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Provider Perspectives: Working with the Male Lifer Reentry Population

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PROVIDERS PERSPECTIVES: WORKING WITH THE MALE LIFER REENTRY POPULATION

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Abstract

The passage of Proposition 57 in California creates a path to parole for individuals who experienced long-term continuous incarceration. For the first time, men who experienced long-term incarceration are joining reentry populations in California, establishing an emerging subpopulation of men on parole who were incarcerated for life sentences or experienced long-term continuous incarceration. In the San Francisco Bay Area, most of these men will receive mental health services provided by Community Mental Health agencies or California Department of Rehabilitation and Correction (CDRC). Research suggests that men who experience continuous long-term incarceration may have symptoms of Post-Incarceration Syndrome (PICS).

However, few studies have investigated mental health professionals' experiences of working with individuals who have been released after experiencing long-term continuous incarceration. Interpretive phenomenological analysis was utilized by the researcher because of the strong need to explore and better understand what providers with clinical expertise are currently experiencing while working with this population. The researcher interviewed four licensed mental health professionals who provide psychological services to this population. Qualitative analysis produced novel findings on 1) how providers understand this unique population, 2) the clinical presentation of PICS, 3) building therapeutic alliances with men who have experienced long-term incarceration, 4) current treatment interventions, and 5) the importance for more clinical training to support the needs of this emerging population. This study also provided insight into treatment implications and the need for further research that supports clinical best practices.

PsyD Program Signature Page

This dissertation, written under the direction of the candidate's dissertation committee and approved by the members of the committee, has been presented to and accepted by the faculty ofthe PsyD Program in Clinical Psychology in partial fulfillment of the requirements for the degreeof Doctor of Psychology. The content and research methodologies presented in this work represent the work of the candidate alone.

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Lastly, I want to dedicate my clinical work to the memory of Jolene Spellman who touched my life and left it forever changed. I loved her dearly and will miss her greatly. She was truly an emancipated woman and wonderful friend.

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Specific Aims

Identification of Problem

The exploratory qualitative research study completed by this researcher explored the clinical presentations of men who were incarcerated for 25 or more years and who were recently released based on California legislation Proposition 57. California Proposition 57 allows for parole considerations for felony offenders. Proposition 57 also changes preexisting policies for juvenile prosecution. This study examined clinical treatment approaches that are currently being used by mental health professionals working with this population. Specifically, this researcher identified which treatment interventions are most utilized by mental health providers working with this subset of the reentry population, as well as important implications for better understanding the clinical needs of this emerging group.

This clinical dissertation explored the subjective experiences of mental health professionals through qualitative analysis of clinical experience working with men who have experienced long-term incarceration. Interpretive Phenomenological Analysis methodology was used because it is especially strong at providing rich exploratory results. Specific themes that were explored include mental health clinicians' knowledge of: (1) clinical presentations within this subpopulation; (2) treatments currently being utilized; (3) available training, education and resources informing mental health providers' work with this population; (4) the potential need for development of additional trainings to bridge the gap between the specific clinical needs of this distinct subculture and community providers; and (5) implications of policy changes and prison reform that will continue to escalate the need for clinicians to provide culturally competent care that is reflective of best practices for this distinct population.

Brief Rational and Alignment with Jesuit Mission of Social Justice

The Criminal Justice System in the United States disproportionately and systemically impacts individuals and communities of color, those in poverty and young men of color. It establishes a lifetime of felony disenfranchisement for many individuals after their incarceration. Racial and ethnic minorities are an overrepresented population in American prisons. More than 60% of people in prison are people of color. Compared to White men, Black and Hispanic men face exponentially higher risk of incarceration. Black and African American men are six times more likely to be incarcerated, and Hispanic men are 2.7 times more likely to be incarcerated when compared to their White male counterparts (Carson, 2018). Young men of color enter the criminal justice system much more frequently and are also more likely to be sentenced to harsher terms of punishment than their white counterparts (Sickmund et al., 2016). A large proportion of the men that comprise the lifer population were incarcerated in late adolescence. These men spent much of their developmental years incarcerated and are in their 50s and 60s at the time of their release. Another subset of this population is men of color, specifically Black and African American men, who were incarcerated as adults frequently in their 20s and 30s and are in their 60s and 70s at the time of their release.

This clinical dissertation aligns with the Jesuit Mission of social justice by examining the unique needs of this emerging subpopulation and it also seeks to disseminate information about clinical best practices while working with this underserved community. As prison reform is accomplished, there is a lack of research on the clinical needs of men who have been continuously incarcerated for 25 or more years. This study sought to add to the clinical research that is underrepresented in the field.

CHAPTER I

Introduction to the Study

Interpretive Phenomenological Analysis (IPA) was utilized so that the study could better understand the complex experiences of mental health professionals who provide psychotherapeutic treatment to men who have been continuously incarcerated for 25 or more years. This study was qualitative in nature because of the need to better understand the subjective experiences of each provider. By gaining insight into the experience of mental health professionals who work within this population, this study effectively identified specific cultural and clinical competencies needed to engage with these individuals, commonalities in treatment modalities already being utilized, and clinical factors that may inform best practices.

The need for this research is further evidenced by the increasing amount of prison reform being done in the state of California and in other states across the country (Porter, 2019). The systems in place that serve this population (e.g., Medi-Cal) rely heavily on community mental health organizations and other California Department of Corrections and Rehabilitation (CDCR) programs to meet the needs of this population. Studies estimate that Proposition 57 will result in the release over nine thousand people from California state prisons by 2022 (Romano, 2017). This massive influx of people reintegrating into society calls for research to gather information about the perspectives of mental health professionals working with long-term, continuously formerly incarcerated men.

This study also contributed to a field of research that is presently underdeveloped and detected possible areas of exploration for future research. Findings will also promote awareness around the cultural factors to promote health and well-being for this population and inform trainings and resources for the mental health professionals that serve them.

CHAPTER II

The Review of the Literature

Introduction

The review of the literature provided insight into the challenges the reentry population faces (housing, employment, healthcare, mental health services etc.), and suggests recommendations for improving the systems that are preexisting as part of the Parolee Service Network (PSN) and the development of more programs to support and bridge the gaps in services provided to the reentry population (Davis et al., 2011). There is significant research on the prevalence of complex trauma and comorbid substance abuse disorders amongst prison and reentry populations (Ditton, 1999). Additionally, there are exploratory studies that look closely at the treatment of these disorders in prison and after release (Dettbarn, 2012). A subset of community mental health research targets identified challenges in providing services to the reentry population within community mental health settings (Visher & Travis, 2003).

In 2011, RAND examined the impact of reentry populations within the state of California. Since the publication of this study (Davis et al., 2011) the Affordable Care Act (ACA) has vastly changed health outcomes for thousands of individuals in the reentry populations. As individuals access health care services, the landscape of many community mental health organizations and other organizations that provide services to this population continue to change to meet evolving populations and their specific needs. With shifts in budgets and spending (Davis et al., 2011), community mental health organizations are beginning to work more closely with reentry populations (Romano, 2017). Community mental health organizations are also providing services to emerging subsets of the reentry population specifically the lifer population. In the state of California, proposition 57 has provided a path for many lifers to be

released on parole. This has increased the number of individuals released on parole in California. Most individuals in this population will receive ACA benefits and be eligible to receive mental health treatment in community based mental health programs (Romano, 2017). There is preexisting research on evidence-based mental health treatment services provided to parole and probation populations (Skeem & Louden 2006). However, they do not specifically target treatment tools and protocols for working with individuals who have experienced prolonged incarceration. The exploratory research of Lien and Kunst (2013) documents a cluster of psychological symptomology reported by lifers while they adjust to life after being released from prison. This research provides a rich, first-hand contextual description of this population and recommends further research on implementing adequate clinical best practices for working clinically with this population. However, current research does not include a broader discussion of what types of psychotherapy treatment model clinicians are implementing nor treatment modalities utilized. This clinical dissertation aims to add to preexisting literature, bridging the gap in research between the recognition of distinct Post-Incarceration Syndrome symptomology and the clinical application and implementation of psychotherapy treatment and clinical best practices.

Project Specific Definitions

Definition of Lifer

As reflected in and defined by the literature a "lifer" is a person who is sentenced to imprisonment for life. Many people receive a sentence of 25 years to life, this includes juvenile offenders who are charged with a prison sentence of 25 years to life. Within forensic settings people are both referred to as "lifers" and self-identify as "a lifer." While incarcerated the "lifer" population is distinguished from the general population and those serving long-term sentences by

the title of their charge. This is reflected in reentry and forensic literature in which identifying terminology persists even after a person is released from prison. As seen in the literature many previous "lifers" still choose to self-identify as "lifers" within the population and for those who provide services and reentry services to them (Liem & Kunst, 2013, p. 333).

Definition of Prolonged Incarceration/ Long-term Incarceration

A review of the Federal Bureau of Prisons (BOP) terminology and an extensive review of the literature does not define a specific length of time that qualifies as long-term or prolonged incarceration. There is variance in the length of time, but all identified research meets the minimum time of at least 15 years of continuous incarceration. For the purposes of this research, the researcher will follow trends seen in literature and will define prolonged incarceration and long-term incarceration as 19 or more years of continuous incarceration (Nellis & Chung, 2013).

Proposition 57

The Public Safety and Rehabilitation Act of 2016, or Proposition 57, passed in the state of California on November 8th, 2016. The proposition became effective on November 9th, 2016 and was applicable to all crimes committed on or after November 9th, 2018. The California Supreme Court previously ruled that parole eligibility and custody credits would apply to those who had committed and been convicted of crimes prior to Prop 57 passing (Couzens, 2017). The aim of Proposition 57 is to provide non-violent felony offenders in California state prisons with a possible path to parole consideration once they have met time served.

> Proposition 57 states that its purpose and intent is to: Protect and enhance public safety, save money by reducing wasteful spending on prisons, prevent federal courts from indiscriminately releasing prisoners, stop the revolving door of crime by emphasizing

> rehabilitation, especially for juveniles. Lastly to require a judge, not a prosecutor, to decide whether juveniles should be tried as adults. (Couzens, 2017, p. 90)

The Proposition has provisions to meet its purpose and intent, including parole consideration for any person convicted of a non-violent felony offense who was sentenced to a state prison and completed the full term of their sentenced primary offense. It also includes a system of Credit Earning, so that The Department of Corrections and Rehabilitation (CDCR) can provide credits to inmates with good behavior and rehabilitative or educational achievements. These credits in turn denote eligibility of different inmates including those seeking to be released on parole once they have met and fulfilled all requirements for parole consideration outlined in proposition 57. As research has noted (Romano, 2017), more lifers and individuals who have experienced long-term incarceration will be released on parole and will be a part of the reentry community prior to the length of their initial sentencing.

Literature Review

Reentry Challenges

One in nine people in prison is currently serving a life sentence, and one third of those sentenced to life will never be granted parole (Nellis, 2016). Violent crimes in the United States continue to decrease - a trend that began 20 years ago. However, the number of people serving life sentences continues to increase specifically in California where more people are serving life sentences than any other state in the country. These sentencing trends persist even though there is limited evidence in the correlation between sentence length and increased public safety (Nellis, 2016).

California continues to face Supreme Court orders to reduce the state's prison population because the medical and mental health care services provided to inmates falls below

constitutional standards (Judicial Council of California Administrative Office of the Courts Center for Families, Children, and the Courts, 2011). These rulings continue to force changes in California correction polices and legislation. Many rulings align with prison reform and policy work being conducted by organizations and in communities that are impacted by high levels of incarceration. Policy changes require individual counties in California to be responsible for meeting the needs of the growing reentry populations. This has led to expanding public health research on the specific needs of individuals being released on parole in the state of California. Davis et al. (2011) addresses the complexities of the reentry process and the difficulties faced by the populations of people released from prison in the state of California. This research includes the larger sociopolitical context of what life looks like for individuals released from prison in the state of California, including issues like housing, healthcare and access to services (Favors, 2018). These issues are widely explored throughout the literature discussing the reentry population across the country as well as in the state of California.

RAND research (Davis et al., 2011) provides the perspectives of individuals who are part of the reentry population and includes their first-hand experiences as well as their thoughts on improvements to the reentry systems. This is a limited and small sample of the population, but qualitative accounts demonstrate similarities across experiences and point to similar areas for improvement. Unlike other research and publications in this field, this study also includes the perspectives of two mental health providers who provide services to the reentry population. Review of the literature in this field very rarely includes provider experiences and perspectives, which is why this clinical dissertation makes a significant contribution to limited existing literature.

Mental Health and Reentry Population

There is a significant amount of research that outlines the prevalence of psychiatric diagnoses that comprise inmate populations. There is also a vast amount of research on the high rates of severe mental illness in prison populations. A significant amount of research looks at posttraumatic stress disorder (PTSD) in prison and reentry populations. Research is starting to discuss the need for further research on the development of mental disorders while individuals are completing prolonged periods of incarceration. Dettbarn (2012) is one of few longitudinal studies that looks at the effects of long-term incarceration on an individual's mental health after release from prison. This study reports a decrease in the prevalence of psychiatric diagnoses after release from prison following long-term incarceration. Additionally, this study reports a positive correlation was found between receiving a minimum of 20 psychotherapy sessions while on parole with a decrease in the prevalence of psychiatric diagnoses. Unfortunately, this study does not provide any additional information about the type or modalities used in the psychotherapy conducted with participants.

With the increasing numbers of individuals being released on parole each year in the state of California, this research is very important to the mental health outcomes of individuals and the communities they reenter. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently published an implementation guide to a successful transition of people with substance use and/or mental disorders from jail and prison. This guide is intended for use by mental health professionals, community members and includes information for both substance use disorders and mental disorders in the reentry population (SAMHSA, 2017). Review of the literature in this field demonstrates the high comorbidity of substance use disorders and past histories of substance use in the reentry population. Wikoff, Linhorst, and Morani (2012) found that individuals being released from prison who have histories of substance abuse were more

likely to be convicted on new charges and reports that their non-substance-abusing peers had lower rates of recidivism. This finding is significant to the reentry population and recidivism demographics, however, for most lifers to be released from prison on parole they are required to engage in substance, mental health and psychoeducation classes while incarcerated to be eligible for parole board hearings. Research on the substance use rates and histories of male lifers being released on parole and the data on recidivism due to substance use related convictions are underdeveloped. The SAMHSA (2017) implementation guide for successful transition of reentry populations outlines 10 guidelines aimed at assessment, treatment planning and identification of post-release services and the coordination of mental health treatment. However, this resource is limited in its focus on transition and not on long-term treatment or services. It focuses heavily on the need for community-based pre-and post-release organizations and centers that will attempt to meet the long-term needs of the reentry population. This implementation tool does not include community providers' perspectives or any specific mental health treatment modalities, or systems utilized as best practice for meeting the needs of individuals released on parole after long-term incarceration. Significant research demonstrates the needs of reentry populations and the positive impact community-based organizations have on successful reentry and reduction in recidivism (Favors, 2018). It is clear from an extensive review of the literature that providing a supportive transitional reentry experience can improve mental and physical health outcomes and reduce psychiatric diagnosis and recidivism.

Community Mental Health Programs/ Providers Working with Reentry Populations

There is a significant amount of research in the community mental health field that specifically targets the treatment of reentry populations. This research focuses on clinical implications and best practices when working clinically with reentry populations (Wikoff et al.,

2012). The quasi-experimental study conducted by Wioff et al. (2012) examined the effectiveness of community-based reentry programing aimed at reducing recidivism and providing individuals with mental health support. This research demonstrates that personalized treatment, case management and financial assistance can help with a positive reintegration into society. While this research provides insight into the impact that mental health professionals can have on individuals in the reentry population, it does include providers' experiences or treatment specific modalities.

Community based pilot studies have also begun to look at the impact of the community the individual is being released to after incarceration (Windsor, Jemal, & Benoit, 2014). Prison inmates are exposed to living conditions that have a lasting impact on health functioning. Incarcerated individuals have higher rates of substance use, mental illness and infectious diseases. Racial disparities in incarceration rates are directly reflected in reentry populations. Individuals being released from prison are more likely to need housing, employment, mental health and substance use treatment. Many individuals are released into communities that have poor labor markets, limited opportunities and high levels of racially based health disparities (Windsor et al., 2014). While there are positive outcomes for community-based programs that focus on empowering individuals in the reentry population to "recreate safe healthy communities" (p. 503.), this may not be possible for lifers reintegrating into society. After decades of continuous incarceration, many lifers being released from prison experience cultural disconnect and do not recognize the communities around them or those in which they are being released to (Liem & Kunst, 2013). There is no current research that depicts the impact on lifers' ability to recreate community and special consideration should be made for lifers who have outlived all surviving relatives. This experience may further complicate an individuals' ability to

interact with the communities around them if they have not processed complicated grief symptoms while incarcerated.

Primm et al. (2005) explores the lack of community mental health services for growing reentry populations. Suggesting that where mental health services are available to these complex populations many of whom have histories of systemic racial, ethnic, and socio-economic disparities, community service providers lack the cultural competence needed to provide adequate screening, assessment and treatment (p. 561). Primm et al. (2005) explores the need for substance abuse treatment in reentry populations and high need for treatment that adequately focuses on the intersectionality of race, ethnicity, substance use, trauma and drug related convictions. This research further expresses a need for mental health providers to be able to provide effective culturally competent care. This article stresses the cultural dissonance in the services that are provided and the level of appropriate cultural competency that is needed to work with complex reentry populations. This article provides recommendations for community based mental health organizations to develop more cultural competency and trainings that include multicultural considerations. Aligned with The American Psychiatric Association guidelines suggestions include comprehensive systems of care that are culturally competent, and which provide evidence-based practices. Primm et al. (2005) clearly explain the cultural uniqueness of the reentry population; however, they do not explore how long-term incarceration like that experienced by lifers may present an even more unique presentation that requires a distinct level of cultural competence. While this article focuses on cultural competency and needs of specific cultural subgroups on parole it does not address the impact of prison culture on individuals and the need for cultural considerations that include emerging populations of lifers on parole.

Post Incarceration Syndrome

Liem and Kunst (2013) focus on the development of psychological problems that result from trauma experienced while individuals are incarcerated for prolonged and long-term sentences. While a substantial amount of research focuses on trauma and the resulting development of PTSD (Goff, Rose, Rose, & Purves, 2007), Herman (1992) introduced the diagnosis of "complex trauma" to better capture the impacts of detention-related psychological problems, a diagnosis hoped to highlight the impacts of chronic and repeated exposure to traumatization.

Based on a review of the literature, many previously incarcerated individuals who served prolong or life sentences and the organizations that provide services to this reentry subpopulation suggest there is a separate constellation of psychological symptoms distinct to this specific reentry population. The exploratory research conducted by Liem and Kunst (2013) clearly depicts the impacts of trauma and PTSD symptomology in the reentry population who have experienced decades of prolonged incarceration. The authors are also able to identify the diagnostic characteristics specific to incarcerated and released prisoners that developed through prolonged incarceration. Post-Incarceration Syndrome (PICS) is a diagnosis they suggest that meets the symptomology of individuals who have been released after prolonged incarceration. They empirically assess the recognizable symptoms of post-incarceration syndrome by conducting in-depth interviews with lifers released from prison. This diagnosis meets preexisting criteria for PTSD and identifies the persistent or recurrent symptoms of:

Institutionalized personality traits resulting from incarceration including: (a) difficulty in trusting others, (b) difficulty engaging in intimate relationships, (c) difficulty making decisions.

Social- sensory deprivation syndrome, including: (a) spatial disorientation and/or (b) experiencing difficulty in interacting socially.

Social/temporal alienation, including: (a) feeling not to belong in social settings (b) thoughts that positive events and situations can be taken away.

By adding PICS as a special subtype of PTSD, Liem and Kunst (2013), suggest more individuals would get mental health treatment that focuses on both trauma and post-incarceration effects. This would assist with more adequate treatment and services for the lifer population and individuals who are being released from prison after prolonged incarceration. This article incorporates qualitative data from 25 lifers as they discuss their mental health and psychological symptoms. The qualitative data collected suggest that there is a specific subset of psychological symptoms experienced by individuals who have experienced 19 or more years of incarceration. Literature and research highlight the cluster of these symptoms being more specific to the lifer population and those who have experienced prolonged incarceration and suggests that the diagnosis of PICS would help to provide more adequate mental health treatment and more successful reentry (Liem & Kunst 2013). The exploratory research conducted with lifers on their mental health symptoms and proposed post-incarceration syndrome includes mental health professionals and organizations that provide services to this population but does not examine the provider perspective. Research questions are focused on the first-hand experience of lifers and the experiences they have dealt with psychologically after being released from prison after prolonged incarceration. The addition of PICS as a subtype to PTSD in the DSM may provide a clear picture for providers about the cluster of symptoms this population may be experiencing. However, there is currently no research addressing what clinical treatments might be best suited for this population and for this constellation of symptoms. There are not clinical best practices included in this research demonstrating the gap in psychological research and clinical application.

Prop 57 and Emergence of Post Incarceration Syndrome in Community Mental Health Settings in San Francisco County

Review of the legislation and policy written to support Proposition 57 provides very little oversight on what protocols will be in place for lifers reintegrating into San Francisco County. Without a finalized plan or standardized implementation for what Post Release Community Supervision (PRCS) or parole will look like for lifer parolees, a lot of uncertainty revolves around their lives after release from prison. As seen thus far, counties are taking on the role of supporting these individual parolees, many of whom are treated as though they are reintegrating like any other parolee. In San Francisco County, these men are channeled through programing established to meet the needs of AB109 and other offenders with criminal justice histories and a need for parole or probation services. For example, after being released from prison on parole in San Francisco County, male lifers are entered into short-term programs, many of which are inpatient programs aimed at targeting dual-diagnosis treatment (Romano, 2017). Many of these programs provide stable short-term housing, daily meals, social support, case management, substance use and mental health groups and optional individual therapy. While lifers are mandated to parole and provided services by the Affordable Care Act and are entered into community-based programs, there is little known about the outcomes of this population and the mental health services they are being provided.

Significance/Proposed Impact

Research, literature and pilot studies clearly identify the need for mental health professionals who provide psychotherapy services to individuals in reentry populations, especially considering the increasing numbers of individuals being released on parole in the state of California after prolonged and long-term incarceration. The impact that the ACA will continue

to impact and shape community mental health care settings and community mental health organizations as this legislation provides access to mental health care services for new and emerging communities. The existing literature as reviewed above suggests a need for improved culturally competent care with special considerations for reentry populations. The emergence of lifers and individuals with long-term incarceration histories in community mental health settings calls for more research and understanding regarding clinical best practices and implications of care for individuals with post-incarceration syndrome.

Conducting a reasonably exhaustive search and review of literature in the forensic and community mental health fields, within California legislation and prison reform materials, and across future implications of current public health policy and implication further demonstrates the need for further research. Literature is underdeveloped in areas such as: emerging reentry populations who have completed long-term and prolonged continuous incarceration, the clinical presentation of lifer population, training for clinicians working with the reentry lifer population most likely to suffer from PICS and complex trauma, clinical best practices and rational for interventions and implementation of interventions.

Review of the relevant literature related to and focused on the topic of this clinical dissertation research project found that the bulk of the literature focused on the historical and sociological events that have led to the emergence of the lifer subpopulation within the reentry populations..

CHAPTER III

Methods

Rational for Qualitative Approach

Interpretative Phenomenological Analysis (IPA) has rapidly become one of the best known and most commonly used qualitative methodologies in psychology (Smith, 2011). IPA was chosen by this researcher because this project involves an exploratory and descriptive analysis of narrative data to better understand the clinical perspectives of mental health professionals working with formerly incarcerated lifers now experiencing reentry into society. Qualitative analysis allowed this study to engage with the deeper levels of meaning and understanding that participants experience while working clinically with men who have been continuously incarcerated for 25 years or more. The intensive qualitative analysis of detailed personal experiences allowed for both individual differences and similarities throughout the data collected. Qualitative analysis allowed the researcher to explore clinical practices and education, which will add to an area of limited clinical research and promote the dissemination of best practices in the treatment of this significantly underserved population.

Interpretative Phenomenological Analysis

IPA was chosen because its utilization provided a detailed and descriptive examination of the psychological phenomena of mental health professionals who work clinically with men who have been continuously incarcerated for 25 or more years or identify as former lifers. The theoretical foundations of IPA are phenomenology, hermeneutics and idiography, which allowed this qualitative approach to examine personal lived experiences (Smith, 1996). IPA examines experience, in its own terms instead of being overly influenced by psychological theorizing or by personal proclivities of the researcher (Smith, 2017). This was made possible

by operating with a double hermeneutic, allowing IPA to not only explore the meaning of personal experience but the process of the researcher's interpretation and meaning making through which 'the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2015, p. 26). The double hermeneutic component of IPA allowed this study to better understand the internal processes of mental health professionals while they make meaning of their clinical experiences and the treatment modalities and interventions they use while working with this population. Additionally, the idiographic commitment IPA has both as a theoretic framework and in analysis allowed this research study to focus on the detailed analysis of each case followed by systemic search for patterns across cases. This study aimed to better inform best practices and clinical treatment modalities and interventions being used while working with the lifer population. Therefore, this IPA study is concerned with not only presenting shared themes but also highlighting the ways in which themes are experienced by individuals.

Project Population and Setting

This clinical dissertation research study included 4 mental health professionals who provide psychotherapeutic care to formerly incarcerated lifers. Sample sizes of 3 to 6 subjects are generally recommended for IPA studies. This sample size provided adequate cases for development of meaningful points of similarity and difference between mental health professionals and highlighted trends in treatment modalities utilized. In focusing on the complexities of human experience and phenomena, a smaller sample size provided a more detailed lens on the experiences of research subjects (Smith, Flowers & Larkin, 2009, p. 51).

Consistent with qualitative paradigm, and with IPA's theory and methodology, this study purposely selected samples (Smith, 2011). The sampling approach was intentionally

done to identify participants on the basis of what they can provide the study with their subjective perspectives on the phenomena of working clinically with this unique population. Participants were recruited through community mental health organizations and organizations that provide reentry services including mental health services to populations being released by the California Department of Corrections and Rehabilitation.

Inclusion criteria included licensed mental health professionals who identify as having substantial clinical experiences working with the lifer population, and/or men who have been continuously incarcerated for 25 or more years. Participants were recruited for their experiences working with men released on parole under Proposition 57 in the state of California. Exclusion criteria included non-English speakers or individuals who are not fluent in English. Participants participated in an interview on the Zoom online platform and interviews were recorded for transcription purposes.

Procedures

Recruitment

Participants were recruited from community mental health organizations that are known to provide reentry services to this population. This included mental health professionals who provide outpatient and residential dual-diagnosis services to the reentry population. Known organizations and individual mental health professionals were emailed (Appendix E) inviting them to participate or refer a known individual who has contact with this population. Prospective participants were contacted via phone or email and completed a brief screening interview to assess for inclusion and exclusion criteria. When prospective participants met criteria for inclusion in this study, they were asked to participate in a full interview. To aid in scheduling difficulties, interviews were completed with participants over

virtual meeting platform (i.e., Skype, Zoom). Once participants scheduled a full 90-minute interview they completed and sign an informed consent (Appendix E) prior to their interview.

Interviews

Semi-structured interviews were scheduled for 90-minutes and were conducted over a virtual meeting platform (i.e., Skype, Zoom). Prior to interview initiation researcher reviewed informed consent (Appendix E) with participant and briefly mention interview agenda. Researcher acknowledged a brief wrap-up period that took place at the end of the interview when participant was presented with mental health resources if the participant wanted to further discuss topics or events with a licensed clinician.

Consistent with IPA research methods, the researcher created an interview schedule (Appendix E) to serve as an interview guide. The aim of an interview schedule is to facilitate a comfortable environment for each participant, which will allow them to provide clear and detailed accounts of their experiences under investigation. Questions were open-ended and expansive so that participants could provide narrative and descriptive responses. Participants were consistently invited to be more analytical in their responses as they acclimated to the interview and responded to questions. Participants were also asked questions addressing adequacy of prior training in understanding and meeting the needs of this unique clinical population.

Prior to the first interview with a study participant, an interview schedule and interview questions (Appendix E) was conducted on a volunteer who was not involved with this study. This helped the researcher gain comfort and ease in the interview setting and ensured that interviews were conducted within the IPA methodology within the 90-mintue time limit. This practice allowed the researcher to note any problems with the schedule and

questions that elicit redundant responses so that the schedule and interview questions could be adapted and modified as needed. This also allowed space for the researcher to evaluate their interview technique.

Outcome Metrics

Interviews were audio recorded and transcribed using digital meeting platform. Researcher also took extensive process notes after the conclusion of each interview. These notes made it possible for the researcher to reflect on the impressions she had of the interactions with the participant. Post interview process notes also served as additional resources for the subsequent contextualization of the interview and development of the researcher's analysis of the interviews (Hollway & Jefferson, 2005).

Human Subjects (IRB)

Institutional Review Board approval for the project (Appendix C). Additional IRB from outside organizations and organizations of recruitment will not be required.

Feasibility Considerations

This study was completed in the proposed timeline (Appendix A). Pre-existing professional connections with community mental health organizations in San Francisco and the referral component of IPA accelerated participant recruitment as planned. Ample time was proposed for the analysis of data collected from qualitative interviews. Additional time spent analyzing and conceptualizing themes of data allowed the researcher to deeply engage with material. While time was allocated for analysis, the researcher began to compile data and started to write results in the form of clinical dissertation. The timeline gave the researcher ample time to complete the clinical dissertation and defend findings prior to Postdoctoral training.

Data Collection

Data collected in this clinical dissertation research study was analyzed using IPA methodology. The focus of IPA was on the analytic attention that is placed on participants making sense of their experiences (Smith, 2007). The common processes of IPA were followed when analyzing data which includes upholding the iterative and inductive cycle of IPA, fluid description and engagement with the transcripts and adhering to the theoretical framework of IPA.

IPA Initial Analysis: Emersion in Transcripts and Initial Annotation

In analyzing data, research involved reflective engagement with each participant's account. This was achieved by reading and re-reading transcripts and listening to the audio recorded sessions multiple times. Multiple reviews of the process notes allowed the researcher to re-contextualize the interview. Initial annotation of transcripts included a focus on the linguistic comments made by participants (Smith, Flowers, & Larkin, 2009). Initial annotation of transcripts focused on meaning units. Further analysis of transcripts focused on descriptive comments and the content contained in those comments. Looking directly at the language employed by participants allowed the researcher to think about the context of their experience and the patterns of meaning in their descriptive accounts.

This comprehensive and detailed annotation and review of interview transcriptions made it possible for the researcher to focus on engaging with the data collected on an interrogative and conceptual level. That stage of annotation was interpretative and involved a focus on the participant's deeper understanding of what they are discussing. More time was allotted for the researcher to engage in this level of annotation, coding and interaction with the data because it required more iteration, reflection, and refinement (Smith, Flowers, & Larkin, 2009). Conceptual

coding provided another lens for the researcher to think about the construction of the participant's experience of meaning making and his/her their connection to his/her lived experience. Deconstruction was also utilized while analyzing the data so that context was considered and the interrelationship between one experience and another could be emphasized appropriately.

Annotation and Developing Emergent Themes

The comprehensive processes of reading and immersing oneself in transcripts allowed for an enriching experience of data analysis in the initial noting and annotation stage. The researcher relied on the knowledge gained through the initial noting process as she moved to the next stage of analysis (Smith, 2010). These analytic approaches produced a larger data set for the researcher to analyze while focusing on the development of emergent themes. Analysis at this stage required the researcher to look for emerging themes in the data sets while also managing the larger data set. Synthesizing data while producing emerging themes put the researcher in the role of organizing data and interpreting the analysis. At this phase of analysis, the researcher utilized developing emergent theme boxes (Appendix D) to organize emergent themes, the original transcripts and the exploratory comments the researcher has. This helped re-focus on the interpretation of the analysis while developing emergent themes in the data sets (Smith, 2010, p. 92.).

Connection Across Emergent Themes

Once the emergent themes were established, they needed to be charted and mapped together. At this phase in analysis the researcher focused on clustering related themes. This allowed the researcher to continue to work deeply with the data and maintain the hermeneutic circle that is part of the theoretical framework of IPA. Searching for connections across emergent

themes highlighted the analytic processes of abstraction, subsumption, polarization, contextualization, numeration and function. These processes provided patterns in the emergent themes and what is called 'superordinate' themes at this point in the analysis process (Smith, 2010). These analytic processes are organized using the same boxed formatting as the developing emergent theme (Appendix D). Researcher managed organizational boxes using tables and corresponding page numbers. Researcher used Word Documents and printed themes and tables as needed to maintain and establish management of data and coding. By developing tables and appendixes to organize each transcript, it was possible for the researcher to develop a brief single case study of each participant's transcript. This was done so that the researcher could incorporate more data with each additional participant.

Themes Throughout Data

Organizing each participant's data with superordinate themes and brief case study allowed the researcher to look for patterns across all cases included. Examining patterns across participant's data will required researcher to draw connections and differences between participant's experiences. The results of this process produced a table of master themes in the data and captured a snapshot of the most salient parts of participant's experiences. The final stages of analysis required the researcher to delve deeper into interpretation of the data in each data set and across all data collected from participants. At this stage of deep interpretation and analysis the researcher will continue to align herself within the theoretical framework of IPA.

Completing Analysis

To achieve this level of analysis the researcher de-identified all participant information and used participant codes to maintain confidentiality. Once de-identified, transcripts were further de-identified as needed so that the data could be manipulated and reworked as needed in

the annotation and analysis process. Researcher utilized Word Documents to enter data into organizational boxes for interpretation and coding. Data was printed as needed so that the researcher could engage with it on a more contextual level. No additional software programs or data entry platform was used to code, analyze or interpret this proposed IPA clinical dissertation research study.

Dissemination

Research findings are disseminated back to participants in hopes of furthering research aimed at better serving the reentry population. Research is made available to clinicians working in this field and other community mental health organizations. The researcher is also available to community organizations to present findings and areas to further research.

CHAPTER IV

Results

Participants

A total of 6 participants were interviewed for this study, 4 participants' responses were included for analysis. The additional participants' interview responses were excluded because they lacked relevant outpatient clinical experiences, or the clinical presentation of their caseload included severe mental illness. Participants were recruited from a variety of sources: agencies dedicated to providing psychological services to reentry populations, community organizations and through professional lectures focused on working with previously incarcerated individuals. Participants were selected by the researcher because of their clinical knowledge and experience working with the targeted population. Participants were interviewed by the researcher via Zoom, interviews were recorded and transcribed by the researcher. Following inclusion criteria all participants are licensed mental health providers at either the doctorate or master's level with multiple years of clinical experience working with several men who were formerly incarcerated for life sentences.

The age of the participants included in this study ranged from 29 to 60 years old, three of the participants self-identified as cis-gender women one as cis-gender male. Three of the participants identify as white and one participant identified as Hispanic. Participants' clinical experiences included providing long and short-term individual psychotherapy, group psychotherapy, psycho-educational group psychotherapy, and cognitive and personality assessment. Participants were provided with pseudonyms to ensure confidentiality and any revealing information was properly de-identified or redacted from the data.

Sarah- Currently works in a reentry program in San Francisco. She has spent over a decade working both in public and private practice with men who have experienced long-term incarceration and are navigating community reentry. She is actively involved in reintegration advocacy work.

Claire- Currently works in the Veterans Affairs Healthcare System. She has 3-years of previous experience working with reentry populations. She reports one year of intensive clinical work with men who were formerly incarcerated for life sentences in both individual and group modalities in an outpatient community mental health setting in San Francisco.

Kate- Currently works in a county funded reintegration oriented primary care setting. She provides psychological assessment and individual psychotherapy to men who were formerly incarcerated for life sentences. She reports having worked with this population for 5 years and some of those years were spent in community mental health outpatient clinics.

David- Currently works in residential and outpatient community mental health organization in San Francisco, CA. He has worked with formerly incarcerated male lifers for over 4 years and he provides individual and group psychotherapy to that population.

Participants were interviewed for this study using a semi-structured interview, following a simple series of open- ended questions. Questions focused on the participant's clinical experiences working with this population, reflections they had on relevant training and education they had sought or received focused on this subpopulation, and areas of focus for future research.

Superordinate Themes and Subordinate Themes

Emergent superordinate themes were captured in prevalence, or emphasis in participants' responses, and were included for analysis because they were related to patterns of responses across participants' responses. Corresponding subordinate themes are included as they relate to participants' responses and provide more contextual richness to better understand participants lived experiences. Interpretations of participants' responses are supported by transcript extracts and have been selected to represent emergent superordinate and subordinate themes. The analysis found six superordinate themes and associated subordinate themes (Table 1).

Table 1.*Constituent Themes Grouped into Domains*

Domain and theme	No. of participants
Superordinate Theme: Understanding of self as individual and provider	
Locating cultural identities	4
Superordinate Theme: Understanding the lifer	
Identity	4
Need to understand complexity of	
Lifer population	4
Parole Boards	4
Pre- incarceration experiences	4
Superordinate theme: Clinical Presentation	
Trauma exposure and PTSD	4
Post Incarceration Syndrome	4
Lifer OCD	3
Superordinate Theme: Therapeutic Alliance	
Reckoning	4
Relationship ruptures and repair	4
Quality of therapeutic relationship	4
Countertransference	4
Superordinate Theme: Treatment	
Treatments Utilized	4
Inclusion of social support	4
Lack of training	
	4
Superordinate Theme: Systemic Racism and	4
Cultural Factors	4
Population specific needs	4
Mass Incarceration	4

Superordinate Theme 1: Understanding Self- Providers Identity

This theme captures responses that participants made while being interviewed. Each participant discussed their understanding of themselves as individuals and as providers. This includes disclosing identities they hold as individuals that they feel impacts their clinical work, ways of being, and relating to the world. Examples include racial/ethnic identities, gender, and socio-economic status. The ways in which each participant presented this material was unique to the individual and the interview. While some participants started their interview by locating themselves and their identities other participants discussed their identities or changing identities throughout the interview. Responses incorporated ways they found their identities to be important or impactful in their clinical work and understanding of the former lifer subpopulation.

> You know, like being white. There's a lot of white female clinicians, we [white female voters] are the ones that got Trump into office. You know what I mean. So, I think, we can't like to presume that the nice white lady thing should get like you there, we need to do more. And I think like part of what has to really get contained is the way that those historical relationships are like playing out in the room between people, otherwise that stuff gets split off. (Sara)

Sara's response demonstrates the way she thinks about her race and gender as it relates to her work with the former lifer population she treats. She also speaks directly to how she understands her identities interacting with others and lager socio-political impacts on her clinical work.

> The male role belief system stuff or like kind of rigid ideas about what men need to be and do. I think that sometimes that can be helpful in prison, but then not help so much out here. And, you know, from my cultural bias was just like, in my mind, like, that's crazy.

> You know, I mean, and I had to check that and be like, well, how does that? How does that work for you? (David)

Similarly, David discusses cross-cultural and gender-specific differences that impact his clinical work and his need to engage more with his bias and belief systems. This theme highlights providers focus on better understanding themselves in relation to this patient population.

Superordinate Theme 2: "Lifer" Identity – Understanding the Other

Each participant focused on their understanding of the former lifer population as it related to their lived experiences working with this population. Responses noted a need to (a) understand the individuals that comprise this population without making sweeping generalizations. Participants focused on (b) the organizational and systemic factors that impact former lifers' abilities to access psychological services while incarcerated. They discussed the motivational force that (c) parole board hearings play on former lifers' engagement with services. Participants also focused on experiences of (d) childhood and complex traumas these men experienced before incarceration.

Individual Experiences

> Yeah, I mean, there's so many differences, the majority of lifers were in for murder, and I don't know if that's because more people in California get sentenced to life for that or if those are the people that don't get out. I'm saying, like, for the people that get sentenced like in Louisiana. It's a really high percentage of people that get sentenced to life for like marijuana possession. So that's what I mean, I think it's really important to be thinking about, like, anybody who's working with lifers who are out in California. It's a specific group, it is not generalizable, you know what I mean, it's really, it's a window into that group. (Sara)

Sara's quote acknowledges broader legislative, political and demographic impacts that shape the former lifer population. As well as the specific difference for men in California and those released from prisons in the San Francisco Bay Area. Her comments are reflected in the current research on sentencing trends across the country.

> Yeah, I wouldn't like to stereotype everyone from the lifer demographic as that, but yeah, I would say that like I typically have different experiences working with lifer guys than I normally do with other reentry clients. (David)

David's comment highlights a similar point of wanting to account for individual experiences and larger constellations or trends in his experiences. While he notes the differences in this subpopulation he is also hesitant to make sweeping generalizations that may oversimplify or not account for individual's lived experiences.

> I don't want to over generalize, but he really took things that gave him and he did it. And it's just like you're just like this like sponge… they [lifers] had in common that was different from some of the guys who were more recently out of prison for the first time or those who did less time. They [lifers] had more distress tolerance, they were less likely to get into a fight or conflicts like that. (Claire)

Claire's account of working with a specific patient draws on her experiences a lifer that may have been unique to this individual. Her comment then expands to include a few generalizable traits she saw in the larger former lifer population with whom she was working clinically.

Access to Services

> I think the biggest thing that I've noticed is that people who have served a lot of years like continuous long sentences like you're describing versus lifers, they don't really have a way to participate in all the self-help stuff in prison without it. I'm threatening kind of the

> toxic masculinity culture there, for lack of a better word, like lifers can say like, "Oh, yeah, I've got to go to AA and cons. I got to try and get out of this place." Right? but like for somebody who's going to get out anyway. It's much harder to actually elect to participate in all this like growth stuff without that being seen a soft or week or whatever. Yeah, lifers kind of have a cover for it in that like they can be doing it because the board expects them to even though they're doing it for themselves. It's so I think there's something about that, that like process kind of offers a sort of a face-saving opportunity that makes it easier for people to participate in what little services are available than people who don't have that face saving kind of cover. (Sara)

In this excerpt, you can see how Sara understands systemic and organizational factors that contribute to the clinical presentation of her former lifer clients. Sara notes that her clients were often more able to engage in mental health services while incarcerated. Which led them to have more exposure to psychological services.

> A lot of the guys that I know, a lot of the lifer guys, I would say they have a lot, they have a lot more extensive knowledge about like therapy stuff from while they were incarcerated. That can go two ways: one of them is like they're really insightful because they've gone through a lot of like group processes. So, they're like willing to engage like just being able to talk about like thoughts and feelings, people could do that. But on the other side, sometimes like guys have been through so many groups that they're very shut off and they are kind of dismissive. (David)

Like all other participants, David also expands on what access to services does to impact the men he sees in outpatient services after they are released on parole. He highlights the differences in this clinical population to those who experience short-term incarceration. While he clearly

identifies the insightfulness that former lifers have, he notes that it can also d to individual differences in how they engage with reentry psychological services.

Impact of Parole Boards

> When you are working more on the individual level I think for group stuff that makes a lot of sense, right, because I think there's a gap between the guys that have like met boards - they've had to do a lot of work. (David)

David highlights the effort and energy many former lifers engage in to be able to meet boards to then be eligible for release on parole. This again reiterates the systems that are in place and are acting agents for change on lifer populations in California.

> There's a, there's like a. psychological incentive for accepting responsibility because you've got to like repair. That part of you that has caused harm. And if you don't do that, then it's hard to live with that. Yeah, which is more what the board expects from people. I think there's that going on with people who have like been sentenced to long sentences versus life sentences. (Sara)

Sara notes the type of psychological work that needs to be done by the former lifer population to have the opportunity to be released as well as the external factors that this population encounters that are different from individuals who have not experienced continuous incarceration.

Trauma exposure prior to incarceration

> A lot of trauma there in general. Yeah, and I mean like, I'm thinking, of another man who was a lifer that I worked with who is just extremely traumatized, complex trauma, just so much complex childhood trauma. (Claire)

Claire notes her experience of working with male former lifers who experienced a lot of trauma prior to experiencing incarceration. Claire reflects on the high rates of childhood trauma in her

former lifer caseload. She explores what it is like to have to address the impacts of complex trauma or exposure to traumatic events in childhood while providing psychotherapy to this population.

> And the same thing for people that have all this trauma, there's too much social injustice baked into who we incarcerate in this country to focus on symptom reduction like treatments without capacity building, clinicians have to help people transform something so that they're not just going back to their baseline. The baseline got people in prison, first place, you know what I mean… I remember doing the CBT group, and it just like having this moment that I'm like I'm standing here in front of a group of 10 men. Almost all of them have been sexually abused by fathers, uncles, almost all of their mothers denied it and told them that they were making it up or they were imagining it or it wasn't really happening. And now I'm telling them that the reason why they're suffering is they're not thinking about things right. Yeah, this is not working for me or them. It's an enactment. You know, and that like when I started getting into more like trauma work and like building containment. Like, that's when I felt like people really had a chance to kind of get disentangled and start like doing something different. (Sara)

Sara discusses how she sees the need for mental health providers to account for exposure to traumatic events, like childhood sexual abuse while working with former lifers. She also provides a clinical example of how she experienced this need in her clinical work with former lifers. Within this clinical example, she explores what she understands to be a need for psychological services that can attend to complex trauma exposure prior to former lifers' incarceration.

> This individual had a long-standing history of mental health treatment in dating back to childhood years, but his psychoses ended up incorporating a lot of the trauma. (Kate)

Kate discusses the role that trauma played on her caseload and in clients she saw with more severe symptoms that included psychosis. Kate notes that exposure to childhood trauma and abuse were pervasive throughout her caseload.

Superordinate Theme 3: Therapeutic Alliance

Participants focused on what it was like to establish a therapeutic alliance with former lifer clients, and the experience of clinical (a) reckoning. Participants explored how they managed experiences of (b) rupture and repair in therapeutic relationships. The quality of their therapeutic relationships (c) with former lifers and the experiences of (d) countertransference they've had with patients. Each participant explored what it was like for them to come to terms with, and make meaning of, working with this subpopulation.

Reckoning

> The thing that I ran into that was really like the hardest was there's this basic kind of like reconciliation between people having been extremely violent and often taking somebody's life. And then this idea of like punishment and what to do about that, and like whether or not redemption is possible, like all these questions that we're not asking, like we're incarcerating people instead of asking these questions and all of these questions come to the forefront with lifers. (Sara)

Sara continues to explore the meaning of reconciliation and reckoning that should be done while working with former lifer clients. She notes her process of trying to make meaning around creating empathy and understanding while working with someone who may have taken someone's life.

> I want to say this in like a more professional clinical way but, I guess, I don't have to, it was interesting for me to like fall in love with criminals and like just really like see the human side of people and their goodness and it's something that I knew, intellectually, but I think that experience really made me more able to do that now with folks who have done things I don't approve of or other things like that. So, I think that's something that is important that I had with lifers. Yeah, that's really, really powerful. (Claire)

Claire goes a step further in explaining her reaction to working with former lifers and her experiences of being able to connect with someone's humanity while acknowledging they have done things that she didn't approve of. While she notes her intellectual understanding of working with people who have committed crimes like murder, she also discusses the deeper meaning it held for her and the impact it continues to have on her in her clinical work.

Rupture and Repair in Therapeutic Relationship

> And he's [David's client] like, "yeah, I don't think that you know, what you are doing" and he didn't actually, he kind of is just like, "this kind of seems like some bullshit." And I think he, I don't know if he left. I think he might have left. I said, like, "would you be willing to meet again" he said, "yes." And I said, so I just said, "I think I might have taken a wrong turn." I was deferential and I was very respectful and I think I said, "You've been through a lot and you've learned a lot and you have a lot of skills and it's probably pretty frustrating for some young guy- Who doesn't have the same experience as you trying to tell you how we're going to do these things without really asking what you want or what would be helpful for you" and then we were, we worked it out like I think he, I think in part he wanted to know that I knew what I was doing. (David)

All the participants explored themes related to rupture and repair and their experiences of navigating ruptures in therapeutic alliances with former lifers. David provides a clinical example of working with a former lifer and having to explore where he may have caused a therapeutic rupture and the conversations it took to have a restorative experience with this client. David explored what it was like for this former lifer to feel as though his lived experiences were being taken into consideration by his mental health provider and his need to feel understood.

Quality of Relationship

> Actually, we had a really great rapport. They felt like nobody really understood what they were going through and granted, you know, I didn't personally have similar experiences but they felt really comfortable and really appreciated, and it was really easy to build rapport with them. (Kate)

Kate discusses that although she did not have shared lived experiences with the former lifers she worked with, she had good rapport with her clients and built strong therapeutic alliances. Kate discusses how her ability to be consistently emotionally supportive made it possible for her to build strong therapeutic relationships with former lifers.

> You know, rapport building and being respectful of the person's background and knowledge are really important because they've seen you know, in 30 years of prison they've probably seen 30 guys or more just like me. (David)

Similarly, David also discusses the need to build rapport for a strong therapeutic alliance and relationship. He expanded on the need to be respectful and able to acknowledge client's individual lived experiences. David discusses what it's like to work with former lifers who have engaged in psychological services while incarcerated and the need to offer a new or different therapeutic experience once they are released.

Countertransference

> I have like this countertransference reaction that was like, I actually got physically sick and I mean I've worked in forensics for a long time. I've never gotten physically sick, so motherhood has really changed my experience of sitting with this. But it was really interesting. I say that because it was, he was very, very hard to sit with like his crime was horrific and it was hard to reconcile how this person sitting in front of me was the same person that can do something like that. And so, my clinical work with him was him trying to reconcile that and like figuring out how to live with it. But it was really interesting to then like feel my own efforts to reconcile that and live with it and pay attention to it. To feel my countertransference and figure out what to do with it and to try not to act it out. To figure out what I needed help with, how it was a window into what he was experiencing. (Sara)

Sara discusses how after years of working with forensic populations she had a novel experience working with a former lifer client. She explored what it was like for her to continue to work to better understand her countertransference and let it help guide her work and help her understand her client.

> Yeah, I mean I think at some point it would feel really, I would feel a little stuck and not really knowing kind of when to go to the next step in therapy. And what I mean by that is that because the level of severity was so high in terms of anxiety in the PTSD symptoms. It was really difficult to like move along with traditional protocols. And so it would, you know, it would be months and I'm talking about like six months of doing grounding that every session before we can move on to, like, you know, one grounding technique before we can move on to like say we started with doing like progressive muscle relaxation. And

> it would take probably about six months before we could move on to a different type of intervention. So I think that was really difficult for me, engaging when they were ready for the next type of intervention. (Kate)

Kate discusses her experiences of countertransference while working with former lifer clients. She notes her difficulties in working with feelings of being stuck because of the need to adapt treatment to the pace that was appropriate for the lifer clients she was working with.

Superordinate Theme 4: Clinical Symptomology

This theme demonstrated participants' understandings of the clinical presentation of the formerly incarcerated men they worked with. Most participants reflected on their experiences of therapeutic relationships with former lifers before discussing their clinical experiences and presenting symptoms of the former lifers they worked with. Participants previously discussed exposure to trauma in childhood or prior to incarceration. However, participants focused on (a) exposure to trauma while incarcerated and the development and continuation of symptoms of PTSD. Participants noted PTSD symptoms, their experiences of (b) PICS and (c) OCD. All Participants included rich clinical material and case examples while discussing their experiences and the meaning they have made of working with former lifers.

PTSD

> Yeah. Um, I think for the individuals that I've seen, they definitely have a very high severity of PTSD symptoms. Very startled extremely hyper vigilant. Worried that people were following them. (Kate)

Kate reflects on her experience of the clinical presentation of the former lifers that she worked with clinically. She not only notes PTSD symptoms but explores what responses one individual she worked with had in response to his feelings of anxiety.

> Yeah, that's hard. You know, I mean, I feel like almost all of the guys I work with have had some level of like hyper vigilance. And You know, complex PTSD probably like almost like probably 90% of them would fill the symptom criteria for that. (David)

David also reports hypervigilance as a common symptom of PTSD that he noted in his work with former lifers, David comments on the high likelihood they met criteria for complex PTSD.

> I mean, there's some people that they're depressed or some people that are anxious in public a lot of people just have this weird like, it's not like really an adjustment disorder. It's not really PTSD. It's like something different, you know, and I can't quite figure it out. Like, I remember I'm working with this one guy who was really having a hard time with anxiety and he was so afraid. Some people, for instance, are anxious about getting hurt like they're really focused on, like, I'm really worried that somebody's going to go off on me. But other people are afraid of like losing their shit on somebody and killing them. So, it's not just that like the PTSD isn't just actually afraid of being a victim. It's also afraid of one's aggression getting pulled out, you know, so it's different. Yeah, like it's like this fear of like having to react in a way that you don't want to, or something and then that I don't know it's confusing. (Sara)

In this excerpt, Sara brings up her experience of working with former lifers who present clinically with symptoms of depression and situational anxiety. She then explores the fears and worries that drive the symptoms of depression and anxiety. She also demonstrates the meaning she has made around the etiology of these symptoms in lifer clients and the fear they have of their own aggression.

PICS- Post-Incarceration Syndrome

> There is, you know, and I guess I've read, there's like a sort of maybe a specific kind that may even though it's not in the DSM that there's a specific kind of like PTSD from long-term incarceration. And like, like the whole like being on the bus thing like that's a specific thing almost every lifer guy can relate to. If I and I will bring it up in groups, and I'll say like, "anyone in here not like the bus?" and multiple guys would be like, "I hate the bus. If it's more than three quarters full I won't even get on." And, you know, if we're doing like a DBT approach to it like, okay so rationally, how dangerous is the bus? and like most of the guys in the group can be like, like a two. But lifer guys can't even get to that point, like emotionally the bus is like a six, and that's what I mean when I get back to like the rigidity. It's like you've been doing this, you've been living in an unsafe environment where someone being up in your space could mean like something really bad is going to happen. For so long that it's pretty hard to like un-fuse that from your reality. (David)

David notes having some understanding of Post-Incarceration Syndrome as a specific type of PTSD for people who have experienced continuous long-term incarceration. He then goes on to provide a clinical example that differentiates the rigidity he experiences when working with former lifers. He notes a sense of rigidity and emotional reactivity that is unlike his other reentry clients. He reflects on what it is like to try to work clinically with former lifers around feelings of safety and anxiety.

> I remember working with lifers and the grocery store was extremely overwhelming, just the choices that are available and knowing what to do. One lifer had that experience, I

> think every time, but especially after being incarcerated for so long and then working so hard to get used to things when he was out. (Claire)

Claire explored a few of her experiences of symptoms that are unique to the former lifer population she worked with that she found interesting in addition to symptoms of depression, anxiety and PTSD. She noted a similar sense of difficulty in addressing these specific issues and experiences of rigidity in this subpopulation.

> I remember this one guy he was really anxious about going out and his life was limited in a response to his PTSD way. His life was being limited like he was not doing stuff because he was so afraid of getting lost all the time. And then after a while working with him like about, you know, like he was afraid of the anxiety of the feelings of vulnerability, I realized he had never not known where he was. Like he had been in prison since he was 17 and once you're in an institution for a day, you know, the layout of the institution you literally can't get lost in prison because there's one entrance and there's one exit. He had never in 40 years, in the last 40 years of his life, he had never been lost. So, like just the feeling of being lost was so discombobulating to him. That like it was enough to make him avoid situations where that might happen. You know what I mean. A couple other people I've worked with have this like really physical response to being out because they hadn't gone up hills. They have not walked up hills like their muscles in their legs had not felt hills in like 20 years because they had been in flat yards for all that time. I mean, think of that. (Sara)

Sara provides clinical contextual knowledge while speaking to her experience of working with former lifers. In her clinical example, she discusses how she experienced working with a lifer on her caseload and the impact his experiences had on her. She reflects on having to come to better

understand experiences that are unique to former lifers that impact their presenting concerns like anxiety.

> A lot of fear of being in spaces with other people, so those lifer individuals would instead of waiting in the waiting room where everyone else was they would position themselves outside or near the way in and way out. I actually had a few of these individuals [lifers]. Surprisingly they were really sensitive to light, so they always wear sunglasses and some of them even wore sunglasses inside. And that's like a coping mechanism too because they didn't want to make eye contact with anybody else. But also because they express the light sensitivity. It's interesting. Yeah. And one of the fears in using public transportation was that someone from their previous life would come after them from previous crimes. Oh, yeah and you know all the classic symptoms, some hyper vigilance, flashbacks, and nightmares about three to four times a week, if not daily. Startled response, very jumpy didn't like to be in the therapy room with their backs against the door. They really wanted to have like an open view of everything was where they were so that things, like if the door was behind them, they would want to be like diagonal to the door. If the blinds were closed, they would want the blinds open so that I could see outside and they would really avoid being around other people -anybody that could be close to them or anyone that could get into conflict with, so they really avoided talking to anyone on the bus when they were coming into clinic. (Kate)

Kate explores what symptoms she noticed in her clients who were former lifers that were different from other reentry clients. She notes specific differences and highlights the clinical constellation of symptoms included in the Post-Incarceration Syndrome while discussing her

clients. Kate's examples add contextual richness to the meaning she made of her former lifer clients and their presentation of PICS symptoms.

OCD

> So lifer OCD is like... you have your own space that you had for a very long time. And whether or not you've had your own cell or you've had a celly that is also lifer, space becomes very important. So, a conflict that comes up a lot in here [therapy sessions] and there in residential treatment, which can be pretty, sometimes can get like scary is the clash between guys that are coming off the street versus guys that are coming out of long, long-term incarceration because space is so important to them[lifers]. Like, if I really were to get into it, I think that, you know, with some lifer it's probably been causing him some problems because he's in that adjustment, it's probably going to be very difficult, where he can't control his space because now he's back into shared spaces with people with different experiences. I definitely noticed a pattern with multiple guys [lifers] where it was just like space was very important to them. That's the way I thought about it as like lifer OCD, but it kind of, it's like a pretty intense, like if it's been going on 20 years that's sort of pervasive. But just like having to have things perfect in their living spaces. (David)

David presented a unique clinical presentation he experienced while working in outpatient and residential spaces with former lifer clients. David refers to "lifer OCD" as a fixation on space and physical surrounding that other participants did not include in a similar way. While all participants focused on former lifers' experiences of their surroundings and spaces like the bus. They also included symptoms of OCD in former lifers. David's clinical experience also included

an obsessive or compulsive way that lifers wanted to have their living spaces organized and the interpersonal conflicts it caused many of them.

> He had PTSD, but also had some OCD tendencies that would pick at his mustache when he felt really uncomfortable, which is a something he developed when he was in prison as a coping mechanism. So, he developed some trichotillomania as a way to kind of cope with PTSD symptoms, which then became very compulsive. (Kate)

Kate reports other ways in which she experienced working with lifer clients who had developed traits of OCD and how she understood it to relate to managing anxiety. She does not highlight the same fixation that David reflects on, but she also explores more unique experiences of working with clients with obsessive and compulsive tendencies.

Superordinate Theme 5: Treatment

This superordinate theme focuses on what types of treatment each provider utilizes in psychotherapy. Each provider reports having a different theoretical orientation; however, many use similar (a) treatments and focus on treating symptoms of anxiety, depression and PTSD. All participants reported including a focus on (b) social support while working with lifers. Participants also reflected on what it was like for them to adapt to working with this population. With special consideration paid to (c) the lack of training or specific training each mental health professional had.

Treatment Utilized

> I was helping out with the coping with stress triggers group that was an interest of mine, trauma education and psychoeducation. Trying to empower people with information about what's going on with trauma responses fight, flight, freeze and when you're triggered. When if people understand it, it's really helpful. So, I found that knowledge

> that's, maybe perhaps just a bias that I have, because it's an interest that I have. Just in general, educating people about that was really helpful giving them that knowledge to try to start to begin to understand it as a first step to learn how to manage it. Um, so that was something that I really leaned into. I was getting into the DBT stuff then, but I wouldn't say that I was using it heavily, heavily with lifers in the beginning of my work with them. It's a similar idea was like that educational skills piece. Yeah, at the time I think it was, it's like being there and being consistent. Yeah, real a reliable source and factor in their like pretty chaotic life. That was probably, you know, not all that I would do now. But perhaps you know just as important. Maybe I'm too self-important now about the knowledge and skills that I do have, we have a lot of information and research in our field to say like actually, those common factors are what matters most. (Claire)

Claire reflects on how she focused most on common factors in her treatment while working with former lifers and on providing psychoeducation and trauma-informed care. Throughout her interview, Claire focuses on the quality of the therapeutic relationships that she had with her former lifer clients. She also expanded on how gaining more clinical experiences and training shifted the work that she does with clients now.

> Well, I guess, because a lot of modalities really are technique based, and they're not theory based, and this isn't a group that, none of these things have been normed on lifers. I guess I'll just answer it by way of example, so I was seeing this one guy for a while. His crime was pretty horrific, and he got out after almost five decades in prison and was really struggling to move through the world you know, in terms of crowds and people moving too quickly, all that kind of PTSD stuff. Um, but he was also really struggling with being free and tolerating being free because when he was in prison, he found some

> solace and being punished for what he did. So, it sort of contained his guilt. And then when he got out his, his guilt was not contained and it also was just like having to revisit his commitment offense, in a way, in terms of, you know, thinking about his own deserving this of being out. It was pretty complicated. And, um, when we began to work, kind of like clinically on his crime… and he said to me about his years of like working with therapists on the inside, about this commitment offense. He said, it's like they can't get into it or they can't get off of it. And it was such an interesting way to capture his experience was that people either wanted to like talk to him about the moment of the commitment offense and like saw that as like the center of his subjectivity, from which everything else was coming from, like a trauma kind of you know that there's this instinct to try and like get to the center and then his other experiences or that nobody went near it, because it was just so dreadful. And so, he expressed to me finding help in our relationship and that he felt like I was able to hold for him, like all of him in a way. You know what I mean. And I think that that kind of like… you know, is this sort of like being able to contain everything and being able to sort of continually expand your capacity as the clinician to contain all of it, instead of like your container is as big and things fit, or they don't. (Sara)

Sara focuses on her understanding for the need for containment of former lifers' experiences while in treatment. She moves away from discussing specific interventions because they are not normed on the former lifer population and instead discusses clinical material that is more representative of how she understands and conceptualizes the need for a therapeutic relationship that the client feels as holding and containing.

> I would a lot of CBT and mindfulness specifically like coping with anxiety as it came up. There was also a lot of psycho education about PTSD and anxiety but also like very concrete grounding strategies to be able to bring down the anxiety level in the moment. Being able to find like coping mechanisms. One patient with PTSD, severe anxiety symptoms, they would do like calming mindfulness exercises, we will do meditation, we will do mindful eating… and I had to spend the good majority of sessions just starting off with a grounding technique and kind of ending with the grounding technique so that the patients will feel safe in the session. (Kate)

Like other participants, Kate discusses her focus providing psychoeducation and trauma-informed care. Kate also highlights her use of CBT and mindfulness-based interventions. This is unlike Sara's response of not noting specific interventions. It also provides more details of what she found to be specifically helpful while in session with former lifers.

> I typically work from like ACT and DBT and I think that it generally, those things have been helpful. But I think that sometimes there's just more rapport building that needs to happen. And I felt like a lot of the guys are pretty receptive to doing mindfulness exercises. So again, the lifer guys are often much more open to doing things like that. They are a lot less guarded about maybe trying weird things like they're like, "okay, I'm willing to try a mindfulness exercise" like they're very open to that. I feel like one of the reasons why ACT is really useful, is like okay, so if I'm hitting a dead end with this thing, then I can pivot to another area. So, like if this guy is having a hard time being willing to, like, get in touch with his physical sensations or something then like let's not. If he doesn't yet have like the willingness to do that or capacity or whatever. Then we can work on values, or we can work on goals. And then if we talked about goals and we can

> get to values. And then if like that seems like something's coming up for him… There's just a lot of flexibility for like what I can do. So, and then the person like has a bunch of shame and it can be like, alright, so let's work on some acceptance and self-compassion stuff. So, there's like a lot of room to move that's good with lifers. (David)

David explores why he uses ACT interventions and how he has found them to be helpful when working with former lifers on his caseload. David also discusses the different interventions within ACT that he uses with former lifers. David's treatment interventions differ from other participants but also reflects and overarching need to treat the patient in ways that meet their current needs. This is a way of adapting treatment to a client's needs and presenting concerns, instead of imposing treatments onto patients.

Social Support as Part of Treatment

> Another thing since I have been working with long-term incarcerated guys, is a big part of it [treatment] as sort of assisting them with getting back in contact with family. Or just to kind of A little bit of like hand holding through that process because there's like a lot of shame involved. There's a lot of avoidance, fear of rejection, anger about like family not calling, not getting in touch for many years and then that process of like reaching out like I remember how difficult it was like, how do we even do that? What do we do? (David)

David's comments about connecting with social support and family were reflected throughout all of the participants' interviews. David notes that helping former lifers establish social support and reconnection with family or a support system. David discussed the importance of reestablishing social supports for his former lifer clients.

> Lifers had a lot more difficulty with coming out and having to figure out technology and trying to use technology to reconnect with family members. So, like not having people around that could help them with figuring this stuff- just overall like the general technology not really understanding what internet was, understanding like how to access things on the internet. (Kate)

Kate focused on how important it was in her clinical work to help former lifers establish a support system and familial support. While David included the psychological barriers that former lifers have while trying to reconnect with family, Kate also includes the lack of understanding some former lifers had with technology that was a barrier for them to be able to connect or create their social support system.

Lack of Training

> I think one of the difficulties as a professional that I found as well, is we don't have trainings on working with lifers. There is possible understanding to like institutional experiences that might contribute to the development of PTSD. But I think in terms of like actual interventions and clinical work for former lifers. It was really difficult to find anything on exactly what to expect. I don't think there's enough training, specifically geared towards individuals who were formerly incarcerated for long periods of time, or life. That education and knowledge has been difficult to access. It's been very difficult finding adaptations to treatment specifically for former lifers. Yeah, and I think it's also very fragmented like parole has some services, but I don't really know exactly like what the former lifer groups really were. (Kate)

Kate reflects on her experience of not getting training or education that could prepare her prior to working with former lifers and her struggle to find information and training that was appropriate

for this population. She also discussed having to adapt treatment to former lifers throughout her interview.

> So, I should look into this again now, because there wasn't anything like additional training or education, I mean when I started working with lifers. I didn't really understand that my first year [working with lifers] and then in my first, few months, like, oh, so just knowing that long-term incarceration is traumatic and that like there's a different kind of trauma, whether not every guy would fit the criteria for PTSD, as it is in the DSM or not. (Kate)

Like Kate, David discusses the lack of training and education he received prior to working with former lifers. David discloses his experience of gaining more clinical exposure to the former lifer population and learning about how he understood the impact of traumatic events on this population.

> Yeah, I remember getting some articles. I remember a lot of it being real time learning while with clients. We did do like DBT training, that I thought was actually very good for working with lifers. Yeah, but that was not specific to, you know, post incarceration populations. I don't think that there was, I don't know. If I'm being completely honest, I don't really remember them being specific to that or post incarceration syndrome. (David)

In a similar way, David disclosed feeling as though he was learning more about clinical presentations of former lifer clients Claire had the same insight and noted limited and not specific trainings geared towards lifer reentry populations.

Superordinate Theme 6: Systemic Racism and Cultural Dynamics

When asked by the researcher to reflect on topics that were important to the participants, but not yet discussed in the interview, every participant described their understanding and views

on (a) the gap in resources and barriers that get in the way when it comes to meeting more of this subpopulation's needs. Participants discussed the lack of proper programs for this emerging subpopulation. Participants discuss (b) the systemic factors that impact this population. Participants reflect on the fact that lifers should be included and involved in more of the conversations that focus on their reentry needs. Finally, participants also disclosed their personal beliefs on mass incarceration and the prison reform movement in California.

Population Specific Needs

> So, like when guys get out of prison, they can get support this way, and there would be guys that had been out for a year or two that could sort of like, help them out and help them. You know, to, like, figure out how to work a cell phone. How to like to use a dating app. You know, like basic stuff like how to get in contact with your family. And I think that some of that stuff is done at Parole, but I know there isn't a good system for that. And I feel like I think the problem is probably you know, maybe funding and then I, you know, I feel like maybe people probably get out of prison and then they, once their life gets on track, they're like, wow, I'm done now, I'm moving on. And so, it's probably just kind of like keeping people engaged in that world is hard and maybe and they're probably under resourced, so they're not getting support if they wanted to start that kind of program. I'm sure some of those programs do exist, but I just don't know about them. But yeah, I mean, as it is, I feel like people end up, some guys have a long history of substance abuse, but I think some of them just kind of end up being in substance programs because that's where the support is, that's where the funding probably is.
>
> I don't feel like strong programs really exists for that specifically you know, I mean, I think that a lot of guys here [residential substance abuse program] do get a lot of support.

> In the program that I work in, but like, I'm not aware and then there's like a housing program and I don't know what that program is like, I have no idea. I don't know what's going on there. Yeah. (David)

David reflects on the specific difficulties that he sees while working with the former lifer population. He notes that other former lifers do tend to support each other but that from his understanding a lack of funding and centralized program for this population is problematic. David also has the same confusion about programing and funding that other participants expressed as well. Participants also comment on the gaps in resource this population would benefit from.

> It's, you know, because our, our healthcare system is not necessarily like directly working with paroles very difficult to get to have continuity of care. But yeah, a lot of Googling, a lot of adapting practices to incorporate some meaningful aspects of like the transition in the salient problems are the, what are the individuals were experiencing when they came out. So yeah, I was doing a lot of Googling. (Kate)

Kate's closing comments mirror the sentiments of other participants as well in that they focus on how the medical side of mental health treatment does not support this population well nor does it provide the same support and continuity that David discusses. Kate discusses the difficulty that lies between parole supportive care and care provided within medical systems taxed to meet the mental health needs of this emerging population.

> The people that we're seeing in California in reentry, who are lifers are extremely resilient like these are people that have managed to not kill themselves, have managed to stay sober and still have some sort of hope. Despite going to the board like 20 times and getting rejected for no reason except politics, while everybody told you it was for

> something else. I mean, they're extremely resilient… I think there's a lot to be learned from the people who figured this out [lifers], out of desperation to repair a part of themselves, you know, and that really gets underestimated like people who have been serving life sentences. Many of them [lifers] had no reason to change, except that they didn't want to live with what they saw in the mirror, all the time and they figured out, even in this really inhospitable environment… So, I think there's a lot to be learned from lifers. I feel like if somebody would just like go in there [federal prison] like collect up like all the things that everybody's figuring out, you could probably find common factors and like build something around that. You know what I mean, but I think the people that are really having to live with this have a lot to teach us about how [to] hold that, you know. (Sara)

Sara explores what she understands about the former lifer population in California, and she also notes that there are specific needs this population has when it comes to reentry services. Like David, she notes the need for former lifers to be included and considered in how to better meet the needs of this emerging subpopulation.

Systemic Racism, and Cultural factors and Mass Incarceration

> Yeah, and one of the things to that I'm thinking about with the lifers in particular who were in sure like three strikes you're out- nonviolent crimes. Like spent 30 years of their life in prison, like for having some drugs that are like possibly legal now. Yeah, like, to me, that's almost like grounds for reparations. Like, at the very least we should be providing like some transition, like better stable transitional housing and like job vocational training. you know therapy support and like anything that would help. Like, at the very least, but to me it's like also in some of those instances, like you know I don't

> want to downplay the fact that some people like committed crimes and like deserve time. (Claire)

Claire notes the cultural and systemic factors that she believes impacts the nonviolent lifer population and supportive care that is provided to them by parole and other systems of care. She discusses that although many former lifers had violent committing offenses, they should be provided with more comprehensive reentry services if they are going to be provided with parole through Proposition 57.

> I think mass incarceration is a giant project of identification defense in this country. Like, I think that it's all countertransference kind of and like if we could bare kind of identifying with people we probably wouldn't need to do this. You know what I mean. So, once you find yourself in the system like the only way that you can help somebody do something different is if you can figure out how to like to tolerate really knowing this stuff and it's hard. I mean, it is not easy. You know, like, people have done perfect things and have had horrific things done to them like it's really, it's challenging, but I think, um, I just think that that's like so crucial to really being present with people. (Sara)

Sara's focus on mass incarceration also provides this study with more insight into how participants think about the clinical landscape they work in and the larger cultural factors that impact what prison reform policy they believe is possible.

CHAPTER V

Discussion

This research study explored the lived experiences of mental health professionals who provide psychotherapeutic services to men formerly incarcerated for life sentences. This analysis identified six superordinate themes and multiple subordinate themes, which provided added contextual depth. Results provided an understanding of the constellation of symptomology, treatment interventions and participants' understanding of the specific needs of this unique subpopulation. Results also provided the researcher with a lens into provider-specific impacts that shape clinical implications. This included the need for providers to be deeply self-reflective, adaptable to population and individual needs, and culturally humble. Participants reported that mental health providers working with this population should have the capacity to provide trauma-informed care.

Superordinate Theme 1

The first superordinate theme identified in data analysis focused on identities that participants reported as having an impact on their lived experiences. Participants discussed how they understood the ways in which race, gender and other shared or cross-cultural identities impacted their clinical interactions with former lifers.

Clinical Implications

All participants explored how it was important for them personally and professionally to think about how their presenting identities, personal bias or beliefs are a part of their subjective experience. Participants also discussed with the researcher how these identities shape the subjective experiences. In many ways, the process of self-disclosing their identities was understood by the researcher as a humanizing experience that called for acknowledgement of

their humanity and demonstrated a strong self-reflective capacity. This process of initial self-identification made it possible for participants to then reflect on their understanding of their client's identities. This sense of holding and being accountable for larger contextual understandings and subjective experiences is also seen in the second theme presented in data analysis.

Superordinate Theme 2

The second superordinate theme demonstrated how participants conceptualize and understand the former lifer subpopulation they work with. All participants highlighted (a) the need to understand the individual they were working with within their lived experiences (b) the lifer's access and ability to engage with psychological services while incarcerated (c) the role of Parole Boards and the impact they have on lifers when compared to other reentry populations, and (d) the high prevalence rates of exposure to traumatic events in childhood or prior to incarceration.

Clinical Implications

All participants explored the need for mental health professionals working with this population to be able to account for the impact of larger systemic and organizational factors that impact former lifers. It is in a similar manner that they suggested the need for providers to approach individuals in treatment from a trauma-informed lens. This reflected participants' understanding of the pervasiveness of trauma and the need for providers to remain responsive to Complex PTSD.

Superordinate Theme 3

The third superordinate theme focused on participant's subjective experiences of their therapeutic alliances with their clients. Throughout interviews, participants reflected on what it

was like for them to engage in therapeutic relationships with specific clients and the larger clinical subpopulation. Participants noted the experience of (a) reckoning and coming to terms with the history of their clients (b) therapeutic rupture and repair (c) the quality of their therapeutic alliance and (d) countertransference that is specifically relevant when working clinically with this subpopulation.

Clinical Implications

Participants' responses demonstrated the need for mental health professionals to approach former lifer clients from a position of cultural humility, respect and authenticity. The results suggested that providers need to be actively engaged in meaning-making processes so that they can develop a deep sense of empathy for, and understanding of, their clients. Participants also discussed how treatment outcomes were positively impacted by strong therapeutic alliances.

Superordinate Theme 4

The fourth superordinate theme focused on presenting symptomology of former lifers and men who have experienced long-term incarceration. Subordinate themes provided deeper richness into participants' clinical experiences working with former lifers and the meaning they made of their experiences. Subordinate themes included (a) working with lifers who experience symptoms of PTSD (b) Post-Incarceration Syndrome and (c) symptoms of obsessive-compulsive disorder. The excerpts of clinical material provided insight into the subjective experience of mental health professionals who work clinically with former lifers.

Superordinate Theme 5

The fifth superordinate theme demonstrates participants' experiences of treating former lifers' symptoms while understanding more unique needs lifers may have while in treatment. This included subordinate themes of (a) treatment utilized and (b) the need to include social

support while considering treatment needs of this population. Finally, all participants focused on (c) the lack of training provided while working with this subpopulation.

Clinical Implications

Mental Health professionals' experiences of working with formerly incarcerated lifers and men who have experienced long-term incarceration is not included in any current research. The treatment interventions and modalities that mental health professionals utilize while treating this population are not represented in any current literature. The strength of exploratory Phenomenological Interpretive Analysis (IPA) in this study is clearly demonstrated throughout the fourth and fifth superordinate themes.

The results of this study produced novel findings on how participants understand the mental health symptoms of their clients and what treatment interventions are currently being utilized. Exploratory research made it possible to gather meaningful and descriptive participant responses that include subjective understanding. Participants note what treatment interventions they find to be effective while treating former lifer clients. Participants also reflect on what it was like for them to adapt and shift treatment to meet the needs of this population. Participants all note the lack of population-specific training they received prior to treating former lifers. Participants explore the overwhelming need for future research, adaptation of treatment interventions and modalities for this emerging subpopulation.

Superordinate Theme 6

The sixth superordinate theme contains participants understanding of systemic and socio-political dynamics that participants find relevant to their clinical work with lifers. This included subordinate themes of population specific needs (a) and (b) systemic, cultural factors and mass incarceration.

Clinical Implications

While exploring clinical experiences, participants all frequently discussed the impacts of systemic racism and oppression on this subpopulation. Participants spoke to the dynamic ways that systems impact this larger population and individual clients. Participants noted a gap in reentry services that meet this population's needs. Many participants noted how a lack of reentry-specific services and confusion around services impacted their clients. Finally, participants frequently spoke to the disconnect between mass incarceration and cultural shifts towards prison reform without providing more stable transitions for individuals undergoing reintegration.

Strengths and Limitations

This study was exploratory in nature because of the lack of existing research that focuses specifically on this large emerging reentry subpopulation in the San Francisco Bay Area. By conducting exploratory research, this study gained a deeper understanding into what mental health providers experience while working with former lifers as well as how they understand their subjective experiences of their clinical work. This dissertation study opens the door for future research to be more targeted in nature and potentially treatment-outcome oriented. It was important for this research to gain a better understanding of the clinical landscape and experiences of providers as it moves future research forward. This dissertation also provides insight into an emerging phenomenon as Proposition 57 continues to make it possible for former lifers to be released on parole in the state of California. Participants had diverse clinical experiences and many worked for different agencies or in multiple different settings providing psychological services to the former lifer population. Participants were also selected because of

their experiences in the San Francisco Bay Area, which is known to be a reentry hub for parole for former lifers.

A limitation of this research study was the small sample of participants (N = 4). While this is an appropriate sample size for an IPA research study, it is in no way exhaustive and calls for additional research focused on gathering more provider experiences with this population. All participants reported using many of the same treatment interventions and modalities. However, each participant reported having a different theoretical orientation. This is reflected in the research results excerpts and could be considered a potential limitation in this study.

Implications and Recommendations for Future Research

This research study brings attention to this extremely under-researched and discussed area of clinical work and clinical population. Future research should include larger sample sizes so that results may be more generalizable across the state of California. Future research could continue to focus on diverse sampling so that results continue to be generalizable while this continues to be an under-researched and discussed emerging clinical subpopulation.

It would also be beneficial for more research to focus on individual organizations and clinical staff so that research can target best practice standards for the former lifer subpopulation. It is possible that future research could provide data needed to produce more specific trainings to mental health professionals that work with the former lifer population. Participants in this study discussed the need for more training in working with former lifers and training that is more specifically targeted at PICS clinical presentation. Participants also discussed the need for former lifers to be considered in future research and in all needs assessments.

Conclusion

With the passing of Proposition 57 in the state of California, there is an emerging subpopulation of men who were formerly incarcerated for 25 or more years entering reintegration services. In the San Francisco Bay Area, many of these individuals receive mental health care services provided by community mental health and CDRC organizations. Research suggested that individuals experience Post-Incarceration Syndrome (PICS) after being released from 25 or more years of continuous incarceration. However, there is no pre-existing research on the treatment of PICS or the psychotherapeutic treatment for formerly incarcerated lifers in the State of California.

This exploratory research study contributes a novel, context- specific depiction of the subjective experience of mental health professionals who provide services to this unique reentry population. This research provides insight into how mental health professionals understand and relate to this emerging subpopulation. This research study also identifies what treatment interventions are being utilized and the clinical features participants report impact treatment outcomes. This exploratory research study provided foundational understanding of mental health professionals experiences of providing treatment to formerly incarcerated lifers. This research makes it possible for future research to expand on existing themes and focus on more specific topics like treatment efficacy.

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Appendix A

IRB Forms

APPLICATION FOR IRB REVIEW OF NEW RESEARCH INVOLVING HUMAN SUBJECTS

Complete the following form and upload this document to the online IRB system in Mentor. In addition to this application, you will also need to **upload any survey/interview questions and informed consent documents for your protocol.**

1. RESEARCH PROJECT DESCRIPTION

Provide, in lay terms, a detailed summary of your proposed study by addressing each of the following items:

Clearly state the purpose of the study (Usually this will include the research hypothesis)

The project that I am proposing is an exploratory study about the clinical presentations of men who have been continuously incarcerated for 25 or more years and who were recently released based on California legislation Proposition 57. This study will examine clinical treatment approaches that are currently being used by mental health professionals working with this population. Specifically, this research will identify which treatment modalities are most commonly utilized by mental health providers working with this subset of the re-entry population, as well as important implications for better understanding the clinical needs of this emerging group. This clinical dissertation aims to explore and qualitatively analyze the subjective experience of mental health professionals with clinical experience working with men who fall into the aforementioned category. Specific themes that will be explored include mental health clinicians' knowledge of: (1) clinical presentations within this subculture; (2) treatments currently being utilized in a community setting; (3) available tools, education and resources informing mental health providers' work with this population; (4) the potential need for development of additional trainings to bridge the gap between the specific clinical needs of this distinct subculture and community providers; and (5) policy changes and prison reform that will continue to escalate the need for clinicians to provide culturally competent care that are reflective of best practices for this distinct population.

Background (Describe past studies and any relevant experimental or clinical findings that led to the plan for this project)

Research, literature and pilot studies clearly identify the need for mental health professionals who provide psychotherapy services to individuals in reentry populations, especially considering the increasing numbers of individuals being released on parole in the state of California after prolonged and long-term incarceration. The impact that the Affordable Care Act will continue to impact and shape community mental health care settings and community mental health organizations as this legislation provides access to mental health care services for new and emerging communities. The existing literature suggests a need for improved culturally competent care with special considerations for reentry populations. The emergence of lifers and individuals with long-term incarceration histories in community mental health settings calls for more research and understanding regarding clinical best practices and implications of care for individuals with post-incarceration syndrome. Conducting a reasonably exhaustive search and review of literature in the forensic and community mental health fields, within California legislation and prison reform materials, and across future implications of current public health policy and implication further demonstrates the need for further research. Literature is underdeveloped in areas such as: emerging reentry populations who have completed long-term and prolonged continuous incarceration, the clinical presentation of lifer population, training for clinicians working with the reentry population particularly the lifer population most likely to suffer from PICS and complex trauma, clinical best practices and rational for interventions and implementation of interventions.

Review of the relevant literature related to and focused on the topic of this clinical dissertation research project found that the bulk of the literature focused on the historical and sociological events that have led to the emergence of the lifer subpopulation within the reentry populations. Rather than on the specific treatment needs or provider needs in treating this unique population.

Research plan (Provide an orderly scientific description of the intended methodology and procedures as they directly affect the subjects)

Interpretative Phenomenological Analysis (IPA) has been chosen by this researcher because this project involves an exploratory and descriptive analysis of narrative data to better understand the clinical perspectives of mental health professionals working with formerly incarcerated lifers now experiencing reentry into society. Qualitative analysis will allow this researcher to engage with the deeper levels of meaning and understanding that participants experience while working clinically with men who have been continuously incarcerated for 25 years. Qualitative analysis will allow the researcher to explore clinical practices and education that will add to an area of lacking limited clinical research and promote the dissemination of best practices in the treatment of this significantly underserved population. This clinical dissertation research study will include

between 4 and 6 participants. This sample size should provide adequate cases for development of meaningful points of similarity and difference between mental health professionals and highlight trends in treatment modalities utilized. Consistent with qualitative paradigm, and with IPA's theory and methodology this study will purposely select samples. Sampling will be done this way so that the participants are selected on the bases that they can provide the study with their subjective perspectives on the phenomena of working clinically with this unique population. Participants will be recruited through known community mental health organizations, and organizations that provide re-entry services including mental health services to populations being released by the California Department of Corrections and Rehabilitation. Study participants will be mental health professionals licensed in the state of California, who have a minimum of 3 years of clinical experiences working with men who have been continuously incarcerated for 25 or more years. Exclusion criteria include non-English speakers or individuals who are not fluent in English. Semi-structured interviews will be scheduled for 90-minutes and will be conducted in-person or over a virtual meeting platform (i.e., Skype, Zoom). Prior to interview initiation researcher will review informed consent with participant and briefly mention interview agenda.

Consistent with IPA research methods, researcher has created an interview schedule to serve as an interview guide. The aim of an interview schedule is to facilitate a comfortable environment for each participant, which will allow them to provide clear and detailed accounts of their experiences under investigation. Questions are open and expansive so that participants can provide narrative and descriptive responses. Interviews will be audio recorded consent regarding audio recording will be obtained from all individuals who participate in this study. All interviews will be transcribed and coded, an exploratory coding system will be applied to explore themes from the interview material. Interview themes will be further organized into clusters.

An initial list of interview questions has been developed (included documents) and will be piloted with an individual who is not one of the study's participants, with the goal of subsequently re-wording, or eliminating questions to facilitate the most impactful interviews. The procedures created for the study will remain the same and measures will be taken to protect the confidentiality of personal information. This pilot study will serve to assess the quality of the questions in generating useful qualitative data, and help the researcher better predict how interview questions may impact participants.

Give the location(s) the study will take place (institution, city, state, and specific location)

Participants will be asked to participate in an interview and will need to meet in person or have the capacity to participate in an online platform like Skype or Zoom. In-person interviews will take place in the San Francisco Bay Area. Each interview will take place in a location that is professional, private, and comfortable to the interviewee regardless of if they take place online or in-person.

Duration of study project

This study intends to be completed by the summer of 2020. This includes data collection and analysis. All data collection (interviews and piloted interview/beta test) will be collected in June, July and August of 2019 and data analysis will begin in September of 2019 and will be completed by February of 2020. The total duration of this study is projected to be approximately 9 months.

2. PARTICIPANTS

2(a) Participant Population and Recruitment

Describe who will be included in the study as participants and any inclusion and exclusion criteria.
Participants in this study must be licensed mental health professionals in the state of California who identify as having 3 years of clinical experience working with adult men who have been continuously incarcerated for 25 or more years and have been released from prison on parole. Participants must be fluent in English, since qualitative research relies heavily on language and important material could get lost in translation.

What is the intended age range of participants in the study?
Participants in this study must be at least 21 years old.

Describe how participant recruitment will be performed.
Participants in this research study will be recruited through a combination of professional networking within community mental health organizations and by referrals from programs and providers in relevant and purposeful(snowball) sampling.

Do the forms of advertisement for recruitment contain only the title, purpose of the study, protocol summary, basic eligibility criteria, study site location(s), and how to contact the study site for further information? ☒ Yes ☐ No
*If you answered "no," the forms of advertisement must be submitted to and approved by the IRB prior to their use.

2(b) Participant Risks and Benefits

What are the benefits to participants in this study?
There are no immediate benefits for participants in this study. Researcher hopes that interviews will facilitate a space for mental health providers to talk about meaningful and important clinical work and experiences.

What are the risks (physical, social, psychological, legal, economic) to participants in this study?
No form of deception will be involved in this study. There is little to no risk involved in participating in this study. This study is voluntary and will utilize interview questions that has been tested and piloted on an individual who is not included in the study.
If deception is involved, please explain.
There is no deception involved in this study.

Indicate the degree of risk (physical, social, psychological, legal, economic) you believe the research poses to human subjects *(check **the one** that applies).*
☒ MINIMAL RISK: A risk is minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.
☐ GREATER THAN MINIMAL RISK: Greater than minimal risk is greater than minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. **If you checked "Greater than Minimal Risk",** provide a statement about the statistical power of the study based on intended sample size, design, etc. to test the major hypotheses)

2(c) Participant Compensation and Costs

Are participants to be financially compensated for the study? ☐ Yes ☒ No If "yes," indicate amount, type, and source of funds.
Amount: Source: Type (e.g.,. gift card, cash, etc.):

Will participants who are students be offered class credit? ☐ Yes ☐ No ☒ N/A

If you plan to offer course credit for participation, please describe what alternative assignment(s) students may complete to get an equal amount of credit should they choose not to participate in the study.

Are other inducements planned to recruit participants? ☐ Yes ☒ No If yes, please describe.

4. CONSENT

4a. Informed consent

Do you plan to use a written consent form that the participant reads and signs? ☒ Yes ☐ No

***If "no," you must complete Section 4b or 4c below.**

If "yes," describe how consent will be obtained and by whom.

All consent forms will be reviewed and signed by each individual who chooses to participate in this study, prior to the interview.

If the participants are minors under the age of 18 years, will assent forms be used? ☐ Yes ☐ No ☒ N/A

If "no," please explain.

Upload to the online IRB system the consent form(s) that the participants and/or parent/guardian will be required to sign, and the assent forms for children under the age of 18, if applicable.

Note: All consent forms must contain the following elements (quoted directly from Office for Human Research Protections regulations, available at: http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm#46.116. The University of San Francisco IRB has consent templates containing all required elements, **and we strongly recommend you use these templates**.

If you believe it is important to create your own consent form, you are free to do so but please ensure that your consent form has each of the following elements and indicate you have done so by checking this box:

☐ I have chosen to create my own consent form and have ensured that it contains the 8 essential elements listed below:

(1a) A statement that the study involves research, (1b) an explanation of the purposes of the research, (1c) the expected duration of the subject's participation, (1d) a description of the procedures to be followed, and (1e) identification of any procedures which are experimental;

(2) A description of any reasonably foreseeable risks or discomforts to the subject;

(3) A description of any benefits to the subject or to others which may reasonably be expected from the research;

(4) A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

(5) A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

(6) For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

(7) An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject; and

(8) A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled**."**

4b. Waiver of documentation of written informed consent (Complete only if answered "no" to 4a)

The regulations allow instances in which the IRB may waive the requirement for documentation of informed consent, that is, the collection of a signed consent form. If you are requesting a waiver of written documentation (signed) of informed

consent, please answer the following questions:

Will the only record linking the participant and the research be the consent document and the principal risk to the participant would be from breach of confidentiality? ☐ Yes ☐ No

Do you consider this a minimal risk study that involves no procedures for which written consent is normally required outside of research (see 2B above for definition)? ☐ Yes ☐ No

Explain why you are requesting waiver or modification of documentation of written (signed) informed consent and how you plan to obtain consent.

4c. Waiver or modification of informed consent (Complete only if answered "no" to 4a)

The regulations also provide an opportunity for the IRB to waive the requirement for informed consent or to modify the informed consent process, provided the protocol meets the following criteria:

(1) The research involves no more than minimal risk to subjects (see 2b above for definition);
(2) The waiver of alteration will not adversely affect the rights and welfare of the subjects;
(3) The research could not practicably be carried out without the waiver or alteration; and
(4) Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

If you are requesting a waiver or modification of informed consent (e.g., incomplete disclosure, deception), explain how your project meets the requirements for waiver or modification of informed consent, as outlined above.

3. CONFIDENTIALITY AND DATA SECURITY

Will personal identifiers be collected (e.g., name, social security number, license number, phone number, email address, photograph)? ☒ Yes ☐ No

Will identifiers be translated to a code? ☒ Yes ☐ No

Describe how you will protect participant confidentiality and secure research documents, recordings (audio, video, photos), specimens, and other records.

All documents, recorded materials, and raw data will be stored electronically and password protected or stored in a locking filling cabinet. All participant information will be coded for confidentiality and to protect participant information and privacy.

Appendix B

Interview Materials

Marker, Laura USFCA ID#20371138

Research Questions:

- What are the experiences of mental health providers who work clinically with the lifer population in community mental health settings? What are implications to care and utilized clinical best practices?

Areas of interest to be explored:

- What is your experience providing psychotherapy to reentry populations?
- What clinical experiences have you had working with lifers in community mental health settings? (Have you provided individual psychotherapy to male lifers? Have you provided group psychotherapy to lifers? Have you provided group psychotherapy to reentry populations that has included lifers?)
- What clinical impressions do you have when thinking about your therapeutic work with male lifers?
- Do you notice any differences between the presenting symptoms of lifers and clients you provide psychotherapy to?
- Do you experience any distinct differences in their (lifers') clinical presentations from other reentry clients you have worked with?
- Are there topics or distinct clinical material that you find relevant to your work with lifers?
- Are there any specific treatment tools, modalities or clinical practices you use while working with lifers? (Why?)
- Are there any specific therapeutic techniques you find to be helpful or unhelpful while providing psychotherapy to lifers?
- Why/ how did you decide to utilize that therapeutic approach?
- Are there any specific barriers to care or treatment that you experienced while working with this population?
- What have your therapeutic relationships been like with lifer clients?
- Are there any specific treatment themes or therapeutic themes or topics you find relevant while working with lifers?
- Has there been any session subject material that has made you reflect on your cultural competency working with this specific group, or even question your competency? What was it and why do you think that was? – *did you do anything about it? Eg, looking up a specific term*
- What in your clinical training do you think has been helpful while working clinically with this population?
- Have you participated in any trainings or educational experiences to prepare yourself to work with this population?
- Have you felt that you needed any additional training or resources to work clinically with this population? If so, have you sought any out? What have you done to feel more competent while working clinically with this population?
- Are there any trainings, educational material or resources you would recommend to another clinician working with this population?
- What have you found to be difficult or challenging while working with this population?

- What have you found to be rewarding while working clinically with this population?