Unraveling Trauma and Stress, Coping Resources, and Mental Well-Being Among Older Adults in Prison: Empirical Evidence Linking Theory and Practice

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Purpose of Study: A theoretical integration of the life course perspective, cumulative advantage, disadvantage or inequality, and stress processing theories provide an important integrated lens to study the relationship between accumulated interpersonal, social-structural, and historical trauma and stressful experiences on mental well-being mental well-being in later life. Design and Methods: This study builds upon the extant literature by examining the mediating role of coping resources on the relationship between trauma and stressful life experiences, post traumatic stress symptoms, and mental well-being among a sample of 677 adults aged 50 and older in prison. Results: The majority (70%) reported experiencing one or more traumatic or stressful life experiences during their life span. Participants also reported on average 11 occurrences of multilevel trauma and stressful life events and lingering subjective distress related to these events. Results of a structural equation model revealed that internal and external coping resources (e.g., cognitive, emotional, physical, spiritual, and social) had a significant and inverse effect on the relationship between trauma and stressful life experiences and mental well-being. Implications: As prisons are forced to deal with an aging population, research in this area can take the preliminary steps to enhance understanding of risk and resilience among older adults in prison. This understanding will aid in the development and improvement of integrated theory-based interventions seeking to increase human rights, health, and well-being among older adults in prison.

Key Words: Trauma, Violence, Abuse, Stress, Older adults, Prisoners, Well-being, Coping, Coping resources, Structural equation modeling, Life stressors checklist, Coping Resources Inventory, Post Traumatic Stress Scale, Brief Symptom Inventory

United States’ prison system is increasingly aging and overcrowded. In 2010, adults aged 50 and older comprised nearly 11% (246,600) of the 2.3 million general prison population (ACLU, 2012). The aging prison population is now over twice as large as it was in 2001 (n = 113,358) and nearly eight times (33,499) larger than it was in 1990 (Aday, 2003). This growth in the aging prison population has been attributed to an overall growth in the older adult population and the passage of the stricter sentencing laws in the 1980s, such as
“Three Strikes You’re Out,” that resulted in longer prison sentences (Rikard & Rosenberg, 2007). As a result, the adult correctional system is grappling with an aging population in need of specialized long-term care (HRW, 2012).

Older adults in prison pose a significant challenge because of their complex health and social care needs; between 16% and 36% of older adults in prison have been diagnosed with mental health problems (James & Glaze, 2006). Older adults in prison also have a host of physical health problems, including arthritis (33%), hypertension (32%), tuberculosis (16%), and HIV/AIDS (10%) (Maruschak, 2008). Furthermore, the stressful conditions of prison confinement are associated with an accelerated aging process such that incarcerated persons aged 50 and older have health profiles equivalent to their counterparts in the community who are aged 65 and older (Aday, 2003). The literature also suggests that older adults in prisons fear for their physical safety because of their diminishing ability to defend themselves from younger prisoners (Kerbs & Jolley, 2007).

Despite exposures to traumatic experiences and stressful life experiences, not all incarcerated persons have compromised mental well-being. Protective factors, such as coping resources, may account for the apparent resilience of those incarcerated who also have cumulative trauma and stressful experiences (Baum and Singer, 1982). Marting and Hammer (2004) defined coping resources as “those resources inherent in individuals that enable them to handle stressors more effectively, to experience fewer or less intense symptoms upon exposure to a stressor, or to recover faster from exposure” (p. 2). Social support may be a particularly beneficial coping resource by increasing an individual’s capacity to lessen emotional and psychological distress in response to trauma and stressful life experiences (traumatic and stressful life experiences; Jacoby & Kozie-Peak, 1997; Haslam and Reicher, 2006). In a sample of 102 older adults in prison, Aday (2005) explored how family and institutional social support influenced incarcerated persons’ feelings of distress related to dying and found that higher levels of social support had a significant and inverse relationship to older adults’ fear of death.

**Theoretical Perspectives**

A theoretical integration of the life course perspective, cumulative advantage, disadvantage or inequality, and stress processing theories provide an important integrated lens to study the relationship between accumulated interpersonal, social-structural, and historical trauma and stressful experiences on mental well-being in later life (Elder, 2003; Pearlin & Skaff, 1996; Pearlin, Schieman, Fazio, & Meersman, 2005; Sampson & Laub, 1997). Based on Elder’s (1974) work, the life course perspective posits that significant life events, which can be personal (e.g., sexual victimization) and/or historical or social-structural (e.g., world war or unfair policies and practices), influence the life course trajectories of individuals. Stress process theory informs the life course theory by emphasizing how the magnitude of a single adverse event or the stacking of cumulative events influence individuals’ life course subjective experiences, including later life mental well-being (Pearlin et al., 2005). Similarly, cumulative advantage/disadvantage theories posit that social-structural disadvantages, such as socioeconomic status and education, may influence later life health and well-being (Sampson & Laub, 1997).

According to stress process theory, individuals who have relatively stable life experiences, such as being mostly free of traumatic and stressful life experiences, generally develop relatively stable life course trajectories, including stable mental well-being (Pearlin et al., 2005). On the other hand, individuals who experience one or more difficult periods of chaos or change, combined with the stressful conditions of institutional confinement, are exposed to heightened risk of adverse mental well-being. Among older adults in prison, these experiences may include being exposed to childhood physical and sexual victimization, the unexpected death of a loved one, being diagnosed with a serious illness, combat, natural, and manmade disasters, and financial stress or poverty (Maschi, Dennis, Gibson, Sternberg, & Hom, 2011; Maschi, Kwak, Ko & Morrissey, 2012; Maschi, Morgen, Viola & Koskinen, 2013).

As a collective, these theories provide a conceptual model in which internal and external coping resources act as a protective mediating mechanism that can reduce the adverse consequences of life course cumulative trauma on mental well-being in later life. This is especially important to consider for vulnerable populations, such as older adults in prison who may experience a lifetime of cumulative trauma and stress, including reentering the community from prison (Maschi, Leigey, & Morrissey, 2013).

The adaptive use of internal and external coping resources may help foster a resilient response or
the accumulation of “protective advantages” over prior and current adverse experiences to help older adults better manage the prison experience (Maschi et al., 2013). The adoption of internal coping resources, (e.g., cognitive, emotional, physical, and spiritual) and external coping resources (e.g., social support) can help to explain why some older adults in prisons with histories of trauma may experience decreased mental well-being, whereas others remain resilient to their adverse affects.

Summary and Hypotheses

In summary, research shows that there is a high frequency of accumulating traumatic and stressful life experiences among criminal justice populations, including older adults in prison. Cumulative traumatic and stressful life experiences are positively correlated with decreased mental well-being. Consistent with life course and stress process theories, internal and external coping resources offer a protective advantage for mental well-being in later life. Yet, an often overlooked vulnerable population in older adults in the criminal justice system, including in prison (Maschi, Sutfin, & O’Connell, 2012). This study builds upon the extant literature by examining the mediating role of coping resources on the relationship between traumatic and stressful life experiences, post traumatic stress symptoms, and mental well-being among a sample of 677 older adults in prison. Using self-report data from an anonymous mail survey and structural equation modeling, the following mediational model was tested: Coping resources will significantly influence the relationship between traumatic and stressful life experiences, post traumatic stress symptoms, and mental well-being among older adults in prison (Figure 1). This information can be used to develop or improve mental well-being prevention, intervention, and advocacy efforts geared toward older adults at risk of or involved in the criminal justice system.

Methods

Research Design

This cross-sectional study was conducted in September 2010 in the New Jersey Department of Corrections (NJ DOC). The survey sample consisted of 677 English speaking incarcerated persons (aged 50 and older). Of the approximately 25,000 adults housed in the NJ DOC in January 2010, 7% (n = 1,750) were aged 50 and older. The NJ DOC generated the sampling frame for the study with a list of names, so that invitations and anonymous questionnaires could be mailed to potential participants and return correspondence could be received. We used the Dillman, Smyth, & Christian (2009) method for mailed surveys to maximize response rates.

A total of 677 questionnaires were returned for an approximate 40% response rate. This estimate falls within the higher range of expected mail response rates, which are 20%-40% for prison populations (Hochstetler, Murphy, & Simons, 2004). The project was part of the first author’s Geriatric Social Work Faculty Scholars Award for a research project on trauma, coping and well-being among older adults in prison. The project was funded by the Gerontological Society of America and the John A. Hartford Foundation.
study was approved by the Fordham University Institutional Review Board.

Sample Description

The survey sample consisted of 677 older adult men (aged 50 and older) serving prison sentences in the NJ DOC in September 2010. The average age of participants was 61 years old (SD = 5.43). The participants were white (43%), African American (41%), Hispanic/Latino (9%), and other (7%). Most (72%) reported having a high school diploma and 10% reported having no high school diploma. About one third reported having a mental health or substance abuse problem, and one third also reported having served in the military.

Most participants were incarcerated for serious offenses, including violent (62%) and sex offenses (29%). Participants had served an average of 156 months (13 years) with a range from 4 months to 42 years served. Almost 1 out of 10 was sentenced to life in prison, and over half were scheduled to be released from prison within 1 year (38%) or 2–5 years (26%). As for family, approximately 21% of participants reported currently being married or partnered. Most participants reported having children (80%), including under the age of 18 (17%), and having grandchildren (58%). One fifth of participants reported having at least one other incarcerated family member.

Constructs and Study Measures

Traumatic and stressful life experiences.—Traumatic and stressful life experiences (cumulative objective occurrences and past year subjective distress) were measured using the 31-item Life Stressors Checklist-Revised (LSC-R; Wolfe, Kimerling, Brown, Chrestman, & Levin, 1996). The LSC-R estimates the frequency of the objective occurrences of lifetime and current traumatic events. It also accounts for stressful life events, such as losing a loved one, health problems, divorce, financial problems, and institutional stress and abuse. Past year subjective distress is measured by the extent to which participants report how much they were bothered (not at all to extremely) by each event in the past year. The LSC-R has good psychometric properties, including use with diverse age groups and criminal justice populations (Kimerling et al., 2000; Norris, 1992; Wolfe & Kimerling, 1997).

Researchers have reported that the LSC-R demonstrates good criterion-related validity among criminal justice populations, including test–retest Kappas of 0.70 (McHugo et al., 2005). The LSC-R is also used to measure cumulative trauma and stressful life events, which are defined in this study as whether or not one or more traumatic or stressful life events have occurred. Traumatic experiences also are defined as those objective events that are consistent with DSM IV-TR Criterion A for PTSD (APA, 2000). Stressful life events refer to life course experiences, such as family separation and losing a loved one that tax the adaptive capacities of persons experiencing them, but are generally not considered traumatic events. Participants report the occurrence of 31 stressful life events. A cumulative score was created for both objective and subjective trauma and stressful life events by adding the 31 items. Table 1 reports the results by item for participants in our study. They are discussed in more detail in the Results section.

Post Traumatic Stress Symptoms (PTSS).—Post traumatic stress symptoms were measured with the PTSD Checklist (PCL) for civilian populations (Norris & Hamblen, 2004; Weathers, Litz, Herman, Huska, & Keane, 1993). Participants were given the more general instructions to assess “stressful experiences in the past” as opposed to one specific traumatic event. The PCL is a 17-item self-administered survey that measures three PTSD symptom clusters: (a) re-experiencing (five items), (b) avoidance (seven items), and (c) increased arousal (five items). It measures past month symptoms using a 5-point Likert scale that ranges from not at all to extremely. Cronbach’s alpha for the scale has been shown to be as high as .91 with civilian populations and ex-prisoners of war (Piotrkowski & Brannen, 2002). The total number of PTSD symptoms was used because information was not available to make a determination of actual or probable PTSD, and this approach is suitable for stress research. In our study, participants experienced on average 15 symptoms.

Coping Resources.—Coping resources were conceptualized as internal and external and were measured using the Coping Resources Inventory (CRI) (Marting & Hammer, 2004). The CRI has good convergent and discriminant validity and good internal consistency with a Cronbach’s alpha of .80 across the subscales (Marting & Hammer, 2004) and has been used with samples of older adults and criminal offenders (Piquero & Sealock, 2000).
This 60-item CRI has four subscales that measure internal coping resources (e.g., cognitive, emotional, spiritual and philosophical, and physical) and one that measures external (e.g., social) coping resources. The cognitive subscale examines the extent to which individuals maintain a positive sense of self-worth and optimism; the emotional subscale measures the degree to which individuals process a range of emotions; the spiritual/philosophical scale measures the degree to which respondents’ actions are guided by family, cultural, or religious traditions; and the physical subscale measures the degree to which individuals engage in health-promoting behaviors. The social subscale measures the degree to which individuals’ social networks of family and friends are able to provide support in times of stress. The participants in our study reported on average high levels of adaptive coping scores: physical (36), cognitive (41), emotional (62), spiritual (51), and social (49).
Mental Well-Being (MWB).—The Brief Symptom Inventory (BSI) was used to measure a range of psychological symptoms (Derogatis, 1993). The BSI is a standardized scale that measures psychological symptoms and has been used with adults and older adults in community and/or institutional settings (Asner-Self, Schreiber, & Marotta, 2006). It consists of 53 items covering nine symptom dimensions and three global indices. The nine symptom dimensions consist of (a) somatization, (b) obsession-compulsion, (c) interpersonal sensitivity, (d) depression, (e) anxiety, (f) hostility, (g) phobic anxiety, (h) paranoid ideation, and (i) psychoticism.

Studies have shown that the BSI has good internal consistency reliability for the nine dimensions, ranging from .71 (psychoticism) to .85 (depression). Test–retest reliability for the nine symptom dimensions ranges from .68 (somatization) to .91 (phobic anxiety). There are three global indices of distress: (a) Global Severity Index (e.g., current or past level of symptomatology), (b) Positive Symptom Distress Index (e.g., intensity of symptoms), and (c) Positive Symptom Total (e.g., number of reported symptoms). This study focused on the Global Severity Index as a major outcome variable; the average index for the participants in our study was 0.74. Test–retest reliability for the three global indices of distress ranges from .87 to .90 (Derogatis, 1993).

Data Analysis

Structural equation modeling was used to test the relationship among the variables of central interest. As shown in Figure 2, the hypothesized model represents a true structural equation model as it combines factor and path analyses (Bollen, 1989) and was used to examine the predictive relationship between each parameter, traumatic and stressful life experiences, post traumatic stress symptoms, and mental well-being. It also examined how coping resources influenced the individual from the effects of traumatic and stressful life experiences, post traumatic stress symptoms, and mental well-being. The base model allows for all three parameters to freely estimate. The standardized regression weight for each parameter (β weight) reflects the relationship between the two variables of the parameter. For instance, a standardized regression weight of .50 means that as one variable goes up by 1 SD, the other variable increases by 0.50 SD. A significant β weight (similar to a regression) indicates a significant directional influence of one variable on another. See Bollen (1989) for a primer on path analysis and structural equation modeling. We conducted our SEM analysis using AMOS.

Findings

Descriptive Results

We report the frequencies and percentages of the occurrence of interpersonal and social structural traumatic and stressful life experiences across the life course and past year subjective distress in Table 1. Participants reported on average 11 occurrences of interpersonal and social structural level trauma and stressful life events (M = 10.96, SD = 5.67). Participants reported subjective distress in the form of being moderately to extremely bothered by these events in the past year (M = 32.01, SD = 24.18). As shown in Table 1, participants reported histories of childhood interpersonal trauma before the age of 16 that included witnessing family violence (48%), being physically attacked (21%), sexual assault (9%), and foster care or adoption (10%), of which over half felt elevated levels of subjective distress. Interestingly, these childhood events possibly required legal or child protective services that went undetected and unaddressed with the exception of foster care and adoption.

Notable life course interpersonal and social structural trauma and stress included being diagnosed with a serious physical or mental illness (41% and 27%, respectively). Family-related stressors included the unexpected death of someone close (60%), forced separation from a child (28%), and being a caregiver of a person with serious illness (24%); and most respondents (60%) reported elevated past year subjective distress. The impact of structural trauma or violence, such as experiencing abuse or stress in prison (53%), serious money problems (52%), a close family member in jail or prison (45%), history of living in a violent neighborhood (44%), and combat or war (15%), was reported and on average 45%–86% of those responding reported high levels of past year subjective distress.

Structural Equation Modeling

In an effort to test the influence of coping resources on the association between traumatic and stressful life experiences, post traumatic stress symptoms, and mental well-being, each parameter was iteratively constrained to zero and the resulting model was compared with the original model. The change in the chi-square statistic indicates the
degree of erosion from the base model's fit, i.e., the revised model is considered a viable alternative if the model fit is not significantly eroded. This procedure—common in SEM (see Bollen, 1989)—permits for refinement of the theoretical model via establishing the value of each model component, parameter by parameter. However, a good-fitting model could have irrelevant components; thus, each parameter is checked for model value.

**Base Model.** — The base model (with all parameters freely estimating; see Figure 2) adequately fit the data ($\chi^2 = 99.36, df = 18, CFI = .95, \text{Root Mean Square Error of Approximation (RMSEA)} = .08[(.07-.10)]$)

![Figure 2. Structural equation model results for trauma and stressful life experiences, post traumatic stress symptoms, mental well-being, and coping resources.](image-url)
as indicated in Table 2. All observed components of the latent variable measuring coping resources were significant and strong ($\beta$ between .54 and .84). The latent variable of coping resources was significantly and inversely associated with traumatic and stressful life experiences ($\beta = -0.23, p < .001$), post traumatic stress symptoms ($\beta = -0.35, p < .001$) and mental well-being ($\beta = -0.08, p = .01$). As expected, there was a significant path between traumatic and stressful life experiences and post traumatic stress symptoms ($\beta = 0.38, p < .001$), which in turn predicted mental well-being ($\beta = 0.83, p < .001$).

Model Comparisons.—In a series of model comparisons, the base model was altered by constraining one parameter to zero in an effort to ascertain if any of the parameters in the base model were not crucial. Finally, the three parameters were constrained to equality (i.e., were assigned identical coefficients) to test the hypothesis that coping resources affected all trauma/mental health variables to the same degree. Each of the model changes resulted in significant fit erosion, indicating that the base model (Model 1) best represents the data and that each of the parameters tested was critical to overall model quality. Coping resources do not exert a similar influence across the three parameters of the model indicating that the three parameters are qualitatively different. See Table 2 for results.

Discussion

This study focused on a vulnerable population, incarcerated older adults, and sought to understand the relationship between traumatic and stressful life experiences, post traumatic stress symptoms, coping resources, and mental well-being among older adults in prison. Most participants reported a history of one or more interpersonal and social structural traumatic and stressful life experiences that occurred in childhood, adulthood, or older adulthood and in different settings, such as family homes, communities, and institutions, such as child welfare services and prison. Many of these events that required clinical and/or legal intervention appeared to go undetected and were possibly unaddressed due to lack of access to services or the lack of quality care. We found that older adults in prison who reported higher scores on cumulative traumatic and stressful life experiences also reported higher degrees of post traumatic stress symptoms and overall decreased mental well-being. Perhaps more informatively, our findings indicate that coping resources have an important mediating effect on the relationship between trauma and stressful life events and mental well-being. Older adults who reported higher levels of internal and external coping resources in the cognitive, emotional, physical, spiritual, and social domains reported greater mental well-being.

These findings build on the existing literature on trauma among mental health that has to date primarily focused on younger age groups and on specific types of trauma (e.g., Abram et al., 2007). The theoretical integration of the life course perspective, cumulative advantage, and stress process theories offers insight into the complexity of interpersonal and social structural factors that have lingering effects on mental well-being among older adults in prison. Despite this aggravation of stressors, the positive use of coping resources suggests that even under the most dire of circumstances people can be resilient. Based on the cumulative social injustices experienced by the majority of participants, this integration should be considered
within a human rights framework in which dignity and respect of all persons, including older adults, are foremost (UN, 1948).

These results also extend the body of literature that examines external protective factors, such as social support, demonstrating that social support facilitates positive mental well-being outcomes among older adults in prison (Jacoby & Kozie-Peak, 1997). The current study provides preliminary evidence connecting theory and practice; in our study, older adults who made use of internal and external coping resources seem to fare better in their mental well-being. Consistent with the resilience literature, particularly among holocaust survivors (Stessman et al., 2008; Shmotkin & Litwin, 2009), these finding suggest that internal and external coping resources decrease the adverse effects of past trauma on later life mental well-being.

Allied health professional and health care practitioners could best serve older adults in prisons if they are competent in assessing interpersonal and social structural trauma, developmental milestones, and coping resources. It is imperative to assess for the objective occurrence of past and current trauma and stress (e.g., childhood physical, sexual, and emotional abuse), and neglect and retraumatization that occurs in health care and institutional settings, in addition to lingering effects of subjective distress related to these events. Useful trauma assessment measures for specific types of trauma, such as combat exposure in older adults, are available (Cook & O'Donnell, 2005). Measures relevant for assessing older adults include the Clinician Administered PTSD Scale (CAPS), the Structured Clinical Interview for DSM-III (SCID), and the Mississippi PTSD Scale, which have been found to have high internal validity with combat veterans (Blake et al., 2000; Hyer, Summers, Boyd, Litaker, & Boudewyns, 1996). However, the extent to which these measures are relevant for diverse groups based on age, gender, and race/ethnicity and criminal justice populations remains unknown. Furthermore, their utility in criminal justice settings have yet to be established (Bright & Bowland, 2008). Professionals also should be cognizant of the important developmental milestones and other social structural factors among older adults, such as financial stress (poverty), retirement, job loss, widowhood, or being diagnosed with a serious illness, which may trigger psychological distress or even PTSD symptoms (Hyer & Sohnle, 2001). Although there are a number of assessment tools that measure developmental milestones in children, these tools do not exist for older adults, especially in corrections (Maschi et al., 2012). This is an area where further development is needed.

As shown in the literature, an assessment of other comorbid mental health problems, physical health, and available social support networks is warranted (Krause, 2004). Given the evidence that coping resources influence the relationship between trauma and stress and mental health distress, assessing incarcerated older adults as to their current and past coping strategies would be an important and beneficial first step toward improving their mental well-being. Prison programming should involve assessment and treatment of multiple coping resource domains and provide numerous potential areas for productive intervention.

In thinking about treatment, it is also imperative to make every effort to tackle not only the short but also the long-term influences of life course traumatic and comorbid stressful life experiences. Currently, much of what is known about assessment and treatment of trauma, especially related to PTSD treatment, is based mostly on research and evaluation studies with samples of children and adults but do not follow these individuals into older adulthood (Hyer & Sohnle, 2001). Longitudinal studies are needed to provide information to help prepare professionals for accurate trauma and PTSD treatment for older adults.

There is limited evidence available about the effectiveness of trauma treatment with ethnically diverse populations of older adults. Some promising practices include the Hyer & Sohnle (2001) PTSD treatment model. This PTSD treatment model is implemented in stages in which older adults’ acute mental health symptoms are first treated, followed by treatment strategies that build older adults’ internal and external coping resources, especially the reinforcement of social support, and how ethnically diverse groups maintain social supports. The findings of this study remind us of the need to be sensitive to social and cultural differences in treatment.

Holistic psychosocial prevention and intervention programs, coupled with advocacy efforts, can prevent the cycle of interpersonal and social structural violence. These programs include empowerment-based and cognitive-based interventions that target identifying and reprocessing negative cognitions, building an internal sense of safety, improving self esteem, and self and group advocacy efforts. Furthermore, activities such as yoga and meditation, which have been shown to increase physical strength and flexibility, promote
spirituality and improve emotional regulation (Maschi et al., 2011; Maschi, Baer, Morrissey, & Moreno, 2012). These findings also support making more time for other activities such as physical exercise, grief and loss counseling, stress management, expressive arts therapies, and social support groups, especially peer led (Maschi, Viola, Morgen, & Koskinen, 2013; Maschi, MacMillan, & Viola, 2013; Randall & Bishop, 2013). There is also a small but growing body of literature that examines spirituality among older adults in prison. For example, Randall & Bishop (2013) found that incarcerated individuals had a strong sense of religiosity and forgiveness, and social resources have a positive influence on their attachment to their lives and valuation of life in general. Aspects of spirituality, such as forgiveness and having a positive outlook, also have been found to be related to later life physical and mental health symptoms (Maschi et al. 2012). Similarly, Maschi and Baer (2012) found that older adults in prison who ascribed positive assumptions about self and others and experienced meaningfulness in the world had better self-reported mental health.

Department of corrections across the country know, as public health experts do, that mentally ill detainees have longer stays of incarceration and are far more likely to reenter the system, resulting in even greater challenges for caring for aging prisoners. These individuals cost far more in additional medical and security staff. A multifaceted intervention program that crosses coping domains may help foster resilience among older adults and minimize the reoccurrence of symptoms related to traumatic and stressful experiences, not only saving on costs of care, but providing for improved communication among the incarcerated, their families, facility staff, and community partners.

This study has some limitations. First, despite its use of random sampling, the NJ DOC sample may not be representative of and generalizable to prisoners in other geographic locations. The study also uses a cross-sectional design for addressing causal questions, thereby precluding causal inferences. The use of a self-administered survey may also be a limitation because some incarcerated persons may have limited literacy although this method has been used with success in other studies and is thought to be especially appropriate when gathering data about sensitive topics. In the case of incarcerated older women, power will be insufficient to conduct complex analyses or draw reliable conclusions.

The focus on a comprehensive and life course cumulative view of traumatic and stressful life experiences and coping resources is a particular innovation in this study because it includes a way to assess the compendium of earlier and later life victimization experiences, grief, and loss, and social structural stressors, including financial strain and institutional stress and abuse. It also uses a broad view of coping resources and assesses individual strengths and social resources that incarcerated person may have that may be strengthened through focused interventions and advocacy efforts. However, future research in this area should include examining human rights abuses in institutional settings, such as prisons (HRW, 2012). Additional studies can more closely examine the life course subjective experiences of traumatic and stressful life experiences on well-being using community and prison samples of older adults. We need further research to examine racial/ethnic and gender differences in the types of objective and subjective experiences, such as racial and class discrimination, coping resources, and in the possible impact these variables have on health disparities. Qualitative data on what older adults report about the kinds of stressors, their subjective experiences of them, and what they do to cope can help guide prevention and intervention planning in prison or during reentry. Finally, understanding the role of risk and resilience that can circumvent pathways of older adults in the criminal justice system from arrest, court, jail, prison, and reentry is needed so that older people also can have more equitable access to justice (Maschi, Sutfin, & O’Connell, 2012).

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