

Free Inside: A Program to Help Inmates Cope with Life in Prison at Maui Community Correctional Center

Elizabeth Duncombe¹, Dawna Komorosky², Evaon Wong-Kim², Winston Turner¹

¹University of Maine at Orono, School of Social Work

²California State University, East Bay

Abstract

This article describes the quantitative results of a study conducted at Maui Community Correctional Center in Hawaii. The program, Free Inside, was evaluated to determine its effectiveness as a rehabilitative tool for inmates. Each of the participants engaged in twelve-week cycles of twice weekly, hour-long classes in yoga, meditation, and chi gung practice. The findings reveal an association between inmate participation and increased awareness, self-esteem, sense of hope, and compassion. The authors recommend that similar programming become a part of the inmate experience in an effort to help rehabilitate and better prepare inmates for re-entry.

© 2005 Californian Journal of Health Promotion. All rights reserved.

Keywords: Rehabilitation, Corrections, Alternative Practices, Meditation

The ability of inmates to cope in prison continues to be an area of concern for both criminal justice practitioners and researchers alike. The current punishment philosophy in the United States often translates into longer time in prison and increased numbers of individuals receiving incarcerative sentences. In 2003, 2.2 million individuals were incarcerated in the United States (Harrison & Beck, 2004). The harsh reality of imprisonment can have a negative impact on inmates, influencing their capacity to adapt to their new environment. Adjustment to prison life is a process that can be affected by a variety of issues. According to Toch (1977) there are eight environmental concerns that impact inmate behavior and adjustment to prison life: privacy, safety, structure, support, emotional feedback, social stimulation, activity, and freedom. The inability to have these concerns addressed manifests in strained inmate tolerance levels and immune systems, compromised inmate physical and emotional health, and increased incidents of aggression and violence (Covert, 1995).

In an attempt to rehabilitate offenders and address their educational, vocational, and psychological needs, prisons offer programs for

inmates. These programs function on two levels. First, they help the inmate adjust to their environment. Second, they provide the inmates with the skills they will need to be successful upon release. There is empirical support addressing the benefits of these programs. Inmates who spend less time in structured activities are more depressed, anxious, and stressed (Wooldredge, 1999). Unfortunately, prison programming did not expand with the prison populations. Inmates leave prison with less treatment and fewer skills to facilitate a smooth transition into the community (Travis & Petersilia, 2001). One innovative approach to working with inmates and their ability to cope inside prison is Free Inside.

Description of Program

Though its teachings are non-denominational, the roots of Free Inside reach from ancient, global, and spiritual tradition. The program is comprised of classes in yoga; meditation, and chi gung practice. The techniques sequenced in each class encourage tolerance for diverse ethnic traditions and provide 'something for everyone.' These practices can be loosely described as forms of stretching, breathing, self-massage, and guided or silent inner reflection. These three

age-old, cost free, and easily learned techniques have been shown to strengthen and repair physical bodies, to soothe extreme emotions, to encourage one's feeling connection to others, and empathy for other people (Alexander, Davies, Dixon, Dillbeck, Drucker, Oetzel, Muchlman, & Orme-Johnson, 1990; Garrett & Carroll, 2000).

Research addressing the physiological benefits of yoga and meditation include the following: relief of headache, migraine, back pain, arthritis, insomnia, nerve or muscle disease, menstrual problems, menopausal disorders, hypertension, heart disease, asthma, ulcers, hemorrhoids, obesity, tuberculosis, diabetes, cancer, substance addiction, and decrease in pain. Other systems that are affected include pulse rate, respiratory rate, blood pressure, and increase in immunity, energy level, endurance, strength, and flexibility. Furthermore, gastro-intestinal function, endocrine function, excretory functions, cardiovascular efficiency, respiratory efficiency also benefit. Yoga has shown to positively impact alpha, theta, delta, and beta brain wave activity, and nervous system equilibrium (Arpita, 1990; Dash & Telles, 200; Feuerstein, 2001; Jevning, Wallace & Beidebach, 1992; Long, Huntley & Ernest, 2001; Malathi, Patil, Shah, Damodaran, Marathe, 2001; Munro, 1984; Nagarathna & Nagendra, 1985). Clearly, the extent of these benefits cannot be ignored. In addition to yoga and meditation, chi gung has shown to significantly improve the lives of those who practice.

Chi gung has been associated with decreased heart rate, blood pressure, respiration rates and improvement of ventilatory efficiency (Lim, Boone, Flarity, & Thomson, 1993; Soo, Kim, Huh, Ryu, Lee, & Chung, 1999). It provides a level of activity internally similar to brisk walking for people unable or unwilling to walk (Kjos, 2003). In addition, it aids in a number of additional medical conditions including long-term disabilities (Trieschmann, 1999), hypertension, heart disease, digestive disorders, immune function, chronic pain, paralysis, Parkinson disease, stroke, and arthritis (Lin, 2003; Sancier, 2001).

The implications of self-administered and cost-free remedies to so many ailments for practitioners of yoga, meditation and chi gung are important. They have the potential to increase personal happiness, which will facilitate a healthy existence. Prison may provide fertile ground, and ample time, in which to incorporate such techniques into daily practice.

The program Free Inside features twelve week cycles of twice-weekly, hour long, prison based classes for men and, separately, for women. In its first year at Maui Community Correctional Center (MCCC) Free Inside was used with two, 20 to 25 member and groups of male inmates who were nearing the end of their sentences for violent and non-violent crimes, and for whom classes were mandatory. It was also taught to a 20 to 25 member group of male Drug Court inmates who resided together in their own treatment dorm and again received assignment to the class. Finally, this program was taught to groups of 5 to 10 female inmates. For some inmates participation was voluntary, and for those who were part of Drug Court, it was mandatory. Classes were taught in the various dorms or modules where inmates were housed; no special props or equipment were brought in by the facilitator, and inmates were allowed to bring towels with them if desired to sit or lie on them.

Upon introduction of Free Inside as an intervention, this study sought to answer the following question indicative of its achievement of the Free Inside objectives: *Does such a yoga, meditation, and chi gung program provided to prison inmates result in benefit to this population's access to their own self healing, inner peace, and compassion for others?*

To answer this question, an examination was made of each inmate client, pre- to post-intervention, in the following areas: a) self knowledge and state of spirituality; b) self-knowledge and state of physical health; c) self-knowledge and state of mental health, including self esteem, depression, and recovery from addiction; d) life outlook, sense of hope, and perceived ability to help one's community and world; e) compassion for other people.

Quantitative data were collected through five self-report scales, administered to program participants pre- and post-intervention.

Procedures

The study was sited at Maui Community Correctional Center (MCCC) in the state of Hawaii, on the island of Maui, in the city of Wailuku. Pre- and post-intervention questionnaires were in most cases administered in rooms other than those used for teaching program classes. The subject was allowed to complete the questionnaires in semi-privacy, yet proximity of the researcher was thought to ensure completion.

The consent form was explained, and with it the voluntary nature of the study, despite the mandatory assignment of the program classes. The five self-report scales were then shown to subjects. Although an offer was made that they be read aloud by the researcher if that were more comfortable for non-readers, none of the subjects opted for this. Scale completion time averaged fifteen to thirty minutes; subjects were allowed privacy during this time while the researcher worked on the opposite side of the room.

Sampling

Random availability sampling was used by the MCCC's Director of Offender Services. No subject preferences or needs were considered in making these assignments, to better control for participant pre-disposition to the areas of physical, mental, and emotional healing being studied. Program assignment was mandatory, and in most cases resulted in study participation, though each client was able to decline the study. This assignment was helpful to further explore the efficacy of this program in reaching those inmates who may have been most resistant to new ideas and therefore unlikely to volunteer. It was anticipated, and shown, that resistant participants (who wouldn't volunteer) would provide one of the truest tests of the thorough efficacy of the program.

Demographics

The demography of participants included: 22 male and 6 female inmates, with ages ranging

from early 20s to late 60s; representative of broad ethnic diversity with heritage including Native Hawaiian, Japanese, Chinese, Filipino, Samoan, Tongan, Marshallese, African American, Caucasian, Native American, and many of mixed ancestry. The sample was representative of as wide a range of offences as are housed by the prison, including convictions for murder, rape, assault, robbery, drug trafficking, and drug possession.

Instrumentation

Five instruments were used in the data collection and these included three published scales and two scales that were created by the first author. Prior to the study each scale was proof read by readers from both genders, varied sexual orientations, and at least five locally predominant ethnicities including Hawaiian, Chinese, Japanese, Filipino, and Hispanic, to guard against provincialism or lack of clarity.

The originally conceived quantitative instruments were two self-report scales created by the first author to fill needs unmet by existing scales, and reduce subject burden. These new scales, the Physical-Mental Wellness Scale, and the Life Outlook-Compassion Scale, were designed with great simplicity to accommodate issues of cultural competency and participant education level and ease.

Each new scale was based on a five point Likert rating system with answers ranging from "never" to "always." The Physical-Mental Wellness Scale, for example, asks participants to chart their responses to statements like: "I get headaches," "I have crying spells," "I feel strong," "I get colds or flu," "I crave alcohol or drugs." Subscales within this instrument focused on qualities specific to "physical wellness" and to "mental wellness."

The Life Outlook-Compassion Scale asks participants to chart their responses to statements like: "I feel at peace with myself," "I like this world," "I want to live," "I feel my situation is hopeless," "I would like to hurt people who have hurt me," and "I would like to help other people." Subscales of this instrument measured qualities specific to "connection" (as

opposed to isolation) and to "compassion." Statements in both scales were worded both positively and negatively, and reverse scoring was used for approximately one third of all items.

The three published scales, added to those two originally conceived, contributed widely tested and recognized validity and reliability to the mix. The CES-D Scale was developed to identify and measure the intensity of depressive symptoms (Radloff, 1977). Testing has shown high internal consistency for this scale (Chronbach's alphas range from .85 to .90), acceptable test-retest stability, high concurrent validity, and acceptable construct validity (ibid.).

The Hope Scale was developed to measure potentially varying degrees of hope in subjects (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle, & Harney, 1991). This instrument uses subscales to glimpse the subject's relationship to goals; the "agency" subscale points to that subject's determination in meeting goals, while the "pathways" subscale looks at that subject's perception of choices in goal attainment. Testing has shown good reliability (with Cronbach's alphas range from .74 to .84 on the total scale, .71 to .76 on the "agency" subscale, and .63 to .80 on the "pathways" subscale), and test-retest reliability of .73 over eight weeks, and .76 and .82 over ten weeks, using two samples (Babyak, Snyder & Yoshinobu, 1993). Convergent validity tests have likewise been run with correlations appearing between the Hope Scale and other established instruments testing goal faith or frustration (ibid.).

Finally, the Rosenberg Self-Esteem Scale was developed to measure the presence or lack of self-esteem in subjects (Rosenberg, 1965). Testing has shown good construct validity (ibid.), high reliability (with a Cronbach's alpha of .88 and test-retest correlations of .83 at one week interval) (Fleming & Courtney, 1984), and correlation with other established instruments (Demo, 1985).

The CES-D, Hope, and Rosenberg Self-Esteem scales were chosen for use because the qualities they measure are vital either to heal from depression, or encourage hope and self esteem in inmate rehabilitation. These three were chosen before others in their respective domains for their simplicity of language and their brevity, important with inmate subjects whose lack of education might prevent focus or understanding. Also supporting their choice was their existence in the public domain and their availability for ready use by the researcher.

Definitions of Variables

In this writing, the terms "inmate," "participant" and "subject" are used interchangeably as each mentioned here is both incarcerated at MCCC, a Free Inside participant, and a subject in this study. Definitions of the program goals, whose achievement this study examines, are these: "Self healing" is the belief in the concept that we humans are designed to be our own best healers. Furthermore, our healthcare begins with knowledge of our bodies combined with knowledge of many home and nature-based, non-invasive paths to healing or preventing illness. "Inner peace" is contentment with what is, or in other words a state of balanced emotions able to experience both energy and calmness, and the ability to refrain from reactivity. "Compassion" is here defined as love or concern for people one knows, for people one has difficulty with, and for people one doesn't know.

Other variables, appearing in the contents of the scales created by this researcher, are these: "Physical health" was inclusive of everything from one's sense of feeling good (or poorly), to one's sense or understanding of physiological conditions such as lung or heart strength, perceived stamina, individual chronic illnesses such as asthma, arthritis, diabetes, and absence (or presence) of pain. "Mental health" was the absence (or presence) of depression, fearfulness, uncontrolled anger, and one's feeling of peace and balance (or upset). "Life outlook" was defined as one's sense of future, and the presence of optimism (or pessimism). "Connection" is one's sense of relationship to, or isolation from, other people in general.

Findings

Five scales were administered pre- and post-intervention to each inmate client. Three of these are published instruments, with high reliability and validity outlined in an earlier section of this article. The remaining two scales lacked prior testing, and so were examined for reliability using Cronbach's alpha. After some modifications suggested by the reliability testing, these two scales were added to the other three for statistical analysis of their scores. At final analysis, 20 inmates completed each scale

at pre-intervention baseline and at post-intervention retest (Table 1). An additional six inmates (four at baseline and two at follow-up) completed only one set of tests. Their data were used for reliability analyses. Finally, scores were normalized using a common 100 point metric for graphed ease of readability (where RoS = Range of original Scale = highest possible score minus lowest possible score plus 1; IN = Interval between Numbers = 100 divided by RoS; ScN = Normalized Score = [$\{ \text{subject scale score minus lowest possible score} \} \text{ plus } 1 \} \times \text{IN}$).

Table 1
Mean Scores for the Pre-Post Measures. N = 20

Scale	N	Pre-Mean (sd)	Post-Mean (sd)	t	sig.
CES-D	20	13.15 (8.31)	7.75 (5.25)	3.53	.002
Rosenburg Self Esteem	20	33.00 (4.64)	34.70 (3.81)	-1.98	.062
Hope Scale	20	23.96 (4.15)	26.91 (3.66)	3.09	.001
Hope "pathways"	20	12.73 (2.12)	13.75 (1.97)	-2.79	.012
Hope "agency"	20	12.13 (2.38)	13.30 (2.13)	-3.09	.006
Physical Mental Wellness	20	65.80 (6.83)	68.20 (6.68)	-2.59	.018
PMW "mental wellness"	20	30.80 (4.0)	32.00 (3.80)	-1.59	.129
PMW "physical wellness"	20	35.00 (4.28)	36.20 (3.79)	-1.59	.129
Life Outlook	20	65.05 (8.29)	64.20 (6.85)	-1.85	.080
LOC "compassion"	20	27.30 (3.85)	27.35 (3.82)	-.070	.945
LOC "connection"	20	34.75 (6.00)	36.85 (4.08)	-2.25	.036

The CES-D Scale, is a twenty item instrument, with sums across all items equaling the score for that subject; item scores range from 0 to 3; four items (4, 8, 12, 16) are reversed scored. Higher total scores suggest increased depression. A baseline mean of 13.15 (sd ± 8.31), with a retest mean of 7.75 (sd ± 5.25) was obtained (Figure 2). A paired sample t-test on these means yielded a t-value of 3.53, which was statistically significant at p = .002. It should be noted that, in addition to the pre-post drop in scores reaching statistical significance, they also indicated a drop from baseline levels predominantly above the clinical indicator for depression, to retest levels predominantly below it. Using CES-D's defined score of 16 or above as indicative of depression, ten subjects, or 50% at baseline scored above this level, while at retest, only two subjects, or

10% scored above this level. Consequently there was a significant decrease in post-test scores overall.

The Rosenberg Self Esteem Scale is a ten- item instrument, with sums from all items equaling the score for that subject. Item scores range from 1 to 4; five items (1, 3, 4, 7, 10) are reverse scored. Higher total scores suggest increased self-esteem (Figure 2). A baseline, of 33.0 (sd ± 4.64), with a retest mean of 34.70 (sd ± 3.81) resulted. A paired sample t-test on these means yielded a t-value of -1.98, which had a p value of .062, indicating a trend, just above the significance level of .05. The small sample size may have contributed to this result. There was a trend in increased scale scores overall.

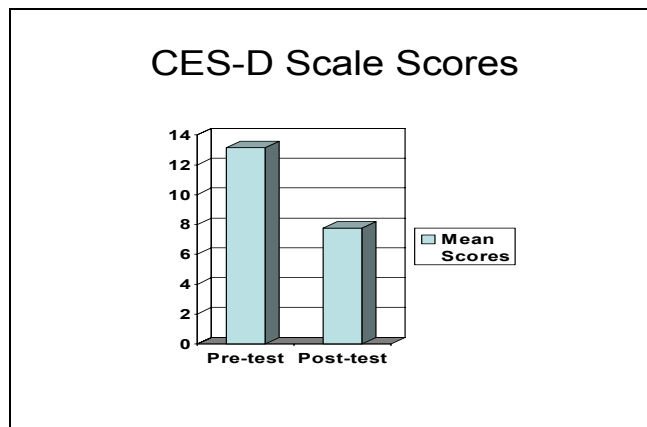


Figure 1

Mean Scores for CES-D Scale Pre and Post Intervention.

Note. N=20. These results show a decrease in levels of depression among the inmates. Pre and post mean scores are significant at the .05 level.

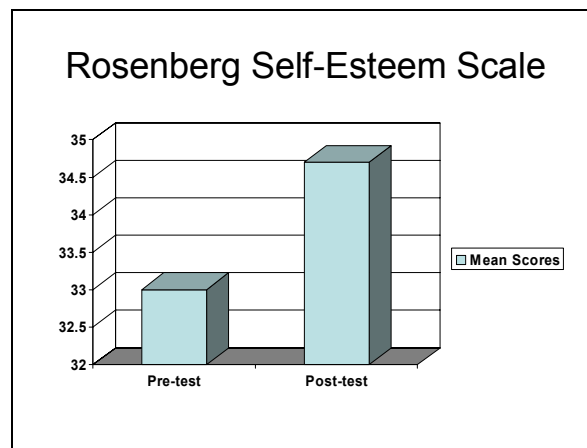


Figure 2

Mean Scores for Rosenberg Self-Esteem Scale Pre and Post Intervention.

Note: N = 20. While there is a noted difference in pre and post scores, they did not reach statistical significance ($p < .062$). However, the results do suggest an increase in self-esteem among the inmates.

The Hope Scale is a twelve-item instrument, with four distracter items (3, 5, 7, 11) whose scores are ignored. The sum of the remaining eight items equals the score for that subject (Figure 3). Item scores range from 1 to 4. Higher total scores suggest increased hope. Within this scale exist two subscales: "agency" (items 2, 9, 10, 12), which suggests determination to reach

goals, and "pathways," (items 1, 4, 6, 8), which suggests perception of choices in reaching goals. A baseline total mean of 24.85 ($sd \pm 3.87$) with a retest mean of 27.05 ($sd \pm 3.73$) resulted. A baseline "pathways" mean of 12.73 ($sd \pm 2.12$) with a retest mean of 13.75 ($sd \pm 1.97$), and a baseline "agency" mean of 12.13 ($sd \pm 2.38$) with a retest mean of 13.30 ($sd \pm 2.13$) were

observed. A paired sample t-test on these means resulted in a total score t-value of -4.14, which was significant at $p = .001$; an "agency" score t-value of -3.09, which was significant at $p = .006$;

and a "pathways" score t-value of -2.79, which likewise was significant at $p = .012$. There was a significant increase in post-test scores overall, and in the "agency" and "pathway" scores.

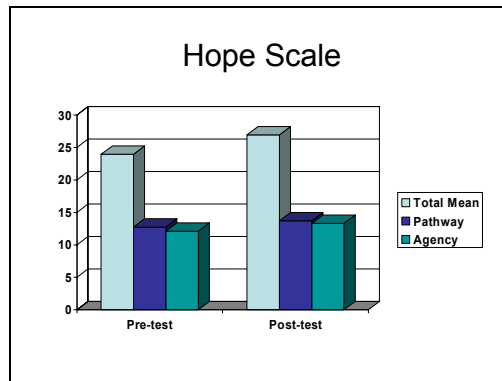


Figure 3
Mean Scores for the Hope Scale Pre and Post Intervention. Note: $N = 20$.
The total mean scores show an increased level of hope among the inmates. Pre and post total mean score $p < .001$. Hope "pathways" yielded a p value of .012. Hope "agency" level of significance reached $p < .006$.

The Physical-Mental Wellness Scale had twenty one original items, with item scores ranging from 1 to 4, and fourteen reverse scored items (c,d,e,f,g,h,m,n,p,q,r,s,t,u). Higher total scores suggest greater physical and mental wellness (Figure 4). In writing this scale its author had conceived of two subscales within it, one focused on physical health and balance, and the second upon mental health and balance. The twelve original "physical wellness" items resulted in a baseline alpha of .68; the nine original "mental wellness" items resulted in a baseline alpha of .84. Items were systematically eliminated from the scales for detracting from overall scale output, resulting in a "physical wellness" baseline alpha of .80 (after elimination of three items: d, f, o), and a "mental wellness" baseline alpha of .85 (after elimination of one

item: n). The increased subscale alphas assured increased scale reliability. Subsequent t-tests were run with these items eliminated. A baseline total mean of 65.80 ($sd \pm 6.83$) with a retest mean of 68.20 ($sd \pm 6.68$) resulted. A baseline "physical wellness" mean of 35.0 ($sd \pm 4.28$) with a retest mean of 36.20 ($sd \pm 3.79$) and a baseline "mental wellness" mean of 30.80 ($sd \pm 4.0$) with a retest mean of 32.0 ($sd \pm 3.80$) were also obtained. A paired sample t-test on these means resulted in a total score t-value of -2.59, which was significant at $p = .018$; an "physical wellness" score t-value of -2.37, which was significant at $p = .028$; and a "mental wellness" score t-value of -1.59, which was not significant at $p = .129$. There was a significant increase in post-test scores overall, and in the "physical wellness" scores.

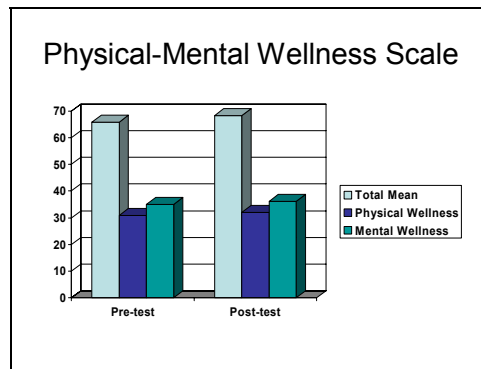


Figure 4

Mean Scores for the Physical-Mental Wellness Scale Pre and Post Intervention.

Note: N = 20. The results here show a slight increase in physical and mental wellness overall. Pre and post mean scores yield a p value of .018. Physical-Mental Wellness “mental wellness” $p < .129$ and “physical wellness” $p < .129$.

The Life Outlook-Compassion Scale had twenty one original items, with item scores ranging from 1 to 4, and eight reverse scored items (e,i,k,l,o,r,s,t). Higher total scores suggest more positive life outlook and awareness of compassion. In writing this scale its author had conceived of two subscales within it, one focused on life outlook, and the second upon compassion. The twelve original “life outlook” items resulted in a baseline alpha of .40; the nine original “compassion” items resulted in a baseline alpha of .36 (Figure 5). These subscales needed modification to improve reliability. By systematically eliminating those scale items which were detracting from overall scale output, a “life outlook” baseline alpha of .79 was achieved (after elimination of eight items: a, b, c, d, f, g, h, j, and addition of five items: i, k, o, s, t), and a “compassion” baseline alpha of .86 was obtained (after elimination of six items: k, l, n, o, s, t, and addition of four items: a, b, c, d). In reworking the subscales, the emphasis of the

former “life outlook” subscale became, instead, an emphasis upon human connection, and was renamed “connection.” The increased subscales alphas assured increased scale reliability.

Subsequent t-tests were run with these modifications in place. A baseline total mean of 62.05 (sd \pm 8.29) with a retest mean of 64.20 (sd \pm 6.85) resulted. A baseline “connection” mean of 34.75 (sd \pm 6.0) with a retest mean of 36.85 (sd \pm 4.08) and a baseline “compassion” mean of 27.30 (sd \pm 3.85) with a retest mean of 27.35 (sd \pm 3.82) were obtained. A paired sample t-test on these means resulted in a total score t-value of -.185 which showed a trend at $p = .080$; a “connection” score t-value of -2.25, which had significance at $p = .036$ ($p < .05$); and a “compassion” score t-value of .07, which was not significant at $p = .945$. There was a significant increase in pre-post “connection” subscales, and an increase trend in total scores.

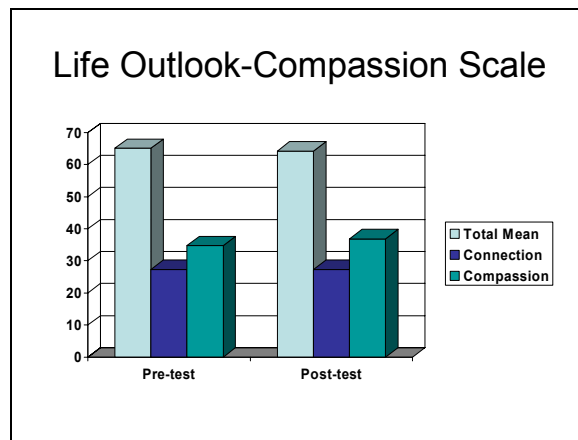


Figure 5

Mean Scores for the Life Outlook-Compassion Scale Pre and Post Intervention. Note: N = 20. The results show a slight increase indicating improved levels of connection and compassion among the participants. The p value for Life Outlook-Compassion “connection” was significant at $p < .036$. However, the total means score and “compassion” mean were not statistically significant for this scale.

Discussion

This study reveals an association between inmate participation in Free Inside program classes and apparently improved state of mind while in prison. The pre and post test mean scores reveal a significant decrease in depression among inmates, significantly increased hope, and a significant increase in their physical-mental well-being. Other results that were not statistically significant but look promising are increases in self-esteem, life-outlook and compassion. Self-esteem score, in particular, reflect a fairly static trait that does not usually fluctuate over short periods of time. However, these are qualities that influence the desired states of self healing, inner peace, and compassion, by bolstering their development in an individual.

The fact that physical wellness, mental balance, and empathy for other people are intimately related calls into question the efficacy of separating these qualities in any programming which aims to deeply rehabilitate criminal behavior. The authors here suggest the inclusion of any or all of these qualities in prison programming schedules. While there is merit in programs focused solely on vocation or academic education, Free Inside can serve as a complement to such programs. Implied, though not here tested, is the continued use and benefits of tools learned in inmates' lives after their release. High recidivism rates illustrate the difficulty offenders have after release from prison. Future research can determine the benefits of these practices and their role in helping offenders cope with stress and anger outside as well as inside prison walls.

References

- Alexander, C., Davies, J., Dixon, C., Dillbeck, M., Druker, S., Oetzel, R., Muehlman, J., and Orme-Johnson, D. (1990). Growth of higher stages of consciousness: Maharishi's Vedic psychology of humandevlopment. In C. Alexander and E. Langer (Eds.), *Higher Stages of Human Development: Perspectives of Adult Growth*. New York: Oxford University Press.

- Arpita. (1990). Physiological and psychological effects of hatha yoga: A review of the literature. *The Journal of the International Association of Yoga Therapists*.
- Babyak, M., Snyder, C., and Yoshinobu, L. (1993). Psychometric properties of the Hope Scale: A confirmatory factor analysis. *Journal of Research in Personality*, 27, 154-169.
- Covert, H. (1995). *Ministry to the incarcerated*. Chicago: Loyola Books.
- Dash, M., and Telles, S. (2001, July). Improvement in hand grip strength in normal volunteers and rheumatoid arthritis patients following yoga training. *Indian Journal of Physiological Pharmacology*, 45(3), 355-360.
- Demo, D. (1985). The measurement of self-esteem; Refining our methods. *Journal of Personality and Social Psychology*, 48, 1490-1502.
- Feuerstein, T. (2001). Health benefits of yoga. Retrieved December 1, 2005, from <http://www.iayt.org/benefits/html>
- Fleming, J., and Courtney, B. (1984). The dimensionality of self-esteem. II Hierarchical facet model for revised measurement scale. *Journal of Personality and Social Psychology*, 46, 404-421.
- Garrett, M., and Carroll, J. (2000). Mending the broken circle: Treatment of substance dependence among Native Americans. *Journal of Counseling & Development*, 78(4), 379.
- Harrison, & Beck (2004). *Prisoners in 2003*. Washington DC: Bureau of Justice Statistics. NCJ 205335.
- Jevning, R., Wallace, R. and Beidebach, M. (1992). The physiology of meditation: A review. A wakeful hypometabolic integrated response. *Neuroscience and Biobehavioral Reviews*, 16(3), 415-424.
- Kjos, V. (2003). Comparison of physiological and affect values for qigong and walking with older adults. Unpublished masters thesis, Arizona State University, Tempe, AZ.
- Lim, Y., Boone, T., Flarity, J., and Thompson, W. (1993). Effects of qigong on cardiorespiratory changes: A preliminary study. *American Journal of Chinese Medicine*, 21(1), 1-6.
- Lin, S. (2003). Research advances in qigong practice and therapy and their relationship to acupuncture (with special relevance to oncology management). Presentation at Maui Memorial Medical Center, June 27.
- Long, L., Huntley, A. and Ernst, E. (2001). Which complementary and alternative therapies benefit which conditions? A survey of the opinions of 223 professional organizations. *Complementary Therapeutic Medicine*, 9(3), 178-185.
- Malathi, A, Patil, N., Shah, N., Damodaran, A. and Marathe, S. (2001). Promotive, prophylactic benefits of yogic practices in middle aged women. *International Journal of Yoga Therapy*, (11).
- Munro, R., (1984). *Yoga biomedical trust survey*. Cambridge, England. Retrieved December 1, 2005, from <http://www.urt.org/recovery/html>
- Nagarathna, R., and Nagendra, H. (1985, October). Yoga for bronchial asthma: A controlled study. *British Medical Journal*, 291, 1077-1079.
- Radloff, L. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401. Reproduced with permission of B.Z. Locke.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Sancier, K. (2001). Search for medical applications of qigong with the Qigong Database. *Journal of Alternative and Complementary Medicine*, 7(1), 93-95.
- Soo Lee, M., Kim, B., Huh, H., Ryu, H., Lee, H., and Chung, H. (1999, August). Effect of qi-training on blood pressure, heart rate, and respiration rate. *Clinical Physiology*, 20(3), 173-176.
- Snyder, C., Harris, C., Anderson, J., Holleran, S., Irving, L., Sigmon, S., Yoshinobu, L., Gibb, J., Langelle, C., and Harney, P. (1991) The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology*, 60(4), 570-585.
- Toch, H. (1977). *Living in prison: The ecology of survival*. New York. Free Press.
- Travis J., and Petersilia J. (2001). Reentry reconsidered: A new look at an old question. *Crime & Delinquency*, 47(3), 291-313.
- Trieschmann, R. (1999). Energy medicine for long-term disabilities. *Disability and Rehabilitation*, 21(5/6), 269-276.

Wooldredge, J. (1999). Inmate experiences and psychological well-being. *Criminal Justice and Behavior*, 26(2), 235-250

Author Information

Elizabeth Duncombe, MSW Candidate
University of Maine at Orono
School of Social Work

Dawna Komorosky, Ph.D.*
Assistant Professor
California State University, East Bay
Criminal Justice Administration
Meiklejohn Hall, Room 4068
25800 Carlos Bee Blvd.
Hayward, CA 94542-3044
E-Mail: dawna.komorosky@csueastbay.edu

Evaon Wong-Kim, MSW, MPH, Ph.D.
California State University, East Bay

Winston Turner, Ph.D.
University of Maine at Orono
School of Social Work

* corresponding author