THE EFFECTS OF ADVERSE CHILDHOOD EXPERIENCES ON MENTAL HEALTH, PHYSICAL HEALTH, AND SPIRITUALITY IN INCARCERATED OLDER MALES

By

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Abstract: The purpose of this study was to determine the unique impact of adverse childhood experiences relative to self-reported well-being among older prisoners. This population has limited data about distal experiences impact proximal outcomes. Data used in this study involved a sample of N = 261 incarcerated men, aged 45 and older, who resided in state correctional facilities in Oklahoma. Hierarchical linear regression was used to determine the association between adverse childhood experiences across physical, mental, and religious/spiritual engagement outcomes. After controlling for demographic variables including education, race, and criminal type, a significant unique association emerged between adverse childhood experience and self-reported feelings of loneliness (β=.11, $p < .05$). It appears that older male prisoners who exposed to a greater number of adverse life-experiences during childhood reported greater feelings of loneliness. An additional 34% of the variance in self-reported loneliness among older male prisoners was explained by exposure to adverse childhood experiences above-and-beyond demographic variables, self-reported physical and mental health, and religious/spiritual engagement. Findings from this study provide evidence-based support relative to the unique effect of childhood adversity on current feelings of loneliness among older male prisoners. Implications concerning study results will be further highlighted regarding how forensic psychologists, clinical social workers, case managers, and other correctional mental health practitioners can provide therapeutic interventions for older prisoners to help lessen cognitive rumination of adverse childhood experiences and enhance emotional well-being.

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CHAPTER I

INTRODUCTION

One in 100 adults in America is behind bars (Pew, 2008). A growing number of these older prisoners are over 50 years of age. Older prisoners are best defined as inmates who are most often charged with a criminal act at a mature age (Aday, 2006). The pathway to aging-in-prison varies for older prisoners (Maschi, Viola, Harrison, Koskinen and Bellusa, 2014). Some are severe short-term sentences for non-violent offenses yet enter prison in poor physical or mental health. Others are recidivists or criminal offenders who spent a majority of their lifespan entering and exiting through the revolving door of prison (Stojkovic, 2007). Finally, others include long- term offenders who commit crime early in life and received 20 years or more to serve out their sentence (Aday, 2006). Regardless, of the three trajectories of imprisonment, the older inmate may have a history of one or more cumulative lifetime disadvantages due to childhood or family adversity, socioeconomic disparities, racial or ethnic disparity, anti-social behaviors, or poor access to healthcare services that impact their overall well-being during imprisonment.

Many older prisoners commonly report an early-life history of exposure to traumatic stressors (Carlson & Shafer, 2010; Haugebrook, Zgoba, Maschi, Morgen, &

Brown, 2010; Maschi, Gibson, Zgoba, & Morgen, 2011; Moloney, Van den Bergh & Moller, 2009). The exposure to acts of family adversity and violence, as well as abuse before age 18 are referred to as adverse childhood experiences (ACEs) (Chapman, Whitfield, Felitti, Dube, Edwards, & Anda, 2004). ACEs are commonly experienced during childhood within the home and behind closed doors from the public eye. Some examples of ACEs include physical abuse or neglect, lethal childhood illness, divorce or separation of a parent, domestic violence, and incarceration of another family or household member. ACEs have a reported association with poor physical and functional health outcomes in adulthood, as well as increased feelings of stress, anxiety, and depression through middle age and older (Chapman et al., 2004). Yet, empirical insights into the impact of ACEs including the occurrence of child abuse, acute/chronic illness, parental marital dissolution, and family economic distress on the well-being of older incarcerated populations has remained limited. Therefore, the current study focused on the associated underlying influence of ACEs on the well-being of older male prisoners.

It is important to note that a large proportion of the research literature has documented empirical evidence regarding the negative association of abusive histories and past traumatic life events on the well-being of incarcerated women (e.g. Brewer-Smyth, 2004; Mc-Daniels & Belknap, 2008; Moloney, Van den Bergh, & Moller, 2009; Wright, Salisbury, & Van Voorhis, 2007). At the same time, there has been little effort among researchers to understand the associated influence of traumatic exposure on the well-being outcomes among older male inmates. Limited effort has been made to empirically examine the reported lifetime history of family violence or childhood abuse experienced by aging prisoners (Carlson & Shafer, 2010; Komarovskaya, Loper, Warren

& Jackson, 2011). The current study was used to fill this knowledge gap concerning how distal life events influence proximal development outcomes among older male prisoners. A final purpose of this study was to understand how spirituality mediates the influences ACE has on physical and scoio-economic health. The current study examined 261 incarcerated older adults between the ages of 42-82 incarcerated in Oklahoma.

Relative to conceptualization of this study, Life Course Theory was used as the underlying theoretical framework to examine how events earlier in life impact outcomes among inmates who age-in-prison. A key assumption of Life Course Theory (LCT) suggests that the chronological age and development stage during the time a life event is experienced has a long-lasting impact on well-being later in life (Elder & Johnson, 2003). Early life events are presumed to be key developmental determinants that shape life-course transitions (e.g., adaptation to incarceration) and age-associated outcomes in well-being.

Using LCT theory as the theoretical basis of this study, four primary hypotheses were explored. First, it was hypothesized that ACEs were positively associated with loneliness. Second, it was hypothesized that ACEs were positively associated with depression. Third, it was hypothesized that ACEs were be positively associated with self-reported health status among older incarcerated males. Fourth, it was hypothesized that high levels of adverse childhood experiences had a low association with a secure attachment to God.

CHAPTER II

REVIEW OF LITERATURE

Well-being is different for older prisoners. Unlike younger prisoners, inmates who reach 50 years of age commonly experience multiple mental and physical health setbacks that require greater medical attention from correctional health staff (Stojkovic, 2007). Among non-incarcerated men, the onset of disease or health problems generally does not occur until after age 70 (Stojkovic, 2007). Some investigators have argued that prisoners maintain a functional age 10-15 years older than non-incarcerated populations (Aday, 2006). In other words, an older prisoner who is 50 years of age would have the biological functioning of an individual who is 60-65 years old. It is assumed that older inmates experience a much earlier onset of disease and impairment than their younger incarcerated as well as non-incarcerated peers (Aday, 2006). This is believed to be due to on-going physical, functional, or mental health problems that are exacerbated by criminal sentences for violent and non-violent offenses (Falter, 2006). Many prisoners feel that resources provided to them by correctional services may be ineffective in addressing current health problems including lingering adversities from the past (Loeb & Steffensmeier, 2006). Among incarcerated men, there is a feeling of distrust in seeking

medical intervention from correctional health service staff. In turn, many older male prisoners prefer to engage in self-care practices in the management of physical health ailments or mental health stressors (Loeb & Steffensmeier, 2006). It can be assumed that continuous exposure to on-going proximal stressors and an inability to seek proper medical assistance may negatively impact the health of individuals who age-in-prison over time (Loeb & Steffensmeier, 2006). Therefore, incarceration may be best defined as a life-altering stressor relative to proper health maintenance. However, there is limited research examination into the unique underlying associated influence of early-life traumas and the health of older male prisoners. It is plausible to assume that negative lifetime traumas (e.g. child abuse, family adversity) encountered long before imprisonment may only increase distrust toward others and thereby contribute to the deterioration of health among older male prisoners.

Theoretical and Conceptual Basis

Life Course Theory (LCT) offers a theoretical basis for studying older prison populations. LCT provides a useful theoretical basis to understand how past life experiences shape current developmental outcomes in the life course of older adults (Elder & Johnson, 2003). Three underlying LCT principles were used to theoretically support this study. First, the age-stage principle assumes that the age and developmental stage (i.e. childhood) during which persons encounter life events are instrumental in determining associated effects regarding physical and mental health outcomes. The age-stage principles further supports the notion that ACEs alter how persons adapt to on-going age-associated changes in later life (Elder, 1998). Second, LCT assumes that human agency is imperative to how persons arrive at decisions and choices involving

complex circumstances or compromising situations throughout the course of living (Elder, 1998). In other words, individuals are active agents of development change. Personal actions, decisions and choices allow individuals to recalibrate and direct the trajectory of life they most desire. However, adaptation to some circumstances in life require a degree of dependence or support from other people. The "linked-lives principle" was a third assumption proposed by Elder (1998) which further explains how individuals shape their development throughout the life course. In particular, the individual's life course is often a determinant of input, demands, and support from family, friends, and others in the social environment. These persons provide assistance or a socioemotional guidance for what is morally acceptable. In addition, they further aid and buffer the severity of failure of an event or hardship during the life course (Elder, 1998).

Dannefer (2003) proposed Cumulative Advantage/Disadvantage Theory (CAD) as an extension of LCT. Dannefer (2003) hypothesized that persons experience an accumulation of advantages and disadvantages in their life course. Those who ascertain multiple personal achievements or accomplishments across the life course tend to maintain greater adaptability to personal setbacks. This allows them to retain a more positive sense of well-being. On the other hand, those who encounter multiple disadvantages (e.g., abuse, divorce, poverty) or make a multitude of poor life choices (e.g., anti-social or criminal behavior) eventually experience greater risk of poor physical and mental health functioning later in life. Consequently, this is assumed to diminish individual developmental adaptation across the life course (Dannefer, 2003).

As persons enter the life-long process of old age, the availability of resources can create opportunities that help counter disadvantages in the life course. Some investigators have noted that incarceration is symbolic of life course disadvantage (e.g., Bishop & Merten, 2011; Carlson & Shafer, 2010). In other words, imprisonment is often reflective of one's exposure to early life experiences such as childhood abuse, poor socio-economic conditions, lack of parental authority, and violent environmental contexts (e.g., neighborhood, household/family violence). When resource availability is limited, individuals have a restricted opportunity structure to overcome disadvantages that may have originated in childhood. It is believed that the accumulation of early-life adversities continues to linger and negatively impact development throughout the life course and into old age (Dannefer, 2003). Furthermore, there is variation within the CAD theory in regards to how individuals may internalize experiences. The impact of parental divorce during childhood could also be a source of relief and happiness for persons whom experience parental marriage strain.

Conceptual Framework

The Developmental Adaptation Model (DAM) provides a conceptual model and framework for examining how distal life events are directly or indirectly associated with proximal or current developmental outcomes (Martin & Martin, 2002). The DAM framework provides flexibility in the integration and organization of comprehensive study variables that are necessary to understand the relationship between distal childhood and familial experiences, psychosocial adaptation, and developmental outcomes. Martin and Martin (2002) cited three ways to use DAM with research investigations: 1.) To

examine the association between early traumatic life experiences and current psychosocial resource use or availability; 2.) To clarify the association between current resource availability and developmental outcomes and; 3.) To determine whether an associated link between early life course trauma and developmental outcomes exists.

Martin and Martin (2002) hypothesized that family adversity and childhood abuse have a salient and lasting impact beyond current psychosocial resources relative to how individuals adapt and experience age-associated outcomes in physical and mental well-being. In fact, scholars have provided some initial empirical evidence that ACEs directly influences the extent to which prisoners maintain psychosocial resources in adaptation during confinement (e.g., Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011). For purposes of this study, DAM was used as a conceptual framework to further test the assumptions of the LTC for the population being examined. ACEs (distal factors) influence the individual's resources and ability to cope with hardships; therefore, influencing their outcomes (proximal factors, see Figure 1).

Adverse Childhood Experiences (ACE) of Prisoners

There has been a limited amount of research on the childhood adversities of older incarnated men. Adverse childhood events (ACEs) are negative events and experiences that an individual experiences before the age of 18 (Felitti et al., 1998). There is empirical evidence that supports a link between personal trauma and well-being among female offenders (e.g. Brewer-Smyth, 2004; Mc-Daniels & Belknap, 2008; Moloney et al., 2009; Wright et al., 2007). Nonetheless, a relatively high proportion of male prisons maintain a reported history of childhood abuse (Johnson et al., 2004). Courtney and Maschi (2012) reported that 70% of incarcerated older adults reported a history of traumatic life events

dating back to their childhood (Courtney & Maschi, 2012). Typically, imprisoned older adults experience one or more traumatic life events during childhood within different settings (e.g., home, community, and other institutions; Maschi et al., 2014). Such events maintain a strong empirical link with poor mental and physical health among incarcerated older adults (Carlson & Shafer, 2010; Courtney & Maschi, 2012; Haugebrook et al., 2010; Maschi, 2014, Maschi et al., 2011). Further proving that ACEs can affect daily decisions and the ability to resist deviant behaviors which causes a pile-up effect on their mental and physical health.

Most common forms of reported childhood abuse and family adversities experienced by men in prison include physical abuse, parental neglect and sexual exploitation (Sergentanis, Sakelliadis, Vlachodimitropoulos, Goutas, Sergentanis, Spiliopoulou, & Papadodima, 2014). Rumination regarding these experiences is associated with increased perceptions of stress, greater feelings of aggression, impulsivity co-occurring psychiatric health problems, greater inclination to smoke, abuse illicit substances, and increased recidivism rates (Hochstetler, Murphy, & Simons, 2004; Sergentanis et al., 2014). Those who had ACEs (including, childhood abuse and traumatic life events) tend to be under a continuous state of perceived stress by the very fact of coming to terms with their past and managing the present status of physical and mental health conditions (Bowles, DeHeart & Webb, 2012; Carlson & Shafer, 2010; Gallagher, 2001; & Wright et al., 2007). These experiences place incarcerated men at a greater risk for poorer well-being in late life.

As previously, stated, traumatic events have a lingering effect; therefore, they may directly or indirectly influence behaviors (e.g. Carlson & Shafer, 2010; Maschi et al.,

2011). In other words, incarcerated older adults can experience various levels of traumatic life events while they are still engaged into the community. Thus, enhancing their chances of departing onto other negative pathways (i.e. being incarcerated). Many imprisoned older adults reported a history of one or more interpersonal and social traumatic life events that occurred in childhood, adulthood or older adulthood (Carlson & Shafer, 2010; Maschi, Viola & Morgen, 2014). Some investigators have noted that trauma often contributes to post-traumatic stress problems as well (Maschi et al., 2011). The emotional aftermath of trauma can remain dormant and linger across time only to be reactivated in late adulthood (Shrira, Shmotkin, & Litwin, 2012). Four types of traumatic experiences are believed to linger and persist across time: (1) surviving a serious or lethal childhood illness (Helder et al., 2011); (2) witnessing the parental marital dissolution, separation, and divorce of one's parents (e.g., Bishop, Randall, Bailey, & Merten (2015); Haugebrook et al., 2010); (3) experiencing family poverty (Yen, Stewart, Scherzer, & Perez-Satable, 2007) and; (4) childhood abuse and neglect (Brewer-Smyth, 2004). Among aging prisoners, investigators have cited childhood abuse as the single most frequently reported ACEs (e.g. Brewer-Smyth, 2004; Carlson & Shafer, 2010; Courtney & Maschi, 2012; Felitti et al., 1998). Yet, there has been limited examination into the combined or cumulative impact of the four primary ACEs types and the well-being of older male prisoners.

ACEs- Childhood Illness

Empirical support with regard to which ACEs-type events have the greatest impact on late-life well-being has remained inconclusive. For example, Chishti and Kiessling (2010) reported that childhood illness maintains a unique and salient effect on

mental health outcomes across the lifespan. Childhood illness restricts the individual from being involved with their peers, family, and other social networks that could accelerate development. Additionally, childhood illness interrupts the ability to be engaged with physical activities and relationships (i.e. adults who experienced a childhood illness were more likely to be single or live with parent; Chishti & Kiessling, 2010).

ACEs- Parental Marital Dissolution

Meanwhile, Haugebrook et al. (2010) suggested that parental divorce/separation as well as abandonment before age 18 appear to have unique consequences during later stages of life. Initial evidence suggest that such experiences may apply to male whom are aging-in-prison. In particular, Bishop et al. (2015) reported that male prisoners who experienced parental marital dissolution prior to age 18 influence the extent to which incarcerated males perceive they can address and resolve the circumstances of incarceration. The sample was found to be less willing to forgive supporting that experiencing parental marital dissolution restricts the individual from adapting to future situations or events (Bishop et al., 2015). Thus, parental marital dissolution may have a unique underlying influence on the well-being of older male prisoners.

ACEs- Childhood Poverty

Multiple scholars have also examined the influence of family poverty during childhood on various outcomes for adults. For instance, older adults who experienced childhood poverty encountered less opportunities throughout life (Yen, Stewart, Scherzer, & Perez-Satable, 2007), and influences the likelihood of incarceration and reoffending (Kjelsberg & Friestad, 2008). Experiencing poverty and poor opportunities during

childhood often lead to non-violent criminal activities such as petty theft and drug-related offenses (e.g., McGahey, 1986; Wilson, 2013). Similarly, these experiences can lead to antisocial behavior and/or delinquent behavior and produce criminal acts. While experiencing childhood poverty may show the effects of poverty, there are other factors as well. Broese Van Groenou and Van Tilburg (2003) concluded that having low socio-economic status during one's entire life (both childhood and adulthood) increased the risk of social isolation, poor health, and poor well-being.

Poverty places persons at risk because they may be living in a crime-ridden environment, with inadequate housing and causes stress on overall well-being. In addition, poverty produces a greater likelihood of depression (Krsteska & Pejoska, 2013). Being is such a stressful environmental background may produce the feelings of prison being a better environment to live and age. Aday (2003) suggest that persons may find a sense of nurture, security, safety, and trust from being imprisoned that they could not find in the general population. Yet, persons are going from one poor environment to another because prisons also have stressors (e.g., internal gangs, noise, and pollution).

ACEs-Childhood Abuse

Empirical literature on childhood abuse has historically documented a clear correlation between physical and sexual abuse and the deterioration of physical and mental health over time (e.g., Johnson, Ross, Taylor, Williams, Carvajal, & Peters, 2006; Mc-Daniels-Wilson & Belknap, 2008). For example, there was an overwhelming number of prisoners who represent childhood victims of sexual and/or physical abuse (e.g., Brewer-Smyth, 2004; Carlson & Shafer, 2010; Courtney & Maschi, 2012; Haugebrook et al, 2010; Johnson, et al., 2006; Maschi et al., 2011; Mc-Daniels-Wilson & Belknap, 2008; Sergentanis et al., 2014; & Wright et al., 2007). Older prisoners were more likely to

report being victims of physical assault before adulthood and it was more common for them to witness sexual abuse compared to younger prisoners (Maschi et al., 2011). Carson and Shafer (2010) reported that a large proportion of their sample experienced childhood abuse, dealt with depression, experienced issues with their physical health, and report higher stress levels.

Physical Health of Male Prisoners

Early decline of physical health conditions for older inmates is caused by being in an unfavorable environment, coupled with the stress of being in prison (Aday, 2006). Not only are older incarcerated inmates coping with challenges from mental health issues, many are also simultaneously challenged by chronic health problems, such as, severe heart problems, diabetes, high blood pressure, shingles, Parkinson's disease, asthma, arthritis, stroke, and other health related issues (Aday, 1994; Stojkovic, 2007). Gallgher (2001) reported it is more difficult for older inmates to participate in "street" living and the activities associated with an autonomous or free lifestyle. This makes the idea of remaining in imprisonment more favorable because of guaranteed shelter, food, and medical care. Most older prisoners often require additional assistance in managing acute and chronic diseases which may directly or indirectly impact performance of daily activities (Stojkovic, 2007). However, incarcerated men are generally more likely to engage in more self-care practices than to seek professional assistance or intervention from correctional healthcare staff (Loeb & Steffensmeier, 2006). This often due to a lack of familiarity and trust toward correctional health professionals. As a result, the prevalence rate of physical and functional decline is often quicker among older

incarcerated men compared to their non-incarcerated peers living freely in the community (Aday, 2003; Haugebrook et al., 2010).

Socio-Emotional Well-Being of Male Prisoners

Older male inmates commonly report high incidence of mental health problems including stress and depressive symptomatology (Aday, 1994). Poor mental health outcomes among older male prisoners often represent malingering maladaptive or anti-social behaviors due to poor emotional regulation of stress. (Gallagher, 2001; Haugebrook et al., 2010; Maschi et al., 2013). Newly sentenced older prisoners have the hardest adjustment to prison life due to being disconnected from an already limited social support network (e.g. being divorced from a spouse or having outlived family and friends), learning new rules and routines, and being fearful of violence by other inmates (Aday, 2003). Long-term older prisoners face relationship deterioration with family and friends living in the community and since communication ceases or is limited; some older prisoners outlive relatives making them feel more isolated (Aday, 2003). Such experiences may renew former thoughts and emotional feelings of past abuses. In addition, for older prisoners who suffer from mental illness, being in prison is even more challenging (Stojkovic, 2007). Support from family has a direct influence on emotional health. To illustrate, Hochstetler et al. (2004) found that support from outside relationships aid the distress and maintain mental health of prisoners.

Religious/Spiritual Activity and Prisoners

The distress of prison and near-absence of familiar socio-emotional resources can often motivate inmates to seek comfort through religious and spiritual behaviors in order to successfully adapt. Many may read the bible, pray, attend pastoral care services, or

meditate as a way to adjust and regulate the hardships of aging-in-prison. In developing Attachment to God Theory, Kirkpatrick (2005) theorized that humans normally seek an affiliation with a higher power in order to decrease feelings of concern or worry. This is especially true when the individual is separated from familiar familial attachment figures, such as a parent, spouse, or adult son/daughter. It is plausible to assume that prisoners engage in religious or spiritual activities as a way to fill the void of not having relatives or friends within their immediate or everyday lives.

Older male prisoners have reported that engagement in faith-based activities serve as a source of strength, trust, and hope (Duggleby & Wright, 2004). Such behaviors commonly come in the form of more frequent religious services or meeting attendance, religious and spiritual conversion programs, and a stronger willingness or disposition to forgive self, others, and situations. (Bishop & Merten, 2011; Bishop, Randall, & Merten, 2014; Gaskins & Forte, 1995; Randall & Bishop, 2013). Thus, increased engagement in religious and spiritual pursuits is believed to be a normative mechanism by which older prisons adapt to personal adversity.

Incarcerated older men were found to have a direct association of religion to the social resources on incarcerated individuals' attachment to their life (Randell & Bishop, 2013). In other words, religious activity only increases the extent to which older prisoners feel like engaging in acts of forgiveness if they are surrounded by persons who encourage them to do so. Allen, Phillips, Roff, Cavanaugh, and Day (2008) further reported that spiritual pursuits, such as forgiveness increased as the duration of imprisonment increased. The more positive one's relationship to God was perceived, the better overall health outcomes they experienced. So, investigating the level of spirituality in

incarcerated older males who had ACEs, would aid in filling the gap in the literature.

Purpose

The purpose of this study was to explore the associations between ACEs with current health conditions and spirituality behaviors of older incarcerated males. The key objective was to distinguish the effect ACEs has on the mental health and physical health for incarcerated older males relative to the three main hypothesis:

H1: It was hypothesized that experiencing adverse childhood experiences will be associated with greater degree of loneliness for incarcerated males.

H2: It was hypothesized that experiencing adverse childhood experiences will be associated with greater levels of depression for incarcerated males.

H3: It was hypothesized that experiencing adverse childhood experiences will be associated with the greater self-reported physical health problems for incarcerated older males.

H4: A. It was hypothesized that high levels of adverse childhood experiences will have a low association with a secure attachment to God.

CHAPTER III

METHODOLOGY

Sample

The current study involved analytical use of pilot data previously collected from June 2006 through July 2007. This data collection involved N = 261 older incarcerated men, ages 42-82 (*M* = 57.59). The participants were imprisoned in 10 state-managed correctional facilities in Oklahoma and the data was collected during the summer of 2006. A database managed by the Oklahoma Department of Corrections (DOC) was used to gather participants that made up the sample. As required by the Oklahoma DOC, prisoners that were housed in medical or psychiatric units, sentenced to death row, or in solitary confinement were excluded from participation in the data collection.

Prison participants were informed of the data collection through an announcement that was approved by the Oklahoma State Univeristy institutional review board (IRB). Study announcements were sent and received by the prison administration staff (e.g., wardens) and unit directors to give to eligible incarcerated persons. The research team then communicated with prison administration staff in a coordinated effort to plan and set data collection visits. Only the participants who volunteered on the specific scheduled

day and time of the research team visit were allowed to participant in the study. Each participant signed an informed consent and completed a written self-report survey. Participants were seated separately and not allowed to sit directly across or next to other participants in order to provide for individual privacy. The prison administrative staff helped the research team identify persons who could not read due to poor vision or illiteracy and these participants had a one-on-one interview with a member of the research team. There was no monetary compensation for participation and each participant was debriefed after completing the survey.

Measurements

Demographic variables that used in the current study are age, race, and education. This information was reported using the following questions: (a) their current age; (b) did they identify with being White, African American, Hispanic American or Latino, American Indian, Asian American, or other; (c) how many completed years of education they had on a scale of 0-6; junior high school, some high school, finishing high school, receiving their GED, or vacation training equivalent, some college, finishing college education, some postgraduate, receiving a master's degree or a doctor of philosophy (PhD). Age and level of education were treated as continuous variables for the original study. For education *1 = completed grade school or less to 9 = earned a doctoral degree.* More so, a low educational level score reflects low education whereas a high score reflects having a greater education. Race was made into a dichotomous variable where *0 = Non-White and 1 = White.*

Social Demographics. The current study used age, education, and criminal type as control variables. Participants were asked to report their age and it was recorded as a

continuous variable. Education was recorded as described above; using a single item indicator. Lastly, criminal type was reported using a single item indicator, by the participants self-report of the reason he was serving time. The criminal types were then be recoded to those who are violent offenders and non-violence offenders based in the definition of violent offenses by the Bureau of Justice Statistics (BJS).

Adverse Childhood Experiences. Using the single item indicators for the four variables that make up the ACEs. Participants were asked if they experienced childhood abuse, parental divorce, childhood illness, and poverty before the age 18. A cumulative index score was created using the single item indicators of the four ACEs variables. The index was coded as *0 = No occurrence of an ACE before age 18 and 1 = an occurrence of an ACE before age 18.*

Depressive Affect. Depressive symptoms was assessed using the 10- item short from of the Geriatric Depression Scale (Yesavage, Brink, Rose, Lum, Huang, Adey et al., 1983), the internal consistency for this scale was α = .85. Participants were asked to rate each item on a *0 = No or 1 = Yes.* A sample item from the scale is *"Do you feel you life is empty*." A high score reflected higher reported number of depressive symptoms, and a lower score reflected a lower reported number of depressive symptoms.

Health. A 46-item self-report checklist of health conditions was used to assess the current health status among prisoners. Various health conditions included heart attack, heart murmur, asthma, emphysema, liver disease, high blood pressure, high cholesterol, diabetes, and hepatitis. Participants were asked to check all health conditions they had experienced within the last 12 months. Items were summed to create a composite measure of current self-reported health conditions that ranged from 0 (i.e., presence of no

health conditions) to 46 (i.e., presence of all health conditions). A high score indicated high number of self-reported health conditions; whereas a low score reflected low number of self-reported health conditions.

Socioemotional Well-being. The UCLA Loneliness Scale-Version 3 (Russell, 1996) was used to assess socio-emotional well-being relative to loneliness. This measurement used five positively worded items *(i.e., How often do you feel close to people?)* and five negatively worded items *(i.e., How often do you feel there is no one you can turn to?)*. A four-point Likert scale was used to rate response (*1= never, 4 = often*). The positively worded items were recorded and summed across negatively worded items to create a summary score of loneliness. A low score reflected low feelings of loneliness, whereas a high score indicated high feeling so loneliness. .Cronbach's alpha across items was .86.

Spiritual Attachment. Spirituality was assessed using the Attachment to God Scale (AGS; Rowatt & Kirkpatrick, 2002). A 9-item scale measuring secure feelings of a person's relationship with God and individual perceptions of anxiety relating to their relationship with God. This measure used a 7-point likert scale and participants identified if the statement described their relationship with God starting with *1 = not at all characteristics of me to 7 = very characteristics of me.* A sample item from this scale is *"God knowns when I need support."* Responses were summarized into a cumulative score in which a high score indicated secure feelings of spiritual attachment and a low score meaning that a low feelings of spiritual attachment. Alpha reliability across the 9-items used was .77, respectively.

Data Analysis

IBM/Statistical Package for Social Sciences (IBM/SPSS) 20.0 was used to analyze the data for the current study. This involved four key steps. First, descriptive statistics (frequencies, means, and standard deviations) were assessed for each study variable. Second, frequency of individual and cumulative index scores across the four ACEs were assessed and reported. Third, a bivariate correlation table accounting for associations among study variables was constructed and evaluated. Fourth, regression analyses was used to consider the underlying association involving the cumulative impact of ACE relative to outcomes including physical health, mental health, and spirituality.

Post-hoc analysis were ran to further examine the findings. Cross tabulations and chi-square test were done to further understand participants relative to reported high or low scores on loneliness. A median split was conducted to categorize the participants in a low loneliness group and a high loneliness group. Lastly, linear regressions were ran to compare the high and low groups within loneliness among the other variables.

CHAPTER IV

RESULTS

Demographics

Descriptive statistics regarding frequencies and percentages are reported in Table 1. The majority of sample participants consisted of middle aged prisoners ranging in age from majority being between the ages of 55 and 64 ($M = 57.59, SD = 8.41$). Over half or 62.5% of sample participants were White compared to 37.2% of the sample who reported being Non-White (e.g., African American, American Indian, Hispanic or Latino or more than one race). Relative to educational attainment, 28% of older male prisoners had completed high school and received a diploma, 25.3% had attended some college, 19.5% had completed some high school classes but did not graduate and 11.5% highest educational level was below high school. Participants were also asked to report the current offense for which they were serving time in prison. Over half or 66.3% of the sample reported serving time in prison for violent offense (e.g. murder, rape, assault). Another 33.7% of the sample reported non-violent offenses which included theft or drug and alcohol type crimes. Furthermore, as seen in Table 2, participants reported experiencing four primary Adverse Childhood Experiences (ACEs) including parental

divorce and separation (47.3%); poverty (36.8%); childhood abuse/trauma (24.5%), and serious/fatal childhood illness (19.9%).

Bi-Variate Correlations

Significant bi-variate correlations were also calculated and are reported in Table 3. Correlations ranged from r = -.17 to r .32. Criminal type (r =.12, $p < .05$) and self-reported health conditions (r =.18, $p < .01$) was positively correlated with age. Meaning that the older the prisoner the more issues they had with their physical health and the more severe their criminal offenses. Meanwhile, ACEs was negatively correlated with age (r =-.15, $p < .05$), illustrating that older prisoners reported less adverse childhood experiences. Education was positively correlated with health conditions (r =.15, $p < .05$) and loneliness (r =.16, $p < .05$) among the participants. These findings suggest that the more educated the prisoners are the more physical health issues and symptoms of loneliness they experience.

Furthermore, criminal type was positively correlated with health conditions (r =.17, $p < .01$), so those with poorer physical health had greater criminal offenses. Race was negatively correlated with depressive affect (r = -.17, $p < .01$). This finding suggest that Whites reported more depressive symptoms than Non-Whites. Also, race was negatively correlated with loneliness (r = -.21, $p < .01$) and illustrating that Whites experienced greater degree of loneliness. So, Non-White prisoners reported less symptoms of depression and overall feelings of loneliness than White prisoners. ACEs was positively correlated with loneliness (r =.17, $p< .01$); suggesting that older male prisoner may experience more levels of loneliness due to accumulation of ACEs. Lastly, attachment to God was negatively correlated to depressive affect (r = - .28, $p< .01$) and

loneliness (r = -.27, p < .01). Those analyses indicate that the symptoms for loneliness and depressive affect decrease with a high attachment to God or spirituality.

Linear Regression Results

Table 4 details the linear regressions regarding the three outcomes (i.e., physical health, mental health and spirituality) and ACEs. Greater age was associated with greater reported health conditions ($\beta = .20$, $p < .05$). Greater education was positively associated with greater self-reported health conditions ($\beta = .16$, $p < .05$). Similarly, violent offenders significantly reported more health conditions they reported ($\beta = .16$, $p < .05$). ACEs were not significantly correlated to self-reported health conditions.

The accumulation of ACEs (Table 7) increased self-reported mental health symptoms ($\beta =.12$, $p < .05$). ACEs explained 34% of variance in loneliness after controlling age, race, education, attachment to God, loneliness, and self-reported health conditions. Race and loneliness ($\beta =.-12$, $p < .05$) were negatively associated, again meaning that Whites experienced more levels of loneliness. However, education ($\beta =.15$, $p < .05$) was significantly and positively associated with loneliness. In others words, Non-White inmates, as well as inmates with greater educational reported greater levels of loneliness. Furthermore, depressive affect status was positively associated to health conditions ($\beta = .29$, $p < .01$) and loneliness ($\beta = .41$, $p < .01$). These analysis illustrates the more self-reported health issues increased the greater their depressive symptoms. Not surprising that those who reported grater loneliness also experiences more depressive symptoms.

Attachment to God was negatively associated to loneliness ($\beta = -.24$, $p < .05$) and depressive affect ($\beta = -.20$, $p < .05$). This suggests that older prisoners feel less lonely

mental health when having a high attachment to God. ACEs had no significant associations to attachment to God.

Post-Hoc Analysis

Two post-hoc assessments were used to further examine the associated link between ACEs and loneliness. Of particular interest was determining the connection to between ACEs and low versus high reported levels of loneliness. To address this relationship, a median split was performed within the loneliness variable (M = 25.00). This resulted in a total of N = 147 participants categorized as low in feelings of loneliness and N = 106 participants who classified as high in feelings of loneliness. Using this median split, cross-tabulations and chi-square testing were first conducted to explore reported prevalence of ACEs among older male prisoners designated as high versus low in feelings of loneliness (Table 5). A significant chi-square difference test emerged relative to older male prisoners reporting experience of a childhood illness before age 18 (χ^2 (1) = 4.8, p = .028). In particular, the percentage of those who reported experience of a childhood illness as well as high feelings of loneliness was higher (27.2%) that what was expected (20.5%) from the remaining participant sample who did not report experience of a childhood illness or high loneliness.

Childhood abuse and poverty did not have significant associations with the high or low loneliness groups. It is possible that other ACEs could have demonstrated an increase in significance if other variables, such as peer victimization (e.g., Copeland, Wolke, Angold, & Costello, 2013), or neglect (e.g., Kaplow & Widom, 2007) had been controlled. Most interesting, parental dissolution demonstrated perfect but non-significant results relative to actual percentages of the population versus expected percentages.

44.8% of the actual sample reported to experience parental dissolution and be lonelier, while 44.8% were expected to experience parental dissolution and be lonelier, refer to Table 5. This result is counterintuitive, gerontology literature that parental divorce or separation of one's parents during childhood contributes to diminished socio-emotional well-being later in life (Silverstein & Giarrusso, 2010).

Next, linear regression analyses were conducted to compare the high and low loneliness groups, to further determine whether ACEs had unique differential effects across inmates identified as lonely versus not lonely (Table 6). Among older prison inmates classified as low in feelings of loneliness, several significant variable relationships emerged. First, health condition were significantly predicted by age (β =.27, $p < .05$) and depressive affect (β =.28, $p < .05$). Older in age and more depressive symptoms predicted greater health conditions. Second, depressive affect was predicted by greater self-reported health conditions (β =.27, $p < .05$) and greater insecurity in one's attachment to God (β = -.26, $p < .05$). Thus, those low in loneliness experience depressive affect when they have increase health problems and have an insecure feeling about their relationship with God. There were no significant associations between ACEs and outcomes of health, depressive affect, or attachment to God for older inmates who experience low feelings of loneliness. Third, depressive affect emerged as the single significant indicator of attachment to God (β = -.28, $p < .05$). Specifically, older male prisoners whom feel less lonely have greater insecurity with their relationship to God.

Comparatively, several significant indicators also emerged for older male prisoners designated as lonely. First, there were no significant relations among ACEs and outcomes of health and attachment to God. Second, self-reported health conditions were

significantly predicted by better education (β =.35, $p < .01$) and higher degrees of depressive affect (β =.37, $p < .01$). Therefore, those with high loneliness experience more health conditions when they have better education and an increase in degrees of depressive symptoms. In contrast, depressive affect was significantly predicted by lower age (β = -.22, $p < .05$), identifying as White (β = -.28, $p < .05$) and lower levels of education (β = -.21, $p < .05$). Specifically, older Non-White male prisoners whom report more loneliness experience less depressive affect when having better education. The most interesting finding within the lonelier group is that, increased ACEs was a significant predictor of depressive affect (β =.17, $p < .05$). Thus, more self-reported adverse childhood experiences created more symptoms of depression among lonelier older male prisoners. ACEs explain 24% of the variance after controlling for age, race, criminal type, health conditions, and attachment to God.

CHAPTER V

DISCUSSION

The purpose of this study was to understand how adverse childhood experiences (ACEs) before age 18 affects the well-being of older male prisoners. Additionally, to examine how ACEs directly affects the mental health, physical health and spirituality of older male prisoners. Based on study findings, it appears that ACEs do have a unique associated impact on the socio-emotional well-being of older male prisoners. In particular, ACEs appear to be linked experienced feelings of loneliness among older prison inmates.

It was originally hypothesized that ACEs would be associated with: (a) greater levels of loneliness (b) reporting more depressive symptoms, (c) greater self-reported health conditions, and (d) a lower secure attachment to God. Results from this study partially supported these hypotheses. ACEs did not have any significant underlying associations relative to outcome of self-reported health conditions, depressive affect, or spiritual attachment. However, ACEs did maintain a direct positive association with of the outcome of loneliness. This suggests that the more ACEs experienced earlier in life, the lonelier the male prisoner may be later in life.

This key finding provides empirical evidence of the underlying impact of ACEs on the mental well-being of older male prisoners. It is generally understood that older male prisoners experience more levels of loneliness due to disconnection from family relatives and friends, lack of belonging to an inside group within the prison community, or not accepting or trusting persons considered as outsiders (e.g., prison guards, correctional health staff) in their daily lives (Cattan, White, Bond, & Learmouth (2005); Loeb & Steffensmeier, 2006). It is further plausible to assume that ACEs may constitute and contribute to a "lingering" of loneliness that transcends during and beyond the older male inmates incarceration period (Loeb & Steffensmeier, 2006). Further longitudinal insight is need regarding the impact that ACEs have on on-going and long-term feelings of loneliness.

According to Carstensen, Isaacowitz, and Charles (1999), Socioemotional Selective Theory (SST) provides a theoretical basis to highlight the influence emotional well-being has in old age. In fact, SST assumes that aging alters the perception of time, and motivates persons to restructure and impose limitations to lifetime aspirations and goals based on emotion. For instance, older adults generally engage in more emotion-focused problem-solving behaviors rather than problem-focus coping strategies (Lockenhoff & Carstensen, 2004). Those who are unable to effectively resolve past and current conflicts across time may easily encounter emotional conditions of stress that further deteriorate physical and mental health functioning (Lockenhoff and Carstensen, 2004). SST is very applicable to older male prison inmates aging behind bars in time. Unlike younger male prisoners, older incarcerated males tend to focus on building emotionally positively and meaningful social networks (Bond, Thompson, & Malloy,

2005). This may be due to the fact that older prison inmates have spent a longer period of their life incarcerated, and thus feel the opportunity for release and future interaction with former familiar or other past familiar social ties is limited. Thus, there is an increased preference not to waste time on superficial social ties that provide little emotional meaning during one's remaining time in prison. As an extension of SST, the Strength and Vulnerability Integration (SAVI) model provides an alternative explanation of emotional regulation persisting across adulthood and into late adulthood (Charles, 2010). One key assumption of SAVI model is that past life experiences sets persons on various trajectories that enhance or limit the exposure to negative experiences. ACEs maybe linked to criminal activity and incarceration as an adult. Carlson and Shafer (2010) found that persons who had their first arrest between the ages of 7- 11, reported more adverse experiences during childhood, furthering a negative trajectory. In addition, there is empirical evidence that older adults tend to avoid negative situations and reframe most daily stressors as positive experiences than younger adults (e.g., Carstensen & Mikels, 2005, Lachman, Rocke, Rosnick, & Ryff, 2008). The SAVI model proposes that these advantages may decline or disappear when stressors are unavoidable, prohibiting adults to regulate negative emotions once they reach late adulthood (Charles, 2010). Therefore, an older male prisoners may not be able to combat loneliness that was produced by ACEs.

Unfortunately, older men are more likely to engage in self-care and are less likely to reach out to correctional healthcare professionals that would otherwise diagnose, treat, or prevent evolving health problems that might impact emotional status (Loeb & Steffensmeier, 2006). Incarcerated men have less social ties to their family and friends

which decreases their social network and can contribute to their loneliness in prison (Aday, 2003). Also, interventions to alleviate loneliness with older adults was examined by Cattan et al. (2005), they found that social support outside of the group (i.e. friends in prison) may impact the willingness to self-help, as well as to increase self-esteem and decrease loneliness. Social networks provide older adults with pathways to experience positive emotions (Lockenhoff & Carstensen, 2004) and in the absence of that network leaves opportunity for more symptoms of loneliness.

A decrease in mental health well-being has also been reported to negatively influence physical health of prison inmate (Gallagher, 2001). Mental despair, depression, and anxiety may surface through physical impairments. In this study, ACEs appear to be significantly linked to depression in the presence of higher levels of loneliness. High feelings of loneliness can spiral into depression due to the absence of social support, happiness, and positive emotional outlets for the individual prisoner (Merten et al., 2012). There are various explanations as to why the older male incarcerated population may feel lonely and depressed. Foremost, incarceration requires confinement from the outside world. This translates into limited visitation from relatives and friends, less social support from friends and other outsiders, and feelings of past stigma that transcend beyond prisons wall into the public domain (e.g., Aday, 2003; Cattan et al., 2005). Some older inmates may even develop the perception that they have become too “institutionalized” to rebound from past or earlier adversities that may have essentially contributed to anti-social acts and eventual imprisonment (Aday, 2003). As a result, inmates who age in prison are vulnerable to cognitive rumination or worrisome thoughts concerning their

past, present, and future connection to the events that lead them to prison and the persons whom they have left behind.

On the other hand, older prison inmates who experience low loneliness also experience less depressive symptoms and greater attachment to God. Ainsworth (1989) hypothesized that as one generates a secure attachment base with their parent, it enables the child to establish more attachment figures throughout the life course. Being in such an inclusive environment, with restricted access to actual attachment figures may push a prisoner to seek God to establish a secure attachment. Older male prisoners may use spirituality to cope with past experiences; therefore, decreasing their depressive affect and minimizes the possibility of rumination. For example, Allen et al. (2008) reported that more activities that are spiritual and a spiritual acceptance was associated to better socio-emotional health.

Several interesting results emerged relative to the differentiation of older male inmates as lonely or not lonely. For example, childhood illness was the only ACE that connected to reported loneliness among older male prisoners. Those who reported having a childhood illness were higher in loneliness than those who reported not having a childhood illness. Dealing with an illness as a child can cause many disruptions in their life and development. For example, if the child spent a lot of time in the hospital and did not have a secure attachment with parents, they did not learn how to securely attach and maintain viable attachment relationships (Ainsworth, 1989). Additionally, they could have been excluded from school events, regular school attendance, and extracurricular activities further increasing anti-social behaviors carried through their life (Chishti & Kiessling; 2010). Alternatively, they may have been motivated to seek other substitute

attachment figures as a way to compensate for the lack of secure attachment feelings with others. These alternative attachment ties can presumably have a positive or negative influence on developmental outcomes (Ainsworth, 1989).

However, the findings for parental divorce or separation showed no differences between those who were reporting high and low loneliness or experiencing ACEs. Empirical evidence within marriage and family literature has indicated that parental dissolution during childhood has long-lasting implications relative to adult development (Amato & Sobolewski, 2001). In addition, parental-child attachment literature suggests that children who experience parental dissolution and experience insecure parental attachment eventually engage in anti-social behavior that contribute to poor mental health experiences across adult life and into old age (i.e., depression; Malekpour, 2007; Ward, 2008). Relative to prisoners, the impact of marital dissolution before age 18 may actually depend on what type of criminal or anti-social act was committed. For example, Bishop et al. (2014) reported that parental dissolution before age 18 can significantly influence pro-social behavior relative to a disposition to engage in forgiveness, particularly if the older male inmate had committed a non-violent offense. Thus, the impact of various ACEs may be offset by activation of prosocial behaviors later in the older male prisoner's life. Further inquiry into this process is needed beyond the results of this study.

Results from this study seem to suggest the demographics may also predict depressive affect to the extent the older male prisoner feels lonely. This appears to be most predictive relative to age, education, and race/ethnicity of the older male inmate. In other words, male prisoners who are older, better educated, and Non-White reported lower depressive affect despite feeling lonely. Merten, Bishop, and Williams (2013)

reported that older African-American prisoners may be better off than their White counterparts due to a greater sense purpose in life, better overall physical health, and emotional resilience. In effect,Non-Whites may be better off because they have greater lifetime hardships, discrimination, and adversities that allow them to become emotionally resilient and more effectively cope with adverse situations (Merten et al., 2013).

The lonelier group experienced more relations among being older, having less education, being White, experiencing more ACEs, reporting higher number of health conditions with the past year, and being depressed. Loneliness appears to act as potential moderator on variables reflecting health conditions, depression, spirituality, and ACEs. In addition, ACEs predicted greater self-reported health conditions, loneliness, but not spirituality.

Limitations and Future Directions

This study includes the ability to target a special population, provides more research on older men, and fills the gap in literature about what contributes to the mental health of aging prisoners. Limitations for this study include the need for a possible larger sample to see associations with ACEs, the findings cannot be generalized for all men because of the sample is incarcerated. Nor can findings be generalized across different geographic areas (e.g. states and countries) due to data be collected in Oklahoma prisons only. In addition, the sample was classified an older adults meaning the findings cannot be generalized for younger prison populations. All the data was self-reported and it can cause a positive bias with participants or withholding information (Paulhus & Vazire, 2007). Finally, this is a cross sectional study and a convenience sample. Due to participation for whom could participate, the sample was voluntary and therefore the

sample used may include prisoners that were more educated with higher well-being. The study could have also been improved by having a comparison sample within or outside prison.

This study is a cross-sectional analysis of this data set. Future studies could take a longitudinal approach to examine how that impact may change in the outcomes. Examining more ACEs factors (i.e. bullying, single parent homes, experiencing death of a parent or close relative) would dig deeper into what accounts for the missing variance. Additionally, researchers should use medical records to report health conditions for more of an objective measure and decrease the chances of error from self-report. Separating the childhood abuse variable into sexual and physical could highlight some differences and more correlations with other variables. Similarly, the findings regarding racial disparities should be further explored because in past studies Caucasians have been known to have better outcome in the face of adversities or incarceration.

Future research should focus on the emotional development and coping strategies of older male prisoners because men are more likely to not reach out for support (Loeb & Steffensmeier, 2006). It could also examine how ACEs is associated to the outcomes, it may be due to participants have not coped with their ACEs and have a lack of significant associations for physical health and spirituality. Finally, a marginal split could be used to examine high or low resilience effects with older incarcerated men. This analysis would identify protective or risk factors that may exist in the population and could be implemented earlier in life to alleviate decreases in well-being.

The results regarding the socioemotional (i.e., depressive affect and loneliness) status are imperative for prison staff, case managers, and counselors to pay attention to

the socioemotional health of prisoners. Due to impact of ACEs, the lonelier older male prisoners are more vulnerable to experience declines in socioemotional health, to help prisoners cope with ACEs and improve their socioemotional well-being in later life. The findings have implications for forensic psychologists, clinical social workers, case managers, and other correctional mental health practitioners who can provide coping interventions for older prisoners. These interventions may lessen cognitive rumination of adverse childhood experiences, which can contributing to loneliness and aid in enhanced emotional well-being.

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Table 1.

Frequencies and Percentages of Demographic Variables

Variable	Frequency	Percentage
Age		
Young-old (45-54)	98	37.6
Old (55-64)	102	39
Old-old (65+)	61	23.3
Race		
White	163	62.5
African American	56	21.5
Hispanic/Latino	12	4.6
American Indian	22	8.4
Other	7	2.7
Education		
Grade School	17	6.5
Junior High	13	5.0
Some High School	51	19.5
High School Diploma		
Vocational Training	5	1.9
Some College	66	25.3
Bachelor's Degree	20	7.7
Some Postgraduate	7	2.7
Master's Degree	5	1.9
Doctorate	1	.4
Criminal Type		
Non-Violent	88	33.7
Violent	173	66.3

Table 2.

Frequencies and Percentages of ACEs

Variable	**Frequency**	**Percentage**
1. Childhood Illness	52	19.9
2. Poverty	96	36.8
3. Parental Divorce or Separation	114	43.7
4. Childhood Abuse	64	24.5

Table 3.

Bivariate Correlations for Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Age	1								
2. Education	-.09	1							
3. Race	-.11	-.09	1						
4. Criminal Type	.12*	-.04	-.05	1					
5. Health Conditions	.18**	.15*	-.12	.17**	1				
6. Loneliness	-.12	.16*	-.21**	-.01	.28**	1			
7. Mood	-.12	-.09	-.17**	.05	.32**	.51**	1		
8. Attachment to God	-.10	.06	.03	-.07	-.12	-.28**	-.27**	1	
9. ACEs	-.15*	.06	-.02	.01	.04	.17**	.10	.05	1
Mean	57.59	5.1	.37	.66	3.96	24.38	3.79	43.3	1.25
SD	8.41	1.58	.48	.47	3.48	5.94	3.08	10.8	1.09

*Note: *p < .05 (2-tailed); **p < .01 (2-tailed).*

Table 4.

Summary of Regression Analysis of Variables predicting Health Conditions, Loneliness, and Attachment to God.

	Dependent Variable of Regression			
Outcomes	**Health Conditions**	**Depressive Affect**	**Loneliness**	**Attachment to God**
	β; t	**β; t**	**β; t**	**β; t**
1. Age (control)	**.20***;(3.19)	-.10 ; (-1.78)	-.87 ; (1.50)	-.12; (-1.89)
2. Education (control)	**.16***; (2.52)	**-.17*** ; (-3.03)	**.15***; (2.76)	.05; (.71)
3. Race (control)	.02 ; (.26)	-.05 ; (-.94)	**-.12***; (-2.08)	-.05 ; (-.65)
4. Criminal Type (control)	**.12*** ; (1.99)	.01 ; (.22)	-.02 ; (-.37)	-.03; (-.44)
5. Health Conditions	--	**.22**** ; (3.88)	.11 ; (1.77)	.02; (.23)
6. Loneliness	.13 ; (1.77)	**.41**** ; (5.62)	--	**-.24***; (-3.07)
7. Depressive Affect	**.29**** ; (3.88)	--	**.41****; (6.52)	**-.20***; (-2.62)
8. Attachment to God	.02 ; (.23)	**-.15*** ; (2.62)	**-.18***; (-3.07)	--
9. Adverse Childhood Experiences	-.02 ; (-.29)	.03 ; (.47)	**.11***; (1.98)	.06 ; (.89)
Model R^2	.20	.36	.36	.15
R^2 Change due to ACEs	.17	.34	.34	.12
Adjusted R^2	.17	.34	.34	.12

*Note: *p <.05; **p < .01.*

Table 5.

Cross tabulations for each ACEs variable related to high and low loneliness.

Variable	Low Loneliness	High Loneliness	Total
	F; %	F; %	F; %
Childhood Illness			
Yes	23; 15.8	28; 27.2	51; 20.5
No	123; 84.2	75; 72.8	198; 79.5
χ^2 (1) = 4.8, p = .028			

Variable	Low Loneliness	High Loneliness	Total
	F; %	F; %	F; %
Poverty			
Yes	47; 32.0	44; 41.4	91; 36.0
No	100; 68.0	62; 58.5	162; 64.0
χ^2 (1) = 2.4, p = .119			

Variable	Low Loneliness	High Loneliness	Total
	F; %	F; %	F; %
Parental Divorce or Separation			
Yes	64; 44.8	47; 44.8	111; 44.8
No	79; 55.2	58; 55.2	137; 55.2
χ^2 (1) = .00, p = .999			

Variable	Low Loneliness	High Loneliness	Total
	F; %	F; %	F; %
Childhood Abuse			
Yes	32; 21.9	31; 30.1	63; 25.3
No	114; 78.1	72; 69.9	186, 74.7
χ^2 (1) = 2.1, p = .144			

Table 6.

Summary of Regression Analysis of Variables predicting Health Conditions, Depressive Affect and Attachment to God within low loneliness and high loneliness groups.

Variable	**Low Loneliness (N=147)**			**High Loneliness (N=106)**		
	Health Conditions	**Depressive Affect**	**Attachment to God**	**Health Conditions**	**Depressive Affect**	**Attachment to God**
	β	**β**	**β**	**β**	**β**	**β**
1. Age	**.27***	-.12	-.14	.19	**-.22***	-.07
2. Education	-.05	-.07	.11	**.35****	**-.28***	-.02
3. Race	.01	-.14	.00	.10	**-.21***	-.06
4. Criminal Type	.11	-.56	-.10	.14	.08	.06
5. Health Conditions	--	**.27***	.11	--	**.36****	-.15
6. Depressive Affect	**.28***	--	**-.28***	**.37****	--	-.20
7. Attachment to God	.11	**-.26***	--	-.12	-.16	--
8. Adverse Childhood Experiences	.28	-.10	-.09	-.03	**.17***	.18
Model R^2	.16	.17	.11	.29	.30	.10
R^2 Change	.11	.12	.06	.23	.24	.03
Adjusted R^2	.11	.12	.06	.23	.24	.03

*Note: *p <.05; **p < .01*

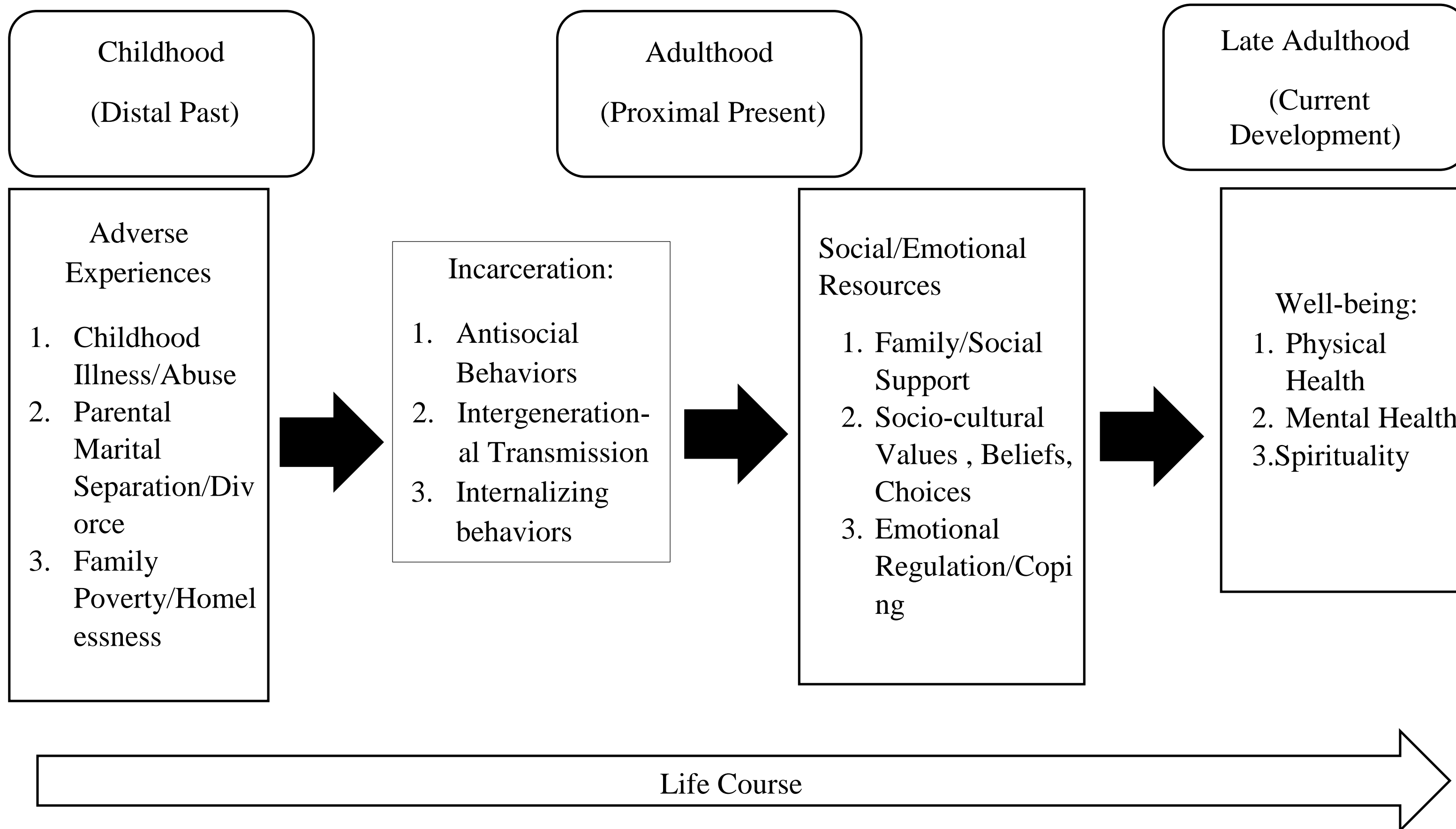
Table 7.

Frequencies and Percentages of Accumulated ACEs

Variable	**Frequency**	**Percentage**
ACEs (0 reported)	75	28.7
ACEs (1 reported)	74	28.7
ACEs (2 reported)	71	27.2
ACEs (3 reported)	19	7.3
ACEs (4 reported)	10	3.8

Figure 1.

Developmental Model of the ACEs across the Life Course of Prisoners.



APPENDICES

Older Adult Survey

Directions: Please answer each of the following questions.

1. Age: _______ Date of birth:___________________________

2. Gender: ______ Male _____ Female

3. Race/Ethnicity

____ White/Caucasian ____ Asian American
____ African-American ____ Hispanic/Latino
____ American Indian ____ Other

4. Marital Status

____ Never Married
____ Married **If so, how many years _________**
____ Widowed **If so, how many years _________**
____ Divorced **If so, how many years _________**

5. **Educational Achievement**

_____ Vocational/Training School _____ Some College
_____ Grade School _____ College Degree
_____ Junior High School _____Some post graduate education
_____ Some High School _____ Master's Degree
_____ High School Diploma _____Ph.D.

a. How many total years of education have you had: __________________________________

6. Annual/Yearly Income

_____ less than $10,000 _____$10,000-$20,000 _____$20,000-$30,000

_____ $30,000-$40,000 _____$40,000-$50,000 _____$50,000 and over

7. Occupation/Work

a. Are you currently retired? ______ Yes ______ No

b. What is/was your primary occupation:____

c. How many years have/had you been in this line of work:_________________________________

d. What is/was the degree of responsibility in your occupation?

_____ Low _____ Medium _____High

d. Do you currently work part-time?

_____ Yes _____ No If yes, how many hours per week?_________________

e. Do you participate in volunteer work?

_____ Yes _____ No If yes, how many hours per week?__________________

8. Residence

a. How long have you lived within your current home or residence?________________________

b. What best describes your living arrangement?

_____ I own my home/residence

_____ I rent my home/residence

_____ Other (please specify____)

c. What best describes the physical and structural condition(s) of your current home/residence:

_____ Excellent _____ Good _____ Fair _____ Poor

d. Do you currently live alone?

_____ Yes No_____ If NO, who do you live with?_______________________________________

f. How long have you lived in the community/setting where you presently reside?_____________

9. Family Background

a. Do you have any children who are presently living?

____Yes ____No **If YES**, how many?____________

b. Are you currently raising a grandchild?

_____Yes ____No **If YES**, what is the child's age________________?

c. Did your parents ever separate or divorce?

_____ Yes _____ No If **YES**, how old were you?____________________________________

d. From childhood through age 18, what best describes the economic situation of your family?

_____ Poor _____ Average _____ Wealthy

10. Life Experiences

a. Were you ever seriously ill as a child?
_____ Yes _____ No If YES, what age and what illness________________________________

b.) Were you ever abused as a child?
_____ Yes _____No If YES, what age?____

c.) Are you a War Veteran? Yes _____ No______ If Yes, what war?_______________________

d.) Have you ever served time in prison?

_____ Yes _____ No If **YES**, how long and how old were you ______________________________

11. Spirituality

a. How often do you attend church, synagogue, or other religious meetings?

____ Never	____ Few times a month
____ Once a year or less	____ Once a week
____ Few times a year	____ More than once a week

b. How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?

____ Never	____ Few times a week
____ Once a year or less	____ Once a day
____ Few times a month	____ More than once a day

12. Service Availability

1.) Are there public transportation services (e.g., local bus, transit bus, or senior van service) available where you live?

Life Events

The following series of questions deal with life-event changes and common experiences people may have in life. Each box represents years or decades of life. Depending on your life experiences, some boxes may be left blank and others may include multiple events that took place within a given decade of your life. Please read each question and answer accordingly.

Marital/Romantic Relations

1. Please indicate at which age/decade of your life you experienced a change in marital status and/or romantic relations (i.e., got engaged to be married, broke engagement, got married, separated, became divorced, or were widowed).

- Place an **"E"** in the age/decade of life when you got engaged to marry
- Place a **"B"** in the age/decade you broke an engagement to be married
- Place a **"M"** in the age/decade of life you were married.
- Place a **"D"** in the age/decade of life you were divorced
- Place a **"S"** in the age/decade of life you were separated.
- Place a **"W"** in the age/decade of life you were widowed.

0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99

Children

2. Please indicate at which age/decade of your life each of your children were born and/or adopted.

- Place a **"1"** in the age/decade of your life when your first child was born/adopted
- Place a **"2" in** the age/decade of your life when your second child was born/adopted . . . etc.
- For multiple children born during one age/decade in your life, place a **"1, 2, 3, . . . etc".**

0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99

Residence

3. **Please indicate at which age/decade of your life you have experienced a change and/or move in residence.**

- Place a **"L"** in the age/decade of life if your change in residence was a **local** move.
- Place an **"O"** in the age/decade of life if your change in residence was an **out-of-state** move.

0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99

Education

4. **Please indicate at which age/decade of your life you have experienced a change in education.**

- Place a **"P"** in the age/decade of life you started school part-time.
- Place a **"F"** in the age/decade of life you started school full-time.
- Place a "**L"** in the age/decade of life you left school.
- Place a **"G"** in the age/decade of life you graduated from school.
- Place a **"R"** in the age/decade of life you returned to school.

0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99

Employment

5. **Please indicate at which age/decade of your life you have experienced any changes in employment status.**

- Place a **"F"** in the age/decade of life you started a part-time job.
- Place a **"P"** in the age/decade of life you started a full-time job.
- Place a **"L"** in the age/decade of life you left the job.
- Place a **"R"** in the age/decade of life you retired from employment.

0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99

Death

6. Please indicate at which age/decade of life you have experienced the death of a close friend, the death of a close family member, and death of a child

- Place a **"1"** in all the ages/decades in which the event occurred
- Place a **"2," "3," . . . etc**. in all the ages/decades if the event occurred more than once in a given age/decade.

	0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
a.) Death of a close friend										
b.) Death of a spouse										
c.) Death of a romantic partner other than a spouse										
d.) Death of a child										

Financial/Legal/Work

7. Please indicate at which age/decade of life you have experienced the following financial, legal and work-related events.

- Place a **"1"** in all the age/decades in which the event occurred.
- Place a **"2," "3,". . . etc**. in all the ages/decades if the event occurred more than once in any given age/decade.

	0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
e.) Gone to jail										
f.) Serious financial problems										
g.) Foreclosure of mortgage or loan										
h.) Took on a major mortgage or loan										
i.) Serious trouble with boss/worker										

Health

8. Please indicate at which age/decade of life you have experienced the following health-related events.

- Place a **"1"** in all the age/decades in which the event occurred.
- Place a **"2," "3," . . . etc**. in all the ages/decades if the event occurred more than once in any given age/decade.

	0-10	11-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
j.) Serious injury or illness										
k.) Serious injury/illness to family member										
l.) Sexual difficulties										

Social Relations

For these questions, please indicate to what extent each statement describes your current relationships with other people. Use the following scale to indicate your opinion.

Strongly Disagree	**Disagree**	**Agree**	**Strongly Disagree**
1	**2**	**3**	**4**

1. There are people I can depend on to help me if I really need it.

   1 2 3 4
2. I feel that I do not have close personal relationships with other people.

   1 2 3 4
3. There is no one I can turn to for guidance in times of stress

   1 2 3 4
4. There are people who depend on me for help.

   1 2 3 4
5. There are people who enjoy the same activities I do.

   1 2 3 4
6. Other people do not view me as competent.

   1 2 3 4
7. I feel personally responsible for the well-being of another person.

   1 2 3 4
8. I feel part of a group who share my attitudes and beliefs.

   1 2 3 4
9. I do not think other people respect my skills and abilities.

   1 2 3 4
10. If something went wrong, no one would come to my assistance.

    1 2 3 4
11. I have close personal relationships that provide me with a sense of emotional security and well-being.

1 2 3 4

12. There is someone I could talk to about important decisions in my life.

1 2 3 4

Strongly Disagree	Disagree	Agree	Strongly Disagree
1	**2**	**3**	**4**

13. I have relationships where my competence and skill are recognized.

1 2 3 4

14. There is no one who shares my interests and concerns.

1 2 3 4

15. There is no one who really relies on me for their well-being.

1 2 3 4

16. There is a trustworthy person I could turn to for advice if I were having problems.

1 2 3 4

17. I feel a strong emotional bond with at least one other person.

1 2 3 4

18. There is no one I can depend on for aid if I really need it.

1 2 3 4

19. There is no one I feel comfortable talking about problems with.

1 2 3 4

20. There are people who admire my talents and abilities.

1 2 3 4

21. I lack a feeling of intimacy with another person.

1 2 3 4

22. There is no one who likes to do the things I do.

1 2 3 4

23. There are people who I can count on in an emergency.

1 2 3 4

24. No one needs me to care for them.

1 2 3 4

Stress

The following questions ask about your thoughts and feelings during the last month. In each case, you will be asked to indicate how often you thought or felt a certain way. Please circle the number that best describes how you thought or felt. Use the key below as a guide.

1 = Never	**2 = Almost never**	**3 = Sometimes**
	4 = Fairly often	**5 = Very often**

1. In the last month, how often have you been upset because of something that happened unexpectedly?

   1 2 3 4 5

2. In the last month, how often have you felt that you were unable to control the important things in your life?

   1 2 3 4 5

3. In the last month, how often have you felt nervous and "stressed"?

   1 2 3 4 5

4. In the last month, how often have you dealt successfully with irritating life hassles?

   1 2 3 4 5

5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?

   1 2 3 4 5

6. In the last month, how often have you felt confident about your ability to handle your personal problems?

   1 2 3 4 5

7. In the last month, how often have you felt things were going your way?

1 2 3 4 5

8. In the last month, how often have you found that you could not cope with all of the things you had to do?

1 2 3 4 5

1 = Never	**2 = Almost never**	**3 = Sometimes**
	4 = Fairly often	**5 = Very often**

9. In the last month, how often have you been able to control irritations in your life?

1 2 3 4 5

10. In the last month, how often have you felt that you were on top of things?

1 2 3 4 5

11. In the last month, how often have you been angered because of things that happened that were outside of your control?

1 2 3 4 5

12. In the last month, how often have you found yourself thinking about the things that you have to accomplish?

1 2 3 4 5

13. In the last month, how often have you been able to control the way you spend your time?

1 2 3 4 5

14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

1 2 3 4 5

Coping

Now, think of what you generally feel and do, when events cause a lot of stress. Circle the answer that best represents the way you deal with stressful experiences. Use the table below as a guide.

1	2	3	4
I usually don't	I rarely	I usually do	I usually do

1. I concentrate my efforts on doing something about the situation I'm in.	1	2	3	4
2. I look for something good in what is happening.	1	2	3	4
3. I learn to live with it.	1	2	3	4
4. I think hard about what steps to take.	1	2	3	4
5. I blame myself for the things that happened.	1	2	3	4
6. I take action to try to make the situation better.	1	2	3	4
7. I try to see it in a different light, to make it seem more positive.	1	2	3	4
8. I accept the reality of the fact that it happened.	1	2	3	4
9. I try to come up with a strategy about what to do.	1	2	3	4
10. I make jokes about it.	1	2	3	4
11. I get comfort and understanding from someone.	1	2	3	4
12. I try to find comfort in my religion or spiritual beliefs.	1	2	3	4
13. I say to myself, "this isn't real."	1	2	3	4
14. I make fun of the situation.	1	2	3	4
15. I get emotional support from others.	1	2	3	4
16. I do something to think about it less, such as go to the movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
17. I've try to get advice or help from other people about what to do.	1	2	3	4

18. I give up trying to deal with it. 1 2 3 4
19. I get help and advice from other people. 1 2 3 4
20. I express my negative feelings. 1 2 3 4
21. I use alcohol or other drugs to help me get though it. 1 2 3 4
22. I pray or meditate. 1 2 3 4
23. I turn to work or other activities to take my mind off things.1 2 3 4
24. I refuse to believe it has happened. 1 2 3 4
25. I say things to let my unpleasant feelings escape. 1 2 3 4
26. I use alcohol or other drugs to make myself feel better. 1 2 3

    4

27. I give up the attempt to cope. 1 2 3 4
28. I criticize myself. 1 2 3 4

Health Status

1. How would you rate your overall health at the present time?

____Excellent ____Good ____Fair ____Poor

2. How is your health compared to what it was like five years ago?

____Better ____About the same ____Worse

3. How much do your health troubles stand in the way of doing the things you want to do?

____Not at all ____A little or some ____A great deal

4. In comparison with other people your age, how would you consider your health status?

____Not as good ____Don't know ____As good ____Better

Personal Medical History

1. Do you currently use tobacco products? ____Yes ____No

If YES, please indicate: **Product** (cigarettes, cigars, dip, etc.):______________________________

How often:____________________ **How long** (months/years)**:**_____________________________

2. Have you ever drank alcohol? _____ Yes _____No

If YES, **how often**:_______________________ **How long** (months/years)___________________

3. Have you ever used illegal drugs or other illegal substances? ____ Yes ____ No

If YES, please indicate: **Type of substance:**____

How often:__________________________ **How long**:____________________________________

3. Your current **weight** is _______________lbs.

4. Your current **height** is ________Feet ________inches

Medication Use

1. How many prescription medications do you currently take: _________________________

2. How many over-the-counter medications (aspirin, etc.) do you currently take:_________

3. How many vitamins and/or herbs do you currently take:____________________________

Functional Ability

1. How is your eyesight (with glasses or contacts)?

____Excellent ____Good ____Fair ____Poor

2. How is your hearing (without a hearing aid)?

____Excellent ____Good ____Fair ____Poor

3. How would you rate your current level of mobility (moving, walking, getting around)?

____Excellent ____Good ____Fair ____Poor

5. How would you rate your current ability to participate in regular physical activities such as hiking, jogging, swimming, biking, golf, tennis. . .etc?

____Excellent ____Good ____Fair ____Poor

Health Conditions

Please check the following disease/health conditions that you have recently experienced or currently have:

____High blood pressure ____Aneurysm ____Abnormal chest X-ray

____High blood cholesterol ____Anemia ____Asthma

____High blood triglycerides ____Diabetes ____Emphysema

____Angina pectoris ____Jaundice ____Bronchitis

____Heart attack ____Hepatitis ____Thyroid problems

____Heart surgery ____Hernia ____Cancer

____Heart failure ____Phlebitis ____Epilepsy or seizures

____Heart murmur ____Gout ____Kidney stones

____Stroke/TIA ____Prostate problem ____Urinary tract problem

____Rheumatic fever ____Osteoporosis

____Arthritis/Rheumatism

____Arteriosclerosis ____Tuberculosis ____Parkinson's Disease

____Alzheimer's Disease ____Cerebral Palsy ____Muscular Dystrophy

____ Liver Disease ____Ulcers ____Circulatory problems

____Eating Disorder ____Obesity ____Glaucoma

____Macular Degeneration ____ Other

(Specify______________________________)

Health Visits

Please list no more than the last three (3) times you have been ill (sick) enough to visit the doctor or prison health clinic, been placed in the infirmary/hospital, or had surgery.

When (Year)?	What was done (surgery, etc.)?	Why was this done?
______________________	____________________________	________________________
______________________	____________________________	________________________
______________________	____________________________	________________________

Activities of Daily Living

1. Can you eat. . .
   a. Without help (able to feed yourself completely)
   b. With some help (need help with cutting, feeding self some foods, etc.)
   c. Completely unable to feed yourself
2. Can you dress and undress yourself. . .
   a. Without help (able to pick out clothes, dress and undress yourself)
   b. With some help
   c. Completely unable to dress or undress yourself
3. Can you take care of your own appearance (i.e., combing your hair, washing your face)
   a. Without help
   b. With some help
   c. Completely unable to maintain appearance yourself
4. Can you walk. . .
   a. Without help
   b. With some help from a person or with the use of a walker, cane, crutches. . . etc.
   c. Completely unable to walk
5. Can you get in and out of bed. . .
   a. Without help
   b. With some help (with help from another person or with the aid of some device)
   c. Completely unable to get in and out of bed; completely dependent on someone else

6. Can you take a bath or shower. . .

    a. Without help
    b. With some help (need helping getting in and out of tub or shower, need special attachments on tub or shower)
    c. Completely unable to bath yourself

Personal Development

The following statements describe thoughts about personal growth and development. After reading each statement, indicate your level of agreement. Circle the appropriate answer.

1. I am not interested in activities that will expand my horizons.

   1 2 3 4 5 6

2. In general, I feel that I continue to learn more about myself as time goes by.

   1 2 3 4 5 6

3. I am the kind of person who likes to give new things a try.

   1 2 3 4 5 6

4. I don't want to try new ways of doing things; my life is fine the way it is.

   1 2 3 4 5 6

5. I think it is important to have new experiences that challenge how you think about yourself and the world.

   1 2 3 4 5 6

6. When I think about it, I haven't really improved much as a person over the years.

   1 2 3 4 5 6

7. In my view, people of every age are able to continue growing and developing.

   1 2 3 4 5 6

8. With time, I have gained a lot of insight about life that has made me a stronger, more capable person.

   1 2 3 4 5 6

9. I have the sense that I have developed a lot as a person over time.

   1 2 3 4 5 6

10. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.

1 2 3 4 5 6

11. For me, life has been a continuous process of learning, changing, and growth.

1 2 3 4 5 6

12. I enjoy seeing how my views have changed and matured over the years.

1 2 3 4 5 6

13. I gave up trying to make big improvements or changes in my life a long time ago.

1 2 3 4 5 6

14. There is truth to the saying that you can't teach an old dog new tricks.

1 2 3 4 5

Companionship

The following questions describe how people sometimes feel. For each question, circle the appropriate number that best describes you.

	Never	**Rarely**	**Sometimes**	**Always**
1. How often do you feel you lack companionship?	1	2	3	4
2. How often do you feel that you have a lot in common with the people around you	1	2	3	4
3. How often do you feel close to people	1	2	3	4
4. How often do you feel left out?	1	2	3	4
5. How often do you feel that no one really knows you well?	1	2	3	4
6. How often do you feel isolated from others?	1	2	3	4
7. How often do you feel that there are people who really understand you?	1	2	3	4
8. How often do you feel that people are around you but not with you?	1	2	3	4
9. How often do you feel that there are people you can talk to?	1	2	3	4
10. How often do you feel that there are people you can turn to?	1	2	3	4

Mood

For the following questions, please check **Yes** or **No**

	YES	**NO**
1. Do you feel that your life is empty?		
2. Do you often get bored?		
3. Are you bothered by thoughts you can't get out of your head?		
4. Do you feel helpless?		
5. Do you frequently worry about the future?		
6. Do you often feel downhearted and blue?		
7. Do you feel pretty worthless the way you are now?		
8. Do you worry a lot about the past?		
9. Do you feel that your situation is hopeless?		
10. Do you frequently feel like crying?		

Life Satisfaction

For each of the following statements, please indicate your level of agreement. Circle the response that best represents your opinion.

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Neither/Neutral

5 = Slightly Agree

6 = Agree

1. In most ways, my life is close to ideal.

   1 2 3 4 5 6 7

2. The conditions of my life are excellent.

   1 2 3 4 5 6 7

3. I am satisfied with my life.

   1 2 3 4 5 6 7

4. So far, I have gotten the important things I want in life.

   1 2 3 4 5 6 7

5. If I could live my life over, I would change almost nothing

   1 2 3 4 5 6 7

Relationship with God

The following statement reflect how people sometimes feel about God. Please indicate how well each statement describes your relationship to God. Circle the number that most honestly reflects your thoughts and feelings. Use the table below as a guide.

1	2	3	4	5	6	7
Not at all characteristic			**Neither**			**Very characteristic**

1. God seems to have little or no interest in my personal problems.

   1 2 3 4 5 6 7
2. God's reactions to me seem to be inconsistent.

   1 2 3 4 5 6 7
3. I have a warm relationship with God.

   1 2 3 4 5 6 7
4. God seems impersonal to me.

   1 2 3 4 5 6 7
5. God knows when I need support.

   1 2 3 4 5 6 7
6. God sometimes seems responsive to my needs, but sometimes not.

   1 2 3 4 5 6 7
7. God seems to have little or no interest in my personal affairs.

   1 2 3 4 5 6 7
8. I feel that God is generally responsive of me.

   1 2 3 4 5 6 7
9. God sometimes seems very warm and other times very cold to me.

   1 2 3 4 5 6

Problem Solving

The statements below describe how some people use God in solving personal problems. Please indicate how often each statement applies to you. Please circle the appropriate response. Use the table below as a guide.

1	2	3	4	5
Never	Rarely	Neutral	Sometimes	Always

1. When I have a problem, I talk to God about it and together we decide what it means.

   1 2 3 4 5

2. Rather than trying to come up with the right solution to a problem myself, I let God decide
   how to deal with it.

   1 2 3 4 5

3. When faced with a problem, I deal with my feelings without God's help.

   1 2 3 4 5

4. When a situation makes me anxious, I wait for God to take those feelings away.

   1 2 3 4 5

5. Together, God and I put my plans into action.

   1 2 3 4 5

6. When it comes to deciding how to solve a problem, God and I work together as partners.

   1 2 3 4 5

7. I act to solve my problems without God's help.

   1 2 3 4 5

8. When I have a difficulty, I decide what it means by myself without help from God.

   1 2 3 4 5

9. I don't spend much time thinking about troubles I've had; God makes sense of them for me.

   1 2 3 4 5

10. When considering a difficult situation, God and I work together to think of possible solutions.

1 2 3 4 5

11. When a troublesome issue arises, I leave it up to God to decide what it means for me.

1 2 3 4 5

12. When thinking about a difficulty, I try to come up with possible solutions without God's help.

1 2 3 4 5

13. After solving a problem, I work with God to make sense of it.

1 2 3 4 5

14. When deciding on a solution, I make a choice independent of God's input.

1 2 3 4 5

15. In carrying out the solutions to my problems I wait for God to take control and know somehow He'll work it out.

1 2 3 4 5

16. I do not think about different solutions to my problems because God provides them for me.

1 2 3 4 5

17. After I've gone through a rough time, I try to make sense of it without relying on God.

1 2 3 4 5

18. When I feel nervous or anxious about a problem, I work together with God to find a way to relieve my worries.

1 2 3 4 5

Forgiveness

For the next set of statements, think how you typically respond to negative events or situations that occur because of your own actions, the actions of others, or circumstances beyond your control. Read each statement carefully. Circle the number on the scale that most honestly describes you. Remember there are no right or wrong answers.

1	2	3	4	5	6	7
Almost always false of me		**More often false of me**		**More often true of me**		**Almost always**

1. Although I feel badly at first when I mess up, over time I can give myself some slack. 1 2 3 4 5 6 7

2. I hold grudges against myself for the negative things I've done 1 2 3 4 5 6 7

3. Learning from bad things that I've done helps me get over them. 1 2 3 4 5 6 7

4. It is really hard for me to accept myself once I've messed up. 1 2 3 4 5 6 7

5. With time, I am understanding of myself for the mistakes I've made. 1 2 3 4 5 6 7

6. I don't stop criticizing myself for negative things I've felt, thought, said or done. 1 2 3 4 5 6 7

7. I continue to punish a person who has done something that I think is wrong. 1 2 3 4 5 6 7

8. With time I am understanding of others for the mistakes they've done. 1 2 3 4 5 6 7

9. I continue to be hard on others who have hurt me. 1 2 3 4 5 6 7

10. Although others have hurt me in the past, I have eventually been

able to see them as good people. 1 2 3 4 5
6 7

11. If others mistreat me, I continue to think badly of them. 1 2 3 4 5
6 7

12. When someone disappoints me, I can eventually move past it. 1 2 3 4 5
6 7

13. When things go wrong for reasons that can't be controlled, I get stuck in negative thoughts about it. 1 2 3 4 5
6 7

14. With time I can be understanding of bad circumstances in my life. 1 2 3 4 5
6 7

15. If I am disappointed by uncontrollable circumstances in my life, I continue to think negatively about them. 1 2 3 4 5
6 7

16. I eventually make peace with bad situations in my life. 1 2 3 4 5
6 7

17. It's really hard for me to accept negative situations that aren't anybody's fault. 1 2 3 4 5
6 7

18. Eventually, I let go of negative thoughts and bad circumstances that are beyond anyone's control. 1 2 3 4 5
6 7

STOP. This concludes the survey. Please take a moment to double-check your answers. Please review that you have completed all sections and questions. **THANK YOU** for your participation in this very worthwhile and important study.

REC'D URC
APR 15 2016

Oklahoma State University Institutional Review Board

Request for Determination of Non-Research or Non-Human Subject

Federal regulations and OSU policy require IRB review of all research involving human subjects. Some categories of research are difficult to discern as to whether they qualify as human subject research. Therefore, the IRB has established policies and procedures to assist in this determination.

1. Principal Investigator Information

First Name: Taishel	Middle Initial: L	Last Name: Douglas
Department/Division: Human Development and Family Science		College: Human Sciences
Campus Address: 100 Iba Hall		Zip+4: 74078
Campus Phone: 816-570-0266	Fax:	Email: taishel@okstate.edu
Complete if PI does not have campus address:		
Address:		City:
State:	Zip:	Phone:

2. Faculty Advisor **(complete if PI is a student, resident, or fellow)** ☐ **NA**

Faculty Advisor's name: Alex Bishop		Title: Associate Professor
Department/Division: HDFS		College: Human Sciences
Campus Address: 233 Human Sciences		Zip+4: 74074
Campus Phone: 4-3989	Fax: 405-744-6344	Email: alex.bishop@okstate.edu

3. Study Information:

HE-07-67

A. Title

THE EFFECTS OF ADVERSE CHILDHOOD EXPERIENCES ON MENTAL HEALTH, PHYSICAL HEALTH, AND SPIRITUALITY IN INCARCERATED OLDER MALES

B. Give a brief summary of the project. (See instructions for guidance)

The purpose of this study was to determine the unique impact of adverse childhood experiences relative to self-reported well-being among older prisoners. Study participants were given many questioners to complete about themselves. The prison administration staff coordinated data collection visits. Only the participants who volunteered on the specific day of the scheduled visit were allowed to be included in the study. Each participant signed an informed consent and completed a written self-report survey. Participants were not allowed to sit directly across or next to other participants in order to secure privacy. The prison administrative staff helped the research team identify persons who could not read due to poor vision or illiteracy and these participants had a one-on-one interview with a member of the research team. There was no monetary compensation for participation and each participant was debriefed after completing the survey.

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Request for Determination of Non-Research or Non-Human Subject

C. Describe the subject population/type of data/specimens to be studied. (See instructions for guidance) Participants for this study included N = 261 male prison inmates, aged 45 and older, currently incarcerated in state managed prisons operated by the Oklahoma Department of Corrections. Data used for this study was previously collected during the summer months of 2006. Data for this particular study consisted of aggregate survey data including age, race, education, and criminal offense (violent vs. non-violent), childhood life events, as well as subjective well-being data concerning loneliness/companionship, self-reported health conditions, and involvement in spirituality. All identifiers and any additional identifying information have since been omitted and stripped from the original data set since Fall 2006 for purposes of use for student research theses.

4. Determination of "Research".
One of the following must be "no" to qualify as "non-research":

A. Will the data/specimen(s) be obtained in a systematic manner?
☒ No ☐ Yes

B. Will the intent of the data/specimen collection be for the purpose of contributing to generalizable knowledge (the results (or conclusions) of the activity are intended to be extended beyond a single individual or an internal program, i.e. widely or universally applicable)?
☐ No ☒ Yes

5. Determination of "Human Subject".

A. Does the research involve obtaining information about living individuals?
☐ No ☒ Yes
If no, then research does not involve human subjects, no other information is required.
If yes, proceed to the following questions.

All of the following must be "no" to qualify as "non-human subject":

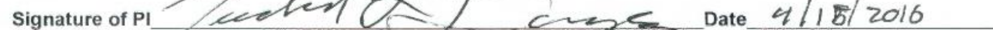
B. Does the study involve intervention or interaction with a "human subject"?
☒ No ☐ Yes

C. Does the study involve access to identifiable private information?
☒ No ☐ Yes

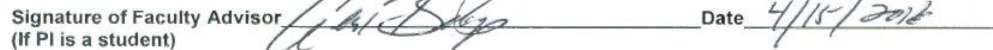
D. Are data/specimens received by the Investigator with identifiable private information?
☒ No ☐ Yes

E. Are the data/specimen(s) coded such that a link exists that could allow the data/specimen(s) to be re-identified?
☒ No ☐ Yes
If "*Yes,*" is there a written agreement that prohibits the PI and his/her staff access to the link?
☐ No ☐ Yes

6. Signatures



Signature of PI __________ Date 4/15/2016



Signature of Faculty Advisor __________ Date 4/15/2016
(If PI is a student)

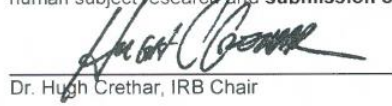
Revision Date: 09/2013 4 of 5

Oklahoma State University Institutional Review Board

Request for Determination of Non-Research or Non-Human Subject

☒ Based on the information provided, the OSU-Stillwater IRB has determined that this project **does not** qualify as human subject research as defined in 45 CFR 46.102(d) and (f) and **is not subject to oversight by the OSU IRB.**

☐ Based on the information provided, the OSU-Stillwater IRB has determined that this research **does** qualify as human subject research and **submission of an application for review by the IRB is required.**



Dr. Hugh Crethar, IRB Chair

4.20.16
Date

VITA

Taishel L. Douglas

Candidate for the Degree of

Master of Science

Thesis: THE EFFECTS OF ADVERSE CHILDHOOD EXPERIENCES ON MENTAL HEALTH, PHYSICAL HEALTH, AND SPITIRTUALITY IN INCARCERATED OLDER MALES

Major Field: Human Development and Family Science with an emphasis in Gerontology

Biographical: Taishel L. Douglas was born in Kansas City, MO. She completed her Bachelor of Science in Human Development and Family Sciences with an emphasis in Child and Family Services in December of 2013 at Oklahoma State University. She also interned at the L.I.F.E. Adult Day Center until she begun working on her Masters of Science in Human Development and Family Science with an emphasis in Gerontology.

Education:
Completed the requirements for the Master of Science Human Development and Family Science with and emphasis in Gerontology at Oklahoma State University, Stillwater, Oklahoma in May, 2016.

Completed the requirements for the Bachelor of Science in Human Development and Family Science with an option in Child and Family Services at Oklahoma State University, Stillwater, Oklahoma in December, 2016.

Experience:
Graduate Teaching Assistant, Housing and Residential Life, 2014-Present
Graduate Research Assistant, Human Development & Family Science, 2014-15
Program Assistant, Adult Day L.I.F.E. Center, 2013-14

Professional Presentations:
Douglas, T. L. & Bishop, A. J. (2016, March). *The effects of adverse childhood experiences on mental health, physical health, and spirituality in incarcerated older males.* Poster presented at the Society of Research for Human Development, Denver, CO.
Douglas, T. L. & Bishop, A. J. (2015, November). Research update: Early and late life exposure to trauma and biopsychosocial well-being in centenarians. On-line at fcs.okstate.edu/component/content/article/30