2021

Master's Level Mental Health Counselor Experiences Working With Offenders in Correctional Settings

Jennifer Bernard
Walden University

Walden University

College of Counselor Education & Supervision

This is to certify that the doctoral dissertation by

Jennifer L. Bernard

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Wynn Dupkoski, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Katarzyna Peoples, Committee Member, Counselor Education and Supervision Faculty
Dr. Jeremy Linton, University Reviewer, Counselor Education and Supervision Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

Master's Level Mental Health Counselor Experiences Working With Offenders in Correctional Settings

by

Jennifer L. Bernard

MS, Troy University, 2010

BS, University of West Florida, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

August 2021

Abstract

Forensic mental health is considered a specialty at a doctoral level, yet a majority of mental health services in correctional settings are provided by master's-level mental health counselors. These clinicians lack the specialized education, training, and experience needed to work with offenders in correctional settings. There is limited research on how master's-level counselors experience providing mental health services in correctional settings and how they manage challenges. The purpose of this qualitative study was to understand the lived experiences of master's-level mental health counselors working with offenders in correctional settings. A hermeneutic phenomenological approach was used to facilitate an understanding of the lived experiences of the nine mental health counselors who participated in this study. Data were obtained through semistructured interviews and data was analyzed by reading transcribed interviews, coding emerging themes, analyzing transcripts, and identifying patterns. After data analysis, the following themes emerged: (a) lack of specialized education and training, (b) environmental challenges, (c) institutional culture, (d) competing goals and values, and (e) mental health treatment in correctional settings. The results confirmed that mental health counselors lacked the specialized education, training, experience, and supervision needed to effectively treat offenders in correctional settings while simultaneously managing the myriad of challenges associated with working in a correctional environment. This study promotes social change by highlighting the need to better prepare correctional mental health counselors while considering the need for ongoing support and training to help them manage correctional challenges.

Master's Level Mental Health Counselor Experiences Working With Offenders in Correctional Settings

by

Jennifer L. Bernard

MS, Troy University, 2010

BS, University of West Florida, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

August 2021

Dedication

I dedicate this dissertation to my son, Brayden. My decision to pursue a doctoral degree was made one night praying that I would be able to provide for you so that you would have the opportunity to have a fulfilling life, despite my being a single mother. Although I set out on this path to better be able to provide for you, I learned so much about myself throughout this journey. If there is one thing in this life that I want you to understand, it would be this: *Those who persevere, overcome*. This journey has been slow and arduous, but son, know there is nothing that you cannot overcome in this world despite the many challenges you will face. My hope is that I have made you proud and you forgive me for the time that was taken from you in my pursuit to complete this degree. As I have told you almost every day of your life, you are the best thing that has ever happened to me. I love you to the moon and back, infinity times infinity, more than anything else in this world.

Table of Contents

Chapter 1: Introduction to the Study

Mental health professionals employed in correctional settings are exposed to a wide range of mental health and behavioral disorders rarely seen in other settings (Magaletta et al., 2007, 2013). Mental health treatment in correctional settings is fundamentally different from treatment in the community (Forrester et al., 2014; Wolff et al., 2013). Mental health professionals must have a working knowledge of the complex interactions among biological, psychological, psychiatric, and social factors that contribute to criminality (Bartholomew & Morgan, 2015). Additionally, counselors must understand that safety and security are essential in a correctional setting and that these settings require "a highly trained mental health workforce that is capable of delivering a very wide range of psychological services" (Varghese et al., 2015, p. 4). In turn, the values of many mental health professionals significantly differ from the values within the criminal justice system (Ward, 2014). Inherently, the criminal justice system is a punitive establishment that can be ethically burdensome to mental health professionals torn between their obligations to the well-being of the offenders and their interests in safety and security (Al-Rousan et al., 2017; Lambert et al., 2015; Ward, 2013). Mental health professionals must navigate between these opposing systems when employed in correctional settings.

Chapter 1 provides an introduction to the research study, including the background, problem statement, the purpose of the study, research questions, conceptual framework, nature of the study, definitions, scope and delimitations, limitations, and significance.

Background

Numerous studies have concluded that mental health professionals who are providing services in correctional settings should have specialized knowledge on working with offenders (Ogloff et al., 2015; Varghese et al., 2015; Wolff et al., 2013). Despite this information, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016), which determines the minimum standards for education and training programs, does not recognize specialized education or training for mental health professionals who are employed specifically in correctional settings. The correctional environment can be challenging, ethically complex, and difficult for mental health professionals working in institutions (Ward et al., 2015). There appears to be limited research on the experiences of master's-level mental health counselors working with offenders in correctional settings.

Forensic coursework in a master's-level clinical mental health counseling program is relatively limited. Instead, coursework mostly focuses on general counseling and psychology proficiencies (Burl et al., 2012; CACREP, 2016). There appears to be a deficit in the literature regarding master's-level mental health counselors' experiences working in a correctional setting, and more specifically in how they manage challenges. Training specific to correctional settings is available through national agencies. However, this training is voluntary. A national survey conducted by Bewley and Morgan (2011) sought to examine who was providing mental health services to offenders in state correctional settings. Approximately 49.3% of the participants identified as having a master's degree in counseling or social work while the remainder reported having a

bachelor's degree, medical degree, a doctorate in philosophy or education, or "other" degree. With roughly half of the providers delivering mental health services in state correctional settings being master's-level clinicians, there is concern about how these providers prepare to work with offenders in correctional settings. This study was needed to assess the current status of mental health counselors experiences working with offenders in correctional settings.

Problem Statement

Forrester et al. (2014) sought to identify ways to improve access to therapy within correctional settings. They determined that traditional mental health services applied in community settings were not effective solutions for correctional settings. Inadequacies in treating mentally ill offenders in a prison environment were discussed in a study by Brandt (2012), who identified a convolution of issues that offenders face in correctional settings. Wolff et al. (2013) discussed the complexity of attributes that offenders may possess in addition to mental illness, including substance abuse, antisocial behaviors, and criminal thinking. Crewe et al. (2014) and Galanek (2013) identified intricate emotional structures within correctional settings. Galanek (2013) reported difficulties for clinicians in determining mental illness in the context of offender behaviors in this highly complex environment. Ward (2013, 2014) and Ward et al. (2015) found that mental health counselors are exposed to ethical conflicts and opposing values in their roles as both treatment staff and correctional staff. They noted the dual roles of mental health professionals, specifically the duty to treat the offender and the obligation to maintain safety and security. Lambert, Barton-Bellessa, and Hogan (2015) conducted a review of

burnout in correctional settings and found evidence that correctional staff experience negative consequences of burnout, possibly at higher rates than in other settings. These consequences include, but are not limited to, psychological strain, emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. While Lambert et al. (2015) focused on the personal consequences of burnout for correctional staff, Lambert, Barton-Bellessa, and Hogan (2015) noted that burnout has consequences within correctional institutions due to turnover, absenteeism, and the increased use of sick leave.

Although correctional staff may experience burnout at a higher rate, there is limited coursework specific to correctional settings. The CACREP has not established minimum standards specific for mental health professionals in correctional settings, and post-master's training specific to correctional setting is merely voluntary. It is important to consider the experiences of these professionals working with offenders in correctional settings. Several studies (Ogloff et al., 2015; Varghese et al., 2015; Wolff et al., 2013) have declared the need for specialized knowledge when working with offenders; however, it appears that little is being done to prepare correctional mental health counselors to effectively provide services to offenders. There is also limited research that assesses how clinicians currently provide clinical services to offenders or that provides in-depth views into their experiences. Despite the literature on the challenges that mental health counselors face in correctional settings, there is little research available on their experiences and how they manage these challenges. In this study, I describe the lived experiences of master's-level mental health counselors working with offenders in correctional settings.

Purpose

The purpose of this hermeneutic phenomenological study was to understand the experiences of master's-level mental health counselors when working with offenders in correctional settings. The study addresses the gap in the literature by exploring the current status of counselor experiences in correctional settings. The study also provides an in-depth analysis of the lived experiences of mental health counselors who work with offenders in correctional settings.

Research Questions

1. How do master's-level mental health counselors experience working with offenders in correctional settings?
2. How do master's-level mental health counselors manage challenges when working with offenders in correctional settings, if any?

Conceptual Framework

In this research, I sought to understand the experiences of mental health counselors working with offenders in correctional settings. A phenomenological approach was chosen to allow me to facilitate an understanding of how individuals structure meaning by studying their lived experiences (Kumar, 2012). Of the phenomenological approaches, both transcendental and hermeneutic phenomenology were considered for this study. Husserl's transcendental phenomenology allows the researcher to *define* a phenomenon, while Heidegger's hermeneutic phenomenology allows the researcher to understand the *meaning* of a phenomenon (Kumar, 2012). Heidegger believed that to understand a phenomenon, one must move beyond providing a

description to facilitating an understanding through *being* (Reiners, 2012). This process requires the researcher to be an active participant in interpreting the phenomenon as it presents itself (Large, 2008). The act of "being there" is known as *Dasein* (Davidsen, 2013). They describe *Dasein* as a way to understand *how* things are rather than *what* they are.

Phenomenological understanding follows a circular movement, known as the hermeneutic circle, in which information moves from individual parts into the whole. This whole expands as more information is obtained (Gadamer, 1986). The primary difference between the two approaches is the ability of the researcher to suspend judgment and bias, also known as bracketing, when studying a phenomenon (Husserl, 1962; Reiners, 2012). Through a hermeneutic lens, the researcher can clarify conditions to facilitate an understanding of the phenomenon being studied (McManus-Holroyd, 2007). Assuming a hermeneutic phenomenological lens for this study offered an understanding of how counselors provide mental health services to offenders. This understanding occurs through a blending of understanding between the researcher and participants (Kumar, 2012). Thus, in this study, I sought to understand the experiences of mental health counselors rather than merely describing their experiences. The conceptual framework is discussed more thoroughly in Chapter 2.

Nature of the Study

In this research study, I assumed a hermeneutic phenomenological perspective and provided a comprehensive description of counselor experiences (Finlay, 2012). This approach was appropriate in understanding the actual experiences of the master's-level

counselors (Bevan, 2014), and specifically for obtaining information through their personal accounts of how they provided treatment when working with offenders in correctional settings. Additionally, I sought to understand how mental health counselors manage any challenges that arise. Through this research, I highlighted the unique experiences of correctional mental health counselors. The results of this study describe the lived experiences of mental health counselors and offer suggestions on how to better prepare these professionals for working in correctional settings.

The participants were selected via purposive sampling. I used criterion sampling, as participants were required to be licensed mental health professionals, possess a master's degree in counseling, and have experienced providing mental health services in a correctional setting. Participants were recruited through a counselor education listserv, CESNET, and the Walden Participant Pool. I also used snowball sampling by asking participants to identify others that may meet the criteria for the study. A request for participation in the research study was posted to the listserv for counselor educators. General guidelines for qualitative phenomenological research recommend the sample size be between six and eight participants (Marshall et al., 2013). However, data were collected from participants until saturation occurred. The participants were interviewed via the Zoom videoconferencing platform. Data were obtained through semistructured interviews to reduce bias. The interviews were then transcribed by a Health Insurance Portability and Accountability Act (HIPPA)-compliant organization. Interview questions included but were not limited to the following:

- Please describe your master's-level counselor education.

- Please describe any coursework specific to corrections that you had at the master's level.
- Please describe any post-master's education that you obtained specific to working in corrections.
- Did you have any supervised experience in a correctional setting or working with offenders at either the pre- or post-master's level? If so, please explain.
- Please share any training that you have completed specific to corrections.
- What has been your experience working in correctional settings with offenders?

Data analysis occurred in conjunction with data collection and included reading interviews, analyzing transcripts, writing and coding emerging themes, and identifying links and patterns (Kumar, 2012).

Types and Sources of Data

1. I conducted semistructured interviews with licensed mental health counselors employed in correctional settings using the video conferencing platform Zoom, which is HIPAA compliant.
2. Follow-up questions and transcriptions were emailed to participants to verify the accuracy of their narratives and to address disparities and missing or unclear information.

Definitions

This section includes the definitions of key terms, concepts, or constructs that may have multiple meanings.

- *Correctional mental health counselor*: According to Sun (2013), there are extreme variations in educational requirements among correctional treatment specialists employed in correctional settings. The Bureau of Labor Statistics (BLS, 2015c) does not recognize correctional mental health counselors but does acknowledge probation officers and correctional treatment specialists. According to the American Bar Association (2011), it is recommended that mental health services in corrections settings be licensed in their respective states. This is not congruent with the BLS, which states that correctional treatment specialists only require a bachelor's degree. Job classifications, including title, educational requirements, and job duties, differ between states and correctional facilities, which makes it difficult to define mental health counselors in correctional settings. Henceforth, correctional mental health counselors will be identified as individuals who possess a master's degree and who provide mental health services to offenders in correctional settings.
- *Hermeneutic circle*: In hermeneutic inquiry, the research follows a circular movement in which information comes from individual parts and is then viewed wholly (Gadamer, 1986). The circle continues to expand as more information is obtained.

Assumptions

The meaningfulness of assumptions that have been made is critical to the purpose of this study. I made the following assumptions based on my personal experiences as a mental health counselor employed in a correctional setting working with offenders as

well as from preliminary data obtained in the review of the literature. These experiences prompted me to seek out additional education and training in order to be more effective in treating mentally ill offenders. Assumptions were made prior to conducting research on this study. First, I assumed that master's-level mental health counselors do not have the necessary education, training, or supervision to provide effective mental health services to offenders. This assumption was made in part due to my experience working as a master's-level therapist in multiple correctional settings. In addition, both Brandt (2012) and Gannon and Ward (2014) identified mental health professionals as ill-prepared and ill-equipped to effectively treat offenders in correctional settings. Second, counselors lack knowledge and understanding of correctional and inmate culture and how this influences offender behaviors. Third, little supervision and guidance are provided to help mental health counselors navigate legal and ethical challenges when working with offenders in correctional settings. Fourth, mental health counselors may rely on evidence-based treatment normed for the community, not offender populations. Finally, little emphasis is given to continuing education and training specific to correctional mental health counselors.

Scope and Delimitations

In this study, I sought to understand the experiences of master's-level mental health counselors working with offenders in correctional settings. The literature review focused on how master's-level mental health counselors are educated, current specialties in mental health counseling, standards of care for mental health in correctional settings, intra- and interpersonal challenges for correctional mental health counselors, systemic

issues in correctional settings, and the culture of both prisons and offenders. The specific focus on these aspects of the literature review provides a comprehensive view of the unique nature of providing mental health services to offenders in correctional settings. Because I sought to understand the lived experiences of master's-level mental health counselors, I chose a qualitative phenomenological approach. The following delimitations were included:

- Participants had to be 18 years of age or older.
- Participants had to hold a master's degree in counseling from a CACREP-accredited program.
- Participants had to hold a license as a mental health counselor in their respective states.
- Participants had to be employed, or previously have been employed, in a correctional setting providing mental health services to offenders for no less than 6 months.
- Participants had to speak the same language as the researcher (English).

To minimize extreme variances, participants must have obtained their master's degree in counseling from CACREP-accredited institutions in order to ensure that their graduate training is commensurate with other participants.

Limitations

Qualitative research is not transferable and is highly specific (Lincoln & Guba, 2007). The participants in this study had variations in their educations, experiences, training, the types of correctional settings they worked in, and the specific cultures of

their institutions and offender populations; therefore, the results of the study are not transferable. Data obtained through interviews may be distorted due to participant bias, judgment, discomfort, experiences, or reactivity to the researcher (Patton, 2002). Therefore, I explored observations during the interviews and asked probing questions. Although the participants reported that the correctional environment affected them, none of the participants reported experiencing any discomfort as a result of participating in the study. I discussed preunderstanding about the study during recruitment and data collection through engagement with participants (Creswell, 2013).

Significance

This study has the potential for social change and highlights the need for specialized education, training, or supervision for mental health counselors employed in correctional settings. Educational guidelines at a doctoral level prepare students with the knowledge and skills to effectively treat offenders (Adkison-Bradley, 2013). However, in the national survey conducted by Bewley and Morgan (2011), master's-level professionals provided the vast majority of mental health treatments to offenders in correctional settings. Long-term social change implications may include changes in counselor education and supervision, clinical training for correctional mental health counselors, or continuing education opportunities in correctional settings.

Summary

Mental health professionals employed in correctional settings may experience higher levels of burnout, such as emotional exhaustion and depersonalization; lower levels of personal satisfaction and accomplishment; fatigue; elevated levels of stress; or

vicarious traumatization (Gallavan & Newman, 2013). Correctional professionals are considered to be ill-prepared and ill-equipped to treat offenders with mental health disorders due to the nature of the correctional environment (Brandt, 2012; Gannon & Ward, 2014). Offenders in correctional settings demonstrate "a constellation of problems with different origins, etiologies, and symptoms, often crossing over the boundaries of mental illness, addictions, and antisocial pathologies" (Wolff et al., 2013, p. 9). The lack of counselor education, supervision, and preparation presents challenges for counselors providing treatment for this unique population.

This qualitative study bridges a gap in the literature by providing an understanding of the lived experiences of master's-level mental health counselors working with offenders in correctional settings. Bartholomew and Morgan (2015) stated that mental health treatment in correctional settings should be effective at reducing future violence and crime. However, it was their opinion that correctional professionals did not understand the intricate relationships between mental illness, crime, and violence in offender populations. Having determined that mental health treatment is not sufficient, a question arose about how well mental health counselors are prepared to work with offenders in correctional settings. As aforementioned, CACREP (2016) has not established specialized education for master's-level mental health counselors seeking employment in correctional settings. In addition, there is limited research related to education, supervision, or training for mental health counselors specifically working in corrections. This study is important because it seems that little attention has been given to understanding the experiences of mental health counselors working in corrections or in

preparing counselors to work with offender populations despite the evidence that these counselors face significant challenges.

A review of the literature is discussed in Chapter 2. It includes information on the literature search strategy and conceptual framework and an exhaustive review of the literature regarding the phenomenon in this study.

Chapter 2: Literature Review

> The act of incarcerating an individual convicted of a crime is a punitive sanction that should result in some degree of mental suffering. (Yang et al., 2009, p. 295)

Given the culture in correctional settings, the prison environment does little for the maintenance of optimum mental health functioning (Goomany & Dickinson, 2015). Offenders with diagnosed mental health conditions often find it more difficult to adjust in correctional settings (Blevins & Soderstrom, 2015). Sarteschi (2013) sought to identify major issues and challenges for offenders involved in the criminal justice system and discovered significant discrepancies in the delivery of mental health services, concluding that the criminal justice system in its entirety is not prepared to handle the needs of mentally ill offenders. Similar findings were published in the National Institute of Corrections (NIC) manual by Hills et al. (2004), who found that correctional staff did not possess the knowledge, training, or skills required to treat mentally ill offenders despite legal and constitutional requirements to provide adequate mental health services to offenders. Although the manual was published in 2004, it is the most recent publication on mental health services in correctional settings by the NIC.

Bewley and Morgan (2011) highlighted the importance of this topic in their national survey examining who was providing therapeutic services in male correctional facilities. The survey aimed to identify the demographics of mental health providers, the structure and purpose of mental health services, and the perceived effectiveness of services to offenders with mental illnesses. Of the 229 mental health providers that participated in the survey from 165 state correctional facilities, approximately 10 (4%)

has obtained a bachelor's degree, 77 (33.6%) had obtained a master's degree in art or science, 36 (15.7%) had obtained a master's degree in social work, 71 (31%) had obtained a doctorate of philosophy, four (1.7%) had obtained a medical degree, and five (2%) had obtained a doctorate of education. The remaining 26 (11%) marked "other" as their degree (Bewley & Morgan, 2011). Therefore, approximately 49.3% of the surveyed providers of mental health services identified as having master's degrees as their highest degree obtained. Remarkably, 57% of the participants reported no training in corrections post-baccalaureate, and only 22.9% reported completing coursework in forensics (Bewley & Morgan, 2011). Despite the evidence that mental health professionals in correctional settings should have the specialized knowledge and skill to work with offenders in correctional settings, it appears there is little education and training specific to correctional mental health counseling at a master's level.

The purpose of this qualitative study was to understand the experiences of master's-level mental health counselors working with offenders in correctional settings. The literature review will begin with my attempt to establish a job description for correctional mental health counselors. This will be followed by an outline of educational requirements for mental health counselors employed in correctional settings. A significant body of literature examines critical challenges that face mental health counselors employed in this unique setting, including ethical conflicts, conflicting goals, burnout, stress, absenteeism, turnover, and exhaustion. Additionally, the distinct culture of both prisons and offenders warrants further discussion. Given the need for knowledgeable and skilled mental health professionals in correctional settings, little

attention has been given to how master's-level mental health counselors apply their education and training to clinical practice when working in correctional settings. I hope that this study brings an awareness of counselor experiences, treatment challenges, and potential strategies to better manage these challenges.

Literature Search Strategy

The search strategy involved a review of several databases, including SOCIndex, PsychINFO, PsychArticles, EBSCO, ERIC, SAGE, SAGE Premier 2017, Education Source, and Expanded Academic Search ASAP. Other relevant information from this study was obtained from the websites of organizations including the CACREP, the American Psychological Association (APA), the National Commission on Correctional Health Care (NCCHC), the NIC, the American Correctional Association (ACA), the Federal Bureau of Prisons (FBOP), the National Center on Institutions and Alternatives, and the BLS. Given that there is no clearly defined title for mental health counselors employed in correctional settings, the strategy for the literature review consisted of using various key words and then reviewing the available literature for studies relevant to correctional mental health counseling. After identifying critical articles, I submitted the titles of the articles into Google Scholar and made an additional inquiry of articles relevant to the identified studies. I also reviewed additional articles that were cited by other researchers. Publication dates were not limited due to the lack of available research on the identified topic. However, efforts were made to identify research that had occurred within the previous 5 years. Several studies were utilized that were more than 10 years old in the sections pertaining to theoretical orientation, prison culture, and the convict

code as they are considered seminal works. The following key words were used in the literature search: *prison culture, prison counselor, counselor education and corrections, counselor education and prison, prison and environment, correctional mental health counseling, correctional mental health, correctional counseling, correctional counselor, correctional treatment specialist, rehabilitation counselor, mental health in prison, mental health in correctional settings, CACREP, CACREP and corrections, CACREP and specialties, prison acculturation, prison social climate, prison ethnography, prison culture, correctional mental health standards, mentally disordered offenders, counselor burnout, hermeneutic phenomenology, hermeneutic circle, interpretive phenomenology,* and *Heidegger and phenomenology.*

The Correctional Counselor

Staff who deliver mental health services in correctional settings do not have a standardized job title. Examining the job requirements and duties of mental health counselors employed in correctional settings proved quite difficult given the variance across institutional settings across states. According to Sun (2013), education requirements for correctional treatment specialists, social workers, and counselors vary from state to state, with most requiring at least a bachelor's degree and having a preference for a master's degree. When attempting to define *correctional counselor* utilizing the BLS *Occupational Outlook Handbook*, the nearest result was "Probation Officers and Correctional Treatment Specialists." According to the U.S. Department of Labor, BLS (2015b), correctional treatment specialists work with offenders in high-crime areas or institutions to help prevent the committing of new crimes. The primary

responsibilities of treatment specialists include evaluating offenders using questionnaires and psychological assessments, risk assessments, release planning, and the planning of educational and training programs to improve employability (BLS, 2015). The listed education requirements for correctional treatment specialists are a bachelor's degree in social work, criminal justice, behavioral science, or a related field (BLS, 2015). The primary job duties of correctional treatment specialists do not align with expectations for clinicians who are able to provide mental health services to offenders in correctional settings.

Voorhis and Salisbury (2014) found that most counseling and therapy services in institutional settings are offered by practitioners trained at a master's level who are expected to provide a wide variety of services in addition to mental health counseling, including prison adjustment, reentry, recidivism, substance abuse, and employability training services. When searching the *Occupational Outlook Handbook* for master's-level counselors, the results included "Mental Health Counselors and Marriage and Family Therapists" and "Rehabilitation Counselors." According to the BLS (2015a), mental health counselors help individuals manage mental health and behavioral disorders in both community settings and mental health centers, while rehabilitation counselors work with individuals that have physical, mental, emotional, and developmental disabilities in settings including community rehabilitation programs, assisted living facilities, and youth programs. The primary duties of rehabilitation counselors include individual and group counseling, evaluation, treatment planning, case management, and advocacy (BLS, 2015). The primary job duties of mental health counselors include diagnosing and

treating mental and emotional disorders and helping clients manage these disorders (BLS, 2015). Although correctional treatment specialists require a bachelor's degree, mental health counselors and family therapists, as well as rehabilitation counselors, all require a master's degree (BLS, 2015). According to the American Bar Association (2011), it is recommended that professionals offering mental health services are licensed in their respective states. Licensure for mental health counselors occurs at the master's level.

Both mental health counselors and rehabilitation counselors treat a wide variety of behaviors and mental health disorders. This appears to align with the goals of correctional mental health counseling (Sun, 2013). Fazel et al. (2016) stated that mental health professionals employed in correctional settings should be aware of the increased prevalence of mental health disorders, including higher rates of suicide, self-harm, violence, and victimization. The authors identified that diagnostic criteria, which are not normed for prison settings, will often overlap with criminogenic factors. In addition, there should be a consideration of whether mental health symptoms develop due to the prison environment or are imported into the prison. Controversy exists regarding how to effectively treat offenders with mental health needs. The next section will explore the current status of education and training for correctional practitioners.

Educating the Correctional Practitioner

Despite the vast majority of mental health services in prisons being provided by master's-level clinicians with little to no education specific to correctional settings (Bewley & Morgan, 2011), it is important to consider the current educational guidelines for master's-level mental health counselors. This section will address education for

master's-level counseling students, counseling specializations, and multidisciplinary organizations that contribute to standards of care and training specific to corrections. It is difficult to provide a clear description of job duties and requirements for mental health counselors in correctional settings given the absence of a distinct identity and professional title. This lack of professional identity among mental health counselors has plagued the profession since 1960 (Bobby, 2013) and will be discussed further in the following section.

CACREP

According to Urofsky (2013), "standards are the framework by which higher education accreditation agencies evaluate the quality of curricula, resources, and services provided by institutions or programs" (p. 9). The Association of Counselor Education and Supervision (ACES) developed standards for counselor education and training programs in the late 1960s and early 1970s (CACREP, 2017). A significant concern for ACES at that time was that the counseling profession lacked a distinct identity (Bobby, 2013). Individual professional identity was defined by Mascari and Webber (2013) as "the way professionals see themselves—influenced by the identity of their preparation program" (p. 16). Presently, the issue of defining the counseling profession continues to be a significant struggle, with continued efforts in the field to catch up to other related professions such as social work and psychology (Mascari & Webber, 2013). As a result of the standards set forth by ACES and to facilitate the development of a counseling identity, the CACREP (2017) was established as a specialized accreditor in 1981. The mission of CACREP is to ensure that minimum standards in education and training are

met across counseling programs. The CACREP is the most recognized accreditor and influencer of the development of a professional identity in the counseling profession (Urofsky, 2013). Although CACREP accreditation is not a requirement for professional licensure as a mental health counselor, most states recognize the standards set forth by CACREP in determining licensure eligibility (CACREP, n.d.). In consideration of the educational requirements for master's-level mental health counseling professionals, CACREP has established eight common core curriculum requirements for counseling graduates, which are outlined in Addendum 1.

In a review of the eight common core counseling curricula, coursework related to forensic populations is absent. However, CACREP has established specialties within the counseling profession with additional educational requirements for master's-level graduates. A concern regarding specialties in mental health counseling suggests that they create fractures within the counseling profession, an issue CACREP has struggled with since 1949 (Bobby, 2013). Despite a great amount of debate among the counseling community regarding specialty areas, revisions to standards are necessary to move the counseling profession forward (Bobby, 2013).

Specialties in Mental Health Counseling

The CACREP establishes standards in counseling that includes entry-level specialty areas. These standards include approximately 165 core standards with an additional 60 standards per specialty focusing on curriculum, content, institutional support (i.e., program, training facilities, students and faculty), clinical and supervision requirements, qualifications for faculty and supervisors, and program identity (Urofsky,

2013). The CACREP standards, including specialties, are revised every 7 years (Urofsky, 2013), and the most recent revision occurred in 2016. The CACREP (2016) standards offer specific content for a few specialized programs, including (a) addiction counseling, (b) career counseling, (c) clinical mental health counseling, (d) clinical rehabilitation counseling, (e) college counseling and student affairs, (f) marriage, couple, and family counseling, (g) school counseling, and (h) counselor education and supervision. To date, correctional mental health counseling is not a specialty at the master's level.

Forensic Specialization

There appears to be a deficit in the literature regarding both education and training specific to correctional settings at a master's level for mental health counselors. However, I was able to identify available research related to education and training for doctoral-level psychology professionals. This was likely because forensic practice is considered a specialization at the doctoral level, according to the APA (2015), despite evidence that the majority of mental health services are provided by master's-level clinicians (Bewley & Morgan, 2011). The literature on doctoral-level psychology professionals was reviewed, and the results are concerning. The next section will review key articles and discuss education and training concerns for doctoral-level psychology professionals.

Roebuck and Zelhart (1965) acknowledged the need for trained professionals employed in correctional settings and researched training and preparation for correctional psychology practitioners. In their review of the literature, Roebuck and Zelhart were unable to clearly identify who was identified as correctional professionals in previous

research and speculated that they might include physicians, psychiatrists, psychologists, social workers, teachers, and chaplains. The authors noted that education at a master's level (in this case, social work) was generic and did not provide specific knowledge on criminology and correctional settings. Roebuck and Zelhart concluded that correctional workers did not have the specialized knowledge or training required to work in correctional settings. Although this article is considered outdated, it highlights concerns regarding a lack of education for correctional settings and was among the first articles to explore the issue of who is considered a correctional professional. The concerns noted by Roebuck and Zelhart remain problematic.

Magaletta et al. (2013) examined how doctoral programs introduced corrections as an area of study and how the required knowledge and skills needed for corrections were transmitted to psychology students. The authors interviewed 170 training directors in clinical and counseling psychology programs across the United States. Approximately 65% (n = 111) reported offering corrections training to psychology students through coursework, faculty interest, or practicum opportunities. However, only 6% (n = 11) of the programs offered forensic coursework. This means that the great majority of participating doctoral programs reported training simply through faculty interest or by offering students an opportunity to practice during practicum. The authors stated that forensic coursework remains "shallow" and a disconnect exists between coursework, faculty experience, and practicum opportunities that does not adequately prepare students for corrections work (Magaletta et al., 2013, p. 7).

Although forensic knowledge appears to be obtained primarily through on-the-job training, Magaletta et al. (2007) recognized the importance of adequate education and training for effective psychological practice in corrections. In their study, Magaletta et al. (2007) surveyed 309 doctoral-level psychologists providing services in the FBOP and inquired about core bodies of knowledge in correctional practice. The participants in this study reported that an understanding of psychopathology was of greatest importance, followed by suicide prevention, environmental factors (understanding how mental disorders manifest in a correctional environment), psychopharmacology, interdepartmental communication and relations (knowledge of prison systems and environments), and ethics (multiple roles of psychologists). The authors concluded that the knowledge needed to effectively work with offenders is primarily obtained through experiential learning, with very little textbook or research-based knowledge of best practices in corrections existing.

The focus on general proficiencies with limited coursework in forensics was also highlighted in several other sources. In the study by Burl et al. (2012), the researchers examined graduate programs that offered training in forensic psychology at both the master's and doctoral levels, including whether or not these programs included core competencies for forensic practice. The researchers identified that forensic coursework varied greatly across the 68 programs sampled (Burl et al., 2012). It was noted that forensic coursework at a doctoral level focused on general competency and acknowledged that the APA views forensic specialization as being at a post-doctoral level, suggesting that specialization occurs through experiential learning on the job, as

discussed in Magaletta et al. (2007). However, experiential learning may not provide post-doctoral psychology professionals with the knowledge and skills needed to work with offender populations. Magaletta et al. (2012) noted a significant gap in the literature related to the pathways between training and employment for forensic psychology students. The authors gathered data from 896 predoctoral students who completed internships with the BOP between 1986 and 2010 in an attempt to track future employment in corrections. The majority of students (n = 695; 78%) who completed internships with the BOP were hired into correctional positions with federal, state, or private agencies (Magaletta et al., 2012). While prior correctional experience was important for employers, internships in correctional settings merely provided a "broad and general training platform" rather than specialized training for psychology interns (Magaletta et al., 2012, p. 1415).

Because there is limited research on master's-level counseling professionals, it is important to note the concerns regarding education and training for doctoral-level psychology professionals preparing for work in correctional settings given that these professionals often provide oversight for mental health services in prison settings. Despite this, several national agencies have attempted to address the need for education and training for professionals employed in correctional settings.

Stakeholders Affiliated With Mental Health Care in Correctional Settings

Several national agencies focus on improving the criminal justice system by targeting correctional systems. The ACA (2002) was founded in 1870 and was one of the first associations developed exclusively for corrections. The mission of the ACA is to

provide an organization for those who share a common goal of improving the criminal justice system through membership, professional development, standards, accreditation, public perception of corrections, international relations, and promotion of the code of ethics (ACA, 2002). Although the ACA is the longest-standing correctional organization, the NCCHC and the Federal Bureau of Prisons have also responded to concerns about the care and treatment of offenders in state and federal correctional institutions.

The NCCHC (n.d.) is an organization committed to improving the quality of healthcare in prisons, jails, and juvenile correctional facilities. The origination of the NCCHC began in the early 1970s after the American Medical Association (AMA) exposed inadequate health services and a lack of national standards in jails. The NCCHC was officially established in 1983. In response to findings from the AMA, the NCCHC established national standards for services delivery in correctional facilities covering care and treatment, health records, administration, personnel, medical-legal issues (NCCHC, n.d.). The NCCHC also established a voluntary accreditation program, educational programs, a certification for healthcare professionals working in institutional settings, and publications. According to MacDonald et al. (2013), the NCCHC offers the most comprehensive set of guidelines and standards and is a highly sought accreditation in correctional settings.

The FBOP (n.d.) was established in 1930 in response to the need for more progressive and humane treatment for offenders, as well as an overall professionalization of correctional service and centralized administration for federal prisons. The goal of the BOP (n.d.) is to protect the safety of the public by ensuring that offenders serve their

sentences in facilities that provide safety and security, humane treatment, and reentry programming while being cost-efficient. To guide policy within corrections, the BOP developed the NIC (n.d.), which provides training, technical assistance, information services, and policy and program development to federal, state, and local correctional agencies. The NIC consists of a director and 16 board members appointed by the U.S. Attorney General. The board was established by Public Law 93-415, the *Juvenile Justice and Delinquency Prevention Act of 1974* (NIC, n.d.; United States Code, 1974). The NIC provides policy direction to correctional institutions to effectively manage institutions; enhance organizational and professional performance in corrections; promote community, staff, and offender safety; improve correctional practices; and enhance the overall effectiveness of correctional services (NIC, n.d.).

Consistent with the mutual goals of improving organizational and professional development in corrections, as well as enhancing the care and treatment of offenders, several national agencies have established standards of care for mental health. Because this study focuses on mental health professionals, there will be a focus on these standards of care for mental health. Of the national agencies discussed, the ACA, NCCHC, and NIC have each established standards of care to help guide mental health treatment and service intervention in correctional settings. This will be discussed further in the next section.

Standards of Care for Mental Health in Correctional Settings

Guidelines for standards in correctional mental health have been established by several agencies, including the APA, the NCCHC, the NIC, the ACA, and the ABA. The

APA established forensic psychology as a specialty in 2001 and founded guidelines for forensic practice in 1981 (APA, 2016). Although the APA established guidelines for correctional mental health providers, the intended application was for pre- and post-doctoral-level psychology professionals. This study specifically focuses on master's-level mental health professionals who work with offenders in correctional settings. However, there is literature available on education and training for doctoral-level psychological professionals working in correctional settings. As mentioned, several studies noted that forensic psychology professionals at a doctoral level have been found to lack the specialized knowledge required to work in correctional settings (Magaletta et al., 2007, 2012, 2013; Gannon & Ward, 2014). Similar findings related to a lack of specialized knowledge in corrections can be found in a critical publication by the NIC. The NIC published a manual by Hills et al. (2004) that addressed historical, legal, and ethical issues related to the care of offenders in correctional settings and offered suggestions on ways to expand and improve the mental health treatment of offenders. According to the manual, correctional staff do not possess the knowledge, training, or skills required to treat mentally ill offenders despite legal and constitutional requirements to provide adequate mental health services to offenders (Hills et al., 2004). Unfortunately, the 2004 manual is the most recent publication from the NIC. The ABA (2011) established criminal justice standards on the treatment of prisoners in February 2010. The *Standards on Treatment of Prisoners* recommends guidelines for service provision to offenders with regards to medical, dental, and mental health treatments. It states that correctional facilities should employ mental health professionals that are qualified and fully licensed

in their respective states (American Bar Association, 2011). However, suggesting that professionals be licensed in their respective states does not appear to be a solution to the overall problem of inadequate mental health treatment for offenders given the concern regarding the lack of coursework specific to correctional settings at the master's level discussed in Bewley and Morgan (2011), Hills et al.(2004), and Roebuck and Zelhart (1965). With inadequate mental health treatment in correctional settings identified as a chief concern, there remains a lack of education and training for correctional mental health professionals, which provides a rationale for the current study. It is unclear how mental health counselors experience working with offenders in correctional settings. In addition, the job duties of mental health professionals in corrections continue to change, with increasing pressure on providers to expand their expertise while facing significant challenges (Voorhis & Salisbury, 2014). These challenges will be discussed in the following section.

Challenges in Correctional Mental Health Counseling

A great deal of literature exists on the challenges for correctional mental health professionals employed in correctional settings. This section will address the major themes that have been identified in the literature in an attempt to provide an overview of the unique challenges of working in an institutional setting, including interpersonal, intrapersonal, and systemic challenges.

Interpersonal Challenges

Several researchers have identified interpersonal challenges when working in correctional settings. Sun (2013) and Voorhis and Salisbury (2014) both identified

conflicting goals and ethics as notable concerns for correctional mental health counselors. Pont et al. (2012) examined ethical conflicts among healthcare and non-medical professionals employed in correctional settings. Dual loyalty, as defined by Pont et al. (2012), is a role conflict that exists when a health care professional has an obligation to both the patient (offender) and the employer (institution), and is the most common dilemma faced in prison settings. Employees are exposed to military-like chains of command and likely to integrate into institutional culture (Pont et al., 2012). The authors found that healthcare professionals may be required to engage in security tasks such as body searches, forensic assessments, evaluation/assessment for disciplinary purposes, force-feeding during hunger strikes, and assisting in practices to carry out the death penalty, all of which may be required by the institution as the employing agency (Pont et al., 2012).

As in Pont et al. (2012), Ward (2013) also noted significant ethical challenges for correctional professionals. Ward addressed the problem of dual relationships in correctional practice across disciplines (mental health, psychiatry, psychology, social work, and law). He identified that professionals employed in correctional settings are subject to two distinct sets of ethical norms: their associated professional ethical codes and those associated with the criminal justice professional. Ward also cited the fundamental difference as the implementation of punishment, which is considered unethical for mental health professionals. Secondly, correctional practitioners are torn between the interests of the offender and the community. Unfortunately, Ward was unable to identify a tangible solution to this duality of opposing codes of ethics across

disciplines. Further complicating these challenges is the lack of knowledge and understanding by prison administration about the code of ethics and professional identity of treatment professionals.

Waters (1999) explored the relationship between work resources and job stress among 20 correctional treatment staff, including educators, chaplains, counselors, recreational staff, and medical staff. The author noted that there was limited research on the effects of stress and environmental factors on non-custodial staff in correctional settings. Although mental health counselors were identified, the researchers did not specify the levels of education of this group of participants. Waters utilized the Job Stress Questionnaire and Work Relationships Index to measure stress and social resources. The results indicated that there was a correlation between stress and work resources, $r = -.40$, $p < .05$ (p. 28). Of the factors that were measured, approximately 50% of the participants reported feelings of being undervalued as a result of the impact caused by conflicting goals among treatment providers and custody staff. This study is important because it was one of the first studies to highlight the distinctive nature of the correctional environment and its impact on mental health staff.

Ferrell et al. (2000) explored levels of job satisfaction among a group of mental health professionals employed in state correctional facilities. The purpose of the study was to explore attitudes and perceptions regarding job satisfaction as it relates to different aspects of job requirements, including individual and group therapy, assessment, crisis intervention, case management, report writing, administrative tasks, supervision, and consultation. There was a total of 162 participants that represented 48 states. Of these, 38

reported having only a bachelor's degree, 99 reported having only a master's degree, and the remaining 22 reported having earned a doctoral degree. The 162 participants had degrees in the fields of psychology, counseling psychology, counseling, and social work. The participants completed a survey developed by the researchers that included demographic information. Overall, the participants reported being satisfied in their jobs as mental health counselors in correctional facilities. Participants reported feeling satisfied with their jobs when they were allowed to take ownership of group therapy, were allowed flexibility and creativity, felt safe when conducting group therapy, consulted with other departments, and received adequate support from prison administration. Ferrell et al. also found that participants felt satisfied when rehabilitation was perceived as the goal of the institution. This study is important because it suggests that mental health professionals report being satisfied in correctional settings when their institutions focus on rehabilitative – not punitive – goals and when prison administration is supportive. The contradiction of punishment versus rehabilitation appears to be significant in other research studies as well.

Lambert, Hogan, Altheimer, et al. (2010) expanded the literature on burnout by examining correctional staff support for punishment or rehabilitation. The researchers were focused on specific factors of burnout including emotional exhaustion, depersonalization, and ineffectiveness in dealing with others at work. Surveys were sent to the 160 correctional employees who participated in the study. Of these, 62% were correctional officers, 3% were unit management staff (counselors, case managers, unit managers), 4% were educators, 3% were medical staff, 6% were business office

employees, 9% were custody supervisors, and the remaining 13% "worked in other areas." The results indicated a significant relationship between burnout and support for either treatment or punishment. Two significant factors of burnout – depersonalization and ineffectiveness in dealing with others at work – were positively associated with support for punishment. Lower levels of burnout and the variables age and position were positively associated with support for treatment. When the employees' positions were examined, the results indicated that non-custody staff was more likely to support treatment while correctional officers were more likely to support punishment. This study highlighted the opposing goals, treatment versus punishment, of treatment and custody staff in correctional settings. Support for treatment may also yield more positive work experiences among correctional staff.

Gallavan and Newman (2013) examined specific factors of burnout (optimism, attitude towards offenders, and work-family conflict) in mental health professionals employed in correctional settings. The researchers requested participation from 15 state and private correctional facilities across the United States. Of those requests, the Oklahoma, Arkansas, Alabama, Missouri, Wyoming, and Pennsylvania departments of corrections agreed to participate in the study. The researchers forwarded either an email or a packet to mental health professionals containing the Maslach Burnout Inventory-Human Services Survey, the Professional Quality of Life Survey, the Life Orientation Test-Revised, the Work-Family Conflict Scale, the Family-Work-Family Conflict Scale, and the Attitude Towards Prisoners Scale. The results indicated that there was a strong correlation between a negative work environment and work-family conflict. An

interesting finding was that mental health counselors' attitudes towards prisoners were not significant when measured against negative experiences at work. However, they were significant when measured against positive work experiences. The researchers considered that more favorable views of offenders might contribute to an overall favorable view of correctional settings. This study is important since it highlights that a negative work environment is strongly correlated with burnout – specifically, work-family conflict in mental health counselors employed in correctional settings.

Several studies noted that treatment staff are more supportive of rehabilitation in correctional settings in lieu of punishment (Ferrell et al., 2000; Lambert et al., 2010; Waters, 1999). Adams and Ferrandino (2008) argued that the institutional need for safety and security often conflicts with the goals of treatment staff who play crucial roles in treating offenders with mental health issues. This conflict is identified in the study of Bertrand-Godfrey and Loewenthal (2011), which described a persistent tension between the therapeutic commitment to the offender and the goals of the prison system.

Carrola, DeMatthew et al. (2016) addressed how clinical supervisors managed the duality between the mental health needs of offenders and security. A primary concern for the authors was that the correctional setting itself presented multiple layers of bureaucracy, which created unique barriers for mental health staff exposed to military-style hierarchical structures while being under the direct supervision of non-clinical correctional staff. Approximately seven individuals who were employed in correctional settings participated in a qualitative interview. The participants each had at least six months of supervisory experience and were licensed as professional counselors, social

workers, or psychologists. The results indicated that supervisors experienced significant challenges related to the correctional environment, notably that safety and security practices often superseded mental health needs and responsibilities. The participants expressed that their clinical training did not prepare them to work within the guidelines of institutional rules and that there was a lack of academic preparation specific to corrections. In fact, the supervisors indicated that there was a need to develop a security identity in addition to wearing the differing hats of mental health counselors and supervisors. The need to develop a safety identity stems from working in an environment where clinical staff are exposed to an inherently unsafe environment of violence, disruptive behaviors, and manipulation by offenders. The authors concluded that the correctional environment impacts the process of clinical supervision for mental health counselors in correctional settings. In particular, supervision was considered effective when the risk of harm to the supervisee was mitigated. The conflicting goals of different job classifications within correctional settings may factor into burnout and will be explored further in the next section.

Intrapersonal Challenges

Studies have shown that employees in correctional settings experience high levels of burnout (Carrola, Oliverez, & Karcher, 2016; Senter et al., 2010). A great deal of literature has explored burnout among correctional officers in institutional settings, but limited research exists on burnout and non-custody staff (Armstrong & Griffin, 2004; Johnson, 2016).

Senter et al. (2010) examined the differences in burnout and stress among 203 psychologists working in various settings (corrections, veteran's administration, community counseling centers, and psychiatric hospitals). The researchers measured burnout using the Maslach Burnout Inventory-Human Services Survey, which determined that there were significant differences among the psychologists employed in each setting. As hypothesized, the researchers concluded that psychologists employed in correctional settings reported experiencing burnout at higher rates compared to their counterparts in other settings. Among the psychologists, those employed in correctional settings reported lower levels of competence and production at work. The study emphasized the need for relevant forensic coursework at the graduate level, ongoing training relevant to corrections, and education about burnout and stress for those employed in correctional settings. The concept of burnout has been explored further in other studies that look at additional problematic issues, including traumatic stress and compassion fatigue.

In her mixed methods study, Johnson (2016) explored how correctional settings affected mental health professionals to better understand secondary traumatic stress, compassion fatigue, and burnout. Johnson noted that although there was available research on secondary traumatic stress and burnout among correctional officers, few studies had explored this concept among correctional mental health providers. The researcher used snowball sampling to recruit eight participants throughout Washington State. The criteria included current, full-time, employment as a mental health employee in a correctional facility; a minimum of one year of experience in the setting; the possession of a master's degree or higher; and being at least 21 years of age. Of the eight

participants, six were master's-level mental health counselors, one was a psychiatrist, and one was a psychologist. In a structured interview, participants were asked to describe their education, employment experience, and job duties as correctional mental health providers. In addition, the participants completed the Secondary Traumatic Stress Survey and the Professional Quality of Life Scale. The qualitative results identified three themes: common diagnoses, changes in worldview, and the challenges of working in a correctional environment. The participants reported that substance use disorders, depression, anxiety, attention-deficit/hyperactivity disorder, posttraumatic stress disorder, borderline personality disorder, and antisocial personality disorder were common mental health diagnoses. Changes in worldview in two participants' statements reflect increased distrust of others, being affected by the traumatic stories of offenders, and that incarceration was a revolving door for offenders. When identifying challenges in a correctional setting, five categories emerged: conflicts with staff, client issues, caseload sizes, systemic issues, and exposure to trauma. Participants described similarities among different correctional settings: that they were plagued with inappropriate and offensive language, vulgarity, bickering, and backstabbing, and that these things were political in nature. Furthermore, institutional issues were problematic. One participant discussed concerns about being a mental health provider within the Department of Corrections given that the culture was not always supportive. Several providers noted poor interactions between correctional officers and inmates, which directly affected mental health providers who were exposed to the chaos, disruption, and overall dysfunction that these interactions caused. The participants in Johnson's study also identified the

importance of detecting manipulation in offender populations. One participant noted, "It's hard to diagnosis anyways. We're not like medical. We don't have the labs and x-rays to find out what it is. We rely on what they are telling us" (Johnson, 2016, p. 54). This participant went on to express that offenders understand the criteria for mental health diagnoses and will report symptoms such as "hypervigilance," terminology typically used by mental health professionals. Mental health providers also discussed the varying sizes of caseloads. Nearly all of the participants reported having high caseloads, with the highest reported caseload being 120. The quantitative results indicated that although many participants were exposed to traumatic material daily, not all of them experienced secondary traumatic stress. The reported traumatic material included significant childhood trauma, sexual trauma, and gang activity. The quantitative analysis of the Professional Quality of Life Survey indicated average levels of burnout and secondary traumatic stress. However, the Secondary Traumatic Stress Survey indicated that three of the eight participants scored high for secondary traumatic stress, and another three scored in the average range. Johnson found that symptoms of burnout and stress resulted in participants experienced depression, anxiety, fear, headaches, and panic attacks. However, the author noted that the surveys were completed within 7 and 30 days, and that three of the participants sought treatment for burnout and stress. Thus, symptoms may not have been identifiable in the follow-up survey. In conclusion, Johnson cited insufficient training and education, unrealistic expectations in job roles, and lack of supervision as reasonable concerns for correctional mental health providers. In addition, the researcher recommended that future research seek to understand the strain placed

upon mental health professionals in correctional settings, what training is needed to address this strain, and the roles of correctional officers' perceptions on their mental health.

Similar to burnout, job stress in correctional settings have been explored in several studies, and the results indicate that non-custody staff experience stress similarly to correctional officers (Armstrong & Griffin, 2004). However, there appear to be different variables that affect the level of job stress (Waters, 1999). Armstrong and Griffin (2004) identified that while there is considerable research on stress and burnout in correctional officers, there was limited research on other personnel working in institutional settings. In their quantitative study, the researchers examined the relationship between workplace stress and personal and environmental characteristics of both correctional officers and treatment staff. The researchers sent a Quality of Work Life questionnaire to all Department of Corrections employees in 10 state prisons within a southwestern state. Of the 9,457 employees, approximately 3,794 individuals participated in the study. Of those participants, 3,091 were correctional officers, and the remaining 703 were religious, medical, dental, and mental health workers. The dependent variables were identified as job stress and health, while the independent variables were role problems, organizational support, quality of supervision, coworker support, intrinsic rewards, and environmental safety. The results indicated that both custody and non-custody staff reported similar levels of job stress and health concerns. It is important to note that there were variations in the level of significance among specific independent variables between groups. For example, perceptions of environmental safety were

significant for correctional officers but insignificant for non-custody staff. This finding was surprising to the researchers, as they anticipated that safety concerns would be a significant source of stress for both custody and non-custody staff. A similar result occurred with the variable related to intrinsic rewards in that non-custody staff reported fewer health concerns when they perceived higher levels of intrinsic rewards. Armstrong and Griffin concluded that employment in correctional settings resulted in moderate to high stress and stress-related health concerns regardless of the type of job the employee held.

Organizational support and job stress were also examined in another research study. Lambert et al. (2017) examined the impact that support by supervisors, management, coworkers, and family had on stress, work-family conflict, and turnover in a prison located in a Midwestern state. The facility was a private prison that housed approximately 450 juvenile offenders that had committed serious crimes. Of the 200 eligible employees for the study, 160 completed and returned the surveys. Approximately 62% of the participants were correctional officers, and the remaining 38% were identified as counselors, case managers, unit managers, medical staff, or education staff. The surveys measuring role stress and work-family conflict were adapted and used for this study. The results indicated positive correlations among role stress and position, age, management support, supervisor support, coworker support, and family support. However, correctional officers reported increased role stress and higher levels of work-family conflict than non-custody staff. Of the support roles, supervisor support was the greatest predictor of role stress. In conclusion, the authors noted that social support

appeared to be a significant factor regarding role stress and work-family conflict and assists staff in navigating the challenges of working with offenders in correctional settings. It appears from Carrola, Oliverez, and Karcher (2016) and Senter et al. (2010) that burnout rates are much higher for employees in correctional settings, and this issue presents further challenges for employers. The next sections will address these challenges, including absenteeism, turnover, exhaustion, and organizational commitment.

In their quantitative study, Lambert, Hogan, and Altheimer (2010) examined the effects of burnout on correctional employees in a Midwest private prison. Surveys were sent to approximately 220 correctional employees, and 160 were returned. Of the 160 participants, 62% were correctional officers and the remaining 38% were identified as "worked in other areas at the facility." Life satisfaction, turnover intent, and absenteeism were measured against three subscales of burnout (emotional exhaustion, depersonalization, and ineffectiveness in dealing with others at work). The results of the data acknowledged a significant negative relationship between emotional exhaustion and life satisfaction. Emotional exhaustion also contributed to higher turnover intent and absenteeism among correctional employees. An interesting result of the study was that long-term effects of burnout were more prevalent in correctional employees with high tenure who reported more emotional problems, physical ailments, and boredom. This study is important because it highlights the implications of burnout for employers, including higher levels of turnover intent and absenteeism. The findings specific to absenteeism and turnover intent were also explored in Lambert, Barton-Bellessa, and

Hogan (2015). However, the authors included additional factors such as views on the use of sick leave, life satisfaction, and support for treatment or punishment.

Lambert, Barton-Bellessa, and Hogan (2015) replicated and expanded on three research studies that focused on the consequences of emotional burnout among correctional staff in prisons. The researchers hypothesized that emotional burnout is associated with support for punishment (versus rehabilitation) and unfavorable views towards inmates. The selected prison was a maximum-security facility that housed approximately 1,100 male offenders. Surveys of adapted studies were sent to prison employees with their paychecks. Employees were instructed to return completed surveys to locked boxes near the entrance and exit of the prison. Of the 400 staff members available for the study, approximately 272 usable surveys were collected in the study. Of the participants, 50% worked as correctional officers; 6% were counselors, case managers, or unit managers; 3% worked in prison industries; 4% worked in education, 3% worked in medicine; 5% worked in the business office; 3% worked in administration. The remaining 26% worked in other areas of the prison. The dependent variables were life satisfaction, support for treatment or punishment, absenteeism, views on sick leave use, and turnover intent. The results were significant and emotional burnout was associated with decreased levels of both life satisfaction and support for treatment. High levels of emotional burnout were also associated with increased absenteeism and negative views on the use of sick leave. When the educational levels of staff were compared, higher reports of satisfaction were associated with participants who had earned college degrees. As discussed in another study, Lambert et al. (2010) found that correctional

officers aligned with support for punishment rather than rehabilitation. The authors also reported a positive significance between emotional burnout and rates of turnover intent. Limitations in this study included adaptations to assessment measures as well as focusing on a single dimension of burnout (emotional exhaustion) (Lambert et al., 2010). While burnout is associated with turnover and absenteeism, Lambert et al.(2013) sought to identify how burnout affected organizational commitment for those employed in correctional settings.

Lambert et al. (2013) examined how one dimension of burnout – emotional exhaustion – was affected by organizational commitment in correctional employees. The independent variables assessed for organizational commitment were moral, continuance, and affective commitment. The authors defined these varying levels of commitment as follows: affective commitment is the employee's choice to attach, identify, or express loyalty to an organization; continuance commitment is the level of dependency and insecurity an employee associates with their organization (the consequence of no longer being employed by the organization); and moral commitment is the employee's perceived duty to the organization. The researchers controlled for the amount of contact an individual had with offenders and for personal characteristics (gender, age, position, tenure, education, and race/ethnicity). The researchers sent surveys to employees at a maximum-security prison, and approximately 272 surveys were returned. The researchers identified both custody and non-custody employees in the survey. They indicated in the discussion that the participants were teachers, vocational instructors, case managers, counselors, and medical staff. The results indicated that all three organizational

commitment domains were statistically significantly related to emotional exhaustion. Staff who reported spending more time with offenders reported higher levels of emotional burnout. The researchers noted a negative relationship between exhaustion and affective commitment (an employee's choice to commit to an organization), which was a strong predictor of emotional burnout – more so than continuance commitment (an employee's dependence upon an organization). Thus, employees reported higher levels of emotional exhaustion when reporting lower levels of affective commitment (attachment, identification, and loyalty to an organization). The researchers concluded that correctional agencies should make attempts to increase affective commitment by improving job satisfaction, providing support to employees, improving staff recruitment and selection, providing accurate job descriptions, providing clear organizational mission statements, providing effective training, and identifying value in employees. In addition, the researchers indicated that correctional employers could experience increased apathy, lethargy, and emotional exhaustion if affective commitment among employees was ignored. This study highlighted a strong correlation between the amount of time employees spent with offenders and levels of emotional burnout. The researchers also identified more effective training as one of several solutions to address burnout in correctional employees.

The literature seems to support higher rates of burnout for employees in correctional settings (Carrola, Oliverez, et al., 2016; Senter et al., 2010), posing significant issues for correctional employers who are left tackling issues such as absenteeism and turnover (Lambert et al., 2010; Lambert et al., 2015). Given this,

correctional employers may find these challenges difficult to address given the variances between levels of institutional security. The next section will continue to address burnout and how it affects the correctional system.

Systemic Challenges

Carrola, Oliverez, and Karcher (2016) explored burnout among master's-level correctional counselors employed at varying security levels in institutional settings (minimum, medium, maximum, and inpatient). The purpose of the study was to understand which variables affected burnout. The study targeted correctional counselors who possessed master's degrees or higher and who provided psychotherapy to offenders in a correctional setting. Of the 205 eligible counselors, approximately 86 usable surveys were returned. The researchers utilized both the Counselor Burnout Inventory and the Maslach Burnout Inventory-Human Services Survey to measure burnout. Differences between the genders of the counselors and the security levels of the facilities were independent variables in the study. The results indicated no statistical significance, which the researchers suggested was due to limited statistical power because of the small sample size. However, they identified several trends that warranted future consideration in research. First, counselor reports of personal exhaustion increased with the level of institutional security (lower levels in minimum security and higher levels in maximum security). Second, female counselors tended to report burnout steadily among different levels of security, but males reported higher levels of burnout in both medium- and maximum-security settings. Third, counselors in inpatient facilities reported the lowest levels of burnout. The authors suggested that correctional counselors may view inpatient

and minimum-security settings as more favorable than medium or maximum settings. The researchers encouraged future studies that focused on burnout in correctional settings but noted that prison settings are often difficult to access. The study also implied that effective interventions are needed to address exhaustion, negative environmental factors, and feelings of counselor incompetence for correctional counselors. The researchers suggested that their study supported outcomes from other research where results indicate counselors working in correctional settings may experience higher levels of burnout when working with offender populations. Although the level of security was not statistically significant, there is evidence that burnout increases as the level of institutional security increases.

Roy and Avdija (2012) examined the relationship between job satisfaction and burnout on the level of institutional security (medium and maximum). The researchers sent an adapted survey from three subscales on the Maslach Burnout Inventory to employees in two medium and one maximum security facilities in Indiana. The total number of participants was 480. Of these, 51.9% identified as correctional officers, 11.9% as treatment staff, 10.6% as managers, 7.1% as educational instructors, 4.6% as human resources staff, and 2.1% as health staff. In addition, 11.9% were listed as "other" (Roy & Avdija, 2012, p. 529). The researchers used a one-way between-groups analysis of variance to measure the prisons' security levels and job satisfaction, which resulted in no significant differences found between medium- and maximum-security settings. To determine burnout, the researchers used a regression analysis on three measures of burnout (emotional exhaustion, depersonalization, and constraints of personal

accomplishment) and the level of institutional security. Employees in medium-security facilities reported lower scores in each of the three levels, and the burnout result was only statistically significant for depersonalization in maximum-security settings. Therefore, the researchers concluded that there was no substantial difference in burnout or job satisfaction between medium and maximum-security settings. A limitation of the study was that the researchers adapted the Maslach Burnout Inventory to their purposes and focused on three factors of burnout among correctional employees. In addition, the researchers did not discuss differences in job satisfaction or burnout among the different job classifications. Consistent with varying levels of institutional security, correctional settings may also contain therapeutic environments.

Bierie (2012b) examined the potential impact that prison conditions had on staff after discovering that the current literature had primarily focused on inmates. The researchers forwarded the Prison Social Climate Survey to a representative sample of staff members employed at facilities within the Federal Bureau of Prisons. From the 3,130 staff, approximately 1,738 usable surveys were returned. The independent variable was identified as prison conditions (sanitation, clutter rodents/insects, privacy, noise), while the dependent variables were sick leave, changes in alcohol and tobacco intake, somatic complaints, psychological complaints, and personal worry. The results indicated that as conditions within prisons worsened, there was an increase in physical and psychological complaints. Primary physical complaints included headaches, stomach aches, and back pain, while psychological complaints included depression and poor concentration. In addition, staff members who perceived harsh prison conditions reported

a significant increase in tobacco and alcohol consumption over the previous six months. The authors noted that the results of their study were consistent with the literature on the quality of life of inmates and prison conditions. The prison environment had a greater impact on staff than offenders due to the added commitment to job responsibilities within the institution.

Research has stressed the importance of education and training specific to correctional settings when working with offenders (Ogloff et al., 2015; Varghese et al., 2015; Wolff et al., 2013). However, the burnout literature suggests that in addition to understanding how to work with offenders, correctional staff should have additional education and training on issues such as burnout (Senter et al., 2010; Carrola et al., 2016), stress/traumatic stress (Johnson, 2016; Senter et al., 2010), compassion fatigue (Johnson, 2016), emotional exhaustion (Lambert et al., 2013), negative environmental factors, and counselor competence (Carrola et al., 2016). When counselors lack the necessary education and training for working with offenders in correctional settings, then burnout may create organizational issues such as absenteeism and turnover (Lambert et al., 2010; Lambert et al., 2015). Additionally, the prison environment and social climate itself impact employees in correctional settings (Bierie, 2012b).

Day et al. (2011) argued that the social atmosphere in prisons is difficult to define due to how research describes this concept. For example, the words *culture* and *climate* are used interchangeably (p. 9). In their study, the researchers sought to provide conceptual clarity to the prison environment by measuring the social climate and examining construct validity in the Essen Climate Evaluation Schema (EssenCES).

According to the authors, the EssenCES is a 15-item assessment that scores three areas: the extent to which the environment is supportive of therapy, whether mutual support is present, and whether or not tension or perceived threats of violence and aggression exist. In addition to examining the construct validity of the EssenCES, the researchers investigated how the scales measured up to other variables, such as disciplinary problems and readiness for treatment. The researchers selected participants from two correctional facilities in Australia. One prison was considered *therapeutic* and the other identified as *mainstream*, however, both facilities offered rehabilitative programs. The total number of participants included 134 prisoners and 102 staff members that were identified as either operational or rehabilitative staff. The between-group results for the mainstream and therapeutic prisons indicated that prisoners in the therapeutic prison reported significantly higher rates of treatment readiness than those in the mainstream prison. Interestingly, while prisoners rated the therapeutic environment as having a more positive social climate, the results were not statistically different from those of prisoners in the mainstream setting. Staff employed in the therapeutic prison reported higher levels of staff interest and support for treatment of prisoners and feeling supported and confident, and acknowledged that they were better able to use their knowledge to assist prisoners than they would have been in the mainstream prison. Although both prisons housed violent offenders and those with substance use issues, disciplinary incidents were higher at the mainstream facility (240 incidents) than in the therapeutic facility (17 incidents). Offender rehabilitation appears dependent on the institutional climate, such as scheduling conflicts and security procedures that interfere with staff members' abilities to deliver

services. The authors noted limitations to direct comparison between the two types of facilities because of differences among inmates, staff, and management. However, the study seems to indicate that although therapeutic environments may increase offender readiness for treatment, they may not change offenders' perspectives about the social climate in prison. The prison social climate has been further explored in other studies, including the impact of prison conditions on correctional staff. The unique environment warrants further discussion on the culture of both prisons and offenders.

Prison Culture

Developing and mastering an understanding of prison culture is emphasized in research at the doctoral level for psychology professionals, according to Magaletta et al. (2012). Given that the majority of mental health services in prison are conducted by master's-level professionals (Bewley & Morgan, 2011), it could be assumed that developing an understanding of prison culture would be equally as important for mental health counselors. When clinical supervision for mental health counselors is examined, the prison environment is noted to cause significant constraints on how supervisors manage their professional identities and responsibilities towards supervisees' mental health (Carrola et al., 2016). This section will provide a broad view of the prison environment followed by a narrower view of inmate culture.

Victimization, Gangs, and Violence

The social climate of prison and its impact on staff and offenders have been explored. Crew et al. (2014) described prison as a tremendously complex emotional

environment plagued by a culture of mistrust, fear, aggression, and violence. Inmates often describe the prison setting as “violent and tense” (Ricciardelli, 2014, p. 242).

Listwan et al. (2014) sought to study the rates of multiple victimizations, or poly-victimization, in prison populations. They measured environmental factors, importation/vulnerability, and protective factors against reported poly-victimization. Approximately 98% of the participants reported either experiencing or witnessing victimization in the eight categories measured. These included witnessing theft, experiencing theft, witnessing fighting, experiencing fighting, witnessing emotional abuse, experiencing emotional abuse, witnessing a sexual assault, or experiencing sexual assault. It should be noted that witnessing victimization was reported at significantly higher rates in each of the categories (theft, fighting, emotional abuse, and sexual assault). Victimization was significantly related to the independent variable of importation/vulnerability (age, race, and mental illness). The data suggested that minorities, those diagnosed with a mental illness, and younger offenders were more likely to experience poly-victimization due to the tendency to engage in high-risk behaviors. The authors hypothesized that the correctional environment roused both aggression and victimization. Additionally, the researchers suggested that victimization may be an “organizing principle” among offenders.

Mears et al. (2013) examined the role that imported inmate cultural beliefs had on violence in institutional settings. The researchers hypothesized that inmates who adhered to the code of the street were more likely to engage in violence and disciplinary actions while in prison and less likely to participate in educational and religious programming.

Their underlying beliefs were congruent with the 1962 importation theory by Irwin and Cressey suggesting that inmates import street culture into institutional settings, which Mears et al. believed would greatly influence behavior, including the propensity to engage in violence, while incarcerated. Participants in this study were recruited from another study that investigated how familial and neighborhood characteristics affected health and development. The dependent variable was identified as the number of self-reported uses of violence while incarcerated while the independent variable was the measure of street code beliefs. The results indicated that an adherence to beliefs from the code of the streets was statistically significant in predicting violence in prison, even when accounting for variables such as the neighborhood the offender came from, socioeconomic status, and previous incidents of violence. Violence decreased slightly when inmates participated in educational and religious programming, however, violence remained statistically significant if inmates endorsed the code of the street. The researchers identified that the code of the street was enhanced when inmates lacked family support, were involved in a gang, and/or had received disciplinary sanctions. In conclusion, when inmates import the code of the street into prison settings, there is a greater likelihood that those inmates will promote, endorse, and engage in violence while incarcerated.

Worrall and Morris (2012) examined the effects that gang association had on inmate violence. They hypothesized that inmate-on-inmate violence would be greater with larger percentages of gang members and that violence would occur more frequently when there were equal numbers of gang members from rival gangs. Data analysis from

multilevel modeling concluded that gang membership was positively associated with violence in prison. In addition, violence was higher with inmates who were younger, had less education, and had lengthier prison sentences. With regard to the second hypothesis related to gang heterogeneity among rival gang membership, the greater the expectation that inmate-on-inmate violence would occur.

Most of what we know about prison culture derives from a sociological study by Donald Clemmer (Chong, 2013; Mears et al., 2013; Paterline & Orr, 2016; Trammell, 2009) that provided the first detailed description of inmate culture in prison and identified commonalities among inmate populations, such as folklores, customs, attitudes, beliefs, and behaviors, which allowed inmates to adapt to incarceration. Following the work of Clemmer, Sykes and Messinger (1960) developed a theory on the structure and function of the inmate social system. They found that inmates follow an explicit code that guides their beliefs and values, and violations of this code are subject to a range of sanctions including violence. The inmate code is organized into five major themes: (a) avoid interfering with inmate interests (i.e., loyalty among fellow inmates, do not "rat" on a con, do not work with prison officials), (b) refrain from altercations with fellow inmates (i.e., "do your own time"), (c) never take advantage of another inmate by means of force or fraud (i.e., do not steal or exploit another inmate), (d) practice maintenance of self (i.e., demonstrate courage and integrity, avoid appearing weak, be tough), and (e) do not offer respect or prestige towards institutional staff (i.e., maintain suspicion and distrust, be committed to fellow inmates; Sykes & Messinger, 1960). From their research, Sykes and Messinger found that inmates strongly supported the inmate code, which provided mutual

aid, loyalty, affection, and respect among the inmate population. However, adherence to the inmate code varied among inmates. Those who deviated from the inmate code were often labeled by other offenders and were subject to punishment by their peers. The ultimate betrayers among inmates were those individuals, referred to as "rats," who worked with and shared information with prison officials. Similar to Clemmer, Sykes and Messinger stated that inmates adopted the code in an attempt to diminish the pains of imprisonment. However, Sykes and Messinger asserted that adoption of the inmate code also provided inmates with a meaningful and supportive social group. While the work of Clemmer, Sykes, and Messinger remains influential in understanding prison culture, the culture within institutional settings has evolved since the 1960s.

The concept of prisonization, or acceptance of the inmate social system, was explored in more recent research by Paterline and Orr (2016), who expanded on inmate social structure. The researchers interviewed 239 male offenders housed in a maximum-security federal prison. The researchers measured prisonization against importation and deprivation models and self-conception. According to Paterline and Orr, the deprivation model hypothesizes that prison conditions account for the formation of prison culture while the importation model suggests that the inmate's prior experiences, specifically the adopting of criminal values before incarceration, shape the prison culture. The researchers broke down self-conception into three measures: self-evaluation, self-concept, and self-efficacy. The results of the multivariate regression exhibited that unemployment before entering prison was the most significant predictor of prisonization, followed by age and level of education. Importation characteristics such as the type of

offense, marital status, race, and the number of previous incarcerations were not significant in prisonization. Deprivation measures included systemic rules, rigid hierarchy of authority, coercive power, and limited autonomy of the inmate in prison settings. The authors found that when both the importation and deprivation models were used together, they provided a better measure for determining prisonization. However, it was noted that deprivation model variables proved to be greater predictors of prisonization, specifically for those inmates who experienced alienation, stigmatization, and victimization. The researchers concluded that inmates entering prison are subject to depersonalization and may assume new roles and identities to adjust to and cope with incarceration.

Inmate Culture

In his qualitative study, Bronson (2006) investigated inmate culture in a medium security prison. The two-fold study included a qualitative pilot examination that included 10 participants and focused on inmate perceptions of their prison experiences, inmate friendships, and inmate perceptions of others' prison experiences. The second qualitative investigation provided a more in-depth investigation of individuals' backgrounds, friendships with other inmates, perceptions of inmate hierarchies, unwritten codes, and expectations, and included 25 participants. Bronson identified several themes in the data, including friendship processes, assimilation to inmate culture, and descriptions of inmate culture. Participants described expectations of how inmates should serve out their incarcerations, although these were sometimes contradictory. For example, offenders reported an expectation that each offender focuses on their own time, saying things like

"staying to yourself," "keep your mouth shut," and "stick to yourself as much as you can." However, offenders also noted the importance of social relationships and forming small, close groups with others. Impression management was considered an important aspect of prison adjustment. Participants shared an avoidance of appearing weak and placed value on appearing willing to utilize violence, if necessary, in order to avoid exploitation by others. The existence of hierarchies among inmates was also discussed, with similar contradictions as previously mentioned. Participants in Bronson's study were not forthcoming about the existence of such social structures, however, they described circumstances that would suggest such hierarchies were prevalent. First, offenders who were convicted of sexual offenses against children were often viewed as having a low status within the hierarchy. Interestingly, offenders who were perceived of higher status were those offenders who were employed within the prison, were associated with volunteer organizations that held fundraisers (specifically involving food sales outside of the institution), those who were educated (notably, those having knowledge of legal matters), and those who were considered good athletes. An interesting discussion in Bronson's study was the discussion of the changing inmate culture, which was initiated by legislative changes in sentencing structures. A change from indeterminate sentencing and parole boards to determinate sentencing creating shifts within prison institutions. As one participant described, older inmates (convicts) were accustomed to a culture based on principles, values, morals, and respect that were often gained by physical means. He continued to say that determinate sentencing significantly changed how inmates served their time, and within a relatively short period of time, many of the younger offenders

began dismissing the older cultural norms within the prison environment. Despite Bronson's interpretation of the changes in inmate culture, Skarbek (2012) suggested that the evolution of the convict code may better be explained by the sudden expansion in the prison population and the prison community's inability to maintain governance in larger populations. Liebling and Arnold (2012) posited similar findings from both Bronson (2006) and Skarbek (2012), describing changes in inmate culture due to the breakdown of hierarchical structures among prisoners as reflected in compositional changes in the prison population (i.e., younger prisoners, mixed racial backgrounds, the influence of "street life" in prison) and sentencing structure.

Liebling and Arnold (2012) sought to describe social relationships between inmates in a maximum-security prison. The authors noted that few studies documented the changing nature of social relationships among offenders within a prison. The researchers observed an experience that was vastly different from that in their earlier study, asserting that the atmosphere was tenser with higher levels of mistrust and fear. Participants in the study described escalating violence within the prison, with 28% reporting that they feared for their safety and 31% reporting that they did not feel safe from being bullied, threatened, or physically harmed. The increasing levels of mistrust amongst inmates were because social interactions were based on convenience, usefulness, or alignment with personal or group agendas rather than genuine relationships. Participants perceived that the changes in inmate culture were influenced by an influx of younger offenders, often describing them as more oppositional and violent. To avoid conflict, inmates are forced to rapidly adapt to the prison setting and follow the codes of

conduct imposed upon them by prominent prison social groups (Liebling & Arnold, 2012). This code of conduct, or convict code, was identified in several studies (Bronson, 2006; Liebling & Arnold, 2012; Skarbek (2012); Sykes & Messinger, 1960) and will be discussed further in the next section.

The Convict Code

The presence of the convict code will be explored more in depth in this section. Mitchell et al. (2016) examined similarities and differences among prison subcultures (adherence to street code or convict code, members of street or prison gangs) and how these influence the prison environment. They found that belief systems among street and prison gangs actively converge in a prison environment, with slight differences in reliance upon formal rules in prison and informal rules in street gangs (Mitchell et al., 2016). The code of conduct is often established by prison gangs who set the standard for appropriate inmate behavior in correctional settings (Skarbek, 2012; Trammell, 2009). Ricciardelli (2014) defined the inmate code as behavioral norms that dictate an offender's social interactions within a prison setting and provide structure, routine, direction, and a sense of protection. In her qualitative study, Trammell (2009) sought to identify how inmates and correctional officers described informal rules as they related to the inmate code. The data used in this study derived from a larger study focusing on informal social control, prison rape, underground economies, gang violence, and racialized violence. However, Trammell (2009) focused on informal rules, the inmate code, and control. The participants in the study described the prison environment as highly organized with rules established by prison gang leaders. As discussed in Bronson (2006), impression

management and appearing "tough" are essential to survival in prison. Trammell's study deviates from previous understandings about inmate code in discussions of underground economies. Prison rules and the inmate code have evolved as a means to control illegal business operations (drugs/tobacco sales, contraband, prostitution, and pornography) within correctional settings (Trammell, 2009). To avoid disruption in prison operations, gangs have established means to resolve conflicts and control violence in prisons. This method of self-regulation was also discussed in Skarbek (2012), who stated that inmates "must devise self-enforcing exchange institutions to capture the benefit of trade" (p. 96). Inmates often avoid engaging in physical altercations that draw the attention of others; instead, they are encouraged to settle disputes in their cells (Skarbek, 2012). However, those engaging in altercations must seek sanction by gang leaders, who are often charged with overseeing negotiations to maintain order in prison (Trammell, 2009). Trammell's study is important because it updated current knowledge on both prison culture and the convict code and offered a new understanding of informal prison rules.

Ricciardelli (2014) examined the inmate code among offenders in Canadian penitentiaries, specifically studying potential factors that drive offenders to adopt the code. Most of the participants in the study described the prison environment as inherently unsafe with little differentiation in hierarchical status, type of crime, or level of institutional security. As in Trammell (2009) and Bronson (2006), Ricciardelli also found that inmates identified a hierarchical structure among offenders based on criminal history and convictions (i.e., higher status for armed robbery, selling drugs, murder, organized crime, and lower status for offenders with crimes against women and children).

Ricciardelli identified several themes within the inmate code of conduct, including never ratting on a fellow inmate or working with a staff member, being dependable, following the rules established by inmates, minding your own business, and either being fearless or presenting yourself as fearless. The idea of minding one's own business is a survival strategy to avoid becoming a target or risk being victimized. Although Ricciardelli noted that the inmate code had evolved since Clemmer's work in 1940 and Sykes and Messinger research in 1960, inmates continue to adopt a common code that identifies expectations and behavioral norms. Ricciardelli differed from that of Sykes and Messinger and found that inmates overall do not form close friendships, preferring dependability rather than solidarity and loyalty. Social relationships in prison are often motivated by a desire to be safe in an environment plagued with violence. Aggression is valued and essential for survival among those who are incarcerated.

Provided the complex nature of the prison environment and the desire to understand the lived experiences of how master's-level mental health professionals experience working with offenders in correctional settings, a qualitative methodological approach will be utilized. This study will assume a hermeneutic approach and the following section will provide an overview of the conceptual framework.

Conceptual Framework

In all human research, there exists a desire is to understand how people structure meaning within the world (McManus-Holroyd, 2007). Phenomenological studies seek to understand the lived experience of individuals, and are either transcendental or hermeneutic (Kumar, 2012; Laverty, 2003). Both transcendental and hermeneutic

phenomenology understand the importance of the lived human experience (Kumar, 2012). Husserl's transcendental phenomenology seeks to *define* a phenomenon, while Heidegger's hermeneutic phenomenology seeks to understand the *meaning* of a phenomenon (Kumar, 2012). Heidegger's hermeneutic phenomenology differs from Husserl's transcendental phenomenology in that Heidegger thought it was impossible to negate personal experiences when studying a phenomenon (Reiners, 2012). This is referred to as bracketing. Husserl requires the researcher to disconnect and suspend judgment (i.e., bracket) so that a phenomenon can be viewed in its purest form, independent of prejudices (Husserl, 1962). According to Laverty (2003, p. 23), Husserl believed that bracketing allows the researcher to see things more clearly. Heidegger believed that it was impossible to assume a critical distance from what is being studied because we are influenced by our prejudices and biases (Davidsen, 2013). In hermeneutic inquiry, the researcher's biases and judgments are critical to the interpretive process (Laverty, 2003).

Hermeneutic phenomenology assists in identifying problems in an individual's life through a genuine desire to broaden one's understanding of a phenomenon (McManus-Holroyd, 2007). It is important to understand the horizon, or culture and history, of the researcher engaging in hermeneutic phenomenological research (McManus-Holroyd, 2007). Qualitative inquiry appreciates the historical and cultural influences of knowledge construction and seeks to develop this knowledge further (Davidsen, 2013; Laverty, 2003). Often, the researcher challenges historical and cultural knowledge in order to move towards a more accurate understanding of current conditions

(McManus-Holroyd, 2007). This historical and cultural knowledge is referred to as our "pre-understanding" in hermeneutic phenomenology (Gadamer, 2006, p. 45). This pre-understanding is why Heidegger believed that the researcher is unable to suspend judgment, because this is constructed by historical and cultural meanings of the world, and thus, towards the world (Laverty, 2003). Ultimately, the researcher will have preconceived notions, or beliefs, about what is studied (Hayes & Fulton, 2014).

Hermeneutic research tends to clarify conditions that enable an understanding of a phenomenon (McManus-Holroyd, 2007). Learning is fostered from personal experiences, and assuming a hermeneutic approach allows the researcher to recognize and understand the limitations in how we come to understand the world (McManus-Holroyd, 2007). The primary goal of hermeneutic phenomenology is to understand the essence of a phenomenon through the blending of understanding between the participants and researcher (Gadamer, 2006; Kumar, 2012; Laverty, 2003). Hermeneutic understanding follows a circular movement where information moves from the individual parts to the whole and vice versa (Gadamer, 1986). This movement is called the hermeneutic circle and expands as more information is obtained (Gadamer, 1986).

Insufficient treatment for offenders with mental health issues in the correctional environment is a critical issue for counselors employed in correctional settings (Brandt, 2012; Gannon & Ward, 2014). The purpose of this qualitative study was to understand how master's-level mental health counselors experience working with offenders in correctional settings. Because I sought to understand the lived experience of master's-level mental health counselors in correctional settings, assuming a hermeneutic

phenomenological approach provided a way to understand how correctional mental health counselors construct their understandings of working with offenders and how they manage challenges. Hermeneutic phenomenological inquiry values the cultural and historical knowledge of both the researcher and the participants (Davidsen, 2013; Laverty, 2003). According to Hayes and Fulton (2014), applying phenomenology to research in healthcare professions can facilitate a deep understanding of issues, which leads to progressive change. Hermeneutic inquiry often derives from our awareness that our dominant ideology offers little assistance in understanding a phenomenon (McManus-Holroyd, 2007) – in this case, how mental health counselors interpret meaning in how their education, training, and experience has prepared them to work with offenders in institutional settings. The literature established that providers are ill-prepared for dealing with the mental health needs of offenders in correctional settings (Sarteschi, 2013).

Summary

The BLS *Occupational Outlook Handbook* provides information on the duties, education, and training requirements for many occupations. When citing corrections as a keyword, the results provided information on probation officers and correctional treatment specialists. Correctional treatment specialists were required only to have a bachelor's degree (BLS, 2015). Sun (2013) stated that educational requirements for correctional counselors vary from state to state. However, the job duties for correctional treatment specialists did not align with research on educational and job requirements for mental health counselors employed in correctional institutions. According to Voorhis and

Salisbury (2014) and Bewley and Morgan (2011), the majority of mental health services in correctional facilities are provided by master's-level mental health counselors. An additional search of the Occupational Handbook did not result in any additional occupation requiring a master's degree that provided mental health support to offenders. The issue is further complicated by the lack of identity for master's-level mental health counselors employed in corrections. This is not surprising given the ongoing struggle regarding professional identity for mental health counselors compared to other related professions, such as social work and psychology (Mascari & Webber, 2013). Studies have outlined the inadequate provision of mental health treatment in correctional settings (Hills et al., 2004; Sarteschi, 2013). More importantly, numerous studies have cited the apparent lack of specialized knowledge and training required for doctoral-level psychology professionals in corrections (Burl et al., 2011; Roebuck & Zelhart, 1964; Magaletta et al., 2013). This is notable because doctoral-level psychology professionals often provide training, supervision, and consultation to staff in correctional settings (Magaletta et al., 2012). Assuming that approximately half of the mental health providers in corrections have master's degrees, it could be expected that doctoral-level psychology professionals supervise master's-level mental health counselors.

Given the concern regarding the lack of education and training for correctional mental health professionals, there is evidence that these professionals encounter significant challenges when employed in correctional settings. Unlike other settings, correctional mental health counselors are often torn between two opposing codes of ethics: that of a mental health provider and that of a correctional worker (Pont et al.,

2012; Ward, 2013). Pont et al. (2012) noted that correctional staff are exposed to military-like chains of command and are likely to integrate into institutional culture. Historically, institutional culture has vacillated between support for punishment and support for rehabilitation (Lambert et al., 2010), creating a persistent tension among mental health staff and institutional staff (Bertrand-Godfrey & Loewenthal, 2011). Ferrell et al. (2000), Lambert at el. (2010), and Waters (1999) all found that treatment staff often favor rehabilitation over punishment.

Research has determined that the prison environment can have detrimental effects on offenders, but it also affects staff employed in correctional settings (Bierie, 2012a). Bierie (2012a) noted that the environment might have a greater impact on staff versus offenders, citing that it leads to physical and psychological issues for employees. Mental health professionals employed in prison settings are exposed to the distinct culture of both the prison and the inmates. Correctional counselors should be aware of prison culture, described as tremendously complex and plagued by mistrust, fear, aggression, and violence, and how this culture influences offenders (Crewe et al., 2014; Liebling & Arnold, 2012; Ricciardelli, 2014). The presence of an unwritten convict code is often established by prison gangs (Skarbek, 2012; Trammell, 2009) and helps guide offender behavior (Bronson, 2006; Ricciardelli, 2014; Trammell, 2009). The challenges for mental health staff employed in correctional settings often lead to issues such as burnout (Carrola et al., 2016; Senter et al., 2010), traumatic stress, and compassion fatigue (Johnson, 2016), and stress (Armstrong & Griffin, 2004; Lambert et al., 2017; Waters, 1999). Additionally, treating offenders comes with some risk to the professional,

including the risk of being assaulted or manipulated (Ricks, 2015). With correctional staff experiencing higher rates of burnout (Carrola et al., 2016; Senter et al., 2010), correctional facilities are faced with issues such as absenteeism (Lambert et al., 2010; Lambert et al., 2015), turnover (Lambert et al., 2010; Lambert et al., 2015), and poor organizational commitment (Lambert et al., 2013).

There appears to be a consensus in the literature that there is a lack of the specialized knowledge and skills required to work with offender populations (Bewley & Morgan, 2011; Hills et al., 2004; Sarteschi, 2013). The difficulty exists regarding how to amend the situation given that educational requirements for correctional mental health counselors vary among states and institutional settings (Sun, 2013). In a review of educational requirements for CACREP accredited master's-level counseling graduates, coursework related to forensic populations and correctional settings appears absent, and correctional mental health counseling is not considered a specialty (CACREP, 2017). Despite this, several national agencies offer guidance for mental health professionals in the form of published standards of care for treatment in correctional settings, including the American Psychiatric Association, the NCCHC, the NIC, the ACA, and the American Bar Association. Despite attempts to address the disparities in mental health treatment in correctional settings, the standards of care are merely suggestive, with the most highly sought accreditation being that of the NCCHC, which is voluntary (MacDonald et al., 2013).

Given the considerable challenges for mental health counselors employed in correctional settings, there is little research on the experiences of master's-level mental

health counselors working with offenders in correctional settings. Therefore, I attempted to fill a gap in the literature specific to master's-level professionals who work with offenders in correctional settings. The methodology is discussed further in Chapter 3.

Chapter 3: Research Method

Master's-level professionals provide the great majority of mental health services to offenders in correctional settings (Bewley & Morgan, 2011; Voorhis & Salisbury, 2014). Given that mental health services in corrections are inadequate (Hills et al., 2004; Sarteschi, 2015), it is important to consider how master's-level mental health counselors are prepared to work in correctional settings and how their education and experience is translated into clinical practice. Forensic coursework at a master's level is not a requirement in CACREP-accredited programs (CACREP, 2016). However, forensic practice is considered a specialty at the doctoral level (APA, 2016). Even at the doctoral level, researchers state that psychology professionals lack the specialized knowledge and skills required to work with offenders in correctional settings (Burl et al., 2012; Magaletta et al., 2007, 2012, 2013; Roebuck & Zelhart, 1965). Post-masters training specific to corrections is available to mental health professionals; however, it is voluntary (NCCHC, n.d.). Often, these doctoral-level psychology professionals provide training, supervision, and consultation to mental health staff in correctional settings (Magaletta et al., 2012). While research exists on education and training for doctoral-level psychological professionals, there appears to be limited literature on preparation for master's-level mental health professionals working in corrections. This qualitative study used a hermeneutic phenomenological lens to facilitate an understanding of master's-level mental health counselor experiences working with offenders in correctional settings.

Chapter 3 includes a discussion on the research design and rationale, the role of the researcher, and the methodology. In this chapter, I restate the research questions,

define the phenomenon, identify the research tradition, and provide a rationale for the chosen tradition in the design and rationale section. This is followed by the identification of the roles of the researcher and participants, a discussion of researcher biases, and the addressing of potential ethical issues. I then discuss the methodology, target population, sampling strategy, participant selection, recruitment, number of participants, saturation, data collection procedures, issues related to trustworthiness, and ethical procedures.

Research Design and Rationale

A hermeneutic phenomenological research design was used in this qualitative study. Research questions in hermeneutic phenomenological studies aid the researcher in understanding the meaning of a phenomenon (Reiners, 2012). A phenomenon is defined as the way we find ourselves being in relation to the world in our day-to-day living (Vagle, 2018). The central phenomenon examined in this study is how master's-level mental health counselors experience working with offenders in correctional settings and how they manage any challenges. The following research questions were formulated to understand the meaning of this phenomenon.

1. How do master's-level mental health counselors experience working with offenders in correctional settings?
2. How do master's-level mental health counselors manage any challenges when working with offenders in correctional settings?

Research Tradition

Phenomenological approaches help researchers facilitate an understanding of the lived experiences of individuals (Kumar, 2012). Phenomenological methodology is

viewed as “being swept up in a spell of wonder about phenomena as they appear, show, present, or give themselves to us” (Van Manen, 2014, p. 26). The intent of phenomenological inquiry is not to study how individuals construct meaning, but to understand how things manifest through our interactions and our “being” in the world (Vagle, 2014). Thus, phenomenology is simply about one’s experience. Husserl, known as the father of phenomenology, sought to unfold the meaning of a phenomenon by providing a description of an individual’s experience (Laverty, 2003; Reiners, 2012). Husserl believed that to truly understand an experience, the researcher’s opinions needed to be set aside, or bracketed (Husserl, 1962; Reiners, 2012). Husserl’s student, Heidegger, disagreed with Husserl that the researcher is capable of remaining objective in phenomenological inquiry, and therefore developed hermeneutic phenomenology (Laverty, 2002). The concept of bracketing is the primary difference between transcendental and hermeneutic phenomenology. Heidegger believed that merely providing a description does not aid in understanding a phenomenon, but understanding the concept of *being* does facilitate a better understanding (Reiners, 2012). In a translated text from Heidegger, Large (2008) stated that Husserl’s seeing and describing method of inquiry could cause a researcher to overinterpret a phenomenon based on their own perceptions, whereas Heidegger’s approach allows for interpretation as the phenomenon presents itself. Thus, the difference between Husserl and Heidegger is that understanding is not merely *looking* at something, but assuming an active approach in interpreting the experience as it presents itself. Hermeneutic researchers often reveal information about a phenomenon that is not well understood (Crowther et al., 2017).

In this phenomenological study, I used hermeneutic phenomenology as the method of inquiry. In this method, the understanding of a phenomenon occurs in a circular movement within the hermeneutic circle (Gadamer, 1986, 1991). The hermeneutic method begins with a pre-understanding, or what is already known about a phenomenon, which marks the beginning of the hermeneutic circle (Yu & Lau, 2012). Although it is important to consider pre-understanding and the acknowledgment of researcher bias and judgment, it is imperative that the researcher not assert their own truth but rather let this information present itself (Gadamer, 1991). Gadamer (1991) stated that prejudice gives power to the hermeneutic problem and defined this concept as "a judgment that is rendered before all the elements that determine a situation have been finally examined" (p. 235). Gadamer (1991) stated that prejudice can be discredited through enlightenment and scientific reasoning.

The rationale for choosing Heidegger's hermeneutic phenomenology lies in the distinct difference between the researcher's roles in transcendental versus hermeneutic phenomenology. While the researcher in phenomenological inquiry is directly involved in the study, Husserl maintained that the investigator must set aside (i.e., bracket) preconceptions, biases, and judgments during the investigation of a phenomenon (Yu & Lau, 2012). However, Gadamer believed that the researcher is unable to suspend judgment because of their historical and cultural knowledge (pre-understanding) of the studied phenomenon (Gadamer, 2006). Recognizing pre-understanding does not hinder the ability of the researcher to understand the phenomenon (Gadamer, 2006). My role as

the researcher, including a description of my pre-understanding, is discussed in the next section.

Role of the Researcher

The role of the researcher is important in qualitative inquiry. The goal of hermeneutic inquiry is to interpret meaning through the blending of the researcher's understanding of information and data obtained from research participants (Kumar, 2012). Both the researcher and the participants reflect on and interpret meaning through the active sharing of personal beliefs, assumptions, and values to develop an understanding of the phenomenon (Conroy, 2003). Therefore, the researcher assumes an active role in hermeneutic inquiry as the primary instrument in data collection (i.e., the interviewer). The hermeneutic researcher circles between the parts and the whole, and as the meaning of the parts change, so does the whole (Boell & Cecez-Kecmanovic, 2010). My understanding, biases, and judgments as the researcher in this study are documented in the following section.

I am currently a licensed mental health counselor in the State of Washington and held a certification as a correctional health professional until March 2020. I have been employed as a mental health counselor providing clinical services to offenders in both the Florida Department of Corrections and Washington Department of Corrections. Early on in my pursuit to work as a correctional mental health counselor, I sought certification as a correctional health professional. Although I obtained this certificate, I perceived that it had little value to correctional employers as no employer suggested that I seek out this certification, nor was it discussed in my almost 10 years of working in corrections.

Working with offenders in correctional settings is incredibly challenging, and I quickly recognized how ill-prepared I was to work with this population. This realization occurred when I experienced manipulation by offenders and that my desire to help was something that was exploited in this environment. This experience was pivotal in my career and I was fortunate to have been supervised by a psychologist who had vast experience in correctional settings and specialized in the clinical construct of psychopathy. My supervisor recognized that the mental health counselors he supervised did not have the education and experience to work with offenders, so he made concerted efforts to provide the education, training, and supervision needed to become effective correctional clinicians. In the 10 years that I worked with offenders in varying correctional settings, I only wish that I had some exposure to the specific challenges that I encountered in this environment before my employment began. It has been my experience that very few of my coworkers and supervisors possessed the specialized knowledge and experience needed to work with offenders or within the correctional system. Most notably, there is a lack of understanding of the correctional system, inmate culture, the conflicting roles among mental health and correctional staff, and how the therapeutic relationship differs with incarcerated individuals.

Despite the many challenges I encountered while employed in corrections, I strongly believe that my clinical interventions were worthwhile, not only to the offenders that I worked with, but to their families, victims, and my community. My hope for this study was to highlight the disparities in the applicability of current education and training for providing mental health services to offenders in correctional settings. My experiences

greatly influenced my pre-understanding of this research and may have impacted this study. Several studies have highlighted the inadequacy of mental health services being provided to offenders in correctional settings (Brandt, 2012; Galanek, 2013; Hills et al., 2004). In my experience, I had no forensic coursework in my master's-level education. My practicum and internship experience included working under supervision with clients who would receive deferred sentences if they agreed to participate in an intensive substance abuse treatment program in a work release setting. Following this, I received a portion of my supervised experience at a post-master's level while employed in a minimum-security facility. However, I perceived these experiences as mere exposure to working with the population and was supervised by individuals who I thought lacked the knowledge and skills that I now consider essential to working with offenders. It was not until a became a licensed mental health counselor and had the opportunity to work in a maximum-security facility with a supervising psychologist specializing in forensic populations that I believe I was provided the training and supervision needed to work more effectively with offender populations. My experiences ultimately served as motivation to research the phenomenon in this study.

In hermeneutic inquiry, the researcher should reflect on their pre-understanding, including biases, while remaining open in the exploration of the phenomenon from the perspective of the participant's experiences (Heinonen, 2015). This process is referred to as hermeneutic reduction. As the primary researcher, I ensured that participants had an understanding of the problem, purpose, and intent of the research study. In addition, I explained how data would be analyzed to reduce potential challenges regarding the

trustworthiness of the study (Kornbluh, 2015). I used semistructured interview questions that were designed to focus on and describe the participant's experiences. To minimize my biases so that they were not reflected in the interpretation of data, I sent transcribed interviews to each of the participants to obtain clarifications on information and to allow them to review the transcripts for accuracy and make any corrections.

Ethical Issues

Artal and Rubenfeld (2017) identified basic requirements for ethical research, including scientific validity, social value, that the benefits of the research outweigh the risk, informed consent, protection of the confidentiality and privacy of participants, equitable selection of participants, protection for vulnerable populations, data integrity, and independent review of the proposed research. Ethical approval was obtained from the Institutional Review Board (IRB) through Walden University (Approval no. 01-07-20-0273578). Participants were asked to review the consent form that addressed the purpose of the study, foreseeable risks, potential benefits, confidentiality, and participants' rights, including the right to withdraw from the study at any time and contact me for more information (National Institute of Health [NIH], 2011). Research participants were assigned numbers, and no identifying information (e.g., name, age, race, institution name) was included in the study. Electronic data were stored on a password-protected laptop and backed up on a USB device that was also password protected. Interviews were conducted through the videoconferencing platform, Zoom. A transcription service was utilized and included a Business Associate Agreement. Research participants were recruited through CESNET, the Walden Participant Pool, and snowball sampling.

Participants were not recruited from my work site. A potential conflict of interest may have been experienced by the participants due to perceived power differentials due to my being a doctoral student. However, this risk appeared to be minimal as I practiced at a master's level. Molyneux et al. (2016) noted that building appropriate relationships in research is important and suggested that instead of a researcher-interviewee relationship, the researcher should strive to develop partnerships with the participants. Therefore, I planned to maintain the position that my focus was on understanding the experiences of the participants and partnering with them to develop an understanding of the phenomenon.

Methodology

Participants

Participant selection in interpretive phenomenology aims to target participants who meet specific criteria and have lived the experience that the researcher is studying (Laverty, 2003). Purposive sampling allows a researcher to gather in-depth information about a particular phenomenon by selecting participants who have knowledge about the phenomenon being studied (Patton, 2002). The justification for purposive sampling in this study was the ability to gather information specific to counselor experiences in correctional settings. This would not have been achieved if random sampling was applied. Criterion sampling was the primary method of sampling used. Snowball sampling is another purposive sampling approach that involves asking participants to identify individuals who have similar experiences to the identified phenomenon that is being studied (Patton, 2002). I used snowball sampling when potential research

participants contacted me but did not meet the criteria for the study. I asked these individuals if they could forward the request for participation to others who met the criteria for the study. Participants had to meet the following predetermined criteria:

- Participants had to be 18 years of age or older.
- Participants had to hold a master's degree in counseling from a CACREP-accredited program.
- Participants had to hold a license as a mental health counselor in their respective states.
- Participants had to be employed, or previously have been employed, in a correctional setting providing mental health services to offenders for no less than six months.
- Participants had to speak the same language as the researcher (English).

I verified that the participants were licensed by conducting a credential search of the participants' names in their respective locations. Sample size recommendations for qualitative research are estimated as being between six and eight participants (Marshall et al., 2013), or until saturation occurs. Saturation occurs when information becomes redundant or when no new data emerges during the interviews (Cleary et al., 2014). There was a total of nine participants in this research study.

Instrumentation

As the researcher, I was the primary instrument in this hermeneutic qualitative study. Data were obtained through semistructured interviews. The primary interview allowed me to gather rich information about each participant's experiences, and I used

follow-up emails to seek accuracy and clarification of the participants' meaning. McConnell et al. (2011) recommended that sufficient time be dedicated to the initial interview and that the interviewer seek immediate clarification. This ensures that the researcher has a safety net and is not reliant on the second interview for purposes of obtaining clarification. The researcher needs to be self-aware during the interview and maintain a critical stance to authentically describe the experiences of the participants while acknowledging how personal attitudes, beliefs, and knowledge are related to the phenomenon (Bevan, 2014). Hermeneutic inquiry relies on the researcher's ability to remain self-aware. Self-awareness can be maintained by having the researcher document their biases (Whitehead, 2004). Semistructured interview questions were used to obtain information about participants' experiences and included but were not limited to the following.

- Please describe your master's-level counselor education.
- Please describe any coursework specific to corrections that you had at the master's level.
- Please describe any post-master's education that you obtained specific to corrections.
- Did you have any supervised experience in a correctional setting or working with offenders at either the pre- or post-master's level? If so, please explain.
- Please share any training that you have completed specific to corrections.
- What has been your experience working in correctional settings with offenders?

- Please describe your work environment while employed in a correctional setting.
- Please provide a description of your job duties and responsibilities while employed in a correctional setting.
- What have been your experiences working with offenders in correctional settings?
- How has your master's-level education influenced your work with offenders in correctional settings?
- What education or training have you experienced that has been valuable to your work with offenders in correctional settings?
- Please describe any challenges you have encountered in applying your education and training to your work with offenders in correctional settings.
- Please describe any supervision you have received while working with offenders in correctional settings.
- Did you experience any challenges while working in a correctional environment? If so, can you explain?
- Did you experience any challenges while working with offenders? If so, can you explain?
- What has been your experience working as a treatment provider with correctional staff within a correctional institution?
- Have you experienced any ethical or legal challenges while working with offenders in correctional settings? If so, please describe.

- How have you managed ethical or legal challenges, if applicable?

While semistructured questions were utilized, I remained flexible in the examination of each participant's experiences, and further questions were asked that were relevant to each individual (Bevan, 2014). Probing allowed me to develop clarification and understanding of the phenomenon and included statements or questions such as (a) "Tell me more about…", (b) "What was that like?" (c) "Describe the environment," and (d) "What did you do?" (McConnell-Henry et al., 2011). It was important to actively listen to each participant's story and acknowledge that they were the experts on their experiences (McConnell et al., 2011). Maintaining a phenomenological lens and engaging in the hermeneutic experience resulted in a broadening of my understanding and view of the phenomenon. New perspectives should be gained from past experiences (Kakkori, 2010).

Data Collection

Obtaining rich data that expresses a thorough meaning of the phenomenon under study depends on the researcher's ability to fully understand and describe the study to participants (Grossoehme, 2014). Therefore, a description of the study was included in the request for participation. Participants who demonstrated an interest in the study had the opportunity to speak with the researcher and were allowed to ask questions to understand the purpose of the study. Data were obtained through semistructured interviews and follow-up emails. Semistructured interviews allowed me to engage in conversational relationships to gather information about the participants (Ajjawi & Higgs, 2007). Interviews were conducted with Zoom, which is a HIPPA-compliant

videoconferencing platform. The interviews were recorded and saved on my laptop. Data analysis occurred in conjunction with data collection. According to Kumar (2012), data analysis in interpretive phenomenology involves seven steps including (a) reading interviews; (b) writing and coding emerging themes; (c) analyzing transcripts and grouping themes; (d) identifying and clarifying disagreements in interpretation; (e) comparing, contrasting, identifying, and describing shared practices and common meanings; and (f) identifying links in patterns and themes (Kumar, 2012, pp. 798-799). The data analysis included the following steps.

- Documenting gaps, unclear information, missing information, or disagreements.
- Recorded interviews were forwarded to a HIPPA-compliant transcription service and then member-checked by participants to ensure accuracy of the transcriptions.
- I read each transcript in its entirety.
- I followed up with participants to address disparities, missing, or unclear information.
- I then clarified any disparities, missing, or unclear information in the original transcript.
- I coded emerging themes from the transcripts using hand-coding and qualitative software.
- Themes were organized based on the semistructured interview questions.
- I then created a general description of participants' experiences.

Data analysis for the study followed the proposed plan stated above with minor modifications. The researcher intended to take field notes, however, this was abandoned during the initial interview with Participant 1 as it presented as a distraction and interrupted the flow of the interview. The interviews were video recorded, and therefore I was able to observe participant behavior when watching the interviews again. The second step was to document gaps, unclear information, missing information, or disagreements. Having an understanding of correctional mental health, I addressed gaps in the initial interviews with participants. For example, Participant 1 reported that offenders "are committed to juvenile corrections for 30 days or so" for an assessment, however, he noted that very few clients completed treatment within 30 days. I asked for clarification to gain a better understanding. Participant 1 reported that the juveniles completed an assessment during that time, but that the duration of treatment was determined by the clinical team. He clarified that treatment was for 30 days "or so, as long as it takes for you to be rehabilitated." Participant 4 noted discrepancies in sex offender treatment between states so I asked her to describe the difference. She reported, "In Utah, they attend sex offender treatment programs because they want to leave prison…If they were accepted, if they completed the program, that means that likely 98% I would say they were guaranteed getting out." Additionally, the first two participants both indicated the trauma was significant, with Participant 1 stating, "You have kids with a history of trauma" and "the environment itself is, I think, traumatizing" and Participant 2 noting that the majority of offenders "have experienced a lot of trauma." Both participants reported seeking out certifications as trauma professionals. As a result of these

observations, I inquired about trauma in subsequent interviews. For example, Participant 6 was asked "Was trauma a big part of what you were seeing?"

The third step was to forward the interviews to a HIPAA-compliant transcription service and then have the participants check the transcriptions for accuracy. However, I modified this step after reviewing the transcribed interviews and noticing missing or incorrect information due to audio quality or transcriber error. Therefore, once the interviews were completed and transcribed, I watched the recorded interviews while simultaneously reviewing the transcriptions and making necessary corrections. Examples of this type of correction included, (a) Participant 4's initial transcription read, "So that's why vendors are treated a little better than you'd law," but when I reviewed the recording, the participant actually stated, "So that's why offenders are treated a little better than Utah." (b) Participant 5's initial transcription stated "And I think the correctional environment just becomes its own little world where people stop" but then the transcript noted a third speaker and reported "inaudible" on the transcript. When the tape was reviewed, the third speaker was actually me responding with "Mm, hmm," so this was deleted from the transcript and then corrected to "And I think the correctional environment just becomes its own little world where people stop being objective about themselves and certainly about other people." Transcribed interviews were then forwarded to participants in the fourth step to ensure accuracy and allow them to make corrections. Of the nine participants, only one participant made a correction. Participant 5 made a correction by deleting "a panel situation" that was transcribed in the interview that was inaccurate. I then corrected the original transcript.

In the fifth step, the transcribed interviews were uploaded into NVivo, and then I created codes based on semistructured interview questions and an understanding of information obtained from the literature review. Codes from the semistructured interview questions included education, training, supervision, experience, and challenges. In the sixth step, new codes were added as more data was collected and analyzed. For example, Participant 1 shared that the noise level in the correctional setting was problematic and stated, "It was very hard to find a place somewhere in the facility that was quiet." Previous studies acknowledged that sensory issues (noise, smell) negatively impacted staff and offenders; therefore, *noise* was added as a code to NVivo. The participants were asked to describe their work environments, and the researcher additionally inquired about sensory issues in subsequent interviews. From this, Participants 6 and 9 both reported being exposed to pepper spray while employed in corrections, with Participant 9 sharing "If somebody [offender] got sprayed…you sat in that…you really can't focus." Therefore, *smell* was added as a code in NVivo. Once the transcripts were reviewed and hand-coded by me, the codes were then collapsed into smaller categories. For example, noise and smell were condensed into the "environment" code. When this step was completed, the following codes emerged: education, training, environment, culture, gangs, safety, competing values and goals, staffing, mental health treatment, trauma, challenges, managing challenges, mental health counselor experiences, and recommendations.

In the final step, I created a general description of participant experiences and then organized them into broader themes. For example, when participants were asked if they felt prepared to work in corrections, I noticed a pattern.

- Participant 8 stated, “my school definitely did not prepare me.”
- Participant 1 reported, “I think from a training standpoint, education standpoint, I wasn’t really prepared.”
- Participant 7 reported, “I do not know if anything would have really prepared me…you’re not really ready to work in a prison.”
- Participant 4 reported, “It is such a learning curve when you go into corrections.”
- Participant 6 reported not feeling prepared and that the expectation was, “you’re going to figure it out.”

None of the participants recalled having coursework specific to corrections at a master’s level. Therefore, the education and training codes were condensed into a broader theme and titled “lack of specialized education and training.” This process continued until the following themes were finalized: (a) a lack of specialized education and training, (b) environmental challenges, (c) institutional culture, (d) competing goals and values, and (e) mental health treatment in correctional settings.

A hermeneutic lens with an established pre-understanding was important for recognizing data saturation (Boell & Cecez-Kecmanovic, 2010). Data collection stopped when saturation occurred. Saturation occurs when information becomes redundant or when no new information emerges during interviews (Cleary et al., 2014; Gentles et al., 2015). I stopped data collection after interviewing nine participants.

Trustworthiness

According to Lincoln and Guba (2007), trustworthiness can be obtained in qualitative research through credibility as an analog to internal validity, transferability as an analog to external validity, dependability as an analog to reliability, and confirmability as an analog to objectivity (p. 18). Credibility in this hermeneutic phenomenological study was established in several ways. I developed pre-determined questions and maintained that any further questions asked were relevant to the participants and remained within the context of the study (Bevan, 2014). Identifying and discussing discrepancies in data increased the credibility of the research study and offered deeper insight into the phenomenon (Patton, 1999). Critical reflexivity, or the identification of power differentials (Kornbluh, 2015), was considered to enhance confirmability in qualitative research. I maintained an awareness of hierarchical differences, how interactions may affect perceptions and feedback between the researcher and the participant, and the potential political implications of the research findings (Kornbluh, 2015). During the recruitment and data collection process, I provided participants with information about data collection and analysis and encouraged questions about the study. I solicited feedback from the participants, which Kornbluh (2015) called member checking. Lincoln and Guba (2007) stated that member checking should be a continuous process and can be achieved through informal testing of the researcher's reconstruction of participants' experiences. I ensured an understanding of the participants' perspectives by asking for clarification and summarizing their statements during the interview process and in the follow-up interview. I allowed the participants to review the transcribed

interviews and check them for accuracy (Conroy, 2003). The feedback I obtained from the participants was included in the data analysis. Transferability is obtained through thorough and rich descriptive data (Lincoln & Guba, 2007). Therefore, I provided descriptions of the participants' respective correctional environments, job duties, requirements, education, training, and experiences.

Ethical Procedures

There were no anticipated ethical concerns related to recruitment materials or processes. I did not plan to recruit participants known to the researcher or from the researcher's work site to avoid potential conflicts of interest. Potential ethical concerns related to the data collection process included participant refusal and withdrawal from the research study, the activation of traumatic memories or experiences related to working with offenders in correctional settings, and sensitivity related to disclosing information about offenders or the correctional system. Participants were informed prior to the study that their participation was voluntary and that they could withdraw at any time during the process. Participants were provided with informed consent electronically and were asked to consent in a return response. Potential ethical issues and risks associated with participation in the study were disclosed in the informed consent. This included having access to mental health services should the participant experience an adverse reaction related to the activation of traumatic memories and experiences. The participants' confidentiality was maintained in the study and the research did not include identifying information about the participants such as their names, ages, marital statuses, professional license number, or the name of the institution where they were employed. I documented

the participants' names and assigned codes on a single password-protected Word document that was only known to me. Recorded interviews, transcribed interviews, and information related to the participants were stored on electronic equipment including a laptop requiring a password for access and a USB memory stick was utilized as a backup for storing research information. I will maintain data in my home office for 5 years, and thereafter it will be destroyed. Ethical issues or concerns were reviewed by the IRB. In addition to the review by the IRB, I completed training at the NIH on protecting human participants. The research did not include the use of incentives, nor were there sponsors affiliated with the study.

Summary

In this qualitative study, I utilized a hermeneutic phenomenological research design to understand participant experiences working with offenders in correctional settings. Through hermeneutic inquiry, I sought to understand how master's-level mental health counselors interpret their education and experience in clinical practice despite evidence from the literature that little preparation exists. I remained faithful to hermeneutic inquiry by maintaining self-awareness and critical reflexivity of personal biases, attitudes, beliefs, and experiences. Researcher biases, judgments, and reactions were documented in field notes and included in the data analysis. Trustworthiness in this study was maintained through techniques that facilitated credibility, transferability, confirmability, and dependability. Ultimately, I acknowledged that alternate perspectives were gained from the research. This knowledge was not considered complete at the

conclusion of the study as hermeneutic phenomenology maintains that knowledge about a particular phenomenon is never fully complete (Davidsen, 2013).

Chapter 4 will discuss research findings and include information on the setting, participant demographics, data collection, data analysis, and evidence of trustworthiness.

Chapter 4: Results

The purpose of this qualitative study was to understand the lived experiences of master's-level mental health counselors working with offenders in correctional settings. Additionally, I sought to identify how this population managed challenges, specifically environmental and cultural challenges, in correctional settings. I structured the interview questions to gather information on master's-level counselor education; coursework specific to corrections; post-master's education, training, and supervised experience specific to corrections; personal experiences working with offenders in correctional settings; how counselors' educations influenced their work with offenders; challenges counselors experienced either with offenders or within the correctional environment; the unique needs of correctional mental health counselors; and any suggestions counselors may have regarding the education, training, or experience needed when working with offenders in correctional settings.

In Chapter 4, the research findings are presented and connected with the hermeneutic phenomenological philosophy. I discuss the setting, participant demographics, data collection, data analysis, and trustworthiness. Following this, I address the research questions, present the data gathered from the participants, and discuss discrepancies. In conclusion, the research is summarized and answers to the research questions are provided.

Research Setting

At the time of the research study and during data collection, the world was facing the COVID-19 pandemic as well as the widespread reactions to social injustice related to

police brutality and racism. The first confirmed case of COVID-19 in the United States occurred on February 27, 2020 (CDC, 2020). What followed were mandatory closures of businesses and schools, stay-at-home orders that varied across the United States, the implementation of social distancing, and mandatory safety precautions. Although the interviews started in the Winter 2019 term, due to unforeseen circumstances, data collection was delayed until Summer 2020. Two participants completed their interviews in the Winter 2019 term, and follow-up emails with the transcribed interviews were emailed to both of them for feedback and the option to set up follow-up interviews, but neither participant responded. COVID-19-related issues were reported during interviews by three of the nine participants in the study, but this appeared limited to a reduction in service provisions such as group therapy or having alternate work schedules. Three of the nine participants were not employed in corrections at the time that data were collected, and one participant was interviewed before COVID-19.

Demographics

I established a set of criteria for potential research participants during the recruitment process. The criteria for inclusion in this research study were that participants were (a) 18 years of age or older, (b) had a master's degree in counseling from a CACREP-accredited program, (c) held a current license as a mental health counselor, (d) were employed or had previously been employed in a correctional setting providing mental health services to offenders for no less than 6 months, and (e) were primarily English speakers. Additional information about each participant included the state in

which they were employed, the type of treatment setting, the offender demographic being served, and the custody level of the offenders or correctional facility.

Participant 1

Participant 1 was a licensed professional counselor and a certified trauma professional in the state of Arizona. He held a master's degree in clinical mental health counseling. He was employed with the Juvenile Department of Corrections for approximately 16 months. He worked with both male and female inmates ages 14 to 19 who were classified as low to medium risk. His job duties included assessment, individual and group therapy, and crisis intervention. He also provided in-service training and instruction to correctional staff on suicide prevention and assessment.

Participant 2

Participant 2 was a licensed professional counselor, national certified counselor, and certified clinical trauma professional in the state of Michigan. She held a master's degree in clinical mental health counseling. She had been employed with the Department of Corrections for approximately 1 year. She worked with adult women in a residential treatment program with severely mentally ill offenders. The offender's custody levels ranged from low to maximum security. Participant 2's primary job duties included evaluations for suicide with offenders in acute care settings who required crisis stabilization, individual and group therapy, supervision of prisoner mentors, and crisis intervention.

Participant 3

Participant 3 was licensed as an associate psychologist in Canada. This license is comparable to a master's-level mental health counselor in the United States. She held a master's degree in counseling psychology. She had been employed with the Correctional Service of Canada for approximately 7 years. She worked with male inmates in a low- to medium-security prison, with most of her experience being in the maximum-security prison located on the same property. Her primary job duties included risk assessments and individual therapy.

Participant 4

Participant 4 was a licensed professional counselor in the state of Colorado. She held a master's degree in clinical mental health counseling. She had been employed with the Department of Corrections for 1 year. She was also employed as a contract provider with the Department of Corrections in Utah as a sex offender treatment specialist for approximately 5 years prior to her position in Colorado. At the time of the study, she worked with developmentally disabled adult men in a therapeutic community. The custody level of these offenders was low. Her primary job responsibilities included individual and group therapy, life skills training, and crisis intervention.

Participant 5

Participant 5 was a licensed professional counselor in the state of Tennessee. She held a master's degree in mental health counseling. She had been employed with the Department of Corrections for approximately 6 years. She worked with female inmates in a facility that housed offenders with custody levels ranging from low-restricted to

maximum security, and she primarily saw offenders classified as low-restricted and residing in general population. Her primary job duties included individual and group therapy.

Participant 6

Participant 6 was a qualified mental health professional in the state of Virginia. She held a master's degree in counseling. She was employed in a juvenile forensic evaluation program within a juvenile detention facility for approximately 4 years. She worked with adolescent males and females. Her primary job duties included completing mental health evaluations, individual and family therapy, and case management.

Participant 7

Participant 7 was a licensed professional counselor-associate in South Carolina. She held a master's degree in counseling and development with a focus on clinical mental health counseling. She had been employed with the Department of Corrections for approximately 2 years. At the time of the study, she worked with male inmates in a maximum-security diversionary housing unit, where she had been for the past several months. The diversionary unit was for offenders with mental health and behavioral issues who were not able to reside in general population. The unit was considered to be an intensive outpatient treatment program. Before this, she worked with offenders in an outpatient setting in general population at a different facility. Her primary job duties included individual and group therapy, crisis intervention, and suicide assessments.

Participant 8

Participant 8 was a licensed mental health counselor and clinical supervisor in the state of Florida. She had a master's degree in counselor education. She had been employed with the Department of Corrections for 9 years. She worked with male inmates in an inpatient mental health unit. The offenders' custody levels in this facility were close management, which is a level below maximum security. Her primary job duties included individual and group therapy, case management, crisis intervention, biopsychosocial assessments, risk assessments, and supervising master's-level counselors. She also provided departmental training to correctional officers and staff members.

Participant 9

Participant 9 was a licensed mental health counselor in the state of Washington. She had a master's degree in clinical mental health counseling. She was employed with the Department of Corrections and County Jail for approximately 4 years. She worked as a counselor in several settings including providing services to offenders in jail, working with males inmates in an inpatient mental health treatment unit in a maximum-security facility, and providing outpatient services to offenders in a low- to medium-security facility. Her job duties included individual therapy, crisis intervention, case management, and suicide assessments. She also taught suicide prevention and assessment to correctional officers and staff.

Data Collection

Qualitative interviews were conducted with a total of nine participants. I determined that saturation was achieved when the information provided by the

participants in the interviews became redundant and no new information was emerging (Cleary et al., 2014; Gentles et al., 2015). Interviews were conducted via Zoom, a HIPAA-compliant videoconferencing platform. The participants and I completed the interviews from our homes in each of our respective states. I was located in Washington, and participants in this study were located in Arizona, Michigan, Canada, Colorado, Tennessee, Virginia, South Carolina, Florida, and Washington.

I did experience some variations in data collection from the designed methodology in Chapter 3. However, this was minimal. First, I had intended to take field notes during the interviews, but this was distracting and appeared to detract from the process, so I decided not to take notes during subsequent interviews. It is important to note that I did record and save qualitative interviews in a password-protected secure drive and that these videos were referenced several times during data analysis. Second, the recruitment process included sending out requests for participation in January 2020 through CESNET, the Walden Participant Pool, and snowball sampling. During data collection, I encountered unusual circumstances with the COVID-19 pandemic as well as nationwide protests addressing racial inequality. On June 5, 2020, Walden posted an announcement that COVID-19 had limited doctoral students' abilities to reach necessary populations for research and asked the Walden community for assistance through participation in student research. Most of the research participants were recruited directly from that announcement or assisted me in forwarding the request to others who met the criteria for participation in the study. Once eligibility was determined, I emailed the consent form to each participant and provided them an opportunity to ask questions, seek

clarification, or express concerns about the study. If the participants still agreed to participate in the study, then they were asked to reply to the email with the words "I consent," and then I coordinated with the participants to arrange the interviews.

The interviews were recorded on Zoom, and once completed, both the video and the audio-only files were saved to my computer. The data were obtained through semistructured interviews that lasted approximately 50 to 90 minutes each. As the researcher, I played an important role in the study and took a hermeneutic approach through a blending of my understanding with the data obtained from the participants (Kumar, 2012). My pre-understanding and biases were reflected in Chapter 3 before data collection began.

The data collection process transpired between January and July 2020. I decided to use an internet-based professional transcription service called Rev who agreed to a nondisclosure agreement. Audio-only files were uploaded to the website, transcribed, and made available for me to download as a Microsoft Word document. I then reviewed the transcriptions for accuracy by watching the recorded videos of the initial interviews and following along in the transcribed documents. I did omit words such as "um" and "like" from the original transcripts. Once this process was complete, I emailed the transcribed interviews to the research participants to review for accuracy, provide clarification, or make any necessary corrections, and I advised them that they could either make corrections or schedule follow-up video conferences with me. Seven of the nine participants responded to the emails and a minor change was made on one transcript.

Data Analysis

Data analysis occurred in conjunction with data collection through the reading of transcribed interviews, the writing and coding of emerging themes, the analyzing of transcripts, and the identification of links and patterns from the interviews (Kumar, 2012). I took a hermeneutic phenomenological approach during the interviews by using semistructured interview questions, as suggested by Reiners (2012). Asking additional questions and probing during the interviews allowed me to inquire about how master's-level counselors developed themselves as professionals when working with offenders in a correctional setting. I assumed that a hermeneutic phenomenological approach was most appropriate for me during the interviews because the terminology was familiar, although I did clarify terms or concepts within the interviews to ensure accuracy of understanding. When information was missing or seemed unclear, I asked participants to clarify during the interviews as well as in follow-up emails.

The hermeneutic circle, or the circular movement that begins with what is already known about a phenomenon (Gadamer, 1991; Yu, 2012), helped me in data analysis as the interviews progressed and themes emerged. In the initial interviews, trauma became an emerging theme and subsequently provided me with a prompt for further inquiry as data collection progressed and more information was gathered from participants. Once interviews were transcribed and checked by the participants for accuracy, and feedback was inserted into the original transcripts, I uploaded the interviews into NVivo, a program that aids in organizing and analyzing qualitative data (QSR International, 2020). Each interview was reviewed again and I organized themes based on questions asked in

the semistructured interviews as well as additional themes that emerged from the interviews. These themes were then placed in codes within the software. Once I had reviewed each of the interviews and highlighted and coded pertinent data, I reviewed the codes and then grouped them into overarching themes and subthemes. The themes that emerged from the data included (a) lack of specialized education and training, (b) environmental challenges, (c) correctional culture, (d) competing goals and values, and (e) mental health treatment in correctional settings.

As previously discussed in Chapter 3, phenomenological inquiry seeks to understand how things manifest through our interactions and being in the world (Vagle, 2014). In hermeneutic phenomenology, the researcher begins the process with a pre-understanding or foresight about the phenomenon being studied (Yu & Lau, 2012). As a licensed mental health counselor working in corrections, my pre-understanding of the phenomenon was that correctional mental health counselors lacked the specialized education, training, experience, and supervision to effectively work with offender populations. This pre-conception marked the beginning of the hermeneutic circle, which is the circular movement of the understanding of the phenomenon being studied (Gadamer, 1986, 1991). As information was obtained, I circled through developing an understanding of counselor experiences through a blending of my understanding with the data provided by the participants in the study. My understanding of the phenomenon changed very little as I analyzed the data with regards to there being a lack of education, training, and supervision specific to corrections. However, I gained an increased awareness of the level of trauma experienced by correctional mental health counselors

and the impact it had on the participants in the study. This impact appeared to be less significant when counselors felt supported by correctional staff and administrators, especially when there was mutual respect and understanding of the competing goals of mental health and correctional staff. In hermeneutic inquiry, the concept of *Dasein*, or being in the world, is formulated through "what is to be found by asking" (Macquarrie & Robinson, 1973, p. 26). My *Dasein* influenced the research as I developed connections to the participants through the shared unique experience of working with offenders in correctional settings. I think that my having an understanding of the correctional system and the unique challenges associated with this type of work allowed the participants to share their true experiences. The research affected me in that it sparked a sense of urgency regarding the need for advocacy for correctional mental health counselors.

The data did include discrepancies related to the settings and characteristics of the offender population. The types of mental health settings ranged from outpatient to intensive outpatient, therapeutic community, residential inpatient, and acute inpatient treatment. Six of the nine participants reported working in more than one of these settings, with most reporting that they had provided crisis intervention or conducted suicide and risk assessments of offenders in acute care who were at risk of harm to themselves or others. In addition, offenders are classified into varying custody levels, or security levels, based on safety and security risk that most commonly include minimum, or low, medium, high, or maximum custody (BOP, n.d.). Of the nine participants, eight had provided mental health services to offenders who had been classified in multiple custody levels simultaneously or had worked in more than one setting while employed in

corrections. One participant who worked with juvenile offenders did not report custody levels for that population. While these variations existed, there remained similarities in counselor experiences as they related to working within the correctional setting and with correctional staff. Clinicians were more likely to experience complexity and complications with offenders at custody levels of maximum security or acute inpatient treatment, which is considered a high level of care. The discrepant information among settings and custody levels was noted in the participant demographic section and highlighted as needed in the results section. It is discussed further in Chapter 5.

Trustworthiness

As discussed in Chapter 3, trustworthiness was established through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 2007). Credibility was established by utilizing semistructured interview questions during each of the interviews along with additional questions that sought to find deeper insights into the counselors' experiences (Bevan, 2014; Patton, 1999). I sought to establish transferability by obtaining rich descriptive data from participants (Lincoln & Guba, 2007). This was obtained by asking questions related to their education, training, supervised experiences, and job duties and requirements, and seeking descriptions of their respective correctional settings, offender populations, and experiences working both in correctional settings and providing mental health services to offenders. Dependability was established continuously throughout data collection by asking questions, seeking clarification, and summarizing counselor experiences as well as by soliciting feedback from participants on the accuracy of their statements in transcripts and follow-up emails (Conroy, 2003;

Kornbluh, 2015; Lincoln & Guba, 2007). Confirmability was established in the recruitment and data collection processes by ensuring each participant reviewed the informed consent forms and provided their consent prior to participation, confirming that the researcher was a doctoral student, providing all participants with the opportunity to ask questions about the research, expressing any concerns, and making sure that the participants understood the purpose of the study.

Results of the Study

The semistructured interview questions provided answers to the research questions on how master's-level mental health counselors experience working with offenders in correctional settings and how they manage challenges. The interview questions asked participants to describe their master's-level educations, whether they had coursework specific to corrections at that level, and if they had any postmaster's education, supervision, or training specific to corrections. Additionally, further questions sought to explore how their education and training influenced their work, and what education and training they considered valuable when working with offenders in correctional settings. Participants described their job duties, responsibilities, and work environments. Participants were asked to describe their overall experiences working with offenders and correctional staff and providing mental health services and treatment within a correctional setting. They were asked if they experienced any challenges, including ethical and legal challenges, and how they managed those challenges. Finally, participants were asked about the unique needs of correctional mental health counselors and their recommendations for the education, training, or experience that they believed

was needed to work in a correctional environment. As previously mentioned, the following themes emerged after the data was analyzed: (a) a lack of specialized education and training, (b) environmental challenges, (c) issues with institutional culture, (d) competing goals and values, and (e) mental health treatment in correctional settings.

Theme 1: Lack of Specialized Education and Training

Education

The participants were asked to describe their master's-level education, training, and supervision, and to elaborate on whether any of these were specifically related to corrections. Of the nine participants, none recalled having coursework at a master's level, postmaster's education, or specialized training specific to working with offenders in correctional settings. Participant 7 reported that if working with offenders was mentioned in her master's program, it was "discussed very briefly," saying, "I wish there had been more." When asked about supervised experience, only one participant had supervised experience working with offenders in a correctional setting while doing their masters-level internship and completing supervision hours for licensure. Once hired, each of the participants reported receiving training for newly hired staff provided by their respective correctional employers. However, the training was not focused on clinical mental health counseling.

Training

Seven of the nine participants described having to go through correctional training but reported that this was alongside correctional officers and was referred to as "basic training" or "new officer academy." Participant 1 shared, "I couldn't march when I was

in the academy. I looked like an idiot because we had to march everywhere. It was definitely paramilitary." Participant 4 also compared training to the military and described a sense of being brainwashed into thinking, "We are a family. We take care of each other." Most counselors reported that the correctional training included classes on self-defense, facility operations, policies and procedures, safety, the use of radios, key safety, inmate manipulation, staff compromise, CPR, and the Prison Rape Elimination Act (PREA). From what participants shared about training, courses specific to their job as mental health counselors were limited to suicide prevention and assessment.

Continuing education specific to clinical mental health professionals working with offenders in correctional settings varied between participants. Participant 1 stated that it was difficult to find courses specific to forensic populations. Interestingly, he shared that one of his job responsibilities was facilitating a class on self-care, burnout, and compassion fatigue for correctional officers to fulfill their annual training requirements. However, he expressed, "I think that there was sort of this assumption that if you're a clinician, you kind of have that figured out than … if you're a correctional officer." When asked if there was anything similar to this for the clinical team, he reported that the team went out to dinner once monthly, but that there was no formal training or resources available. He did seek out training and certification as a trauma professional, as did Participant 2. Because trauma was prevalent among offenders, Participants 3 and 5 both received training or certification in Eye Movement Desensitization and Reprocessing (EMDR) and attended conferences after being hired. Participant 3 stated, "It is such a learning curve when you go into corrections, and I think

that they [corrections] really are doing a disservice to their new hires by not providing them more training from the beginning." She shared that, after hiring, training does continue. However, like Participant 1, most of what she learned, she learned on the job after many years. Participant 4 also noted that she felt her training was lacking, so she spent time researching ways to become an effective correctional mental health counselor on her own.

Participant 1 reflected on his education and training and shared, "I felt that it was lacking, to be honest. I felt that working in a correctional environment was so different … I think that from a training standpoint, an education standpoint, I wasn't really prepared." He went on to say that most of what he learned about providing clinical services to offenders happened through "trial and error" and anecdotal discussions during supervision from providers who had been in corrections for longer. This lack of specialized education and training was reflected in many of the participant's interviews. Participant 6 shared that much of what she learned from her master's level education was hard to implement in the field. She stated that when she walked in, she told herself, "put the books back on the shelf and you just need to pay attention … to learn from hands-on experience." She jokingly said that being a mental health counselor in a correctional environment was like "taking the Disney princesses and telling them that they were going to be in an Avenger's movie … and you're going to figure it out." When Participant 7 was asked about whether she felt prepared to work with offenders in correctional settings, she replied,

> No, honestly. But then again, I don't know if anything would have really prepared me for it. I feel like I could have been the most skilled clinician in the world, but you're not really ready to work in a prison environment.

This sentiment was also shared by Participant 8, who stated, "my school definitely did not prepare me at all for what I went through."

None of the participants in this study reported having coursework specific to corrections at a master's level. While many reported attending correctional training upon employment, the training appeared more relevant to correctional officers than clinical mental health staff. Many of the participants shared that training occurred on the job, but they still felt unprepared to work with offenders in correctional settings. Several of the participants reported seeking education and training specific to corrections as continuing education, but, as Participant 1 shared, opportunities were limited.

Theme 2: Environmental Challenges

A unique aspect of providing mental health services to offenders is that the services are provided within a secure correctional facility where the offenders are housed. All nine of the research participants reported encountering environmental challenges.

Physical Challenges

The participants were asked to describe the physical environment of their facility and many of the participants reported challenges related to the building structure. Participants 1 and 5 both reported that the correctional facilities in which they were employed were built before 1980, and both described them as "old." Participant 1 reported that the building was not in good repair and stated, "conditions-wise, it was not

great." He shared that a coworker was unable to work in her office due to mold caused by leaks when it rained. Participant 9 also experienced water damage in her office and described rust-colored water that leaked from the roof and dripped down her office walls. Participants 2, 7, and 9 all reported that their offices were essentially converted cells that were made into offices for mental health counselors and were located directly in the units where the offenders lived. Participant 4 shared that offenders often complained about conditions, with common issues being that lights were inoperable, running water was not available in cells, or toilets was clogged. She shared that offenders often intentionally flooded their cells with toilet water, something that was also shared by Participant 9.

Sensory Challenges

Many of the participants reported sensory disturbances, with primary issues related to noise levels and smells. Of the nine participants, eight reported that noise was a significant concern and that issues ranged from the sound of locking mechanisms, buzzing from control rooms, loud vents, and disruptive noises from officers and offenders that included yelling, kicking, screaming, and banging. Most of the participants noted that the noise levels impacted their abilities to provide mental health treatment to offenders.

Participant 1 reported that his office was located on the unit where the juvenile offenders were housed. He described his experience as follows:

> It was loud and crazy, it was a horrible environment to do therapy. I would have, or oftentimes, I would get interrupted where I was trying to work ... I would hear my radio in the background constantly. I would hear the TV, I would hear the kids laughing, yelling, joking with each other. I would hear them screaming. I would

> hear them fighting when they were fighting … I would hear officers barking orders … doors opening … the locking mechanisms are all automated … when they lock, then it's very loud.

He reported adjusting to this challenge by finding rooms that were not being used that were quieter, or seeing offenders during times when they were supposed to be in other areas, such as lunchtime, just to have the capability to provide services with fewer noise disruptions. Like Participant 1, Participant 9's office was also located on the unit where offenders were living, and she shared that she was able to overhear what was occurring on the unit and what offenders were saying. She reported, "You just kind of had to learn how to cope with the screaming … so, that was difficult, to get my work done sometimes in that setting."

Participant 5 shared similar experiences and noted that the sounds of keys and locking mechanisms were loud, that the noise levels were disruptive to treatment, and that she too had to become creative in finding alternate spaces in which to provide therapy with fewer distractions. She shared her experience as follows:

> I would say like a typical session, I might have two or three people come in and out of a room. And then even in the private rooms, the noise level can be disruptive … you have people yelling at each other … the security officer yelling, you'll have people occasionally, they get called down to see me and they're impatient and they don't want to wait and so sometimes they'll try to disrupt my current session.

Participant 5 also made attempts to see offenders in alternate locations, including staff break rooms or the offender's living unit. She reported that these rooms provided more privacy and were significantly quieter, however, these sessions would sometimes be disrupted by officers who were coming in and out to microwave their lunch.

Participants 2 and 7 reported that the noise levels varied from day to day. However, both reported that the noise was oftentimes aggressive outbursts from offenders who were yelling or arguing. Participant 2 reported that the offenders would become combative at times and the correctional officers would have to intervene, and the unit would then be shut down and the offenders would be required to go back to their cells. Participant 6 noted that the noise was terrible when she had to visit a juvenile in an adult correctional facility and stated, "I can hear the mentally ill. I can hear them screaming, banging their heads. One of them was like, 'I'm going to throw shit on this wall if you don't get me out.'"

Participant 8 reported that the noise level had become a significant problem within her institution due to a lawsuit that she believed made officers afraid to discipline offenders and maintain previous standards. She shared her experiences with providing individual and group therapy to offenders on the units:

> There's constant noise, kicking and yelling, and screaming while you're trying to do things … they're [administration] making us do a lot of sessions outside of the classrooms. So, they built tables in the wing. And you're trying to conduct group and you're trying to do all this stuff and they're [offenders] screaming and kicking and yelling. So, the counselor has a choice. I either continue and try to

> shout over them or cancel group and then these guys don't get their hours. So, it's a struggle right now.

She shared an experience of witnessing a coworker being overwhelmed and stressed after conducting one of these groups and stated, "a couple of her inmates that were in the group called psychological emergencies because they [offenders] were going crazy overhearing that [yelling, screaming, banging] for an hour straight. So, it's just not therapeutic."

Of the nine participants, four made references to smells in the environment. Two participants noted that smells were previously an issue, but due to lawsuits or COVID-19, this had improved. Participants 2 and 7 both reported having offenders who did not maintain their hygiene and would refuse to shower or have their laundry cleaned. Participants 6 and 9 both reported experiencing more disturbing smells. Participant 9 worked in a maximum-security unit and reported being exposed to oleoresin capsicum (OC), which is commonly referred to as pepper spray. She stated:

> If somebody got sprayed with OC, like you sat in that … you could get off the unit…but it wasn't as doable if you were needing to work and needing to get stuff done … I think once or twice I was actually stuck in my office … that was hard because you really can't focus when you're coughing to the point where you are feeling you have to gag … I don't think a lot of counselors could say … "I'm dealing with pepper spray today."

As previously mentioned, Participant 9 also reported that on occasion, offenders would intentionally flood their cells and that the toilet water would contain fecal matter.

She also noted that offenders would intentionally smear their feces in their cells on the walls and doors. This was also reported by Participant 6 when she visited a youth offender in an adult correctional facility and reported overhearing offenders threaten to throw fecal matter on the walls of the cell. When describing the smell of the facility, she reported, “It stinks really bad … Honestly, if I could describe it, it smells like dirty, funky gym socks and dirty butt. It’s so disgusting.”

Systemic Challenges

In addition to physical and sensory challenges, the participants also reported significant systemic challenges related to staffing and resources. Eight of the nine participants reported that staffing and turnover were problematic in their facilities. Participant 4 stated that they were “chronically” understaffed and under-resourced and that the facility was “constantly hiring.” Participant 7’s experience was similar, and she reported that they were “so severely understaffed, it’s not even funny” and that turnover was “huge.” Participant 1 noted “significant turnover” among officers as well, and shared that those officers that managed to remain for long periods “either were burnt out or were doing their own thing.” Participant 7 also reported that officers were often overworked due to being short-staffed and, as shared by Participant 4, the facilities were hiring new staff every week.

Staffing issues were not only problematic for correctional officers, but also mental health providers. Five of the nine participants reported inadequate staffing or significant caseload sizes. Participants 3 expressed frustration that for the 375 offenders who needed mental health services, there were only three providers. She stated, “There’s a lot of

people who could really need our help … we got people begging and they [offenders] give up after a while." Participant 5 reported that of the 800 women in her facility, approximately 600 receive some type of mental health treatment, and there are six mental health counselors in the institution. She shared,

> I follow such a large amount of people that I feel … internally, I'm feeling rushed … I believe that therapy is about creating space both physically and emotionally and seeing what happens. And so, sometimes I do not think that I am creating that space because I don't feel it within myself either.

Participant 7 reported that she and one other counselor split a mental health caseload of approximately 300 offenders. However, she noted that although there were 300 inmates on the designated caseload, the two mental health providers were essentially responsible for the entire population of offenders within the correctional facility. She expressed this frustration and stated:

> I understand security staff are short, but so is mental health … You can't expect them [mental health providers] to go through and see 150 inmates once every three months, complete treatment plans once every six months, and keep up to date on every other thing that needs to be done. Because it seems like there's a new job duty or new paperwork … that needs to be done every day.

Participant 9 also reported similar caseloads to Participant 7 and stated that for the 300 offenders on the mental health caseload, there were two mental health counselors and a psychologist, but that the counselors split the caseload. She stated,

> So, obviously you can't see 100 to 150 guys a week every week. So, we had to pretty much figure out who was needing therapy the most, who needed an annual check-in … for the most part, we saw our guys once a month, some were once every three months, and every six months.

As in the case described by Participant 7, although 300 offenders were designated as needing services, the two counselors were responsible for the entire population within the facility, which exceeded 800 offenders. She went on to say that she oftentimes found herself feeling as though "we were just trying to put out fires rather than actually doing good psychotherapy." She further expressed that even if they had been staffed appropriately, other resources were also limited. Participant 9 reported that she expressed issues with her office being on the living unit and that she wanted to also conduct groups, but the facility was not built to properly deal with the growing need for mental health and the space needed for this service. She expressed, "It was like fighting tooth and nail to get any of that stuff done for us, which was really frustrating." Participant 3 reported that the administration frequently moved the mental health counselors' offices until "we ended up being way back in some building."

Participant 5 reported that at times, she hesitated to offer services to an offender due to the size of her caseload, administrative restrictions on how often she could see offenders, or a lack of space to provide services. Similarly, Participant 3 reported that she did as much as she could with limited resources and expressed that she did not have the resources or time to invest in long-term therapy with clients. She reported, "we're being held back from doing our job in many different ways because of funding and lack of

resources." This same frustration was also reported by Participant 6, who said that an integral part of her job was to find community-based resources to prevent recidivism but reported that this was unsuccessful. She stated, "I always felt like I was hitting a dead end, always felt like I was disappointing to the kids. I always felt like I wasn't doing my job and it was very frustrating."

The lack of resources was also challenging when providing treatment to offenders. Participant 7 reported that it can be difficult to discuss coping strategies with offenders because of the lack of resources. For example, she was not able to provide colored pencils to offenders because specific items were not allowed in their cell. She also expressed that while it would be easy to suggest that offenders separate themselves from a situation or go work out, that this was difficult when they were confined to an eight-foot cell and not able to move freely within the institution. The lack of coping strategies led an inmate to make an inappropriate request to Participant 7, who shared her discomfort when an offender asked her to stand in front of his cell while he masturbated to completion because it would reportedly "relieve all the stress."

Safety Challenges

Most of the participants reported that safety was an issue in correctional settings. While most did not have a sense that their safety was always at risk, that the environment itself presented a risk to correctional officers and the offender population.

Out of the nine participants, eight described the correctional setting as an inherently unsafe environment for offenders. Participant 1 reported, "it's not a safe environment, it's just not." Participant 3 reported that most of the violence between

offenders is the result of or either debt issues or gang issues. In addition, it can be difficult to provide mental health services to offenders who may not feel particularly safe emotionally when returning from therapy to their assigned living area. Participant 4 shared that offenders at her facility shared rooms and that there being two men in cramped quarters could result in acts of aggression. Participant 7 stated that although offenders did not share rooms at her facility, "I'm pretty sure if they did, somebody would get hurt." Participant 5 stated, "not everybody feels safe in their own room. And even if they do feel relatively safe in their room, they're kind of reacting to a lot of stuff all the time." Participant 9 provided an example of offenders reacting to their environments all the time and how they became "paranoid" when coming to her office to see her for therapy. She reported that some clients often were fearful of what other offenders were thinking and that some of their fears "were legitimate." Participant 7 shared an example of how incidents among offenders can create an overall sense of feeling unsafe:

> There was a pretty big riot about two years ago … about eight inmates were killed. Now, it wasn't technically a riot, like all the news sources reported it as a riot, but it was a targeted attack … they [offenders] went through, they got the inmates they wanted to get, and that was that. There were some guys who were injured in the struggle that ended up on my caseload … they constantly worry … for their safety as to whether or not their roommate's going to stab them, or steal their money, or try and sexually assault them.

She shared that victimization does occur in prison and that offenders have been sexually assaulted by their peers. She reported that one offender was forced to perform oral sex on a peer and soon after an attempted suicide, and ultimately was transferred to the prison's psychiatric unit. Safety is not only a concern among the offender population but also for staff.

Participant 9 expressed concern over the growing incidents of staff assaults and self-harm among the inmate population and stated,

> We work in a risky environment … we can't assume that security is going to keep us safe … we need that understanding that we don't work in a community setting and that we have to be very careful and remember that every day so that we don't put ourselves in a dangerous situation.

Three participants – 1, 3, and 5 – all shared personal experiences where there was a sense of not feeling safe. Participant 5 shared that after having to make a report of child abuse, the offender became threatening, and she reported, "It felt almost physically threatening when I was in the room with her." Participant 3 reported that the officers often feared more for her safety. She shared several experiences, the first being an incident where an offender was "trashing his cell." She utilized de-escalation techniques and he agreed to speak with her outside of his cell. She recalled feeling confident that he would not hurt her in any way, but that the officers were positioned above her on a "gun walk" with their loaded weapons aiming towards the offender while she interviewed him. On another occasion, she shared,

> I had an inmate, he was cuffed … he had a spit shield on … the whole metal over his face … he was at a segregation review and he got up and he started to lurch at me and within, I don't know, our officers have such a fast response … it was like the blink of an eye. There were like 10 officers on him. He was on the ground and the pepper spray had been deployed. And, I just sat there …. and finally, I gasped, like what the heck just happened?

Participant 1 reported having one experience where he had to see a juvenile who had a history of officer assaults and presumably held a high rank in the Gangster Disciples gang. He shared:

> I'm confident that I could say that he's killed people. He was 16, but he was very strong, very muscular, very well built and I think there was a sense in me that when I was meeting him alone … where I was more aware of my surroundings, a lot more aware of exit routes and what the hell I am going to do if this doesn't go well.

He continued,

> Towards the end … the last few months when I left, one of the juveniles actually made a shank and stabbed one of the officers in the face, which was probably one of the more serious assaults that we saw. That one gave me some pause, although officers were targeted a lot more than clinical staff … I think that is just part of prison culture … it's kind of gnarly sometimes.

Every participant in this study reported dealing with at least one environmental challenge while working as a mental health counselor in a correctional setting, with many

experiencing a combination of challenges. Overall, participants described the correctional environment as disruptive and non-conducive to the provision of adequate or effective mental health services. Conditions were considered poor in many institutions and counselors were exposed to repulsive and disturbing smells (feces, pepper spray, poor hygiene), loud and disruptive noises (locking mechanisms, yelling, screaming, kicking, banging), aggression and violence (verbal threats, fighting, assaults, victimization), inadequate space, lack of privacy, limited resources, large caseloads, inadequate staffing, burnout, and turnover.

Theme 3: Correctional Culture

Many of the participants shared their experiences of a unique culture within correctional facilities involving both the institutional staff and offenders. At times, these cultural influences impacted treatment in significant ways.

Inmate Culture

Each correctional facility operates under its own policies, procedures, and rules. However, there is an unspoken set of rules that offenders seemingly abide by. Participant 2 reported, "prison has its own rules in terms of prisoner behavior. Its own language. Its own little world." Participants 1 and 3 both expressed that offenders often have to be aware of not giving off the appearance that they are "weak" and that they "have to put on a brave face…a tough face in order to protect themselves." Participant 1 shared that they often become hypervigilant and "on guard" to remain aware of their surroundings. Participants 4, 5, and 9 all referenced the convict code about not snitching in prison and stated, "Offenders don't snitch on each other. That is like a known code," and "There is a

stigma against snitches … their code is just so ingrained … they really have to kind of abide by this code of not telling the police." They expressed that oftentimes, because they were technically correctional staff, that offenders would view them as "the police," and that offenders' adherence to the convict code would often interfere with them seeking out mental health treatment, or if they were in treatment, they often reported feeling distrustful or cautious in what they shared. Participant 4 acknowledged the presence of the convict code with the offenders and would share with them, "I know that you guys have something that you follow aside from the obvious rules that we have … I am not going to get into that too much … but I am here to help you to make better decisions." She felt it was important to bring up, but did not pressure the offenders to disclose underlying factors that may have been influencing how they thought or behaved, and cited, "Offenders have a huge issue with new therapists for that."

Several of the participants acknowledged manipulation as part of the inmate culture. The participants were educated on these behaviors at the beginning of their employment while going through correctional training. For mental health counselors, these behaviors manifested in offenders' attempts to misuse mental health services to obtain perceived benefits, particularly offenders who were housed in closed or maximum-security institutions. Participant 7 reported that offenders would report thoughts to harm themselves and stated,

> We get a lot of guys who say they are suicidal … or they'll say, "I'm suicidal, homicidal" like it's all one word … nine times out of ten it's primarily guys who

> are trying to get a transfer to a different institution … they think that if they say it [suicidal] they're going to get their way.

She reported that offenders often became educated on mental health terminology and symptomology and would report these issues to a psychiatrist to be prescribed medication to help them sleep since poor sleep is a common complaint among offenders. However, she noted that poor sleep is not eligible for mental health treatment at her facility. Additionally, she stated offenders will also seek out mental health services for certain protections:

> Especially when it comes to uses of force … they [officers] cannot just go in on an inmate unless he is doing something really stupid … but, if it is a planned use of force, that means mental health has to be involved … if they get a write up in prison, then mental health has to be involved to make sure they are not being unfairly charged due to their mental status. Now, I am sorry, if a guy is masturbating … that is not a mental health issue … it's a behavior issue. But they [offenders] think because of their "mental health," that means it will get them out of certain charges.

Participant 4 also reported that offenders will often report that they are suicidal in an attempt to be removed from a particular unit or to avoid being in general population. She shared that in her experience, offenders will use mental health as a means to avoid paying a debt or because they feel unsafe. Participant 8 reported that trying to manage these behaviors can be challenging. She stated that while not all offenders engage in manipulation, her facility housed "the worst of the worst" in terms of behaviors,

manipulation, and what they are willing to do to achieve the desired outcome. She worked in an inpatient mental health unit, and stated,

> The biggest thing we are seeing now is the self-harm. They [corrections] have made the inpatient unit so desirable … air conditioning … they get more in inpatient. They now allow female staff, officers, to work in inpatient. I mean, I know that sounds like a silly reason, but you got these guys who have life in prison and that's all they want is to spend time around females … and so, it is so desirable for inmates to be in that setting [inpatient] that they are willing to take it to the extreme … I compare it to a cruise ship … to this all-inclusive resort … and get all these special privileges.

Participant 5 shared that as the offenders become frustrated with their lives, she also acknowledged their willingness to "take it to another level." Participant 9 also worked in maximum security and shared that those offenders were the most behaviorally inappropriate. She reported there were a lot of guys "who would just get into fights because they didn't get what they wanted."

Institutional Culture

As described earlier in the training section, the participants described the correctional environment as having a paramilitary or military-style culture. Participant 1 described the culture as follows:

> It's very black and white, it's very rigid. It was very clear in a sense of right, wrong, we do this this way, we don't do this this way. I think there were situations that were more neutral or required greater levels of complexity, there

> was a lot of pushback about that … because it was like, "No … this is what we are supposed to do and we're not going to change it because this is how it's done."

Participant 4 expressed a sense of "narrow-mindedness" and she thought that the corrections environment shared the same mentality of the military in the sense of following orders with the expectation, "just don't complain." Participant 1 expressed frustration that there needed to be drastic changes, but that change felt like it took forever. This frustration was also shared by Participant 7 who stated, "Nothing ever moves quickly with the Department of Corrections." She reported that oftentimes units lacked direction or established policies on how they should be operated. Participant 5 expressed her concerns about the culture and shared,

> So, punishing those less powerful, kind of kick the dog syndrome. Like, when you have had a hard day and you come home, and you yell at your kids. I think that the inmates are just those kids that are there all the time. And so, a lot of people that work in corrections can kind of get away with some pretty terrible mistreatment of the inmate population.

Participant 1 also reported witnessing officers being "horrible" and would overhear them yelling, cursing, and telling the offenders that they were "a piece of shit." He shared that overall, the majority of the interactions with officers and offenders were good, but that for some officers, "it was kind of a free-for-all … which I think wasn't helpful … [it] also made the environment kind of chaotic."

The participants also shared their experiences with being providers within a correctional environment that was characteristically chaotic, traumatic, and sometimes violent. Some of the participants were affected by their time spent employed as correctional mental health counselors. Participant 1 shared:

> I only witnessed a few assaults that I would say were pretty bad. Mostly it was the self-harm that I found more disturbing. That was what I think was more distressing for me. What I actually found to be more traumatic than anything else was the hyperarousal and awareness of my surroundings even when I wasn't there. I was so much more sensitive to noises and I think that my startle response got a lot higher after working there.

Participant 9 also shared some of her experiences:

> I mean, I have seen guys hanging, I have seen guys cutting themselves, I've had guys slamming their head into the door that I'm standing at … I've seen guys taken to the ground, I seen fights, I've seen … like, a lot … a lot of different kinds of traumas.

Participant 6 described certain aspects of her job working with juvenile females as the most "gut-wrenching, heart-grabbing" experience. She shared,

> I've worked with 10-year-olds, 11-year-olds, 12-year-olds who were runaways … they were prostituting, they were being sex-trafficked. And, it was willingly. … just to hear them talk about going to have pregnancy terminations, because if they were pregnant, they couldn't work … they would get abused, they would get beat up.

Participant 3 reported that she often was called to intervene during crises. On one occasion, she was asked to assess an offender whom she had been treating while he was in segregation. She shared that when she arrived, she noticed several officers and nursing staff around the offender's cell. She learned that the offender had taken multiple medications and shared,

> My response … so we have to extract him and get him to an outside hospital … And they're [nurse and officers] like, "No, we're not touching him, I am not getting sued." The nurse wouldn't do anything. The officers wouldn't do anything … I was really upset … I was like this is bizarre … this is so stupid … right then and there I know this is not what I was trained to do.

She reported that she began documenting the situation and made phone calls to clinical staff, but ultimately the offender became faint and the officers did arrange for him to be transported to an outside hospital where he received treatment and survived the overdose attempt.

Participant 5 shared that sometimes the troublesome behaviors did not come from the offenders but from the correctional staff. She stated,

> There was a situation where about four officers just, frankly, beat up an elderly woman, an inmate. I reported it to adult protective services, but they basically told me that they don't deal with corrections. If it happened in a correctional system, they don't go and investigate … and what that meant was the officers were not punished … officers repeatedly having sexual relationships with inmates ...

> unfortunately that's not uncommon … the correctional environment just becomes its own little world.

Participant 3 shared similar stories about staff and reported that a nurse recently was terminated from her job after an inmate died after pepper spray was deployed. She reported that the nurse was alone on her shift and watched the incident occur and did not intervene. She stated, "you get a really unhealthy environment, then you're dealing with a lot of unhealthy behaviors as well." Participant 7 expressed frustration and stated,

> I know that there's these officers that are calling these guys names, are messing with food, or causing these outbursts … it's frustrating because you try so hard. In all the good work that I do with an inmate, it can just be totally undone by one bad officer.

Participant 5 shared these experiences and reported that systemic failures are often disempowering for both offenders and mental health counselors. She expressed how she felt being a part of the correctional system,

> I rationalize it like, well, I'm genuinely trying to go in and do my best and it's better for me to be there and be a good presence and a healthy person in this environment than to not be there. But then I wonder … am I being complicit though? With this maltreatment, should I be at the news? I mean, we see all these kinds of things come out and it doesn't necessarily change the system … I have not figured out the answer yet.

Participant 1 reported feeling a sense of hopelessness:

> Even though at times I felt impactful and I felt effective as a clinician, I think those times were … well, not as often as I would have liked … I felt that a lot of things that were barriers to me were outside of my control … despite my attempts to advocate.

Sometimes the offenders reacted to their environments. Participant 3 reported that offenders would file false allegations against staff for misconduct. She had an experience where an offender alleged that she asked him to expose his penis to her. She stated, "you think that if you have actual misconduct that somebody's going to complain about you, but then you get these people who are just bored. They have nothing to do. And, nobody prepares you for that." Participant 7 also shared her experiences with offender behaviors:

> These guys are understandably stuck in the room for what seems like 24 hours a day … they get antsy … they get restless, they start yelling and screaming. Or, if I am going on the unit, I hear some very lewd comments about my appearance … I have to constantly be dealing with that … it's not just me, it's any female … they're [offenders] making comments and then I also have to deal with the loveliness of public masturbation.

All of the participants acknowledged a distinct culture among both offenders and the institution of corrections itself. Among offenders, participants noted an unspoken set of rules that influenced thinking and behavior, which included not appearing "weak," hypervigilance, distrust of correctional staff, and using manipulation to get their needs met. The institutional culture was comparable to a military or paramilitary structure that was hierarchical, rigid, and adherent to policies and procedures and where orders were

expected to be followed and carried out. For many of the participants, this structure was unfamiliar and often difficult to navigate. This difficulty was noted by several participants working with offenders who reported suicidal or homicidal ideations. Counselors often had to determine the risk of self-harm or suicide while taking into consideration secondary gain and manipulation. This was further complicated by cultural influences and factors in the correctional environment such as interactions with officers, the complex social structure between offenders, the differences in crisis response between correctional and clinical staff, and systemic failures in the correctional system. Ultimately, most of the participants acknowledged that both offender and institutional culture had impacted their abilities to provide adequate and effective mental health treatment to offenders in correctional settings.

Theme 4: Competing Goals and Values

Eight of the nine participants acknowledged that competing goals existed between clinical mental health staff and correctional staff: the goals of rehabilitation versus punishment. Many of the participants shared their experiences with trying to navigate providing mental health treatment to offenders and managing the nuances of being in a correctional setting, with several describing it as a "constant battle."

Participant 1 noted that there was often a "rift" between treatment staff and correctional staff, including officers and administration. He reported that there was not a great working relationship between the two and that he often felt as though the competing forces were a hindrance. He reported that in juvenile corrections, the offenders were sent for "treatment," so the lengths of their sentences were often determined by the clinical

team. He shared that while he understood the need for accountability, he felt that the punishing nature of the correctional staff would often sabotage treatment. He expressed the differences in approaches, with the correctional mindset being,

> These kids are criminals, we're going to make them submit and we're going to make them change their behavior by forcing them into it … if the kid was acting out, the officer would want to scream and yell and try to get that kid under control, whereas the clinical staff would address that situation differently. Oftentimes we were accused of being soft … or inmate lovers … in the agency, there was a staff of about 500 to 600 people and the clinical team was 15. In a lot of ways, it felt like a losing war.

Participant 2 shared some overlap in the difficulty of managing the needs of the offenders and their overall need to be managed within the facility. She would participate in developing management plans for offenders that targeted behavioral issues, but acknowledged that this created a difficult situation for officers whose jobs were already difficult and who were already stressed. She shared that her job at times was to restrict an offender's freedom for mental health reasons, but that at times, the officers would provide objections and become frustrated with her decisions because they wanted the offender to remain locked in their cell for behavioral reasons. She felt at times that there was a lack of support, but reported that those instances were less common for her.

Participant 3 reported that "there is a lot of competing interests." From her perspective, the officer's goals were the safety and security of the institution, while her

goal was to "keep people alive and help them to cope in a really bad situation." She found herself asking,

> Are we here to help them get better? Or, are we here to punish them? Like, what is the role of the prison? We don't even know, right? We have programs that have been watered down so much that … they're kind of a joke.

Like Participant 1, she also experienced being called a "con lover, or inmate lover" by correctional staff.

Participant 4 experienced a lot of tension and friction as a mental health provider working with correctional staff. It was her experience that she often felt bullied by correctional officers and that there was competition between the two sides. She provided an example that mental health providers were required to make decisions about placing offenders in restraints to prevent them from hurting themselves or others, but in trying to make the determination, she sometimes feels pressured to skip her assessment and that the officers wanted to quickly move to restraints. She was passionate about her role as a mental health provider, and when asked to describe her goals, she stated:

> To treat the offenders, that is my goal. Always. No matter where I go to, I want to help the guys. If I talk to offenders or clients as a therapist, my goal is to make the symptoms better, make progress. I want to see that happen … if my goal was to treat the offenders, then their goal is to protect the customer … the goal of keeping offenders? To contain them. That's it. They [correctional staff] don't care about what we do. They don't care about the quality.

Participant 5 identified that the primary goal within corrections is keeping the facility secure but thought that this became more of a struggle over power and control. She shared the need for mental health clinicians to treat the offenders and, like the previous participants, described an experience where goals conflicted:

> Mental health staff have this opportunity, this window where we can deescalate the situation prior to it getting bad, that doesn't always happen … so, you have somebody, let's say with a severe mental health disability … that gets super punished because they can't regulate their emotions and they're impulsive and you're looking at them maybe going on administrative segregation, which is essentially isolation for a year and a half at minimum, which is incredibly psychologically harmful … yes, this person spit in this person's face, but let's take into context her larger issues and see if we can do something different and that putting her just in a room by herself for so long.

When asked about competing goals between correctional staff and mental health staff, Participant 7 stated, "Yes. 100%." She went on to provide a recent example where an offender was being transferred to another institution but was refusing to go. So, correctional staff were prepared to extract the offender from his cell using force, because the decision to transfer was final. She stated that the offender's mother contacted the mental health supervisor and asked to talk to her son because she believed she would be able to talk him into complying. When the mental health supervisor approached the warden about having the mother talk to her son, the request was denied. Participant 7 reported being in disbelief and stated, "It's a simple phone call … so, you'd rather go in

on an inmate, probably end up either he's getting hurt, one of your officers getting hurt, or both."

She went on to express that these types of conflicts between clinical staff and correctional staff occurred frequently. She expressed frustration in having correctional staff doubting clinical decisions. She provided an example of deciding that an offender needed to be transferred to a higher level of care in the stabilization unit, but received pushback and identified the reasoning being primarily related to "either officers being lazy or there's not quite enough staff, but there's enough staff … it's just whether or not that captain is going to tell his staff, sorry, you're going to have to get a little bit of overtime for this." Similarly, Participant 3 experienced a situation where the warden questioned a clinical decision to place an offender in an observation cell after determining he was at risk of suicide. She recalled that he cornered her in an office and demanded that she reassess the offender. She interpreted that her decision "disrupted the budget" because overtime would be needed so that an officer could observe the offender.

Participant 8 reported varying experiences. She had worked in corrections for many years and stated that with the experienced staff there are no competing goals and values, but with the newer, less experienced officers, there is some conflict. She reported:

> They're [experienced officers] not about punishment, they're about consequence. They're about holding people accountable and giving consequences for behavior, but they also understand and appreciate what I have to do. I think it's the newer people, the people that don't have that professional training … their motivation is more about the punishment … not seeing our [the mental health] side of things.

Participant 9 also reported varying experiences and related this to the different facilities she had worked at, but also recognized that competing goals existed. She reported that it was difficult at times to convince correctional staff about offenders' needs for mental health services. She expressed that the mentality at times was that because an offender was in prison, they should not be receiving help, or that if the offender had in any way "wronged" the officer then they [correctional officers] were less likely to work cooperatively with mental health. When working in the maximum-security unit, she reported officers were frustrated with feeling as though mental health professionals did not understand their desire to maintain safety, while mental health professionals tried to balance safety as well as trying to rehabilitate offenders. She shared her experiences having to deescalate offenders prior to correctional staff interventions, such as the use of pepper spray, and often felt like mental health interventions were often done to "check a box." In her overall experience, she stated, "I don't think that we [mental health] are really a part of the rehabilitation anymore. I don't know if we ever really have been."

While Participant 6 did not report competing goals and values with the officers or correctional staff that she worked with directly, she did report disproportionality in the corrections system as a whole. She shared an experience where she completed mental health assessments on two youth offenders that had committed similar crimes, one being white and the other black, and how it broke her heart that the officer allowed the white juvenile's mother to pick him up and take him home while the black juvenile remained in detention for approximately two years. She stated,

> That's the one thing I feel, like corrections is not corrections. I don't think it is corrections, because you are not correcting any criminal behavior … I, as a person, who has hands-on experience, believe that there is minimal correcting going on in America's correctional system. I just wish that we could do more.

This sentiment was directly mirrored by Participant 4, who stated, "It would be nice if we could focus on treatment … this is not treatment, especially in corrections."

Competing goals and values between clinical mental health treatment staff and correctional staff have long been identified in the literature. This continues to problematic, with eight of the nine participants in this study noting it to be a considerable challenge. The conflict was described as a "constant battle" that leads to tension, friction, disagreements, and conflict among staff, and at times, impacts and hinders mental health treatment. Traditionally, correctional goals focus on safety and security while clinical goals focus on treatment. This is also referred to as "punishment versus rehabilitation." Despite these competing goals and values having existed for decades, none of the participants reported sustainable or systemic solutions to this pervasive problem. A few experienced clinicians described ways of working cooperatively between the disciplines, but found that challenges persisted, with systemic issues related to staffing (understaffed), turnover (hiring new and inexperienced staff), and budgeting (lack of funding, overtime).

Theme 5: Treatment Challenges

The participants reported a lack of specialized education and training as well as feeling unprepared to work with offenders in correctional settings. Many of the

participants essentially learned along the way while on the job, and encountered challenges in providing mental health treatments to offenders. Participant 1 found himself relying on supervision or consulting with colleagues to help him navigate, and stated, "I learned through trial and error … just figuring it out and adapting as I go … I had some suggestions and just kind of anecdotal sorts of discussions with people who had been in corrections longer than I had."

Several of the participants reported that it was challenging to apply what they had learned in their master's programs to counseling offenders in correctional settings. Participant 6 initially expected that her experience would be "by the book" and more reflective of what she learned in school, but she quickly found it difficult to implement what she had learned in the field. Participant 1 shared that standard coping strategies are not applicable in correctional settings where the environment is restrictive, so he had to become really creative in how he helped his clients to cope with mental health symptoms.

Participant 9 was taught how counselors communicated with clients but found that what she had learned was not applicable in corrections. She shared:

> I didn't have sessions. I stood cell front and talked to people for less than 15 minutes … sometimes I would pull them out … but it was never like a real hour-long session … all of the stuff I learned to do in an hour-long session now I have to condense … so what is it that I have to ask?

She continued, "And then, once I was actually in the prison my guys were handcuffed to the wall. How do you go about that when … your session is about body language? Because they can't move." Participant 7 similarly reflected this sentiment,

> It's not going to be a simple, "Lay back on my couch and tell me how you feel." It's having yourself be prepared to work with what you are given … when I was in grad school … I was focused on sitting in chairs opposite of each other, talking to each other … they didn't tell us, "Oh hey, when you have a guy who's handcuffed and sitting in your office, this is how you need to do it." So, it's been a lot of adjusting to try and figure out how to work with these guys.

Participant 8 recalled being taught a specific type of counseling, including the session length, remaining focused on the client, and being almost "touchy-feely," but said that this style of counseling could be harmful and that working with offenders requires the counselor to "approach it from a different mentality." She went on to share challenges for counselors in applying their education and training when working with offenders in correctional settings:

> I think some people came in and were inmate advocates, so to speak … the psychological services director has told us many times that is not our function … that's hard because when you're trained … you are an advocate for your patients … We had about eight counselors get on board with the idea that the inmates were being mistreated … the staff was abusing them … It was all inmate report … it's not always fact, they'll [offenders] try to play whatever angles they can get … staff [counselors] were falling for that … they were doing inappropriate things with inmates … printing off resources that they shouldn't have been … giving them things from our supplies … crossing boundaries and developing alliances … they all left on the same day, they left their posts, they abandoned their patients,

> they just walked out … it turns out that nothing that they were accusing anybody of was founded … it wasn't therapeutic … all they were doing was enabling them [the offenders].

Participants 1 and 9 both mentioned being more cognizant of boundaries and, at times, being more assertive and direct with clients. Additionally, both expressed a heightened need to be aware of their personal safety. Participant 9 stated:

> I am not going to allow them [offenders] to sit closest to the door because I need to feel safe … you shouldn't fiddle with your hands or keep them up whenever you are talking to a client … but in prison or even in the jail, I would be talking to guys five feet away from me and they're just out and about … you don't know what they are going to do, so you have to keep your hands up.

Participant 9 not only expressed an awareness for his safety, but also the safety of the officers. He often chose to respond to incidents within the facility that required the use of physical intervention. He stated:

> I know that some of the other clinicians weren't as comfortable with it as I was … just personally speaking, it felt less uncomfortable to do something that maybe was … outside my scope of practice than it was to sit and watch something happen…that's just a personal value that I have. That felt worse for me than breaking up a fight.

Many of the participants reported significant levels of trauma among the offender population. Participant 1 stated that many of the juveniles had histories of trauma, and felt that the correctional environment itself was also traumatizing for the youth.

Participant 2 shared this same experience, and both participants sought out additional training and certification to become trauma professionals. Participant 3 reported, "The fact is, many of these people [offenders], we all know, have had horrific backgrounds; they have horrible coping strategies." However, she found it difficult to treat trauma within the correctional system because offenders transferred quite often and continuity of care was an issue. Both she and Participant 5 reported that the trauma that they were dealing with was more complex than what they had encountered with patients in community mental health. In addition, Participant 5 added that not only were the traumas more complex, but also, they were often combined with personality disorders or dissociation. She expressed that treatment could be destabilizing and that offenders would turn to drug use as a means to cope in prison. Participant 7 also reported many offenders she worked with having personality disorders and trauma, and like previous participants, she reported that the trauma occurred both in and out of prison. Participant 6 reported that trauma was so significant in the juvenile population that a separate trauma unit was created. Many of the juveniles were exposed to domestic violence or sexual assault, or witnessing others being shot, stabbed, or brutally beaten. She shared that she had witnessed generational patterns that contributed to the cycle of repeated involvement in the legal system, and provided the following example:

> We had a group project … they [juveniles] had to make a collage of their goals. One of my kids … he sat there and … I said, "What's wrong?" He said, "Ms., what you want us to do? My goals are never going to happen for me … I know what I want, but the way my life has been set up, my Dad went to jail, my

> grandfather went to jail … My grandfather was the biggest drug dealer in our neighborhood. I don't know anything else … you asking me to use words and pictures to describe my goals … I don't even see how I'm going to achieve my goals."

She expressed feeling heartbroken by his expectations and went on to share that he continued coming in and out of the juvenile correctional system.

Challenges existed for many of the participants, and finding solutions and ways to manage these challenges proved to be quite difficult. Many of the participants had difficulty answering the question about how they managed challenges in correctional settings. Participant 1 sought out supervision but expressed concern with clinical leadership. Participant 5 openly stated she had yet to find the answer, but also sought support from her supervisor. Participants 2, 3, and 8 all reported that addressing issues immediately, having strong communication, and working together within a multidisciplinary team was important. Participant 2 stated that she educated officers on her role and scope of practice consistently. She stated:

> It's just clear communication … just say no … that sounds simple … "Sorry, I can't do that. That's not my scope of practice. That sounds like that would put my license on the line and I'm not willing to do that." You have to have that rapport, and some days, we're not happy with each other … but I feel at the end of the day we always come back together as a team.

Participant 8 added that if she brings up an issue and it is not resolved, then she follows her chain of command and notifies the supervising psychologist.

Many of the participants noted considerable differences in their expectations from their master's programs or experiences in community settings and their experiences providing mental health treatments to offenders in correctional settings. Participants shared examples of these differences, which included time constraints, frequent interruptions and distractions, limited client resources, clients who are restrained, counselor characteristics, and increased awareness of safety. The participants in this study also shared the increased prevalence of trauma experienced among offender populations both in and out of prison as challenges.

General Narrative

The research questions sought to obtain information on master's-level counselors' education and training to understand the experiences of master's-level counselors working with offenders in correctional settings and to find out if they experienced any challenges, and if so, how they managed them. Despite the participants being employed in different states and working with offenders whose custody levels varied, the participants shared similar experiences, and no discrepant cases occurred in this study. The participants reported a lack of specialized education and training specific to working with offenders in correctional settings. Many participants learned through trial and error on the job and found it difficult to apply their educations and clinical training without modifications when working with offenders. The correctional environment and its distinct culture presented unique challenges to mental health counselors, which added to the complexity of providing treatment to an already complicated population. These challenges interfered with the provision of services and overall treatment outcomes.

Participants described their frustrations with being providers in multifaceted correctional systems. While many faced challenges, few were able to verbalize how to effectively manage these challenges. The result was that many decided, or expressed a desire, to leave corrections and explore other opportunities. Interestingly, quite a few of the participants reported that despite the frustrations of working in corrections, many of them enjoyed working with offenders, and it provided them with invaluable clinical experience.

In consideration of the hermeneutic theoretical process, the participants also shared similar pre-conceptions about lacking the specialized education, training, and supervision necessary to prepare them for working with offenders in correctional settings. This foresight motivated many of the participants to seek out their own education and training or to seek out consultations with supervisors and peers. The participants' *Dasein* seemed to be formulated by the education and training they had obtained along with a cycle of trial and error and learning from past experiences. Many of the participants navigated the correctional system using their best judgments despite not always having the resources or support to follow through with decisions. The participants seemed to struggle with their *Dasein* and how to be mental health counselors in intricately complex and complicated environments.

General Summary

Master's-level mental health counselors working with offenders in correctional settings lacked the specialized education, training, and experience necessary to effectively manage the mental health needs of this population. Forensic coursework at a

master's level is sparse, and continuing education in this field is also limited. Mental health counselors in this setting often rely on learning through trial and error with a population that has an assemblage of behavioral and mental health issues and within a system with competing goals and values that often conflict with treatment needs. The correctional system has vacillated between the need for punishment versus the need for rehabilitation. This continued struggle affects the ability of mental health counselors to navigate within this system effectively and find a balance between the treatment needs of offenders as well as the safety needs of correctional institutions. Counselors acknowledge that safety is imperative as they are faced with their own challenges in an inherently unsafe environment. Correctional mental health counselors are exposed to violence, aggression, and manipulation in addition to other heavily researched environmental conditions that have been shown to negatively impact prison staff and offenders. They must navigate all of this while trying to fulfill their duties as treatment providers. These counselors often lack the strong supervision and support that would help them navigate the perpetual challenges of this environment. Correctional mental health counselors are likely to experience burnout and trauma while working in these settings.

Summary

In this study, I utilized hermeneutic phenomenological inquiry to understand the lived experiences of master's-level mental health counselors working with offenders in correctional settings. I interviewed nine mental health counselors across the US who were either employed or had been employed as counselors in correctional settings. From the data analysis, the following five themes emerged: (a) a lack of specialized education and

training, (b) environmental challenges, (c) challenges regarding correctional culture, (d) competing goals and values, and (e) the difficulty of mental health treatment in correctional settings. The participants reported lacking the specialized knowledge and education needed to effectively work with offenders in correctional settings. They were exposed to environmental challenges including deplorable conditions, sensory disturbances, system challenges, and safety issues. The participants noted the distinct culture of both the offenders as well as the institution, which varied across correctional settings. Participants also struggled with the competing goals of corrections and treatment. Often, it was difficult for the participants to navigate between the two. The remaining challenge for participants was in providing effective mental health treatments to a population with complex needs.

Chapter 5 will summarize the key findings of the study, provide an interpretation of the findings, discuss the limitations of the study, offer recommendations, discuss implications, and conclude the study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this hermeneutic phenomenological study was to understand the experiences of master's-level mental health counselors working with offenders in correctional settings. Several studies (Ogloff et al., 2015; Varghese et al., 2015; Wolff et al., 2013) have determined the need for specialized knowledge when working with offenders. However, it appears that little is being done to prepare correctional mental health counselors to effectively provide services to offenders. Forensic practice is considered a specialty at the doctoral level (APA, 2016). However, the great majority of mental health services being provided to offenders in correctional settings are done by master's-level professionals (Bewley & Morgan, 2011; Voorhis & Salisbury, 2014). Although many prison systems have endorsed using evidence-based practices, little is known about the provision of mental health services or their effectiveness (Blevins & Soderstrom, 2015). This study was important because it seems that little attention has been given to understanding the experiences of correctional mental health counselors or preparing counselors to work with offender populations despite evidence that correctional staff faces significant challenges.

This study presented several key findings. Participants reported they had not received education or training specific to working with offenders in correctional settings prior to their employment in corrections. Many of the participants experienced environmental challenges such as noise disruptions (e.g., yelling, screaming, banging, kicking, etc.), systemic issues (e.g., understaffed, under-resourced), and challenges related to working in an environment that was inherently unsafe and affected treatment

outcomes. Most notably, almost every participant reported experiencing competing goals and values between mental health and correctional staff in the classic "punishment versus rehabilitation" debate recognized in the literature. The cultures of both offenders and correctional staff appeared to impact mental health treatment for offenders. Offenders reportedly followed a code, or an unspoken set of rules, and mental health professionals attempted to maneuver between this code and offender manipulation all while trying to manage treatment in a correctional setting that was not always conducive to treatment. Many of the participants reported experiencing treatment challenges unique to correctional mental health environments. This will be discussed further in the next section.

Interpretation of Findings

In reviewing the literature, I was not surprised that none of the participants in this study recalled having coursework specific to corrections at the master's level. In the 2011 study by Bewley and Morgan, only 22.9% of the 229 participants reported having completed coursework in forensics. A review of the common core curriculum and specialties in mental health counseling revealed that correctional mental health counseling is not considered a specialty at the master's level (CACREP, 2016). Rather, it is considered a specialty at the doctoral level (APA, 2016). The participants in the study reported that they were exposed to corrections during their new employee training once hired, but that this education and training appeared to be lacking in clinical applications for mental health professionals, except for training on suicide prevention and awareness and offender manipulation. Some of the participants reported seeking continuing

education specific to correctional mental health counseling but found their options to be limited. Several of the participants recognized the need for additional education and training in trauma and sought certification as trauma professionals.

A concerning outcome of this study was that all of the participants reported that learning occurred on the job, which presented significant challenges. The literature review presented evidence of the lack of education and training for mental health providers in correctional settings, including how this resulted in inadequate treatment for offenders (Brandt, 2012; Fazel, 2016; NIC, 2004; Roebuck & Zelhart, 1965; Sarteschi, 2013). However, despite the prevalence of this problem dating back to 1965, it appears that little has changed. There are legal and constitutional requirements to provide adequate mental health services to offenders (Hills et al., 2004). Despite this, the prevalence of legal challenges that impact mental health services in correctional settings remains problematic, as was evidenced in several interviews with participants in this study. Participants 7 and 8 both shared how the threat of lawsuits influenced their work, whereas others shared knowledge of, or described witnessing, what they considered to be reportable offenses by correctional staff that could have had legal implications.

Ajji and Hughes (2019) shared their experiences providing counseling to offenders in correctional settings and stated that the provision of mental health services requires constant flexibility and the ability to modify or abandon clinical approaches utilized in community settings when working in correctional settings. Although these requirements were noted, the participants in this study further extended this knowledge. A notable modification for many of the participants was abandoning the idea of

traditional interactional styles between a therapist and client. In their master's programs, the participants recounted that an individual session would be a 60-minute session with the therapist and client seated across from one another, with the counselor demonstrating the ideal characteristics of a mental health practitioner and working towards developing a strong therapeutic alliance in counseling. However, an individual therapy session in a correctional setting resembled something far different. Carrola et al. (2016) stated that mental health professionals are not prepared to work within the guidelines of institutional rules and, as a result, experienced challenges related to the correctional environment. Correctional mental health counselors were challenged with considerable time constraints, a lack of space and privacy, interruptions, disruptions, and restrictions.

One participant noted that individual sessions were 15 minutes or less, with several of the participants noting that sessions were not conducted in private or quiet spaces. Many of the participants reported having to interact with offenders by standing and speaking to them through a secured cell door. The need to meet at offenders' cell fronts was reportedly due to crisis intervention and assessment, inadequate staffing, disruptions within the institution, or a lack of available space. The participants noted that these interactions made it impossible to maintain confidentiality. For some participants, even if the offender was able to meet face-to-face with the mental health counselor in an available room, privacy continued to be problematic. One participant reported meeting with offenders in a staff break room and that sessions were interrupted when staff or officers came in to use the microwave to heat their lunch. Others reported that therapy spaces were shared or sessions were conducted in the presence of correctional officers.

When counselors were provided offices to meet with clients individually, several participants noted that these offices were nothing more than converted cells located in the same areas where offenders were housed. This posed an issue with both privacy and noise disruptions.

For most participants, the noise level posed a significant challenge and oftentimes presented a barrier to treatment. When considering the expectations of a traditional individual therapy session, many counselors and clients alike would not anticipate experiencing sounds such as yelling, screaming, banging, fighting, the clanging of steel bars and doors, the popping sound of locking mechanisms, jangling of keys, the buzzing of controls, and intermittent radio traffic. Bierie (2012) noted that prison conditions such as privacy and noise impacted correctional staff, but the degree to which they impacted the mental health counselors in this study is unknown. However, the noise disrupted treatment enough that many of the participants sought out alternate times and locations to meet with offenders, albeit not always successfully. The disruptiveness of the noise sometimes resulted in abruptly terminating individual sessions, canceling group sessions, or being unable to complete additional clinical tasks such as documentation. Although many participants reported that the noise in their environments was not conducive to treatment, it seemed they had little option but to learn to manage and cope with disruptions.

Another unexpected challenge for participants was having to meet with clients who were handcuffed or secured to a chair or a wall for the safety of the clinician, or based on the security level of the offender. Safety and security are more prevalent

concerns in correctional settings than in other clinical settings for mental health counselors. The participants acknowledged that the correctional environment is inherently unsafe, with many of them witnessing or having knowledge of deaths, physical and sexual assaults, violence, illegal drugs, weapons, and gang activity. This was also confirmed in previous research by Carrola et al. (2016) and Johnson (2016). However, the participants verbalized more concerns about the safety of offenders and correctional staff than about their personal safety. Although I anticipated that participants would express safety concerns, I did not expect for their concerns to be rooted in the safety of others and not their own welfare. While initially surprising, Johnson (2016) also noted that non-custody staff reported more concern for correctional staff. On occasions when participants discussed safety, I noted that they did not appear to be distressed when recounting these incidents. Some seemed even to joke about the incidents upon reflection. One participant denied having ever felt afraid, even expressing her confidence that she would not be harmed despite sharing experiences where officers had to physically engage and subdue an offender who lunged at her and where officers positioned themselves on a gun walk with loaded guns aimed at an offender who prior to meeting with her was reported to be "out of control." While meeting with this offender, she recalled thinking, "I'm just sitting there going, are you kidding me?" Another participant reported that an officer was assaulted and stabbed in the face by a juvenile offender and reported, "that one gave me pause" but then seamlessly attributed this to "prison culture."

The culture that exists in correctional settings and among offenders was discussed in the literature review and confirmed in this study. Many of the participants

acknowledged offender culture, including adherence to the convict code. Sykes and Messinger (1960) identified major themes among inmates, including not being a "snitch," not working with prison staff, maintenance of self (avoiding appearing weak), and maintaining suspicion and distrust of staff. These themes were mirrored by some of the participants in this study, who shared that offenders often lumped treatment professionals into the same category as "officers" or "cops" as they were employed by the Department of Corrections. Many shared that offenders were mindful of what they shared in counseling sessions, where the limits to confidentiality exceeded harm to self or others, with some counselors being unsure or unclear on what behaviors were reportable according to their correctional facilities. Several of the participants reported that offenders engaged in impression management and avoided wanting to appear "weak." Both the participants in this study and those in research by Bronson (2006) noted the value of this was to avoid being targeted for exploitation by others. Ricardelli (2014) stated that the inmate code provided structure and direction for offenders, but purported that it also provided a sense of protection. From this study, it did not appear that the "code" among offenders served to protect them, as participants seemingly highlighted that offenders felt most unsafe with each other. Manipulation was also a concern for mental health staff, who shared that offenders would often take advantage of the system in an effort to meet their needs, which included safety, preferential treatment, or housing. The participants in this study shared that offenders were willing to go to extreme measures to get their way by engaging in self-harm, reporting they were suicidal or homicidal, or assaulting staff.

Although mental health staff acknowledged inmate culture, they also experienced the nuances of institutional culture. Pont et al. (2012) found that employees are exposed to military-like chains of command and are likely to integrate into institutional culture. The participants described being exposed to military or paramilitary structures and hierarchies when working in correctional settings. Participants reported struggling with the rigidity and strict adherence to policy and procedures typically associated with military structure, especially when recounting experiences where alternate solutions could have resulted in more favorable outcomes. One participant provided an example of how authorizing a phone call for an offender could have gained his compliance with a transfer without the need to use force, lessening the chance of potential injuries to officers and the offender. The competing goals and values between correctional staff and mental health counselors are prevalent in the literature and further confirmed in this study.

The conflicting goals of rehabilitation and punishment have long been debated in corrections. Bertrand-Godfrey and Loewenthal (2011) stated that these conflicting goals resulted in persistent tension between treatment and correctional staff. There is a great need to find a balance between these two competing goals (Adams & Ferrandino, 2008). Despite this knowledge, the participants in this study confirmed that competing goals and values between mental health counselors and correctional staff persist to this day. Lambert et al. (2010) reported that non-custody staff were more likely to support treatment while correctional staff were more likely to support punishment. The participants in this study confirmed these opposing goals. The literature review identified

that the implementation of punishment is considered unethical for health professionals (Sun, 2013; Pont et al., 2012; Voorhis & Salisbury, 2014; Ward, 2013), yet there appears to be no solution for how to effectively manage this conflict (Ward, 2013). Although many of the participants in this study experienced this challenge, some participants managed this conflict by addressing issues immediately through open and honest communication, clearly communicating their job duties, communicating what was within their scope of practice, and seeking out supervision or consultation. It was not surprising that the participants experienced competing goals and values, but the participants' accounts of how these conflicting ideologies were represented in the behaviors of correctional staff were unexpected and seemed to only further promote a culture of mistrust between staff and offenders. Many of the participants reported witnessing officers yelling, cursing, or demeaning offenders. For some participants, the culture of corrections seemed to tolerate some level of offender mistreatment. Previous research noted that providers had witnessed "poor interactions" between offenders and correctional staff, noting that the relationship was chaotic, disruptive, and dysfunctional (Johnson, 2016), and participants in this study added to these concerns. A few of the participants reported having knowledge of more egregious incidents of maltreatment, abuse, and even deaths of offenders while they were in the care of correctional staff. It should strongly be noted that the participants in this study did not directly witness the more egregious allegations nor can I verify these reports. Furthermore, while negative interactions with correctional staff were experienced, the large majority of interactions between the mental health counselors in this study and correctional officers were either

neutral or positive. Almost every participant cited that correctional officers experienced being chronically understaffed and under-resourced, resulting in mandatory overtime and burnout. Inadequate staffing was also a significant challenge for mental health professionals.

Many of the participants reported that their caseload sizes exceeded 100 or more offenders. However, this number merely reflected those offenders who were designated as needing mental health services. A previous study by Johnson (2016) identified mental health caseloads as high as 120 clients per counselor. A few of the participants reported that their responsibilities were not limited to those offenders assigned to their caseloads, but that they were ultimately responsible for the mental health needs of the entire prison population in their respective facilities. More than half of the participants expressed their frustrations with their considerably high caseloads and expressed feeling as though they were merely "putting out fires" or "slapping band-aids" on issues rather than providing quality clinical mental health services. A few participants shared that this required them to triage the mental health needs of offenders. As a result, participants reported that offenders went for long periods without mental health treatment and that interventions often were just not effective in meeting the needs of offenders.

Limitations

The limitations of this study were identified in Chapter 2 and will be discussed further in this section. Issues such as education, training, experience, correctional setting, and institutional culture were specific to individual participants. Therefore, the results of this study are not transferable (Lincoln & Guba, 2007). The participants in this study

attended CACREP-accredited master's-level counseling programs and were licensed in their respective states, which may have had variable requirements. Only one of the participants in the study had education, training, or experience in corrections, prior to working in corrections. This pre-conception was formulated by me prior to the study and confirmed by the participants' experiences as reported in this study. The participants were all located in different states and institutions with varied security classifications. Patton (2002) suggested that data from interviews could be distorted due to bias, experience, discomfort, or reactivity to the researcher, and it was suggested that observations be recorded. I found field notes to be distracting during the interviews, so observations were noted when recorded interviews were reviewed several times during data analysis. I shared their personal experience as a mental health counselor in correctional settings with some participants prior to the study, but this was limited. My *Dasein*, or being, in this study may have affected the participants' levels of comfort in sharing their experiences due to my familiarity with being a correctional mental health counselor. The participants in this study did not appear to experience discomfort during qualitative interviews. Participants were aware of my experience when they were asked for clarification or asked probing questions specific to correctional knowledge and experience. This pre-understanding aligned with the hermeneutic phenomenological research design and was the starting point of the hermeneutic circle towards coming to an understanding of the experiences of mental health counselors working with offenders in correctional settings.

Recommendations

In alignment with the roles of counselor education and supervision, the recommendations will be organized as follows: (a) counseling, (b) supervision, (c) training, (d) research, and (e) advocacy.

Counseling

Participants in this study highlighted the lack of specialized education, training, and supervision for correctional mental health counselors despite their attempts to seek these out on their own. However, in following the hermeneutic circle, the participants offered a few notable recommendations for counselors either working in corrections or entering into the field based on their own interpretations and understandings. Participants 1 and 9 both noted the importance of self-care. The literature has established that the correctional environment and culture has adverse effects on the well-being of both offenders and correctional staff (Armstrong & Griffin, 2004; Carrola et al., 2016; Gallavan & Newman, 2013; Goomany & Dickinson, 2015; Johnson, 2016; Lambert et al., 2010; Senter et al., 2010; Waters, 1999). This was further confirmed in the present study when participants recounted being exposed to acts of aggression, violence, self-harm, suicide attempts, inappropriate sexual behaviors, and staff misconduct all while navigating competing goals in a seemingly endless cycle of client progress and regression. Several participants reported being tasked with facilitating training on self-care, burnout, and compassion fatigue for correctional staff, but acknowledged that there was no formal training or ongoing support for mental health professionals. Participant 1 expressed thinking that there was an assumption that mental health counselors would

have “figured out” how to manage this on their own without support. However, several of the participants reported some level of burnout and stated that self-care is essential for mental health counselors working with offenders in correctional settings. Participant 9 shared,

> We [counselors] see a lot … so, being able to have some form of self-care or something specifically for our mental health counselors so that they can decompress. I think, just as the officers deal with stuff, it’s really hard for us to kind of get out of a session or get out of work and then go home and talk to people who don’t deal with it all. It’s hard … to get some help in that regard … I think I could have probably lasted longer had I had the training … the self-care … and felt like I was making a bigger difference … it was unfortunate that’s how I ended up feeling by the end of it.

Another notable recommendation from participants in this study was the importance of establishing and setting boundaries. The clinicians reported that this was not only important when working with offenders, but also when working with correctional staff. Competing goals and values posed challenges for mental health counselors at times. Participants 2, 3, 4, 5, 7, and 9 shared experiences where their clinical decisions were challenged by correctional staff due to competing goals, ideologies, or systemic challenges (staffing, budget). These seemingly occurred during incidents where counselors determined that an offender was at risk of harm to themselves or others and required alternate placement or observation. Participants 2 and 3 both responded to these incidents by establishing clear boundaries, being assertive, and

effectively communicating counselor roles, responsibilities, and obligations guided by ethical guidelines and legal requirements within their respective states.

Supervision

A majority of the participants reported that having an understanding of correctional culture was important for correctional mental health counselors. Most shared their struggles with providing mental health treatment in an environment where competing goals created tension in an ongoing battle between rehabilitation and punishment. The military-style structure in correctional culture was unfamiliar to many of the participants. Participant 5 shared that she would have liked to have been prepared to work alongside correctional officers and known how to better interact with others who approached issues with a security mindset. Because these challenges are unique to working in corrections, ongoing supervision and consultation are necessary to help clinicians navigate the complexities and intricacies of a system that needs to consider the unique mental health needs of offenders, motivation and engagement concerns, the impacts of criminal thinking and behavior and mental health and treatment in corrections, environmental challenges, cultural considerations among offenders and correctional staff, cooperation within multidisciplinary teams with diverse goals and values, systemic challenges, and treatment considerations.

Given that correctional mental health counseling is not considered a specialty at the master's level, education and training specific to forensic populations and correctional settings is minimal. Supervision may serve as a critical component in providing ongoing education, training, consultation, and support for correctional mental health counselors. It

would be beneficial for clinical supervisors to be knowledgeable about research and recommendations relevant to correctional mental health and to consider implementing suggestions after careful consideration. Many of the participants in this study reported seeking supervision, but their experiences varied. Several of the participants' experiences seemed more positive when their supervisors were experienced, knowledgeable, and supportive.

Training

Many of the participants expressed a need for education and training specific to the correctional system and providing mental health services to offenders. When asked what recommendations he would suggest to better prepare mental health counselors for corrections, Participant 1 stated,

> I would want them to have a greater understanding of the needs of that population [offenders] and what treatment looks like so they are prepared going in and don't have to do the proverbial "trial by fire" … more training on addressing criminogenic behavior … thinking … would be really beneficial … and a greater understanding too about the criminal justice system.

This sentiment was also shared by Participant 9, who stated,

> I think we [correctional counselors] need training on corrections as a whole … I've never done anything specific to corrections before and I just was thrown into it and it was just like, "All right, good luck. Have fun." I think it would have been an awesome opportunity if we were able to actually have training.

As aforementioned, Participant 6 also felt a sense of being unprepared and said that being a clinician in corrections was like being a Disney princess and all of a sudden being told that you would have to become an Avenger. She thought similarly to Participants 1 and 9 and shared the sentiment that "you just have to figure it out." Both Participants 6 and 7 shared that they would have liked their master's programs to explore more treatment settings, including corrections, in their coursework. Participant 6 shared that she "got a lot of theory, a whole lot of theory, but not enough practical work." She stated that master's-level counselors are required to participate in residencies, so she suggested that correctional mental health counselors similarly participate in supervised experience when first employed in correctional settings. Participant 5 likewise stated, "regular supervision from somebody experienced in corrections is probably the biggest need."

Participant 1 added that he felt that the correctional system felt flawed "from the ground up," and that the culture led to feels of being overwhelmed, hopeless, powerless, and burned out. Participant 2 also shared that burnout is problematic. She expressed that having more connections with other correctional mental health counselors would be beneficial. Both she and Participants 1, 4, 5, and 7 all felt that more continuing education specific to corrections was needed and that clinicians should be knowledgeable about trauma. Participants 4, 5, 7, and 8 all reported that correctional counselors should have strong boundaries when working with offenders. They reported that manipulation is a concern in correctional settings and several shared stories of counselors crossing or blurring these lines, which can be damaging or dangerous in a correctional environment.

Participant 8 reported that client self-reports are considerably different in correctional settings and stated that clinicians should have training on congruence between observed and reported symptoms. She stated, "you have to rely more on what you see rather than what they [offenders] say, because what they say is most often not really the case." She shared an example:

> I have one [counselor] in training right now and she believes every single little thing an inmate says. Like, if he says he's hearing voices, it automatically goes on his treatment plan … she automatically thinks he needs psychotropic medication … it's not the right treatment for that individual.

She furthermore expressed a strong need for clinical training and a focus on objective information and observations when working with offenders in correctional settings due to the elevated comorbidity of personality disorders and manipulation. Her recommendation seems to support Galanek (2013), who stated that clinicians may have difficulties when determining mental health issues in offenders in the context of behaviors in a complex correctional environment. Participants 1, 7, and 9 also expressed a need for counselors to know about personality disorders, specifically antisocial personality disorder. Previously, researchers noted that offenders present with a convolution of problems in addition to mental health issues, including antisocial behaviors and criminal thinking (Brandt, 2012; Wolff et al., 2013). Two of the participants shared that counselors have brought in or provided offenders with items that are not authorized and thus considered contraband, even if the item was as innocuous as a

piece of candy. In prison, this could potentially become a safety and security concern as it may lead to staff compromise.

It is important to note that several participants in this study reported limited opportunities for continuing education specific to correctional mental health counseling. As mentioned in Chapter 2, the NCCHC is an organization that is committed to improving healthcare in prisons and offers educational opportunities, including certification, specific to corrections. Currently, becoming a certified correctional mental health counselor is voluntary. Encouraging, supporting, and incentivizing continued education and training specific to corrections could further improve the overall effectiveness of mental health services in correctional settings.

Research

In reviewing the research, recommendations, and data obtained from participants in this study, I found no clear guidance, direction, or integration regarding mental health treatment and services in correctional settings. Despite there being evidence in the literature of the ineffectiveness of mental health treatment in corrections (Bewley & Morgan, 2011); Forrester et al., 2014; NIC, 2004; Sarteschi, 2013), clinicians make valiant efforts in trying to formulate and navigate solutions within this highly complex and challenging environment. More research is needed on the implications of the lack of specialized education, training, and supervision for mental health counselors and the impacts that this has on them.

Advocacy

I hope to bring awareness to the dilemma faced by mental health counselors working with offenders in correctional settings. Participants in this study suggested ongoing supervision, support from clinical supervisors and correctional staff, and continued education and training opportunities specific to corrections. I sought to add to the already established literature on the overwhelming need for more effective mental health treatment for offenders. Given the current focus on social injustice and inequality in the U.S., this study hopes to bring an awareness to offenders, considered a vulnerable population, who also experience similar injustices within the vast criminal justice system.

Implications

The hope for this study is that I provide a voice for mental health counselors working with offenders in correctional settings. The potential for social change involves not only highlighting the need for specialized education, training, and supervision for these clinicians but also implementing ongoing support and training comparable to that for other correctional staff who go through annual training on self-care, burnout, and compassion fatigue. Additionally, there appears to be a need to revise how we provide mental health services to offenders in correctional settings, beginning with providing the appropriate education, training, and supervision to prepare correctional mental health counselors working in these settings.

My *Dasein* was affected by this study in that it sparked a sense of urgency to advocate for the needs of correctional mental health counselors. The *Dasein* of the participants – their experiences, interpretations, and understandings of being correctional

mental health counselors in correctional environments – seemingly occurs experientially through trial and error. This is in direct opposition to counselor training where education is grounded in research and our ethical obligation to utilize evidence-based practices. It is important to note that because this study is a phenomenological inquiry, the results of the study are not generalizable to all correctional mental health counselors.

Conclusion

Several studies acknowledged the need for specialized knowledge, training, and skills when providing mental health services to offenders (Bartholomew & Morgan, 2015; Magaletta et al., 2007; NIC, 2014; Roebuck & Zelhart, 1965). Upon reflecting on existing recommendations and comparing them to current recommendations, seemingly little has been done to impact how correctional mental health counselors are prepared, and much less has been done to improve the overall provision of mental health treatment in correctional settings. There seems to be a significant need to raise awareness regarding the experiences of mental health counselors working in this setting. This awareness could lead to acknowledging the need for additional preparation and advanced training along with ongoing supervision and support, which could ultimately lead to better outcomes in treatment for offenders with mental health concerns. In conclusion, the hope is that this research further supports the need to assess and evaluate competing forces between mental health and correctional staff so that the two can be fully integrated and more congruent.

References

Adams, K., & Ferrandino, J. (2008). Managing mentally ill inmates in prisons. *Criminal Justice and Behavior*, *35*(8), 913-927. https://doi.org/10.1177/0093854808318624

Adkison-Bradley, C. (2013). Counselor education and supervision: The development of the CACREP doctoral standards. *Journal of Counseling & Development*, *91*(1), 44-49. https://doi.org/10.1002/j.1556-6676.2013.00069.x

Ajjawi, R., & Higgs, J. (2007). Using hermeneutic phenomenology to investigate how experienced practitioners learn to communicate clinical reasoning. *The Qualitative Report, 12*(4), 612-638. https://doi.org/10.46743/2160-3715/2007.1616

Ajji, A., & Hughes, J. (2019). Counselling in men's prisons. *Therapy Today*, *30*(10), 36-39.

Al-Rousan, T., Rubenstein, L., Sieleni, B., Deol, H., & Wallace, R. B. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. *BMC Public Health, 17*(1), 1-9. https://doi.org/10.1186/s12889-017-4257-0

American Bar Association. (2011). *ABA standards for criminal justice: Treatment of prisoners* (3rd ed.). https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/treatment_of_prisoners.pdf

American Correctional Association. (2002). *The history of the American Correctional Association.*

http://www.aca.org/ACA_Prod_IMIS/ACA_Member/About_Us/Our_History/ACA_Member/AboutUs/AboutUs_Home.aspx?hkey=0c9cb058-e3d5-4bb0-ba7c-be29f9b34380

American Psychological Association. (2016). *Specialty guidelines for forensic psychology*. http://www.apa.org/practice/guidelines/forensic-psychology.aspx

Armstrong, G. S., & Griffin, M. L. (2004). Does the job matter? Comparing correlates of stress among treatment and correctional staff in prisons. *Journal of Criminal Justice, 32*(6), 577-592. https://doi.org/10.1016/j.jcrimjus.2004.08.007

Artal, R., & Rubenfeld, S. (2017). Ethical issues in research. *Best Practices & Research Clinical Obstetrics & Gynecology, 43,* 107-114. https://doi.org/10.1016/j.bpobgyn.2016.12.006

Bartholomew, N. R., & Morgan, R. D. (2015). Comorbid mental illness and criminalness implications for housing and treatment. *CNS Spectrums*, *20*(3), 231-240. https://doi.org/10.1017/S1092852915000231

Bertrand-Godfrey, B., & Loewenthal, D. (2011). Delivering therapy in prison: An IPA study researching the lived experience of psychotherapists and counsellors. *European Journal of Psychotherapy & Counselling, 13*(4), 335-355. https://doi.org/10.1080/13642537.2011.625197

Bevan, M. T. (2014). A method of phenomenological interviewing. *Qualitative Health Research*, *24*(1), 136-144. https://doi.org/10.1177/1049732313519710

Bewley, M. T., & Morgan, R. D. (2011). A national survey of mental health services available to offenders with mental illness: Who is doing what? *Law and Human*

Behavior, *35*(5), 351-363. https://doi.org/10.1007/s10979-010-9242-4

Bierie, D. M. (2012a). Is tougher better? The impact of physical prison conditions on inmate violence. *International Journal of Offender Therapy and Comparative Criminology, 56*(3), 338-355. https://doi.org/10.1177/0306624X11405157

Bierie, D. M. (2012b). The impact of prison conditions on staff well-being. *International Journal of Offender Therapy and Comparative Criminology, 56*(1), 81-95. https://doi.org/10.1177/2F0306624X10388383

Blevins, K. R., & Soderstrom, I. R. (2015). The mental health crisis grows on: A descriptive analysis of DOC systems in America. *Journal of Offender Rehabilitation*, *54*(2), 142-160. https://doi.org/10.1080/10509674.2015.1009965

Bobby, C. (2013). The evolution of specialties in the CACREP standards: CACREP's role in unifying the profession. *Journal of Counseling and Development*, *91*(1), 35-43. https://doi.org/10.1002/j.1556-6676.2013.00068.x

Boell, S. K., & Cecez-Kecmanovic, D. (2010). Literature reviews and the hermeneutic circle. *Australian Academic & Research Libraries*, *41*(2), 129-144. https://doi.org/10.1080/00048623.2010.10721450

Brandt, A. L. (2012). Treatment of persons with mental illness in the criminal justice system: A literature review. *Journal of Offender Rehabilitation, 51*(8), 541-558. https://doi.org/10.1080/10509674.2012.693902

Bronson, E. F. (2006). Medium security prisons and inmate subcultures: The “normal prison.” *The Southwest Journal of Criminal Justice, 3*(2), 61-85. http://swacj.org/swjcj/archives/3.2/Bronson.pdf

Bureau of Labor Statistics. (2015a). *Occupational outlook handbook: Mental health counselors and marriage and family therapists*. United States Department of Labor. https://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm

Bureau of Labor Statistics. (2015b). *Occupational outlook handbook: Rehabilitation counselors*. United States Department of Labor. https://www.bls.gov/ooh/community-and-social-service/rehabilitation-counselors.htm

Bureau of Labor Statistics. (2015c). *Occupational outlook handbook: Probation officers and correctional treatment specialists*. United States Department of Labor. https://www.bls.gov/ooh/community-and-social-service/probation-officers-and-correctional-treatment-specialists.htm

Burl, J., Shah, S., Filone, S., Foster, E., & DeMatteo, D. (2012). A survey of graduate training programs and coursework in forensic psychology. *Teaching of Psychology*, *39*(1), 48-53. https://doi.org/10.1177/0098628311430313

Carrola, P. A., DeMatthews, D. E., Shin, S. M., & Corbin-Burdick, M. F. (2016) Correctional counseling supervision: How supervisors manage the duality of security and mental health needs. *The Clinical Supervisor, 35*(2), 249-267, https://doi.org/10.1080/07325223.2016.1214856

Carrola, P. A., Oliverez, A., & Karcher, M. J. (2016). Correctional counselor burnout: Examining burnout rates using the Counselor Burnout Inventory. *Journal of Offender Rehabilitation, 55*(3), 195-212.

https://doi.org/10.1080/10509674.2016.1149134

Centers for Disease Control and Prevention. (2020). *Coronavirus disease 2019 (COVID-19).* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

Chong, C. (2013). Inmate-to-inmate: Socialization, relationships, and community among incarcerated men. *Berkeley Undergraduate Journal*, 26(2), 1-137. http://escholarship.org/uc/item/6469m059

Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: Does size matter? *Journal of Advanced Nursing*, *70*(3), 473-475. https://doi.org/10.1111/jan.12163

Conroy, S. A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods*, *2*(3), 36-62. https://doi.org/10.1177/160940690300200304

Council for Accreditation of Counseling & Related Educational Programs. (n.d.). *About CACREP*. http://www.cacrep.org/about-cacrep/

Council for Accreditation of Counseling & Related Educational Programs. (2016). *2016 CACREP Standards*. http://www.cacrep.org/for-programs/2016-cacrep-standards/

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among the five approaches*. Sage.

Crewe, B., Warr, J., Bennett, P., & Smith, A. (2014). The emotional geography of prison life. *Theoretical Criminology, 18*(1), 56-74. https://doi.org/10.1177/1362480613497778

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in

hermeneutic phenomenology research: A methodological device. *Qualitative Health Research, 27*(6), 826-835. https://doi.org/10.1177/1049732316656161

Davidsen, A. S. (2013). Phenomenological approaches in psychology and health sciences. *Qualitative Research in Psychology, 10*(3), 318-339. https://doi.org/10.1080/14780887.2011.608466

Day, A., Casey, S., Vess, J., & Huisy, G. (2011). Assessing the social climate of prisons. *Criminology Research Council, 427*, 1-40. https://doi.org/10.1037/e620432012-001

Dykstra, D. I. (2014). *Radical Constructivism and Social Justice: Educational Implications*. ScholarWorks. https://scholarworks.boisestate.edu/physics_facpubs/156/

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). The mental health of prisoners: A review of prevalence, adverse outcomes and interventions. *Lancet Psychiatry, 3*(9), 871-881. https://doi.org/10.1016/S2215-0366(16)30142-0

Federal Bureau of Prisons. (n.d.). *About us.* https://www.bop.gov/about/

Ferrell, S. W., Morgan, R. D., & Winterowd, C. L. (2000). Job satisfaction of mental health professionals providing group therapy in state correctional facilities. *International Journal of Offender Therapy and Comparative Criminology, 44*(2), 232-241. https://doi.org/10.1177/2F0306624X00442008

Finlay, L. (2012). Unfolding the phenomenological research process: Iterative stages of "seeing afresh." *Journal of Humanistic Psychology*, *53*(2), 172-201.

https://doi.org/10.1177/0022167812453877

Forrester, A., MacLennan, F., Slade, K., Brown, P., & Exworthy, T. (2014). Improving access to psychological therapies in prisons. *Criminal Behaviour and Mental Health, 24*(3), 163-168. https://doi.org/10.1002/cbm.1898

Gadamer, H. (1986). *Truth and method*. The Crossroad Publishing Company.

Gadamer, H. (1991). The hermeneutic circle. In Alcoff, L. M., *Epistemology: The big questions,* (pp. 232-247). Blackwell.

Gadamer, H. (2006). Classical and philosophical hermeneutics. *Theory, Culture & Society, 23*(1), 29-56. https://doi.org/10.1177/0263276406063228

Galanek, J. D. (2013). The cultural construction of mental illness in prison: A perfect storm of pathology. *Cult Med Psychiatry, 37*(1), 195-225. https://doi.org/10.1007/s11013-012-9295-6

Gallavan, D. B., & Newman, J. L. (2013). Predictors of burnout among correctional mental health professionals. *Psychological Services, 10*(1), 115-122. https://doi.org/10.1037/a0031341

Gannon, T. A., & Ward, T. (2014). Where has all the psychology gone? A critical review of evidence-based psychological practice in correctional settings. *Aggression and violent behavior*, *19*(4), 435-446. https://doi.org/10.1016/j.avb.2014.06.006

Gentles, S. J., Charles, C., Ploeg, J., & McKibbon, K. (2015). Sampling in qualitative research: Insights from an overview of the methods literature. *The Qualitative Report, 20*(11), 1772-1789. https://doi.org/10.46743/2160-3715/2015.2373

Goomany, A., & Dickinson, T. (2015). The influence of prison climate on the mental

health of adult prisoners: A literature review. *Journal of Psychiatric & Mental Health Nursing*, *22*(6), 413-422. https://doi.org/10.1111/jpm.12231

Grossoehme, D. H. (2014). Research methodology overview of qualitative research. *Journal Health Care Chaplain, 20*(3), 109-122. https://doi.org/10.1080/08854726.2014.925660

Hayes, C., & Fulton, J. (2014). Framing interpretive phenomenological approaches to educational research. *British Journal of Mental Health Nursing*, *3*(2), 76-80. https://doi.org/10.12968/bjmh.2014.3.2.76

Heinonen, K. (2015). Van Manen's method and reduction in a phenomenological hermeneutic study. *Nurse Researcher, 22*(4), 35-4. https://doi.org/10.7748/nr.22.4.35.e1326

Hills, H., Sigfried, C., & Ickowitz, A. (2004). Effective prison mental health services: Guidelines to expand and improve treatment. *US Department of Justice: National Institute of Corrections.* https://doi.org/10.1037/e311482005-001

Husserl, E. (1962). *Ideas: General introduction to pure phenomenology* (W. R. Boyce Gibson, Trans.). Routledge. (Original work published 1913)

Johnson, N. S. (2016). *Secondary traumatic stress, compassion fatigue, and burnout: How working in correctional settings affects mental health providers* (Doctoral dissertation, Antioch University).

Kakkori, L. (2010). Hermeneutics and phenomenology problems when applying hermeneutic phenomenological method in educational qualitative research. *Philosophical Inquiry in Education*, *18*(2), 19-27.

https://doi.org/10.7202/1072329ar

Kornbluh, M. (2015). Combatting challenges to establishing trustworthiness in qualitative research. *Qualitative Research in Psychology, 12*(4), 397-414. https://doi.org/10.1080/14780887.2015.1021941

Kumar, A. (2012). Using phenomenological research methods in qualitative health research. *Journal of Human Sciences*, *9*(2), 790-804.

Lambert, E. G., Barton-Bellessa, S. M., & Hogan, N. L. (2015). The Consequences of Emotional Burnout Among Correctional Staff. *SAGE Open, 5*(2). https://doi.org/10.1177/2158244015590444

Lambert, E. G., Hogan, N. L., & Altheimer, I. (2010). An exploratory examination of the consequences of burnout in terms of life satisfaction, turnover intent, and absenteeism among private correctional staff. *The Prison Journal, 90*(1), 91-114. https://doi.org/10.1177/2F0032885509357586

Lambert, E. G., Hogan, N. L., Griffin, M. L., & Kelley, T. (2015). The correctional staff burnout literature. *Criminal Justice Studies*, *28*(4), 397-443. https://doi.org/10.1080/1478601X.2015.1065830

Lambert, E. G., Hogan, N. L., Keena, L. D., Williamson, L., & Kim, B. (2017). Exploring the association between different types of social support with role stress, work-family conflict, and turnover intent among private prison staff. *Journal of Applied Security Research, 12*(2), 203-223. https://doi.org/10.1080/19361610.2017.1277866

Lambert, E. G., Kelley, T., & Hogan, N. L. (2013). Hanging on too long: The relationship

between different forms of organizational commitment and emotional burnout among correctional staff. *American Journal of Criminal Justice, 38*(1), 51-66. https://doi.org/10.1007/s12103-012-9159-1

Lambert, E., Hogan, N. L., Altheimer, I., Jiang, S., & Stevenson, M. T. (2010). The relationship between burnout and support for punishment and treatment: A preliminary examination. *International Journal of Offender Therapy and Comparative Criminology, 54*(6), 1004-1022. https://doi.org/10.1177/2F0306624X09348585

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International journal of qualitative methods*, *2*(3), 21-35. https://doi.org/10.1177/160940690300200303

Liebling, A., & Arnold, H. (2012). Social relationships between prisoners in a maximum security prison: Violence, faith, and the declining nature of trust. *Journal of Criminal Justice*, *40*(5), 413–424. https://doi.org/10.1016/j.jcrimjus.2012.06.003

Lincoln, Y. S., & Guba, E. G. (2007). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation [Special Issue]. *New Directions for Evaluation, 30*, 73-84. https://doi.org/10.1002/ev.223

Listwan, S. J., Daigle, L. E., Hartman, J. L., & Guastaferro, W. P. (2014). Poly-victimization risk in prison: The influence of individual and institutional factors. *Journal of interpersonal violence*, *29*(13), 2458-2481. https://doi.org/10.1177/0886260513518435

MacDonald, R., Parsons, A., & Venters, H. D. (2013). The triple aims of correctional

health: Patient safety, population health, and human rights. *Journal of Health Care for the Poor and Underserved*, *24*(3), 1226-1234. https://doi.org/10.1353/hpu.2013.0142

Macquarrie, J., & Robinson, E. (1973). *Being and time.* Oxford, UK: Blackwell Publishers.

Magaletta, P. R., Patry, M. W., & Norcross, J. C. (2012). Who is training behind the wall? Twenty-five years of psychology interns in corrections. *Criminal Justice and Behavior*, *39*(11), 1405-1420. https://doi.org/10.1177/0093854812449404

Magaletta, P. R., Patry, M. W., Dietz, E. F., & Ax, R. K. (2007). What is correctional about clinical practice in corrections? *Criminal Justice and Behavior*, *34*(1), 7-21. https://doi.org/10.1177/0093854806290024

Magaletta, P. R., Patry, M. W., Patterson, K. L., Gross, N. R., Morgan, R. D., & Norcross, J. C. (2013). Training opportunities for corrections practice: A national survey of doctoral psychology programs. *Training and Education in Professional Psychology*, *7*(4), 291-299. https://doi.org/10.1037/a0033218

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in qualitative research? A review of qualitative interviews in IS research. *Journal of Computer Information Systems*, *54*(1), 11-22. https://doi.org/10.1080/08874417.2013.11645667

Mascari, J., & Webber, J. (2013). CACREP Accreditation: A solution to license portability and counselor identity problems. *Journal of Counseling and Development*, *91*(1), 15-25. https://doi.org/10.1002/j.1556-6676.2013.00066.x

McConnell-Henry, T., Chapman, Y., & Francis, K. (2011). Member checking and Heideggerian phenomenology: A redundant component. *Nurse Researcher, 18*(2), 28-37. https://doi.org/10.7748/nr2011.01.18.2.28.c8282

McManus-Holroyd, A. E. (2007). Interpretive hermeneutic phenomenology: Clarifying understanding. *Indo-Pacific Journal of Phenomenology, 7*(2), 1-12. https://doi.org/10.1080/20797222.2007.11433946

Mears, D. P., Stewart, E. A., Siennick, S. E., & Simons, R. L. (2013). The code of the street and inmate violence: Investigating the salience of imported belief systems. *Criminology, 51*(3), 695-728. https://doi.org/10.1111/1745-9125.12017

Mitchell, M. M., Fahmy, C., Pyrooz, D. C., & Decker, S. H. (2016). Criminal crews, codes, and contexts: Differences and similarities across the code of the street, convict code, street gangs, and prison gangs. *Deviant behavior*, *38*(10), 1197-1222. https://doi.org/10.1080/01639625.2016.1246028

Molyneux, S., Tsofa, B., Barasa, E., Nyikuri, M. M., Waweru, E. W., Goodman, C., & Gilson, L. (2016). Research involving health providers and managers: Ethical issues faced by researchers conducting diverse health policy and systems research in Kenya. *Ethics of Health Systems Research in Low and Middle Income Countries, 16*(3), 168-177. https://doi.org/10.1111/dewb.12130

National Commission on Correctional Health Care. (n.d.). *About us.* http://www.ncchc.org/about

National Institute of Corrections. (2004). *Effective prison mental health services:*

Guidelines to expand and improve treatment. https://doi.org/10.1037/e311482005-001

National Institute of Corrections. (n.d.). *About us*. http://nicic.gov/aboutus

National Institute of Health. (2011). *Protecting human research participants: NIH office of extramural research*. https://phrp.nihtraining.com/index.php

Ogloff, J. P., Talevski, D., Lemphers, A., Wood, M., & Simmons, M. (2015). Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. *Psychiatric Rehabilitation Journal, 38*(1), 16-23. https://doi.org/10.1037/prj0000088

Paterline, B. A., & Orr, D. (2016). Adaptation to prison and inmate self-concept. *Journal of Psychology*, *4*(2), 70-79. https://doi.org/10.15640/jpbs.v4n2a6

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 43*(5, Pt. 2), 1189-1208.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Sage.

Pont, J., Stover, H., & Wolff, H. (2012). Dual loyalty in prison health care. *American Journal of Public Health, 102*(3), 475-480. https://doi.org/10.2105/AJPH.2011.300374

Reiners, G. M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing Care*, *1*(5), Article 1000119. https://doi.org/10.4172/2167-1168.1000119

Ricciardelli, R. (2014). Coping Strategies. *The Prison Journal*, *94*(4), 411–434. https://doi.org/10.1177/0032885514548001

Ricks, E. P. (2015). *The rock and the hard place: How the prison psychotherapist balances treatment needs with security needs* (Doctoral dissertation). University of Texas.

Roebuck, J., & Zelhart, P. (1965). The problem of educating the correctional practitioner. *The Journal Criminal Law and Criminology, 56*(1), 45-53. https://doi.org/10.2307/1140595

Roy, S., & Avdija, A. (2013). The effect of prison security level on job satisfaction and job burnout among prison staff in the USA: An assessment. *International Journal of Criminal Justice Sciences, 7*(2), 524-538.

Sarteschi, C. M. (2013). Mentally ill offenders involved with the U.S. criminal justice system: A synthesis. *Sage open*, *3*(3), Article 2158244013497029. https://doi.org/10.1177/2158244013497029

Senter, A., Morgan, R., Serna-McDonald, C., & Bewley, M. (2010). Correctional psychologist burnout, job satisfaction, and life satisfaction. *Psychological Services*, *7*(3), 190-201. https://doi.org/10.1037/a0020433

Skarbek, D. (2012). Prison gangs, norms, and organizations. *Journal of Economic Behavior & Organization*, *82*(1), 96–109. https://doi.org/10.1016/j.jebo.2012.01.002

Sun, K. (2013). *Correctional counseling: A cognitive growth perspective* (2nd ed.). Jones & Bartlett Learning.

Sykes, G. M., & Messinger, S. L. (1960). The inmate social system. In R. A. Cloward, D. R. Cressey, G. H. Grosser, R. McCleery, L. E. Ohlin, G. M. Sykes, & S. L.

Messinger (Eds.), *Theoretical studies in social organization of the prison* (pp. 5-19). Social Science Research Council.

Trammell, R. (2009). Values, rules, and keeping the peace: How men describe order and the inmate code in California prisons. *Deviant Behavior*, *30*(8), 746-771. https://doi.org/10.1080/01639620902854662

United States Code. (1974). *Public law 93-415.* https://www.gpo.gov/fdsys/pkg/STATUTE-88/pdf/STATUTE-88-Pg1109.pdff

Urofsky, R. (2013). The Council for Accreditation of Counseling and Related Educational Programs: Promoting quality in counselor education. *Journal of Counseling and Development*, *91*(1), 6-14. https://doi.org/10.1002/j.1556-6676.2013.00065.x

Vagle, M. D. (2018). *Crafting phenomenological research*. Routledge.

Van Manen, M. (2016). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Routledge.

Varghese, F. P., Magaletta, P. R., Fitzgerald, E. L., & McLearen, A. M. (2015). Counseling psychologists and correctional settings: Opportunities between profession and setting. *Counselling Psychology Quarterly*, *28*(2), 200-214. https://doi.org/10.1080/09515070.2015.1016479

Voorhis, P. V., & Salisbury, E. J. (2014). *Correctional counseling and rehabilitation*. Anderson.

Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. *Aggression and Violent Behavior*, *18*(1), 92-100.

https://doi.org/10.1016/j.avb.2012.10.006

Ward, T. (2014). The dual relationship problem in forensic and correctional practice: Community protection or offender welfare? *Legal and Criminological Psychology*, *19*(1), 35-39. https://doi.org/10.1011/lcrp.12039

Ward, T., Gannon, T. A., & Fortune, C. A. (2014). Restorative justice-informed moral acquaintance resolving the dual role problem in correctional and forensic practice. *Criminal Justice and Behavior*, *42*(1), 45-57. https://doi.org/0093854814550026.

Waters, J. E. (1999). The impact of work resources on job stress among correctional treatment staff. *Journal of Addictions & Offender Counseling*, *20*(1), 26-38. https://doi.org/10.1002/j.2161-1874.1999.tb00138.x

Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advanced Nursing, 45*(5), 512-518. https://doi.org/10.1046/j.1365-2648.2003.02934.x

Wolff, N., Frueh, C. B., Huening, J., Shi, J., Epperson, M. W., Morgan, R., & Fisher, W. (2013). Practice informs the next generation of behavioral health and criminal justice interventions. *International Journal of Law and Psychiatry, 36*(1)*,* 1-10. https://doi.org/10.1016/j.ijlp.2012.11.001

Worrall, J. L., & Morris, R. G. (2012). Prison gang integration and inmate violence. *Journal of Criminal Justice*, *40*(5), 425–432. https://doi.org/10.1016/j.jcrimjus.2012.06.002

Yang, S., Kadouri, A., Révah-Lévy, A., Mulvey, E. P., & Falissard, B. (2009). Doing time: A qualitative study of long-term incarceration and the impact of mental

illness. *International Journal of Law and Psychiatry, 32*(5), 294-303. https://doi.org/10.1016/j.ijlp.2009.06.003

Yu, C.-C., & Lau, K.-Y. (Eds.). (2012). *Phenomenology and human experience*. Traugott Bautz.

Appendix: Semistructured Interview Questions

1. Please describe your master's-level counselor education.
2. Please describe any coursework specific to corrections that you had at the master's level.
3. Please describe any post-master's education that you obtained specific to corrections.
4. Did you have any supervised experience in a correctional setting or working with offenders at either the pre- or post-master's level? If so, please explain.
5. Please share any training that you have completed specific to corrections.
6. What has been your work experience working in correctional settings with offenders?
7. Please describe your work environment while employed in a correctional setting.
8. Please provide a description of your job duties and responsibilities.
9. What have been your experiences when working with offenders in a correctional setting?
10. How has your master's-level education influenced your work with offenders in correctional settings?
11. What education or training have you experienced that has been valuable to your work with offenders in correctional settings?
12. Please describe any challenges, if any, with applying your education and training to your work with offenders in correctional settings.
13. Please describe any supervision you receive while working with offenders in correctional settings.

14. Do you experience any challenges working in a correctional environment? If so, can you explain?
15. Do you experience any challenges working with offenders? If so, can you explain?
16. What has been your experience working as a treatment provider with correctional staff within a correctional institution?
17. Have you experienced any ethical or legal challenges when working with offenders in correctional settings? If so, please describe.
18. How have you managed ethical or legal challenges, if applicable?
19. In your opinion, what are the unique needs of master's-level counselors who work in this environment.
20. What education, training, or experience do you think is needed for working with offenders in correctional settings?