manipulative types of behaviors such as gaming for housing, association with possible gang affiliates. You have the illness clearing up and the criminality comes to the forefront.

The narrative at work here is one of presentation with symptoms of severe psychiatric disorder that remit under psychopharmaceutical intervention, with subsequent emergence of a criminal personality. This process of criminal emergence is seen as indicative of the inmate population, and consequently of a portion of the inmates in mental health treatment. It should be noted also that those inmates in mental health care who did not meet the criteria for a personality disorder were not seen as disruptive of the narrative of underlying nature masked by Axis I disorder. These inmates were seen as having a “stable personality” obscured by the illness (Rhodes 2004, p. 157). That is, the characterological traits of a personality disorder and disordered subjective states are not mutually exclusive, but rather are constructed by members of the mental health staff as potentially co-morbid conditions. A diagnosis of severe psychiatric disorder (Axis I) is not synonymous with criminality, but a diagnosis of ASPD is synonymous with criminal behaviors, and an individual’s presence in prison strongly suggests the immutable character traits of ASPD (Lurhmann 2000, p. 115). Individuals diagnosed with severe psychiatric disorder may be presumed to meet diagnostic criteria for ASPD due to their criminal records.⁹ But rather than fostering a “therapeutic nihilism” (Moran 1999), mental health providers in PNP did constitute co-morbid Axis II conditions as likely responses to social contexts rather than immutable personality traits. A mental health staff member further discussed his nuanced view on the presence of ASPD among mentally ill inmates at PNP and how it may be assumed among inmates in their care:

Q: Could you have someone who has schizophrenia and who is also heavily invested in criminal culture?

A: Yes, you get them two ways. First, you get them when they were a criminal before they developed the illness. They were heavily in the criminal lifestyle in their teens, and then they developed schizophrenia. Or you can get them where they have schizophrenia, and for whatever reason, they go to prison, and in prison they learn to adapt to an anti-social lifestyle. Many guys are not doing anti-social behaviors until they get into drugs. Many have anti-social personality disorder because of their lifestyle. You get into the chicken vs. the egg. Would they really be in prison *unless* they were Axis II? If you really want to get technical, a lot of them don't really meet the criteria [*for antisocial personality disorder*] ...by known history.

Of note here is that this staff member admitted that many inmates did not meet the criteria for ASPD "by known history", meaning that the disorder is presumed solely by their presence in PNP, or within community contexts of drug use and sales. Also of importance is the comment on how individuals in prison learn to adapt to the "anti-social lifestyle", indicating that the prison itself is an etiological agent for personality disordered behaviors (Foucault 1977, pp. 266–267). The toxicity of the prison is assumed to generate particular behaviors among inmates that can be constituted as anti-social.

The Prison Environment: "It's All So Social"

Consistent with Rhodes' (2004) observation that the prison is an environment that is "bound to cause harm" (p. 119), the prison environment was identified by staff as an etiological agent for Axis I disorders and Axis II personality disordered symptoms or "traits". The toxicity of the prison environment was understood by PNP's mental health staff to increase psychiatric symptoms, create increased risks for first episodes of severe mental illness, and contribute to the clinical presentations of inmates during assessments. In discussing the institutional context and how it plays a role in the construction of psychiatric disorder, mental health staff reflected:

75 percent of what the inmates bring to us is centered around the inmate. The other 25 percent really have nothing to do with the inmate. It's just reflecting what's happening in the environment. Trying to focus on them as the treatable object in that situation is futile.

⁹This identification of co-morbid Axis I and Axis II conditions among prison populations directly informs two current discourses among forensic mental health and community mental health researchers which seeks to explain the prevalence of individuals diagnosed with severe psychiatric disorder in U.S. prisons and jails. The criminalization hypothesis posits that within the context of U.S. policies of hyper-incarceration, individuals diagnosed with severe mental illness and who do not receive appropriate community mental health care are arrested and sentenced for low grade misdemeanor or drug crimes, and are then ensnared in the criminal justice system (see for e.g., Torrey et al. 2010). This criminalization hypothesis would argue that not all individuals in prison who are diagnosed with a severe mental illness meet criteria for anti-social personality disorder. The counter-hypothesis, or the criminogenic hypothesis, is that "mentally ill offenders" are a heterogeneous population. For example, those meeting criteria for inclusion in the "criminalization" group are certainly present in the U.S.'s criminal justice system. However, the criminogenic hypothesis also posits a sub-group of offenders who meet diagnostic criteria for co-morbid severe Axis I disorders, substance abuse disorders and Axis II personality disorders, and whose criminogenic traits and risk factors are the primary cause of their incarceration, not untreated mental illness (see for e.g., Skeem et al. 2011). Based on staff interviews, individuals in mental health care at PNP were a heterogeneous group, who could fit within either the criminalization and criminogenic hypothesis, suggesting multiple pathways of incarceration for individuals diagnosed with severe psychiatric disorder. Anti-social personality disorder, although a mental disorder within the DSM's nosology, (Lurhmann 2000, pp. 112–116), is constituted as an entirely different entity than serious psychiatric disorders such as schizophrenia. Both disorders may lead to incarceration, but there is more culpability ascribed to the individual with co-occurring ASPD (Epperson et al. 2011; Lurhmann 2000, pp. 112–114; Skeem et al. 2011; Rhodes 2004). Policy positions which acknowledge criminality (ASPD) and severe mental illness as co-occurring among incarcerated populations actually approach the co-occurrence of anti-social personality disorders and severe mental illness as equally treatable through anti-psychotic medication *and* Cognitive Behavioral Therapy (CBT) (Epperson et al. 2011). It should be noted that the use of CBT within the prison setting has been critiqued extensively by Waldram (2008, 2012).

Things might get amplified in here because of all the environmental pressures and stressors. It's all so social. There's so many things going on in the inmate population that affects presentation at times and exacerbates symptoms.

You can't just look at the diagnosis all the time. You have to look at the individual circumstances they're in.

Rather than a biological reductionist construction of illness, mental health staff focused substantially on the context in which behaviors occur in order to constitute diagnosis as well as ascertain etiology and toxic stressors that worsen symptoms. The primary example that staff provide is that individuals with severe mental illness may have increased symptoms if they are placed in one of the disciplinary segregation units: either the jail of the prison (the disciplinary segregation unit or "the hole") or the prison within the prison, the supermax unit (Haney 2003; Rhodes 2004, pp. 111–114). Not only is the environment of these units intentionally toxic (as being placed there is a punishment), but the inmates housed in these units may also affect inmates' psychiatric disorders through pervasive and ongoing harassment. In these instances, symptoms just do not arise "spontaneously" as part of the illness. The individual's illness experiences are profoundly embedded in the social context of the institution and may also affect clinical assessments. The context of the clinical encounter is crucial, whether it be in one of the segregation units in which an inmate may present aggressively or may be unresponsive; cell-side on the cell block, where inmates may present as guarded due to other inmates and staff being in the vicinity; in an office visit, where an inmate may feel more comfortable sharing cognitions and affective states; or in the IPU, where within the controlled context of the examination, inmates may either conceal or reveal symptoms, depending on the perceived outcome of the diagnostic interview (Rhodes 2000, 2004, pp. 150–152).

Staff also discussed how the general prison environment itself may encourage anti-social behaviors. As the staff member quoted earlier suggests, anti-social behavior may be adapted as a means of adjusting to the penitentiary's social context. Another mental health staff member remarked:

You're evaluating them in prison, which in itself is an environment that fosters the development or presentation of very primitive behaviors. The prison fosters anti-social behavior, even from people who are not anti-social even in their basic personality traits.

Pacific Northwest Penitentiary was characterized by staff as having undergone significant changes in the inmate population in which younger inmates are now present in larger numbers (Hunt et al., 1993, see also Liebling 2004, p. 359). These individuals, termed "young bangers", were noted to engage in behaviors primarily for the purpose of achieving status among their gang affiliates. These behaviors included high levels of extortion, violence, harassment and disregard for social hierarchies in the institution. PNP staff observed that engagement in these antisocial behaviors among younger inmates fostered a "hyper-vigilance" and "paranoia" among inmates. Interpersonal challenges tended to produce an aggressive response. This was seen as integral to maintaining the hyper-masculine front necessary to having the respect of one's inmate peers (Kupers 2005). In this context, then, what can be construed as anti-social, borderline or paranoid? Understanding the context in which behaviors occur enables staff to sort through the complexities they observe, and informs attempts to arrive at some level of diagnostic certainty. I now turn to two clinical narratives which incorporate the salient domains discussed in the previous narratives, and reveal how clinicians enact professional psychiatric knowledge while attempting to take into account the prison environment. I also attend to how illness construction may be linked to more than provision of treatment, and how institutional

concerns for safety and security within the prison converge with these processes, revealing what is at stake in the prison's local moral world.

Constructing Mental Illness in the Penitentiary

Case 1: "Huge Pandemonium"

The first case discussed by a mental health case manager reveals the difficulties at arriving at some clinical certainty within the penitentiary. In this clinical vignette, the clinician attempts to assess behavior that can be attributed to an Axis I severe psychiatric disorder (psychosis), or to some traits of an Axis II personality disorder, which clinicians tend to associate with manipulative behaviors:

A: I saw a guy this morning, a crisis call, huge pandemonium...his mother died... he has an Axis I psychotic disorder and was recently taken off involuntary meds and placed on voluntary meds. I'm treating it as a crisis. I saw him for an hour, set it up for him to see a contractor, and I'll see him again Friday. There's nothing I can find collaterally in the system to say Mom died, so I get a hold of his correctional counselor who called his home...The counselor says, *'No, Mom didn't die, everyone's doing fine'*. So now what am I working with? Someone who feels they needed to get up here to see me because they feel they're really decompensating or somebody where's there some other gain that they want. The inmate didn't want a single cell, so I'm just trying to weave through how I'm going to handle it when I see him tomorrow and Friday. I'll have to confront him, *'We called home and your Mom didn't die'*, and we'll take it from there and see what his response is to that.

Q: Is he delusional?

A: We don't know. Is it the voices that told him Mom died, and that's what set him off, and he truly believed that his mother died, and he's delusional and paranoid around this? Or is it some of his Axis II traits he displayed strongly in the inpatient psychiatric unit and to his prescriber? It's throughout his chart. So when I confront him and tell him his mother didn't die, I'll have to see how he reacts to it. If he firmly believes his mother died, and he has this look of horror on his face, maybe it's more of his Axis I, and he truly believes it happened, and maybe the inpatient psychiatric unit can reconsider the meds or a better option.

Q: So even though you're dealing with people with an Axis I diagnosis, you have to be concerned about manipulation?

A: Absolutely.

This narrative reveals how the mental health staff attempts to constitute illness behavior through professional knowledge while also taking into account the social context of the prison. The inmate has been diagnosed with a psychotic disorder—a disorder that, untreated, can create risk for inmates acting violently. The seriousness of the situation is indicated by the inmate's history of involuntary medication, his history of inpatient admission, and the clinician "treating it as a crisis" and referring to a contractor, a valuable resource in the mental health system. In constructing the illness episode as a severe one, the clinician references discussions with a prison correctional counselor and discusses how the perceptions of the prescriber indicated the presence of Axis II traits. The institutional record confirms diagnosis and history, a method for discerning prison "truths" for correctional staff (Foucault 1977, pp. 189–191; Rhodes 2004, pp. 150–151; Waldram 2012, pp. 110–111). The Axis II traits lead the clinician to question whether there is attempt at manipulation, perhaps to attain a single cell: a highly prized commodity in the institution in which most men are housed together in 5 × 8 cells. The clinical judgment of the staff, perhaps in

conjunction with the inpatient unit's observational records will be used to sift through the complexity. Due to the severity of the inmate's illness (psychosis), presence of Axis II traits, and the classification of events as a "crisis", alleviating the distress of the inmate is also embedded in institutional concerns for the safety of the inmate, staff and other inmates (Waldram 2012, p. 29). Within this discussion, there is more to the clinician's work than easing the inmate's anxiety. This is not simply an inmate's behavior that "ruptures the sense of inevitability fostered by routine" (Rhodes 2004, p. 107), but it is a concern that the behavior could escalate, and place others—or the inmate himself—at risk of harm.

Case 2: "Like a Gordian Knot"

A mental health staff member discussed an inmate that had been particularly difficult to "manage" within a segregation unit. Included in this narrative are interpretations of inmate behavior which could have been the result of an Axis I psychiatric disorder, anti-social behavior, or due to the extreme difficulties in coping with his medical issues while also being incarcerated in one of the worst housing units in the state department of corrections:

I had a young inmate come in with no history of mental health, but a history of heavy methamphetamine abuse. He came in with substantial medical issues.¹⁰ We were pretty sure it wasn't a result of the meth abuse, since he'd been in the hospital for four months. Then he spent the next four months in the segregation unit assaulting staff, cursing staff, masturbating, parading nude, singing all night, crying, not sleeping. If you look at it, it might be mania, bipolar. On the other hand, it may be anti-social behavior. He had an extensive incarceration history before coming to the prison. Maybe it's a personality change due to medical condition. Maybe it's none of these things. How do you manage the behavior then? We took a gamble, that at his age, to be sentenced with this medical condition, it had to have had a significant impact on his personality and his view of the world. And so we went to bat, and had a battle with medical. Of course, he's engaging in this anti-social behavior, cursing at the doctor, masturbating at the doctor, just getting assaultive towards the doctor. We finally advocate for him and get him ongoing medical care,¹¹ an interesting thing... Now after months of this he says to staff, '*Hi, how are you doing? I'm sorry for the things I said to you before*'. So, personality change due to medical condition? Probably. Maybe anti-social, but I don't know. He's not psychotic. You get these kind of extreme mixes of things. It is like a Gordian knot, where you have to untangle it, follow this strand here, that one there. Sometimes we're successful, sometimes we're not.

Here DSM criteria are being utilized to construct an illness—perhaps bipolar disorder—due to the lack of sleep, hyper-sexuality, and singing all night. The context is a segregation unit, so is this also affecting the inmate's behavior? Had the toxic stressors of a disciplinary unit precipitated a first break of mental illness in a young inmate with an extensive methamphetamine abuse history? Here, the staff brings in developmental history to understand the behaviors. There was no mental health history, but a significant history of incarceration, likely indicative of an ASPD. And the complexity is compounded by the presence of serious medical issues. This clinical narrative is also significant in that the mental health staff also negotiates with medical staff—acknowledging the medical staff's

¹⁰I intentionally obscure the medical condition of the inmate to provide further confidentiality to the narrative.

¹¹The inmate was not being denied medical care, but due to his acting out toward the doctor, his medical care was being delayed. Within the prison context, medical care is provided to all inmates, but if the inmate cannot engage with the physician, it could jeopardize the inmate's health. Within the context of this narrative, mental health staff had to advocate and negotiate with medical to ensure that the inmate's medical needs were being met. This can be a common role for mental health case managers in prison, i.e., negotiating more immediate appointments, and requesting that physicians or nurses respond to the requests of the inmate, even though the inmate's behaviors have been assessed as "malingering", "behavioral" or "all in their head".

construction of the behavior as anti-social—but also advocating that the inmate needs treatment, that there may be some other underlying causes for the behavior besides aggressive criminality. It is also important to emphasize that the clinician cannot disengage from the situation, leaving the inmate's actions to disciplinary processes. The clinician is embedded in relationships with the disciplinary segregation officers and medical staff and must assert professional knowledge of mental health to assist in the inmate's "management" (Rhodes 2004, p. 154). Even though some of the behavior is consistent with an Axis II personality disorder, the inmate's disposition still comes within the purview of the mental health treatment system as part of these working relationships to assess whether a severe mental illness is present and treatable, diminish aggressive behavior, and ensure appropriate medical care.

Clinicians discussed how they pragmatically focused on inmates' symptoms or dysfunctional behavior within the prison, rather than a strict accounting of psychiatric symptoms (Lurhmann 2000, pp. 42, 51). This mental health clinician's statements reveals a pragmatic response to inmates' behaviors, which preclude separation from traits and states, and attends to maintaining the safety of the inmate in her care, and consequently other inmates and staff:

For me, as a clinician, I'm treating an individual, and I'm not going to separate out their character from their symptoms because sometimes it's their character that's causing them problems in their life, sometimes it's their symptoms. I can't separate out his character from his psychotic experiences. It's all part of the same package. When I think about it, it's complicated, but I respond to it practically. I spend less time on trying to create a comprehensive assessment of it and more try to treat the symptoms or behaviors in a way that's going to help him feel better and keep others safe. My response is about managing the emotion, no matter where it comes from.

Another staff member discussed how attending to disordered behaviors is linked to maintaining a safe and secure institution—not only for staff, but for the other men incarcerated at PNP—and how behaviors are responded to pragmatically, not just through the application of diagnostic categories:

They may have the diagnosis, but is it impairing them in this environment? The challenge is not so much the label, but what is the behavior that is likely to result or is resulting from his disordered way of being in the world, and how do we as an institution manage that behavior, so that the institution is safe and orderly. It's not just for the safety of the client, since everyone is in such close proximity to each other, the system doesn't want them acting out around a few dozen people.

These quotes reveal that diagnostic processes are linked to more than assessing illness and providing appropriate treatments. The professional construction of illness, and therapeutic interventions, can certainly be construed as "supporting custodial control" or safety and security within the prison (Rhodes 2004, p. 153; Waldram 2012, p. 29). However, the quote also reveals that these custodial concerns are also intertwined with humanist concerns for the provision of appropriate mental health treatment. These men are in "impossible environments" may be at risk of victimization and are also at risk of enmeshment in an institutional disciplinary apparatus that stringently responds to aberrant behavior (Blitz et al. 2008; Haney 2003; Rhodes 2004, p. 158). A staff member's comments reflected these humanist concerns¹²:

These are real people in a really difficult environment. How can you identify and treat these people, the people that so easily get lost in the system...in a system that's not set up for it, and not have things get worse? It's not just the intellectual

part of that's fascinating...with the difficult diagnostic dilemmas, but it's also the humanist part of it.

Construction of psychiatric disorder within the penitentiary reveals it is not an either/or proposition, either entirely in service of treatment or custodial concerns, but is reflective of how professional psychiatric knowledge, embedded in prison, attends to both processes, and that these mandates of treatment and safety are intimately linked. By constituting aberrant behavior as psychiatric disorder, professional psychiatric knowledge works to maintain order or "safety and security" within the penitentiary—identifying inmates as in need of treatment and minimizing risks to the orderly operation of the institution. These processes also open possibilities for treatment (Rhodes 2004, p. 108) to men who are perceived as having intensive pathologies and who are enmeshed in a carceral environment that was not created to attend to their psychiatric disorders.

Discussion and Conclusion

The mental health treatment system at Pacific Northwest Penitentiary reflects a particular form of local psychiatric knowledge intimately embedded within the social and cultural context of the prison. The encapsulation of the mental health system in the institution is in contrast to the specialized treatment units that are the focus of recent prison ethnographies (Waldram 2012; Rhodes 2004). This particular structural arrangement is one type of prison mental health system that operates within the myriad correctional institutions of the United States (Bewley and Morgan 2011). The deep enmeshment of the mental health staff within PNP's structures contributes to the unique nature of the mental health system described. For example, the mental health staff's contextualization of inmates' behaviors can only be achieved through intensive and ongoing interactions between not only the staff and inmates, but also between the mental health staff and other corrections staff, particularly security officers. Understanding the complexities of inmates' institutional life is also facilitated by the mental health staff's active engagement with the penitentiary's structural and relational environment (e.g., the use of isolation as punishment; the posturing and manipulative behaviors engaged in by prisoners). The hyper-contextualization that occurs within diagnostic processes is informed by intensive interactions with the security staff, who provide ancillary observations on inmates in their housing units or work areas, thus contributing to clinicians' attempts to arrive at some level of diagnostic certainty. The ability of mental health staff to engage with inmates on cell blocks, disciplinary units, work areas and common areas also contributes to clinicians' ability to contextualize inmates' illness experiences. These, then, are not mental health care providers sequestered in an "outpost within the prison" (Rhodes 2004, p. 132), making diagnostic decisions using individual judgment and DSM criteria alone.

This network of inputs also contributes to mental health staff member's tolerance of diagnostic ambiguity. Context becomes a critical component of diagnostic processes, and staff recognize that behaviors may be challenging to interpret and that the diagnostic process is complicated by how inmates respond and react to the prison environment. Ethical discourses among mental health staff at Pacific Northwest Penitentiary are thrown into relief by an institutional memory that recalls a formerly fragmented system of mental health care

¹²Rose (1996, pp. 91–93) provides a critical perspective on how psychological expertise *ethicalizes* the power and authority of the psy disciplines, conducting it in such a way that "it appears to be in the best interests of those who lives they will affect – be they worker, prisoner, patient, or child" (p. 93). Here, I attempt to show that there is an ethical discourse among mental health staff, particularly in the context of institutional history in which comprehensive mental health services were not provided, and many inmates with severe illness could not function in the institution, relegating their lives to units of "total control" (Rhodes 2002, 2004). Inmates with severe psychiatric disorders in the U.S. prison system are also at risk of "deliberate indifference", or non-receipt of care (see for e.g., Elliot 1997), and thus further enmeshment in punitive institutional processes. Mental health staff discussing "humanist" concerns of ethical treatment of the mentally ill, then, is a significant aspect of the discourse of "what is at stake" for mental health professionals.

that could not respond to the intensive needs of inmates. But these ethical concerns are also predicated on mental health providers' understandings of the consequences of working with "real people in a really difficult environment." All of these elements of constituting mental illness, while not absent in other treatment or institutional settings, operate within the particular institutional structure of Pacific Northwest Penitentiary in these particular ways.

Co-morbid conditions of the inmate population were incorporated into illness constructions, and constitutions of "mental illness" were not biological reductionist accounts of disorder. Inmates were not assessed as simply "behavioral" cases or malingerers (Lurhmann 2000; Rhodes 2004). Rather, inmates who were in the care of the mental health treatment system at PNP were understood to be both severely mentally ill and also to have pervasive patterns of dysfunctional behavior attributable to immutable characterological traits, challenging developmental histories, and as often dysfunctional, but also plausible responses to the "impossible" environment of the prison. Analysis of narrative data revealed mental health staff members held nuanced views of the co-morbidities characteristic of the inmate population, and felt that these disorders inextricably converged among many inmates who received treatment. This construction of how individuals' immutable traits are embedded within transitory states of serious illness contrasts with the dichotomy of DSM diagnostic categories (Gaines 1992b, p. 14). It is these shifting, indeterminate, disordered inmate subjectivities that problematize the carceral examination and create the clinical complexities discussed by these mental health professionals. Identification of Axis II traits or disorders among inmates did not discharge them from care (Lester 2009), place them solely in custodial control (Rhodes 2004) or diminish the likelihood of therapeutic interventions (Waldram 2012). Rather, mental health staff discussed the seriously mentally ill in their care as *inmates*, and thus there was an expectation that they would display signs of Axis II behaviors "every now and then", if not consistently, in their clinical encounters. The challenges involved in interpreting inmates' behaviors through the professional lens of biomedical psychiatric and the psy disciplines were responded to pragmatically, rather than through strict application of diagnostic criteria. However, clinicians were perplexed and confounded at times in interpreting behaviors, as a shifting nexus of personality traits, biological based disorders, medical conditions, pathological developmental histories, and substance abuse intersected among inmates in mental health treatment. These complexities are reflective of the problematic nature of biomedical psychiatric knowledge as applied to varying social and cultural contexts. They also underscore the need for continued ethnographic work among prison mental health professionals and clinicians who work with community forensic populations. Future ethnographic work should continue to examine the relationship between treatment and custody, in order to contextualize how forensic mental health providers enact treatment while embedded within institutional and community contexts of control (Cuddeback et al. 2009; Holton 2003).

Mental health staff took into account the institutional context of behaviors in attempts to constitute an inmate's behavior as "mentally ill" and in need of interventions. Illness presentations were discussed as intimately linked to the prison environment. The toxic stressors in the environment were seen as a potential catalyst for increased psychiatric symptoms, and the environment of the prison was recognized for its potential to promote anti-social behaviors. This illness construction draws attention to specific institutional social and cultural processes that inform assessment practices. Inattention to context may increase risks for misidentification of disorders, over-diagnosing and over-prescribing, as well as contribute to assessing aberrant behaviors as malingering. Institutional mandates for mental health staff to respond to inmate's behaviors are negotiated, contested and enacted between prison staff and the inmate as an "analyzable object" enmeshed within these institutional relationships (Foucault 1977, p. 190; Rhodes 2004, p. 134). Rather than a process with a

definitive endpoint, illness constructions seem to be open-ended, indeterminate and negotiated among staff in the Pacific Northwest Penitentiary.

Lacombe (1996) has discussed how Foucault's conception of power has been mischaracterized as solely being a mechanism for control, and that the "examination" is a productive act, not only an act that objectifies individuals (Foucault 1977, pp. 184–185). It is also an act that enables agency (e.g., resistance) and discursive engagement for those who are the objects of the examination (Rhodes 2000). Questions remain as to how severely ill inmates themselves, housed in the general prison population and engaged in treatment, constitute the experiences that are the focus of institutional therapeutic interventions.¹³ Further thickly descriptive research is necessary on how inmates constituted within the social category of "severely mentally ill" live within the social and cultural context of general prison populations rather than highly controlled treatment units (Rhodes 2004, pp. 102–103). This type of ethnographic work is noted solely for its absence in the literature.

The institutional mandate to identify inmates with mental illness and provide comprehensive mental health services is inextricably tied to maintaining safety and security within the prison. The institutional memory (Waldram 2012, p. 228) of Pacific Northwest Penitentiary, revealed within staff and inmate narratives, recalls that inmates with untreated mental illness have committed suicide, assaulted staff or harmed other inmates.¹⁴ The maintenance of the institution's order entails more than getting inmates to "comply"; rather, it is also grounded in concerns for the personal safety of all those working and living within the prison (Liebling 2004, pp. 300–301). The professional construction of psychiatric illness and its classification of an "out of control" entity or person (Lurhmann 2000, p. 45) may contribute to the experience by staff and some inmates of predictability and stability within the prison's anxiety and paranoia-provoking environment (Liebling 2004, p. 283). Mental health staff must not only attend to these institutional mandates for safety and security, but also the seemingly discordant mission of providing treatment. It is this convergence of mandates that reveals what is most at stake for mental health staff within prison contexts.

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¹³In regards to inmates diagnosed with severe mental disorder, Rhodes (2000, 2004) does examine how inmates insert themselves into the diagnostic categories of a prison's psychiatric knowledge. I suggest here that for inmates diagnosed with severe psychiatric illness, future institutional ethnographic research should focus on how inmates meaningfully constitute their illnesses, the meanings that are brought to bear on their treatment experiences, and how their narratives are incorporated, diverge, or contest correctional treatment systems' constructions of psychiatric disorder. Waldram (2012) has already provided analysis of how this occurs for incarcerated sex offenders. Analysis of this sort would move further from analyzing penal practices as solely systems of control (Lacombe 1996), and allow richer understanding of how inmates diagnosed with severe disorders perceive the treatment they receive and how they constitute their own illness experiences (Kleinman 1988, p. 7; Rose 1996, p. 171).

¹⁴For example, security officer and inmate narratives collected during this fieldwork revealed a mentally ill inmate stopped taking his medication, had increased psychotic symptoms, and threatened other inmates on his cell block with pieces of glass from a broken mirror.

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