HIV seroprevalence rates for people incarcerated in prisons are 10 to 100 times higher than rates for other groups. The most recent U.S. Bureau of Justice statistics indicate that 2.4 percent of the 880,000 inmates held in prisons are HIV-infected. Of these, at least 17 percent have AIDS.

While limited resources and, occasionally, the adversarial roles of participants make it difficult to provide state-of-the-art mental health services in prisons, HIV-related services are in fact a common component of mental health care in these settings. However, little has been written to guide front-line providers in delivering clinical services to people labeled “inmates” with HIV disease. This article is one attempt to integrate theory and clinical practice for professionals working with this population.

The Prison Environment

Stepping into a correctional environment is akin to entering the Twilight Zone. Prison conditions, barriers between inmates and staff, and stigma combine with the dysfunctional psychological profile of many prisoners to create a toxic treatment milieu that opposes the two most basic mechanisms of therapeutic change: renewing the client’s sense of hope and engaging the client in a supportive relationship.

Primary among these influences is the fact that prisons control people through power and fear. This power differential constructs an inescapable barrier between staff and inmates that frequently discourages HIV-infected inmates from using mental health services. As one inmate states, “You may call yourself a psychologist, but to me you’re just another guard.” Alternately, inmate participation in HIV clinics is enhanced when correctional institutions elevate the status of HIV-infected prisoners, offering them privileges such as nutritional supplements, preferential quarters, and special work arrangements.

A sense of powerlessness among inmates combines with the prejudice common among people who live and work in prisons to further isolate HIV-infected inmates. Specifically, an inmate with HIV disease must contend not only with the negative self-image of a convicted felon but also with other degrading stereotypes indicated by labels such as “queer,” “homo,” “druggie,” and “pervert.” This challenge easily overwhelms natural coping mechanisms, and it is not surprising that many inmates use extreme forms of denial to deal with HIV disease.

These social conditions exacerbate the already dysfunctional belief and value systems with which many inmates enter prison. Several researchers have described the cognitive-emotional-behavioral characteristics that pervade the personalities of most offenders. While it is important to avoid ascribing these inclinations to every inmate, this catalog offers some perspective. Among these characteristics are mollification, entitlement, super optimism, cognitive indolence, habitual lying, secrecy, distrust, vigilance to gain control and exercise influence over others, expectations of being victimized, the avoidance of appearing weak, and an underdeveloped sense of responsibility.

The effects of all of these factors on perceptions of people in the prison system is dramatic. When more than 200 corrections professionals were asked to list phrases they believed accurately portrayed inmates, more than 95 percent of
As HIV becomes more and more a part of prison life—prison HIV rates are already several times the general population seroprevalence—prison administrators will be unable to avoid this issue. But, while prison officials are appropriately censured in the press for horrific prison conditions—both for HIV-infected and uninfected inmates—the true horror is that we as citizens are responsible for these conditions: prison conditions are a reflection of society’s disagreement about the goals of prisons and our ambivalence about the rights of prisoners.

The debate about the role of prisons in U.S. society has been reignited in recent years as the Supreme Court has ruled on significant defendant’s rights cases, as more defendants are sentenced to death and are actually executed, as federal balanced budget initiatives have sought to eliminate “amenities” such as prison gyms, and as the victim’s rights movement has burgeoned.

At the center of this debate is the conflict between victim’s rights and prisoner’s rights, concepts seen as being diametrically opposed. It is this polarization of ideas and beliefs that has made it impossible to come to agreements about the goals of imprisonment. What are these goals? To get criminals off the streets so they can cause no further harm to individuals? To protect society from the effects of crime? To deter people who might break the law? To punish criminals for the pain and suffering they have caused? To rehabilitate criminals so that they may rejoin society?

Most would agree that all of these goals are valid. Disagreements arise in prioritizing these goals, with vocal minorities emphasizing punishment or rehabilitation, and I suspect the large majority hoping that prisoners will simply get and keep criminals off the streets.

Working through Denial

Many inmates tend to externalize their problems and exhibit little desire to change. According to the Stages of Change theory, developed to describe the behavior change process, these individuals can be characterized as “precontemplators.” Inmate precontemplators blame others for their disease and lack awareness of how their antisocial behavior contributes to their misery. For example, during an HIV antibody test counseling session, one newly HIV-diagnosed inmate went into a tirade, blaming his wife for infecting him. He ignored his own numerous and risky sexual liaisons outside the marriage and the fact that he forced his wife into sex work to support his drug habit.

The greatest challenge for prison mental health workers is helping inmates overcome such denial. This challenge is complicated by the fact that for many inmates, denial is an adaptive mechanism used to cope with lengthy incarcerations and to avoid the fact that they have little control over their lives. By distracting themselves with everyday concerns and activities, they are able to maintain normalcy. Many inmates continue to use this already active denial to cope with HIV disease until the final weeks of illness.

This is further complicated by the fact that prison values denigrate feelings such as fear and sadness as “weak,” and male inmates find little privacy that might allow for the expression of these emotions. In addition, distrust among inmates makes it difficult to develop peer relationships that might foster emotional support.

Individual Therapy and Group Support

In response to this profile, clinical interventions should focus on consciousness raising, dramatic relief, and environmental re-evaluation to move inmates out of pre-
It is difficult to establish support group and peer counseling programs in correctional settings—where the keepers must remain in control—because these programs empower inmates.


contemplation and engage them in the therapeutic process. While many inmates will refuse mental health services, most will accept antibody test counseling, and this may be a route toward offering support.

For inmates who express an interest in psychotherapy, it is important to establish a viable therapeutic contract, especially since the expectations of HIV-infected inmates seeking counseling services may be very different from those of the therapist. It is not uncommon for HIV-infected inmates to seek therapists help in some decidedly non-therapeutic tasks, for example: absorbing their own sins; giving them special privileges; colluding with their denial, super optimism, and sense of invulnerability; or legitimizing anger toward the “system.” Failure by therapists to fulfill these expectations can result in immediate or premature dropout from therapy. But, therapists who accept this agenda do a tremendously disservice to inmates. Instead, prison therapists should emphasize from the beginning that therapy is a collaboration seeking inmate self-acceptance and an integration of neglected parts of the inmate’s life.

Despite their best intentions, many inmates experience difficulty building a therapeutic alliance. One way of working through self-protective emotional resistance is to help inmates articulate and externalize their inner turmoil and conflicts, especially in terms of HIV disease. Expressive intervention techniques such as the Walker Visuals are useful in this context. For example, when an emotionally constrained inmate was asked to select the Walker Visual that best represented what he was feeling about HIV disease, he chose an image that he described as a man standing at the edge of a cliff. As he talked about what the image meant to him, themes of isolation, despair, and suicide emerged for the first time.

Inmates who have been involved in crime and antisocial behavior for much of their lives tend to have superficial and stark interpersonal relationships, which can make it difficult for them to acknowl-
however, by educating administrators about their benefits and by continually monitoring these programs to ensure that inmates remain focused on prosocial ideas.

Jonathan’s Journey

Jonathan contacted a therapist in prison shortly after being diagnosed with HIV disease. He had about one year remaining of a six year sentence. Angry, confused, and guilty about his failure to parent his two young sons, he remembered his father's failures. He recounted how from the age of four his father had beat him, labeling him a "little devil.” Jonathan said the label stuck, and for the next 30 years, he was a heavy drug user and had committed hundreds of crimes. He came to therapy yearning to be a good parent to his sons, but knowing he did not have much time left and fearing his resolve would fail him.

Therapy began by encouraging Jonathan to evaluate the advantages and disadvantages of change. Using psychodramatic techniques, he realized that giving up his criminal thinking and behavior would be difficult, but that the payoff was worth the effort. Under his therapist’s guidance, he read material on criminal values and completed a detailed life review. This process solidified Jonathan’s commitment to change. He began to keep a daily journal of his criminal thinking patterns, which became a focus of therapy. The goal of treatment centered on helping Jonathan catch his criminal thoughts before they turned into actions, and ultimately replacing them with responsible cognitions and prosocial values. Once Jonathan demonstrated more consistent and responsible thinking, therapy encompassed communication and parenting skills training.

As a result of therapy, Jonathan stopped gambling and stealing food from the prison dining hall, and contacted his family. After his release, he went home and for three years remained drug-free, lived with his family, worked two jobs, and became an active PTA member. But as his physical condition worsened, Jonathan was unable to work. Fearing that he had become a burden to his family, he despaired and robbed a bank. A few months later, he died in prison. Before he died, however, Jonathan acknowledged to his former therapist that for three years, he had controlled the “devil” and been a good and loving father, and that this had been a triumph.

Conclusion

In approaching the task of HIV-related therapy in prisons, mental health providers should focus on three questions. First, how do we create opportunities to assist inmates who tend to perceive themselves only as victims of HIV disease and their environment when they may also be victimizers who inflict emotional and physical suffering on others? Second, how do therapists balance the desire to help inmates with their strong countertransference and negative emotional reactions to the severe character pathology they encounter on a daily basis? Third, how do prison clinicians deal with the conflict between the welfare of their clients and institutional mandates?

With the help of a strong professional support and consultation network and an understanding of prison culture, mental health providers can respond to these questions and provide beneficial care. Serious illness often cuts through the “cops and robbers” games and brings out the most positive character traits of incarcerated clients. Despite its daunting nature, it is a task that can be both manageable and rewarding.

Clearinghouse: Prisons and AIDS

References


Late-Stage AIDS and Prison Populations
C. Kenneth Bowles, PhD

While inmates infected with HIV disease usually decline mental health services while they are asymptomatic, this often changes as they progress to full blown AIDS and experience a dramatic shift in their psychological needs. As their symptoms worsen, inmates with AIDS are no longer able to use denial to deal effectively with their illness and they become more willing to trust staff and other inmates.

Inmates with HIV disease have a varied and complex relationship with prison, especially as they near the end of life. While some recount going on criminal binges after learning they were seropositive, the majority of inmates deny the possibility of future criminal activity, often citing as a deterrent the fear that future incarceration could result in death in prison. Death in prison is so undesirable that many inmates continue to question why they have not been released on humanitarian grounds. *

On the other hand, one of the author’s clients said that he had committed a federal crime so that he would be imprisoned and less of a burden on those who had been caring for him. Others receiving inpatient medical care at or near the end of their lives appear to be satisfied with prison, perhaps because they have nowhere better to go at the time of death.

These distinctions become important when looking at the psychological needs and coping strategies of inmates in the late stages of HIV disease. For these purposes, inmates can be separated into three categories: those who will clearly live to be released, those who will not, and those resolved to beat the odds and somehow survive long enough for release from incarceration. (This latter group has expanded with the availability of protease inhibitors and triple combination antiviral therapy.)

Supportive Counseling

Mental health treatment for seropositive inmates usually consists of supportive counseling, either individually or in support groups, rather than psychotherapy for mental or personality disorder pathologies. This approach is supported by both clinical experience in prisons and study results that find that people with AIDS have low aggregate rates of mood disorders and psychiatric distress. 1 The content of supportive counseling is likely to focus on sharing information and concerns about everyday symptoms and medical treatment. This aspect is particularly important because many prison physicians do not have the time or skill to satisfy inmate demands for information, reassurance, and attention. As a result, many inmates with AIDS are anxious and poorly

Counseling focuses on topics such as frustration with prison and illness, the assault on client’s self-image, and death.

*Compassionate release from federal incarceration requires that the sentencing judge be presented with significant information not known at the time of sentencing and be confident that the inmate will not engage in future criminal activity.


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See also references cited in articles in this issue.
informed about the course of their illness. In addition, inmates usually need to learn how to deal more effectively with medical staff, how to avoid reinfection with HIV, and how to secure legal financial support if released.

Important components of counseling include encouragement and personal validation regarding living with AIDS. Many inmates have low frustration tolerance. Many are heavily invested in their body image. Some struggle with feeling unlovable in an already unloving environment. And most face not only physical death, the social death of imprisonment, and the loss of loved ones and material possessions, they also face loss of respect within the prison community. Counseling elicits these concerns focusing on topics such as frustration with prison and illness, the assault on client’s self-image, and death. Often, providers must approach these issues using small, circuitous steps, for example, shaking hands frequently to impart touch and to help dispel feelings of negative body image.

Because the correctional setting provides fertile ground for negativity, it is important to help inmates with AIDS refocus energy on enhancing their everyday life experience. While they do have to deal with separation from friends and family, and restrictions in choice, they do not have to worry about funding for medical care, finding transportation to treatment and activities, securing adequate housing and nourishment, or responding to many other daily concerns. When they focus on what they have and what they can develop for themselves while incarcerated, inmates can enhance their pleasure and sense of well-being, and reduce their anxiety unhappiness.

Mental health providers also help medical and correctional staff understand the needs of inmates with HIV disease. While inmates may have ready access to medical and psychiatric care, they may have reduced access to anti-anxiety and pain medications due to the potential for abuse in prison settings. Mental health practitioners can help medical practitioners distinguish between actual need for these medications and “drug-seeking behavior.” They can also help medical and correctional staff recognize disruptive behavior that may be due to HIV-related cognitive impairment. For example, when a female nurse asked one inmate to turn around and pull up his shirt, he proceeded to turn around, bend over, and drop his pajama bottoms. This resulted in his being disci-

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Death and Dying
While dying inmates have the same needs as other dying people, the prison environment restricts them from having those needs met. Dying inmates are commonly removed from regular prisons and placed in prison hospitals. There, they often have difficulty making new friends and may become withdrawn as a result of physical weakness or in order to hide their illness from other patients. Furthermore, security considerations limit visits from prison friends and family members. Finally, nursing staff are typically cautioned against the type of physical touch that may be encouraged in community hospitals, and other staff members do not usually have the time to meet all of the psychosocial needs of these patients. To respond to this situation, some commentators have described how inmate volunteers can be trained and supervised by staff to become effective hospice workers. Typically, volunteers become best friends of dying inmates and are allowed special access to them. Such programs ensure that inmates dying with AIDS know they will not be abandoned as death draws near.

Conclusion
Mental health providers in a correctional setting need to balance their professional responsibilities, empathy for AIDS patients, and the realities of often working with personality disordered clients and conservative co-workers. While this may sometimes be a complex environment, the willingness to get involved is often the central factor in providing effective treatment.
Prevention for Incarcerated Drug Injectors


In most developed countries, injection drug users represent the single largest category of prison inmates, according to an international review article on injection drug use and incarceration. Since high rates of HIV infection in prisons are primarily the result of injection drug use, the most effective HIV prevention intervention would be to reduce the numbers of injection drug users in prisons.

Most injection drug users are jailed for drug-related property crimes, rather than drug possession or supply, and incarceration is common in this population, especially among male drug users. It is estimated that one-tenth of an injection drug user’s career may be spent in prison.

HIV risk is heightened in prisons because inmates lack sterile injecting equipment and condoms. A review of nine studies of injection drug use in prisons found that 42 percent of respondents reported injecting drugs while in prison. Sharing of injection equipment is far more common in prisons than outside prisons, and the nature of sharing episodes is characterized by very high rates of partner change and random mixing of inmates. In response, prisons have implemented approaches—including HIV education of prisoners and correctional staff, the provision of bleach for cleaning syringes, conjugal visits, voluntary drug-free prison wings, drug counseling, and random drug screening—that are moderately effective.

Four strategies that might be more effective have proven politically unpopular. One of the most effective—and controversial—ways to decrease HIV transmission in prison is to reduce the number of injection drug users housed there by diverting drug users, replacing incarceration with drug treatment and community service. Barring this approach, prison methadone programs are the next most effective intervention. Currently, only seven countries (and not the United States) provide prison drug detoxification and only five offer methadone maintenance. A third way to reduce HIV transmission in prisons is through syringe exchange, which has proven effective outside prisons but which raises concerns among correctional officers because it provides inmates with potential weapons. Finally, prisons should distribute condoms, even though this may contradict prison objectives to condemn sexual contact between men.

Primary versus Secondary Control in Prisons


Primary control—the belief that desired outcomes can be achieved through one’s own actions—was, as predicted, associated with lower levels of psychological distress for White prison inmates, but had no effect on distress for African American inmates.

In addition, according to this small study of seropositive incarcerated men and contrary to expectation, secondary control—a sense of control derived through the ability to adjust to or accept existing realities—was correlated with higher levels of distress among some subjects.

Researchers interviewed 95 men initially and 78 men during follow-up three months later in order to study control in a group that typically has very little control. They measured primary and secondary control, life stressors, health status, psychological adjustment, and symptoms of depression and anxiety. Of the 78 men who participated in both interviews, 47 percent were White, 37 percent were African American, 19 percent were Latino, and 4 percent were Asian American. The average age of these participants was 35.4; the average time since HIV diagnosis was 3.4 years; and the average educational level was 12 years.

Researchers hypothesized that primary control would have greater adaptive value than secondary control, that participants would employ primary control before secondary control, and that secondary control would act as a back-up strategy to primary control, employed when primary control was not possible or effective. In addition, they postulated that primary control would be stronger early in the
process and secondary control would be more common later in the process, acting as a buffer against the loss of primary control.

Primary control was correlated with decreased psychological distress at the time of both initial and follow-up interviews. On the other hand, secondary control was associated with higher levels of psychological distress for participants who had low levels of primary control; thus, secondary control did not act as a backup for primary control. This may be true because inmates with HIV disease by the nature of their circumstances have so little control. In other populations, acceptance can be viewed as a choice, but among inmates, acceptance may be too closely aligned to helplessness to respond to psychological distress.

Finally, while White and African American participants had similar levels of primary control, African American participants did not derive the same benefits from this situation as did White participants. Although the researchers could cite no direct evidence to explain this difference, they suggested that it might be related to the degree to which an ethnic culture was either individualistic or collectivistic. Primary control is an individualistic concept, in concert with mainstream White American culture but in conflict with the more collectivistic African American culture. For African American inmates, adjustment to prison life may involve more of a focus on group identity, for example, finding safety and support through association with other group members.

Measuring group-oriented sense of control might better predict psychological distress in this subpopulation.

Prisons, Rape, and AIDS


Ideological systems surrounding gender identity, gender politics, and dominance hierarchies contribute to the spread of HIV within prison populations. According to a commentary and review of the literature, hierarchies in North American prisons are frequently established through sexuality and rape, which functions, as it does in free society, as an exercise of power.

There are 1.4 million men in U.S. prisons, and this number has tripled since 1975. An estimated 9 percent to 20 percent of male inmates become victims of sexual assault.

Many prisoners establish dominance through displays of hyper-masculinity such as extreme muscular build-up, violence, and tattoos. Among these displays is rape, which is often used by men of one racial group to subordinate another, by older prisoners to establish rank over newcomers, and by prison guards to threaten prisoners. Men who rape other men in prisons often think of themselves as “straight” and their victims as “fags.” In addition, as in the outside world, rape in prisons is often overlooked by prison authorities, denied by victims, and ignored by society at large.

It would be a mistake, however, to interpret prison rape mainly as an inter-male power dynamic. Women are symbolically present in this world, and rape often represents domination of women. The prison phrase “make a woman out of you” means that you will be raped, and rape-based relationships between prisoners are often described as relations between “men” and “women.”

Male inmates’ vulnerability to HIV infection is also linked to the social construction of masculinity. Traditionally, men perceive and define sexual behaviors in terms of sexual risk-taking, sex without love, and sex as a game of conquest. All of these perspectives increase HIV risk.

Next Month

“Psychoneuroimmunology,” the theory that psychological state, the nervous system, and immunity relate to one another, has been around since the 1960s, remains controversial. Early in the course of the HIV epidemic, health providers hypothesized a relationship between disease progression and “co-factors” such as stress and depression, but it is only recently that HIV disease has become an arena for testing psychoneuroimmunological approaches.

In the February issue of FOCUS, Jeffrey M. Leiphart, PhD, Clinical Director of the AIDS Response Program at the San Diego Lesbian and Gay Men’s Community Center, reviews the literature on psychoneuroimmunology and its applications to HIV disease. Steve W. Cole, PhD, Post-Doctoral Fellow at the University of California, Los Angeles School of Medicine, discusses the biological mechanisms that underpin psychoneuroimmunological theory.
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