Being “on Point”: Exploring the Stress-related Experiences of Incarceration

Lauren C. Porter

Abstract

Prior studies establish a link between incarceration and stress-related health, but relatively little is known about perceived stressors among current and former prisoners. To better understand the stress-related experiences of this population, in-depth interviews were conducted with 25 former inmates in upstate New York and northeast Ohio in 2012 and 2013. Participants were asked about their health during and after prison, with all participants describing aspects of their incarcerations as stressful. The most commonly identified primary stressors (i.e., stressors while incarcerated) were interactions with correctional officers, interactions with medical staff, and fear of other inmates. Post-release, employment troubles emerged as the most cited secondary stressor. Surprisingly, few participants described feeling stigmatized following their imprisonment. Findings carry implications for the long-term health and well-being of ever-incarcerated individuals and point to the need for further research, both quantitative and qualitative, on stress-related health among correctional populations.

Keywords
over/underrepresentation, diversity issues, disproportionate representation, legal and policy, autism, population description

Approximately 1.6 million Americans are currently in prison, and more than 11 million spend time in local jails each year (Glaze and Parks 2012; Minton 2013). The vast majority (95 percent) of prisoners are eventually released (Hughes and Wilson 2003), constituting a group so large that some have classified it a “felon class” (Uggen, Manza, and Thompson 2006). In response to the sheer number of Americans who experience incarceration, researchers have amassed a large body of work examining the consequences of imprisonment. Taken together, this research suggests that incarceration worsens an individual’s life chances along several domains, including economic, social, and health outcomes.

The study of incarceration and health is relatively nascent, but thus far, findings tell a story that is consistent with this larger body of work: Former inmates are worse off than similarly situated peers. Although those in poor health are more likely to end up behind bars, studies demonstrate a causal linkage as well (Massoglia 2008). However, studies have “done a better job showing that incarceration matters rather than why incarceration matters” (Massoglia and Pridemore 2015:303). While literature highlights a number of potential stressors likely confronted by current and former inmates (e.g., loss of freedom, economic strain, marital dissolution), few studies explore the firsthand accounts of this population.

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Furthermore, while prison ethnographies consistently paint prison life as straining (Clemmer 1940; Goffman 1961; Irwin and Cressey 1962; Sykes 1958; Zamble 1992), scholars have focused more on the processes of adaptation and coping than on specific sources and experiences of stress. Somewhat perplexingly, as the United States entered an era of mass incarceration, the practice of qualitative research on these topics also declined (Wacquant 2002).

Exploring the subjective accounts of former prisoners is essential for gaining a comprehensive understanding of the relationship between incarceration and stress-related health. Although a qualitative approach cannot speak to causal linkages between perceived stressors and health outcomes, it does provide insights into the types of events or experiences that are perceived as stressful by this population. Specifically, this study explores self-identified stressors of incarceration among 25 former prisoners. In line with a stress proliferation perspective (Pearlin, Aneshensel, and LeBlanc 1997), perceived stressors are classified as either primary (while incarcerated) or secondary (post-release). Three primary stressors were common across participants: interactions with correctional officers, interactions with medical staff, and fear of other inmates. Once released, unemployment was the only frequently identified secondary stressor. Although prior work identifies stigma as a central mechanism linking incarceration to post-release hardships, feeling stigmatized after release did not emerge as a perceived stressor. Implications for understanding the health risks faced by correctional populations are discussed, as are suggestions for future research.

PERCEIVED STRESS AND THE STRESS PROCESS

There is growing interest in the link between stress and disease, with one line of research finding that social and economic hardships get “under the skin” and lead to poor health (McEwen 2012). In general, the stress process involves both a stressor and stress response. While a stressor is a perceived threat, the stress response is the physiological, psychological, or behavioral response to that threat (McEwen 2000). Originally developed to aid the body in acute survival situations (e.g., fleeing a predator), stressors of the modern world such as relationship or financial strain can cause a body’s stress response to be activated for months on end (Sapolsky 2004). The human body is designed to adapt to acute stressors through this process (allostasis), followed by a return to a baseline state of well-being. However, if a stressor is excessive or prolonged (i.e., chronic), the amount of strain on the body can prevent it from returning to baseline (Frodl and O’Keane 2013).

The brain plays a central role as both the target and mediator of the stress process (Ganzel, Morris, and Wethington 2010). Either unconsciously or consciously, the brain determines which stimuli are threatening and regulates the body’s response to those threats (McEwen and Gianaros 2010). A series of appraisals ensues, including evaluations of the stressor’s emotional salience, intensity, or difficulty and importance relative to an individual’s personal, social, and environmental context (Cacioppo and Gardner 1999; Ganzel et al. 2010). For example, a college student taking a difficult exam may experience relatively more stress if earning a passing grade is required to pass the course. Likewise, the death of a spouse may be especially stressful if an individual is dependent on the spouse for financial or social support. While primary appraisals of a stimulus are relatively quick and unfiltered brain responses, secondary appraisals involve a more conscious and iterative processing of the threat, including a consideration of coping resources available and past successes in combating similar stressors (Monroe and Kelley 1995). Social and economic factors related to support and resources play an integral role in the processing of a stressor by influencing the appraisal of a perceived threat as well as aiding in an individual’s resiliency or vulnerability (Eisenberger et al., 2007; McEwen and Gianaros 2012; McEwen and McEwen 2017).

In a direct sense, cumulative or chronic stress can increase the wear and tear on the body (McEwen 2012; see also Pearlin et al. 1997), leading to health complications, such as heart disease, poor immune functioning, depression, and obesity (Björntorp 2001; Epel et al. 2006; Hammen 2005; Kaplan et al. 2013; Lupien et al. 2001; McEwen 2012). Indirectly, stressors can also affect health by leading to unhealthy behaviors such as overeating, sleep deprivation, smoking, and substance abuse (Fishbein et al. 2006; Kaplan et al. 2013). In the following section, I review relevant
theory and research on prison life and reentry, which suggests a number of potential stressors for this population.

INCARCERATION AND STRESS

Incarceration likely exposes individuals to both acute and chronic stressors. For example, being assaulted by another inmate could be considered acute, while worrying about being victimized may be more chronic. In addition, incarceration is an event that entails both primary and secondary stressors—a process referred to as stress proliferation (Pearlin et al. 1997). Consistent with prior work, primary stressors of incarceration are conceptualized as those experienced during incarceration, while secondary stressors are those that incarceration leads to post-release (Porter 2014; Schnittker and John 2007; Turney, Wildeman, and Schnittker 2012).

In his classic study of prison life, Sykes (1958) describes the pains of imprisonment in terms of deprivation, drawing attention to the loss of liberty, autonomy, heterosexual relations, material goods, and security experienced by inmates. To Sykes, imprisonment is especially painful because an individual’s confinement “represents a deliberate, moral rejection of the criminal by the free community,” where he is not allowed to forget that “he has foregone his claim to the status of a full-fledged, trusted member of society” (pp. 65–66). In another classic study of prison life, Goffman (1961) argues that prison is a “total institution,” which curtails the self. According to Goffman, an inmate is stripped of prior identities and roles, forced to “engage in activity whose symbolic implications are incompatible with his conception of self” (p. 23). For example, an inmate must be deferential to officers and may be required to ask permission to satisfy basic human needs, such as using the bathroom. The effect of imprisonment on identity is described by Goffman as both immediate and devastating as prisoners are subjected to a series of degradations and “abasements” starting at their admission. Sykes’s work also speaks to this phenomenon, remarking that a prisoner is transformed from an individual into a “semi-human object, an organism with a number” (p. 6).

The stressors of imprisonment may also include volatile interactions with other inmates. For example, in 2004, 16 percent of state prisoners reported a fight-related injury since their admission (Maruschak 2008). In a sample of 400 inmates in Tennessee and Kentucky, Lahm (2008) finds that reported victimizations were fairly rare, but 17 percent of inmates reported assaulting another inmate in the past year. In addition to the oppressive prison environment, inmates are socially isolated from each other and from the outside (Ostfeld 1987). Being socially isolated is a stressor in its own right (Yang et al. 2013), but isolation can exacerbate the amount of harm inflicted by other stressors. As noted, social support is integral to the appraisal of stressors and can influence an individual’s susceptibility to a given stressor (see also Kamarck, Manuck, and Jennings 1990; Steptoe 2000).

Some ethnographic work suggests that inmates see their release as the endpoint of prison stressors (Zamble and Porporino 1988). However, research shows that ex-inmates encounter a new set of challenges on the outside (i.e., secondary stressors), including difficulties finding employment, housing and forging relationships (Hagan and Dinovitzer 1999; Patillo, Western, and Weiman 2004; Western, Kling, and Weiman 2001). These stressors may also include feeling stigmatized (Uggen, Manza, and Behrens 2004), diminished social standing (Schnittker and Bacak 2013), marital challenges (Lopoo and Western 2005), and struggling to maintain parenting roles (Turney and Wildeman 2013). Secondary stressors may also be more chronic; they may not have a perceivable endpoint, and in the long term, they may require healthy coping mechanisms to mitigate their damage to health.

Post-release hurdles following prison are often attributed to the “overwhelming significance of its stigma” (Schnittker and John 2007:127). Indeed, employers are reluctant to hire ex-felons (Pager 2003), and landlords are hesitant to rent to them (Geller and Curtis 2011; Roman and Travis 2006). According to Goffman (1963:5), former prisoners would be considered a stigmatized group based on “blemishes of individual character.” As a result of this “spoiled identity” (Goffman 1963), others avoid and discriminate against the individual. Although stigma may indirectly affect ex-inmates through these channels (e.g., not getting a job), the effects may also be more direct. For example, feeling stigmatized may damage self-worth and perceived social standing (LeBel,
Social standing is a significant source of health variation since it reflects “the degree of autonomy and control individuals have and their opportunities for full social engagement” (Marmot 2004:46).

Consistent with prior work, research finds a link between incarceration and depression—a mental illness often catalyzed by exposure to stressors. Schnittker, Massoglia, and Uggen (2012) find that incarceration more than doubles the likelihood of dysthymia and increases the odds of major depression by 50 percent. Porter and Novisky (2017) find that incarceration increases depressive symptoms and that the relationship operates through material hardship. Also, Western and colleagues (2015) find that material hardship is pervasive among a cohort of recently released prisoners in Boston and that extreme material hardship is accompanied by feelings of anxiety and isolation.

In sum, prior research suggests that incarceration disproportionately exposes individuals to stressors, which may have enduring effects on health. However, research lacks a more nuanced understanding of perceived stress, and that the relationship operates through material hardship. Also, Western and colleagues (2015) find that material hardship is pervasive among a cohort of recently released prisoners in Boston and that extreme material hardship is accompanied by feelings of anxiety and isolation.

No restrictions were imposed on the sample with respect to participants’ demographic characteristics or incarceration experiences (e.g., race, age, type of facility, sentence length). Semi-structured interviews were conducted face-to-face at local coffee shops and restaurants. The length of each interview ranged from 45 minutes to three hours, with most lasting around 1.5 hours. Interviews followed a general guide, with each interview beginning with the following question: “Do you think incarceration affected your health?” The remainder of the interview was largely shaped by how a participant answered this question (e.g., yes or no). If a respondent said that incarceration was irrelevant, the second question was, “Why do you think that is?” If a participant felt that incarceration did affect his or her health, the second question was, “In what way?” About 60 percent of participants reported incarceration was harmful overall, 28 percent said that it was beneficial, and 12 percent felt it had no effect. Among the 60 percent who thought the impact was completely or mostly negative, stress was the leading health factor discussed. For the 28 percent with...
positive views on incarceration’s role in their well-being, less access to drugs while in prison was the dominant reason cited. Other reasons cited for prison having a positive influence included feeling safer from violent victimization, access to health care, more opportunities for exercise, and a healthier diet. Notably, each participant who fell into this camp had a history of drug use and experienced lengthy prison histories. The decision to label incarceration as overall negative, positive, or irrelevant depended on how individuals conceptualized health and which dimensions were most important to them (e.g., mental vs. physical; fitness vs. disease). Interestingly, however, all participants identified incarceration as stressful without being asked directly about stress.

Although participants were asked about their perceptions regarding the role of incarceration in their health, it is not the goal of this study to establish whether incarceration did in fact affect their health. Rather, this question is suited for a quantitative analysis. In these interviews, importance was placed on trying to understand the perceptions and interpretations of participants. In addition, each participant was asked about daily life in prison, what the staff and other inmates were like, and what it was like when they (first) got out of prison.

The sample consisted of 24 males and 1 female. Before the interview began, the participants were asked a few standard questions about their race, age, and how long it had been since their release. The sample was 62 percent black, with an average age of 44 years old and a range of 22 to 62 years old. The average number of times incarcerated was four across participants, and the median time since release was two years. Participants were not asked about the total time they spent behind bars due to the difficulty in recalling and calculating multiple spells, but interview data reveal that experiences ranged from a few months in jail to nearly 25 years in prison.

Interviews were digitally recorded and then transcribed by the researcher using Express Scribe, free transcription software available online. Consistent with a grounded theory approach, transcriptions were analyzed using open coding (Strauss and Corbin 1990). The coding of qualitative interview data is an inductive and iterative process. Interview transcripts were read for emerging themes and initial concepts throughout the study period. Stress was an early and pervasive theme even though no participant was directly asked whether they felt incarceration was stressful. After this theme became apparent, the follow-up question, “What was stressful about it?, became a standard part of the interview. Following from this initial theme, selective coding was used in which all text pertaining to stress was explored for common experiences or sources of stress. Experiences were not coded as perceived stressors unless explicitly identified as stressful. Finally, focused coding was carried out on these subthemes, which involved further exploring relationships between experiences and comparing these with preexisting literature and theory (Charmaz 2002). NVivo software was used throughout the process to aid in coding, analysis, and organization of the data. Institutional review boards at Ohio and New York universities approved all research conducted.

**PRIMARY STRESSORS OF INCARCERATION**

I wouldn’t send my worst enemy to prison. Prison is for nobody. (Winston, 62-year-old black male)

The most commonly identified primary stressors of incarceration were interactions with correctional officers, interactions with medical staff, and fear of other inmates (see Table 1). Perhaps most revealing is that former prisoners overwhelmingly identified social aspects of their incarceration experiences as stressful as opposed to physical or environmental aspects, such as losing their freedom or unsanitary conditions. These results somewhat comport with the symbolic interactionist arguments of Sykes (1958) and Goffman (1961), who both identified the imprisonment experience as socially degrading and identity altering in part because of interactions with staff and other inmates.

Jon, a 26-year-old black male, referred to the “overwhelming sense of anxiety” brought on by prison life as being “on point.” As he recollected, “I just remember always being, we called it being ‘on point.’ What that is, is an action-readiness, like I’m ready for action. I’m ready for action at all times.” Most inmates spend years in this environment, and being on point may be a particularly dangerous component of the incarceration
Being on point may be likened to the fight or flight response—or stress response. If chronically activated, the stress response contributes to stress-related conditions such as obesity and depression (Block et al. 2009; Jackson, Knight, and Rafferty 2010). Drawing on the firsthand accounts of former prisoners, these perceived stressors are discussed in more detail in the sections that follow.

## Interactions with Correctional Officers

Seventy-two percent of participants identified interactions with prison staff as stressful, 32 percent of whom felt mistreated and “looked down on” by correctional officers in particular. The following accounts reflect various experiences that relate to this feeling:

One officer searched me and they’re allowed to do searches, but I thought, I thought the officer was being a little freaky. He told me to bend over so I bend over. He told me to spread my cheeks so I spread my cheeks. He said do it again—I did it again. Then when he told me a third time I was like, “Yo what’s going on?” I said, “Why you gotta look up my ass three times?” You know? And then he says, “Yo I do whatever I want to, this is my world.” (Calvin, 52-year-old black male)

Certain COs was alright, and certain COs wasn’t alright. I had one CO just treat us like crap. He would come in and say “god is here. I’m god.” And you know, and he was a piece of crap. I really didn’t like him. (George, 47-year-old black male)

If you’re gonna pick this line of work, you know, to be around inmates, I think you gotta help ’em, you know? Not belittle them or think down on them. That’s what a lot of officers do . . . they look down on us, think we’re bad people. (Wesley, 35-year-old white male)

As noted, feeling “lower” in status disrupts health since those lower on the social ladder experience more stress than those with higher standing (Mar-mot 2004). Indeed, inmates possess little control and have little recourse when it comes to being dissatisfied with how they are treated. In addition to feeling degraded or belittled, some participants feared the officers. For example, participants described officers using erratic and at times unlawful measures of control. Wesley explained the threat of correctional officers as follows:

The police are what you really gotta worry about in there. Not the inmates. The police’ll set you up in there. They’ll put like a weapon inside your cubicle—you piss a guy off, if you do something—those officers, they got their little inmates they are all cool with . . . and if the inmates don’t like you the cops’ll fuck with you.

These participants expressed a general distrust of correctional officers and often described feeling worried that a correctional officer would “mess” with them. For example, the previous excerpt is similar to the accounts of two other participants:

I was stressed every day. I was anxious every day. Just . . . waiting for that day to be home. How I always used to worry

### Table 1. Perceived Primary Stressors of Incarceration across Participants.

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<thead>
<tr>
<th>Stressor</th>
<th>Illustrative Quotation</th>
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<tbody>
<tr>
<td>Interactions with correctional officers (N = 8)</td>
<td>“It was really frustrating because, you know, you’re trying to better your life and they’re more or less judging you like the rest of them” (Jason, 50-year-old white male)</td>
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<tr>
<td>Interactions with medical staff (N = 15)</td>
<td>“I was always worried I was going to get sick in there . . . and I saw the treatment of people and it really worried me” (Bernard, 51-year-old white male)</td>
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<tr>
<td>Fear of other inmates (N = 10)</td>
<td>“I always worried that I’m gonna set this guy off . . . is he going to need to retaliate now, things like that. Just not knowing the environment and not knowing who I’m with and the potential for danger . . . it’s stressful.” (Jon, 26-year-old black male)</td>
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about . . . like an officer doing something bad to me . . . thank god I don’t have that anymore. (Jon, 26-year-old black male)

They can be real jerks. They can do anything they want to. They can put you in a box if they want. Plant something in your locker . . . they can do whatever they want. (Joey, 49-year-old white male)

Similar to policing research, inmates may perceive some correctional officers as biased and/or corrupt (Weitzer, Tuch, and Skogan 2008). The accounts of participants also parallel ethnographic work by Goffman (1961) and Sykes (1958), who highlight the tension between inmates and correctional officers. In particular, Goffman observes that officers must “coerce inmates into obedience while at the same time giving the impression that humane standards are being maintained” (p. 92). This may lead to a great deal of variation in the behavior of officers, some of whom may use “off the books” tactics to achieve compliance. Sykes (1958:83) also argued that prison officials are “another hazard in the pursuit of an inmate’s goals” and that an inmate may try to bond with officers and “betray his captives if it advances his interest.” This may be a difficult decision for inmates since one path poses danger in terms of other inmates, while the other may increase tension with officers.

In addition to the correctional officers, 60 percent of participants identified stressful interactions with medical staff. While most work on prison life examines inmate-guard relations, findings suggest that interactions with other prison staff may be consequential as well.

Interactions with Medical Staff

Medical staff are primarily responsible for the care of inmates while officers are agents of control above all else. Though ex-inmates distrusted and disliked some correctional officers, they seemed to regard their behavior as more or less expected. This was not the case for medical personnel. Somewhat surprisingly, participants discussed interactions with medical staff as distressing more often than interactions with officers. Further, the tones of participants when recalling interactions with medical staff were noticeably more emphatic and negative. Even with respect to body language, participants would shrug their shoulders when talking about officers mistreating them but would shake their heads, raise their voices, and throw their hands in the air when discussing medical staff. In short, their expectations of medical staff did not seem to align with the reality of their experiences—a form of mental discomfort referred to as “cognitive dissonance” (Festinger 1957).

It is possible that a history of precarious encounters with the police prepared participants for tense relationships with correctional officers. For example, negative attitudes toward the police are more common in disadvantaged areas, which tend to have elevated rates of crime (Schuck, Rosenbaum, and Hawkins 2008). Correctional officers are also responsible for the control of inmates, which arguably sets inmates and officers at odds from the outset. On the other hand, negative experiences with medical staff may be more surprising given that these staff provide aid rather than regulation. Contradicting beliefs create mental discomfort for individuals. With respect to patient experiences in general, a patient’s experience can impact his or her satisfaction with care, but so does the incongruity between expectations and experience (Thompson and Sunol 1995).

Trust was also central to inmates’ poor interactions with providers, but in a way that is somewhat counterintuitive. Rather than distrusting the medical staff, as was the case with officers, most participants described the medical staff as not trusting them. Sykes (1958:66) argued that one role of correctional officers is to serve as a reminder for each inmate that he has forfeited his “status of a full-fledged, trusted member of society.” Similarly, this may extend to the medical staff based on the perceptions of these prisoners. For example, two participants recounted the following:

I seen people in there when I was in there have heart attacks and they didn’t believe ‘em . . . and then they end up dyin’. I mean, you, you know how many people I’ve seen die in the last 7 years? 24 people. You know? Or more. I mean it’s crazy, I mean you don’t, you don’t treat people like that. Everybody’s human. Now I know some people aren’t fit to be human because of what things they do. But most everybody is human. (Jason)

You’d meet a nurse—they’d be angry, they’d be short, they’d be disrespectful, they would never believe you. They would never believe me. (Jon)
Some acknowledged that this distrust was likely tied to the abuse of medical care by inmates. One participant even described doing this himself:

I think my priority was more drug use than going to the doctor. I understand where they’re coming from where they won’t give you certain prescription drugs or do certain things for you, because a lot of us are conniving and trying to get drugs from them or trying to get . . . some type of fix from them, you know? I know . . . I tried it in the past. I went to the doctor before to try and get something . . . just something to get high in jail. So, I understand where they’re coming from. If I was running a facility and I had a bunch of drug addicts trying to get drugs I’d want to know where they’re at, what they’re trying to do. (Wesley)

Only one participant reported lying to the nurses and doctors, but others perceived it to be a common occurrence. Bruno, a 61-year-old black male describes, “Anything to get attention or to get drugs. It’s a game to some of them.” Another participant admitted he would have tried to finagle drugs from the psychiatrist if he had served more time. With a wide grin, Willie shared, “I would’ve did the deal like everyone else . . . played it up, got me a few little sleeping pills . . . go talk to the little shrink every week or whatever.” When asked why he thought people “played up” their mental health issues, he stated the following:

It has to be a combination. The giving up part . . . um, that has to be one of the biggest ones. But then . . . there’s pretty much nothing else to do. I mean, seeing doctors, talking with the psychiatrist, maybe you’ll see a pretty lady . . . these are major events for an inmate if you know what I mean. If the only way I can get out of my confinement is to go see a psychiatrist because I’m severely mentally distraught . . . then, that’s probably what I’m gonna do. (Willie, 44-year-old black male)

A handful of participants sympathized with the medical staff, but others were frustrated by this lack of trust, feeling they were unfairly lumped in with other inmates (e.g., “They treat everyone just the same, you know? You’re a convict. You’re going to be treated just the same as the next convict.”). Based on research examining the relationship between social standing and health and between perceived discrimination and health, these experiences may equate to higher levels of perceived stress, which in turn affects health. In addition, blacks in the general population are less likely to trust medical professionals and seek treatment (Boulware et al. 2003; Casagrande et al. 2007; Doescher et al. 2000; Schnittker, Freese, and Powell 2000). Negative exchanges with medical staff in prison could validate preexisting attitudes among disadvantaged blacks especially, which would threaten health behavior post-release (e.g., seeking treatment).

Participants also spoke of a lack of urgency, being misdiagnosed, and being prescribed treatments that were a “joke.” For example, Bernard remembered his experiences going to “sick call” while in prison:

The urgency, and the concern . . . is highly highly minimal. Um, you know, I think unless it’s really life-threatening. But like I said I saw a man have a heart attack and there wasn’t the urgency I thought there should’ve been. I just, you know, it was like . . . when you’re sick, you need help. It’s not like you want to wait around. And you were gonna wait. (Bernard, 51-year-old white male)

Medical staff are not agents of control by design, although they hold immense power. Inmates use sick-call presumably because they need medical attention. Similar to seeing a doctor or a nurse outside of prison, they must wait to be examined and treated. Literature on the patient-doctor dynamic suggests that a “good” patient is a “patient” patient (Katz 2002; Mulcahy, Parry, and Glover 2010), expected to accept long wait times that are usually indefinite. These waits, although expected on the part of patients, are still “psychologically and sometimes physically detrimental” to patients (Mulcahy et al. 2010). Even in the general population, patients are made to wait for long periods and are often at the mercy of doctors to educate them about their illness and recommend treatment. These same power dynamics are magnified in prison. Prisoners have no choice but to visit the medical personnel on staff, and they must wait without recourse. The psychological impact of long waits is likely palpable since a person who
is kept waiting is reminded of “how utterly insignificant he is as compared with the person for whom he waits” (Schwartz 1974:856). One participant even interpreted the long wait times as a deliberate ploy on the part of the medical staff to prevent inmates from seeking care:

One thing I always remember is that I would have to sit there for the longest time before I even saw anybody. I felt like they made it as uncomfortable as possible so I wouldn’t use it again. (Jon)

When participants did see a medical professional in prison, they often described appointments as a continuation of this feeling. Participants recounted conditions being misdiagnosed, mis-treated, or disregarded. For example, Willie described an experience in which the nurses did not take his spider bite seriously and mocked him:

When I put the uniform on I felt something bite me. And I knew it was a spider bite. When they brushed it off I killed it, so I seen it. But I immediately started the procedures to try to see the nurse or the doctor . . . or whatever. And I found it very difficult to get medical. It was very difficult. I first showed them the little bite. And they were like “uh uh, he must be some kinda girl or something, look at that little thing.” But I knew I had been bitten by a spider, and uh, and I said “all I’m sayin’ is this is a spider bite. It could be bad.” Of course, 8 days, 9 days later, when there’s a hole in my knee . . . um, and I could stick my finger in the hole, then they kind of believed me. I had to be able to stick my finger in it before they thought it was serious enough to go see someone.

As noted, relationships with providers seemed especially impactful for participants because they did not align with expectations, while the adversarial relationship with guards seemed more expected. However, interactions with each type of personnel were described as stressful for participants in part because they felt devalued or degraded. Finally, the third stressor identified by participants was based on interactions with other inmates.

**Fear of Other Inmates**

Fear of other inmates was identified as a stressor by 40 percent of participants. Interestingly, only two participants reported being victimized while in prison (8 percent). One was cut by another prisoner through the bars on his cell. A 42-year-old Latino male, Diego, said that an inmate cut him after being upset about losing a game in the yard (“I thought we was cool and all of a sudden he cuttin’ me! Through my . . . right here, man” [lifts shirt to reveal a scar approximately one inch long underneath his rib cage]). In another case, Kevin, a 22-year-old white male and first-time inmate said that another inmate “choked him out.” The attack was spurred by Kevin accidentally bumping the other inmate’s knee when opening a door. Kevin had not noticed the infraction. He reflects, “The whole mental thing of me, you know, trying to think of who I could have a problem with or who might have a problem with me all the time . . . is extremely stressful.” This dynamic was also observed by Sykes (1958), who noted that inmates live in perpetual anxiety about other inmates, “uncertain of whether or not today’s joke will be tomorrow’s bitter insult, the prison inmate can never feel safe” (p. 78). Further, inmates are aware that if they are “tested” by another inmate, either fighting or not fighting could make them a future target. For example, if an inmate fights and wins, he could be a target for another inmate looking to prove himself. If he does not fight or if he loses, he will be seen as weak. This dynamic led many participants to isolate themselves. As one participant exclaimed after being asked how he coped with this fear—“Yeah, I coped! Isolate! Kept to myself.”

Importantly, former inmates who fell into this category and did not directly experience victimization still feared it could happen. Jon, another first-time inmate, felt ill-prepared for the experience. He identifies a similar dynamic as Kevin:

There was this background noise of stress because there was always a chance of danger. There was always a chance of violence or something like that. It was always in the back of my mind that something bad could happen at any time, so the stress of that . . . you never know who you’re around. Something that might be so trivial to you or anyone on the outside like bumping into a guy or saying something in the wrong way . . . I
always worried that I’m gonna set this guy off, is he going to need to retaliate now, things like that. Just not knowing the environment and not knowing who I’m with and the potential for danger . . . it’s stressful.

Participants were uncertain about who might be a threat and what actions might make themselves targets, but fear also stemmed from witnessing others being assaulted and feeling uncertain how to defend themselves in the event. On the one hand, being able to fashion and hide a prison weapon may provide inmates with a certain sense of safety but on the other hand could make them more fearful of getting caught by correctional officers. Charles (53-year-old black male) and Jon each described steps they took to prepare for an attack. Charles wrapped his arms in fabric to block a potential razor attack. “It’s crazy,” he said, “I never would have thought of that.” Jon slept with a “heavy duty” pen not permitted in prison because of its sharpness and remembers thinking that he could also use his radio as a weapon— “I used to sleep right next to my radio and I used to think that if anything was going down and I had to use that, I would.” One participant aptly described how exposure to prison violence can lead to this anxiety:

If you’re not mentally unstable before you go to prison? Trust me . . . when you come out? Trust me . . . when you come out? Oh yeah . . . there will be some mental scars. Because you see death. You see death. It’s not like you read it in the paper—you see it. You see it right before your face. You see the fight. You see the knife. You see it go into the guy’s heart, you see it going in his neck, you see him going down, you see the guy stabbing him while he’s on the ground . . . then you see them put everyone down on the ground and you hear he’s dead. So, you actually saw a guy get murdered! (Francis, 53-year-old black male)

Some participants had trouble sleeping for fear of being victimized. Denise, a 48-year-old black woman, recalls sleeping in a room full of other inmates on bunk beds: “So you actually sleepin’ next to a murderer. You got a murderer over here and a murderer over there . . . and a murderer right there on the top bunk.” Similarly, Jason remembered, “most of my bunkies I ended up with was murderers,” “I had to guard myself at all times,” and “watch my back all the time.” In a recent study, Testa and Porter (2017) find that former inmates are more likely to suffer from inadequate sleep and insomnia. The experiences recounted by these participants may provide some insight into the causes of sleep problems in this population.

As noted, prior research suggests that perceived stressors are likely to continue post-release due to the social, educational, and financial barriers that await many prisoners returning home. In the next section, I review insights relayed by participants about experiences they perceived as stressful after their release.

SECONDARY STRESSOR(S) OF IMPRISONMENT: UNEMPLOYMENT

In this study, only one common secondary stressor emerged: unemployment (48 percent). This could in part be a function of the sample since many participants were recruited from reentry seminars, where employed former inmates may be less likely to attend. However, this also corresponds strongly with prior work showing that ex-felons face formidable challenges in the labor market (Western 2002; Western et al. 2001) and that material hardship is a key contributor to post-release well-being (Porter and Novisky 2017; Turney et al. 2012; Western et al. 2015). These participants described a range of experiences related to their employment struggles, including being stressed about repeated rejections, feeling overwhelmed and uncertain about the application process, and feeling as though their parole requirements added extra complications (e.g., time constraints). As Calvin, a 52-year-old black male, describes: “You’re supposed to find a job, but where are you supposed to start? I put in for 10–15 jobs. They didn’t call me back. I was overqualified or it wasn’t in my field.” After nine years in the system, Calvin felt overwhelmed and underprepared for the challenges facing him post-release. Considering the fast pace with which technology progresses, nine years may be a particularly long time. For example, inmates being released today may have been admitted during a time when online job searches were in their infancy. In another example, a participant claimed that the inability to afford a personal cell phone
and living at a halfway house were frustrating in this respect:

I’m starting to get down, or not down, but a little restless. But like I said I’ve done a lot of construction work and there are some guys still working but there’s no hiring going on right now. So I got a resumé and it’s geared toward restaurant work. I’ve gotten a few interviews and I thought they went pretty good. And I’m having problems with my voicemail. The one place wanted to hire me but they couldn’t get ahold of me. So, about two weeks after the interview I see the ad in the paper again. So I called them up and the guy says we’ve been trying to get ahold of you for a couple weeks. (Rick, 53-year-old white male)

In Rick’s case, he was dependent on the communal phone at the halfway house to receive messages from employers. This was one case where he described not getting a message from an employer who allegedly called and left a message with a staff member. Francis, who served 10 years, evoked another dimension of joblessness that was stressful for him:

I couldn’t even take you to dinner with the money I make. So, I just feel manless . . . because I can’t contribute to my own well-being. I’m not going back to selling drugs, that’s for sure. But who knows? Situations like this sort of exacerbate what you went through in prison especially if you can’t find a job, you can’t find housing, you can’t get a full-time job. You . . . you carry that pain with you every day.

Unemployment may be especially damaging to males given the central place of employment to masculine identity (Collinson and Hearn 2005; Michniewicz, Vandello, and Bosson 2014). As Francis articulated, he felt “manless” because he could not support himself or others. Francis pointed to his specific conviction as a likely culprit for his difficulties in the labor market, saying he understood that people would not want to hire “a weasel like that.” Francis was convicted of fracturing his daughter’s pelvic bone and leg. He pleaded innocent and was continuing to file appeals post-imprisonment. Interestingly, Francis was one of only four participants who described feeling as though his status as an “ex-felon” affected his experiences on the job market. These four “outlier” participants included one female, two sex offenders (including Francis), and Roger, a 57 year old black man who robbed over 100 convenience stores. With the exception of Roger, these three participants all have something in common: Their offending is especially counter-normative or amoral. Criminal behavior is much less likely among females, and sex offenders are modern society’s “boogeymen” (Tewksbury 2014). Similar to Francis, Bernard felt that his status as a sex offender was responsible for his issues on the job market. He was convicted on four counts of sexual battery against adolescent males. He reflects,

It was very hard because they labeled me a sex offender and I did not really know what that meant . . . the ramifications of it. That has definitely affected my health mentally, physically, and everything else because I’ve had to continually fight just to survive. And um, knowing that I’m an educated person and knowing that I have capabilities and knowing that I can get a job, and when they find out about the offense, or something to that nature, you know, I lose the job. Um, so . . . it’s really been very high stress, which perpetuates the blood pressure I guess.

The female in the sample, Denise, felt stigmatized by her criminal record on the job market as well. She explained, “Just one of those who got caught up in the system. And now [employers] just gonna look at me always as a criminal.” A chef at an upscale restaurant prior to her stint behind bars, Denise was frustrated by being repeatedly turned down for kitchen staff positions. In the last example of stigmatization, Roger reflected on his labor market difficulties:

I went through periods . . . of time since ’08 to where it was like in and out of jobs . . . um . . . because of background checks, and I didn’t realize that until actually I started seeing that I was actually qualified for so many different jobs and I’ve had numerous interviews with employers . . . I mean, really good jobs, and the final question was always—“Have you ever been convicted of
a felony?” And, yeah. You know, it’s actually caused me to live like really below the poverty level . . . and it hasn’t been really good.

This is illuminating because it highlights the role that interpretation plays in ex-inmates’ experiences of what is objectively the same perceived stressor—unemployment. That is, the perceived cause of unemployment may be part of the appraisal process and affect how stressful this difficulty is perceived to be. Indeed, there was a time when Roger did not perceive his labor market problems as resulting from discrimination. Later, he began to reinterpret his difficulties as being caused by his criminal record.

Regardless of whether ex-felons interpret their struggles as motivated by discrimination or not, certain outcomes may be the same (e.g., being unemployed). However, the effect of being unemployed on health may be contingent on how ex-felons interpret the reasons for it. As noted, the cognitive processing of a stressor is crucial to the body’s response to it (see also Folkman and Lazarus 1980), and stressors that are perceived as less controllable tend to be most harmful (Thoits 1983, 1987). Being jobless may weigh more heavily on ex-felons who perceive their job difficulties as resulting from their criminal records and thus largely out of their control. Those who perceive their struggles as resulting from general or environmental factors are also less likely to develop stress-related conditions (for a discussion of perceived discrimination as a stressor, see Williams and Mohammed 2009). For example, unemployment weighs less heavily on individuals in contexts of high unemployment rates (Ahn, Garcia, and Jimeno 2004; Frey and Stutzer 2002; Graham 2005). Two participants expressly denied the role of discrimination in shaping their labor market difficulties: “It’s not because I’m a convicted felon . . . I’m not going to use that excuse. It’s just the economy. I think people use that excuse because it’s easy” (Wesley) and “Having felonies and things of that nature didn’t stop me from getting a job” (Charles, 53-year-old black male). It is possible that these participants were reinterpreting their experiences in a way that was more palatable to them. However, this would ignore an important possibility: Feeling stigmatized may be highly variable among ex-felons. Even if employers or others in the community are in fact discriminating against ex-felons, it may be “unfelt stigma” in that their labor market difficulties are not necessarily interpreted in this light. The concept of “felt stigma” was used by Scambler and Hopkins (1986) to describe the experiences of those diagnosed with epilepsy, referring to the fear of being treated discriminately and to feelings of shame associated with having a stigmatized identity. Yet some individuals with stigmatized identities may not feel stigmatized. While “unfelt stigma” may be less relevant in understanding the collateral consequences of incarceration for outcomes such as marital dissolution or employment (i.e., outcomes that presumably do not rely on individuals feeling stigmatized), it may hold more importance for understanding health outcomes. In the discussion, I further expand on these possibilities and suggest directions for future research.

DISCUSSION

Using in-depth interviews with 25 former inmates, this study investigated the stress-related experiences of incarceration. In particular, participants identified three primary stressors (interaction with correctional officers, interaction with medical staff, and fear of other inmates) and one secondary stressor (unemployment). In general, participants described a great deal of uncertainty with respect to each source of perceived stress. As one participant described, this uncertainty led he and other inmates to be “on point” at all times during their incarceration. Importantly, stress research suggests that chronic activation of the stress response can have deleterious consequences for health, including heart disease, poor immune functioning, depression, and obesity (Björntorp 2001; Epel et al. 2006; Hammen 2005; Kaplan et al. 2013; Lupien et al. 2001; McEwen 2012). This study helps to contextualize research on the link between incarceration and health—especially mental health (Porter and Novisky 2017; Schnittker et al. 2012; Turney et al. 2012). While this body of research suggests that incarceration worsens psychological well-being, this study helps “fill in the blanks” with respect to the types of experiences and events that are perceived as stressful by this population.

A few limitations of this study must be noted. For one, it is possible that interactions with medical staff were highlighted more often than they would be in other studies because interviews
started with the question—“Do you think incarceration affected your health?” Thus, participants may have been primed to think about their experiences with nurses and doctors. Second, permission was denied by the New York Department of Corrections to access state correctional facilities, and therefore this study was conducted with former inmates only. This presents possible issues with recall as some former inmates may recall the events of their incarcerations more accurately than others. However, the bias seems minimal since all but one ex-inmate was still on parole and therefore were released from prison fairly recently. Third, findings cannot be generalized to the total current or former inmate population.

The dominance of social stressors highlighted by participants is important considering the range of other potential stressors that prison life presents, such as a loss of freedom, physical discomfort, crowding, and movement restrictions. However, this is not altogether surprising considering prior research suggesting that social stressors can exert powerful influences on health and well-being. Indeed, Link and Phelan (1995) argue that some social conditions are fundamental causes of disease, such as limited access to resources. Given the pervasiveness of incarceration in the United States, it is worth considering whether incarceration may constitute another “fundamental cause of disease” worth understanding and addressing, especially among disadvantaged populations. While the potential for infectious diseases to spread quickly and easily in correctional settings has been highlighted in prior work the social stressors of incarceration warrant attention as well.

This study also shows that interactions with prison staff beyond correctional officers are important to consider to fully understand the incarceration experience. Interviews revealed stressful interactions with medical staff while incarcerated that revolved around feelings of degradation and distrust. Interestingly, Goffman (1961) identified mental hospitals and prisons both as total institutions, sharing many of the degrading characteristics that strip away an individual’s identity and self-worth. Even in medical settings outside of prison, the patient-doctor relationship is beset with dynamics that can lead to feelings of dehumanization and degradation (Manookian, Cheraghi, and Nasrabadi 2014). Vulnerability and suffering are linked to a perceived loss of identity and dignity in general (Cockerham 2004), and patients must typically wait to see a doctor or nurse, disrobe and replace their attire with a de-personalized paper gown, and they lose much of their privacy during the appointment. Patients must also depend on medical personnel to diagnose and treat them (see Baillie 2009). These same dynamics are likely magnified in prison, where individuals are often occupying an even more vulnerable position relative to their caretakers: They are prisoners and patients. Future research should explore these dual statuses, or “prisoner as patient,” which could be important for understanding a range of health-related outcomes among former inmates, including their likelihood of seeking or adhering to medical treatment post-release. Additionally, participants appeared to perceive their interactions with medical staff as being more stressful than interactions with correctional officers. The experiences relayed by participants were typically told with a tone of surprise (e.g., “To me, being in the medical field you need to . . . you know, worry about the patient.”). Poor interactions with staff in caretaker roles (e.g., psychiatrist, social worker, etc.) may be particularly stressful for inmates since they may also involve a mismatch between expectations and experience (Thompson and Sunol 1995). Future work should explore these interactions from the perspectives of prison staff as well to gain a more comprehensive understanding of these dynamics.

This study ends on a note about stigma and offers suggestions for future research. Prior work suggests that stigma is one of the principal mechanisms linking incarceration to negative outcomes post-release, including poor health (Maruna, Immarigeon, and LeBel 2004; Schnittker and John 2007; Uggen et al. 2004). However, as noted by other scholars, “most research on labeling theory has ignored the intervening component of internalization” (LeBel 2012b). That is, most work does not examine the degree to which ex-felons internalize or “feel” stigma. For example, using a sample of formerly incarcerated persons, LeBel (2012b) finds that levels of perceived stigma vary based on a number of factors, including social bonds and race. Ray, Grommon, and Rydberg (2016) also find that about 43 percent of formerly incarcerated persons in their sample of 30 did not anticipate stigma acting as a barrier in their job search. Those who were less likely to anticipate stigma had supportive social networks, although the authors note that most did not rely on these networks to secure employment, instead showing a tendency toward self-reliance. Interestingly, each study finds that social bonds may
mitigate the internalization or perception of stigma among formerly incarcerated persons. In the present sample, 44 percent of respondents spoke of having supportive or motivational family ties. For example, nine respondents spoke specifically about how important their family’s support was during and after incarceration. Most of these accounts described emotional rather than instrumental support. For example, the following excerpts show various examples of social support in the sample:

I’m back in contact with all of my family now. I go on Facebook now. I don’t use it for friends or nothing like that, but being able to go on there and see my family, you know? Seeing what they’re doin’, it makes it easier, you know? To have people in your life . . . the support. (Wesley)

Right now I don’t have anything but family. I mean, my sisters live out of state, but I call them all the time. (Rick)

I got grandkids, I got a daughter. Now I work, I take care of them. I went shopping for them for Christmas. My granddaughter is 11 and she was 1 when I went away. They happy because we do things together now, and that’s what I didn’t get a chance to do before. It feels good. (Tyrone, 53-year-old black male)

That phone was really the only thing that, that keeps me, uh, it kept me just, communicating with people in general. Cuz, you go in there, you know I felt like absolute garbage. I had no idea what I was doing, you know, I was, if I couldn’t talk to anybody it woulda been a lot worse. But I could so . . . it wasn’t too bad. (Kevin)

Notably, none of these participants was one of the four who described feeling stigmatized post-release. Given that almost half of respondents spoke of supportive social bonds, this may help to explain why the mentions of feeling stigmatized post-release are few in number. As suggested by prior work having supportive social ties may help to mitigate the effects of having a “spoiled identity” (Goffman 1963; LeBel, 2012b). Future research should investigate the variation in “felt” versus “unfelt” stigma in this population. For example, the salience or “feeling” of stigma may also depend on an individual’s offense type, background, or the community in which he or she resides. While identifying valid measures of “felt stigma” in available survey data can be a tall order, subjective social standing and perceived discrimination could be reasonable proxies in lieu of better alternatives (see Porter 2014; Schnittker and Bacak 2013). Additional qualitative research would also be fruitful to further explore the conditions under which ex-inmates “feel” stigmatized, what meaning that stigma carries, and how an offender’s background or community shapes this meaning (see also Uggen et al. 2004).

NOTES

1. This study examines perceived stress among former inmates rather than collecting objective indicators of stress (e.g., cortisol). This is an important distinction since the perception of an experience or event as “stressful” may vary. For example, Marmot (2004:121) notes that someone higher in social standing may remark about deadlines at work if asked about stress, while someone lower on the gradient will speak of monotony, boredom, and that they “die a little when they come to work each day because their work touches no part of them that is them.” Perceived levels of stress and sources of stress may be influenced by a range of social, economic, and psychological factors.

2. Prior work suggests that former prisoners may be socially disadvantaged relative to never-incarcerated individuals (Western and Pettit 2010). However, the participants in this sample spoke positively about the presence and role of social ties in their lives. This could indicate a “selection effect” in that participants who agreed to take part in the study may be relatively prosocial and handling their reentry better than those who did not participate. In addition, much of this prior work examines the quantity or presence of social ties rather than the quality of relationships. More qualitative work would be beneficial to explore the nature of relationships that are present in the lives of current and former prisoners.

REFERENCES


