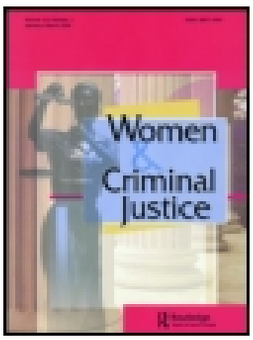

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Psychotropic Medication Experiences of Incarcerated Women: A Qualitative Inquiry into Conundrums of Access and Identity

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The study examines narrative data from in-depth, semi-structured interviews with 25 women in a medium security prison with the hope of deepening the knowledge base related to women's beliefs about their mental health problems, mental health care during incarceration, and especially their experiences with psychotropic medication. The findings highlight the functional role of psychotropic medication in the lives of incarcerated women, while also emphasizing problems with limited access to prescribers, preferred medications, and other forms of mental health treatment. Trauma, substance use, and the impact of medication use on sense of self all emerged as interfacing with quality of life.

Keywords access to medication, forensic mental health, incarcerated women, lived experiences with psychotropic medication, psychosocial aspects of psychotropic medication

The number of women incarcerated in jails and prisons in the United States continues to rise at alarming rates (Glaze & Kaeble, 2014) and research consistently shows these women disproportionately experience mental health challenges (James & Glaze, 2006; Prins, 2014) and use psychotropic medications (Beck & Maruschak, 2001; Langner, Barton, McDonagh, Noel, & Bouchard, 2002). Indeed, psychotropic medication remains the predominant treatment modality in most correctional facilities (Baillargeon, Contreras, Grady, Black, & Murray, 2000). Heavy reliance on psychotropic medication is thought to be due to a lack of resources for alternative or complementary approaches (Baillargeon et al., 2000; Langner et al., 2002; Wilper et al., 2009). This reality—plus the relatively limited scope of current research—provides a strong rationale for additional inquiry into psychotropic medication use among incarcerated women. Most notably, research to date inadequately gives voice to women's lived experiences related to psychotropic medication use in forensic settings. The present study specifically examines narrative data from in-depth, semi-structured interviews collected in conjunction with a larger quantitative study (see Bentley & Casey, 2017) that attempts to deepen and extend those findings related to women's beliefs about their mental health problems, mental health care during incarceration, and especially their experiences with psychotropic medication. We sought to address this major gap in the forensic mental health literature and further build a knowledge

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base with potential for informing more effective and compassionate responses to the mental health needs of incarcerated women.

BACKGROUND AND RATIONALE

Since deinstitutionalization, the need for mental health services and programming within correctional facilities has increased dramatically in response to increased rates of incarceration among women with mental health challenges (Dlugacz & Wimmer, 2013; Griffiths, Willis, & Spark, 2012; Kilty, 2012). According to the most recent data from the Bureau of Justice Statistics, an alarming 73% of female inmates in state correctional facilities in the United States experience some kind of mental illness or mental health challenge, including one of a number of serious mental illnesses, personality disorders, and sleep and adjustment disorders (James & Glaze, 2006). Data from the early 2000s found that 22% of offenders in female state correctional facilities were prescribed psychotropic medication (Beck & Maruschak, 2001), and these medications constituted almost half—a whopping 42%—of all prescriptions for medicine for incarcerated women (Langner et al., 2002). More recent data suggests this may be the tip of the iceberg (Wilper et al, 2009).

The limited literature related to psychotropic medication use among incarcerated populations has heavily emphasized difficulties related to adherence among this population (i.e., Ehret et al., 2013; Shelton, Ehret, Wakai, Kapetonovic, & Moran, 2010). Gray, Bressington, Lathlean, and Mills (2008), for example, surveyed a small group of incarcerated men and women and found that feeling motivated to take medication and attributing symptom improvement to medication predicted adherence. In one of the few studies conducted exclusively with incarcerated females, Williams, Hollis, and Benoit (1998) considered how attitudes impact adherence, finding that, although the majority of females incarcerated in a juvenile detention center were skeptical about the potential benefits of psychotropic medication, those in the sample who had previously taken psychotropic medication were more likely to identify its potential efficacy.

Other studies have examined access to psychiatric care and issues related to medication management. One study found that offenders had decidedly limited access to psychiatric providers during incarceration in the form of infrequent or brief appointments and reported feeling there was no one to adequately explain their treatment (Bressington, Gray, Lathlean, & Mills, 2008). Another study found that offenders believe that mental health providers often ignore their requests related to psychotropic medication (Bowen, Rogers, & Shaw, 2009), or conversely, coerce them to use psychotropic medication (Dlugacz & Wimmer, 2013; Kilty, 2012). The literature also suggests significant difficulties related to continuity of care, such as lack of consistency between prescribers at different facilities (Griffiths et al., 2012) or lapses in receiving medication upon entering or transferring between institutions (Bowen et al., 2009).

Previous research that explicitly examined the lived experiences related to psychotropic medication of *non*-incarcerated mental health consumers may have relevance here. For example, one recent qualitative inquiry (Lacasse, Piel, Lietz, Rider, & Hess, 2016) sought to understand how consumers experience the treatment process related to the use of psychotropic medication and, not surprisingly, found that consumers highly value informed consent, self-determination, and therapeutic engagement with their prescribers. Additional studies have investigated the symbolic meaning medication has for the lives and identities of consumers.

For example, Bentley (2010) found medication, "incites meaning, influences identity, and impacts life" (p. 488) and was a prominent part of their journey with mental illness. For some consumers, psychotropic medication holds the promise of recovery from mental illness, but it can also represent dependency or powerlessness (Bentley, 2010; Gabe, 1991; Jenkins et al., 2005; Liersch-Sumskis, Moxham, & Curtis, 2015). Psychotropic medication holds symbolic meaning for the families of patients as well, for whom medication represents respite from the familial chaos associated with illness (Vedana et al., 2016). Thus, the present study builds on previous research to generate deeper and richer knowledge about the complex topic of psychotropic medication use by women during incarceration, exploring numerous topics underexplored with incarcerated and non-incarcerated persons alike, such as the impact medication has on women's lives and emotional experiences related to its use during their time in jail or prison.

METHOD

Design

As part of a larger study into incarcerated women's experiences with psychotropic medication (Bentley & Casey, 2017), the researchers conducted a phenomenological, qualitative inquiry to investigate women's experiences with and beliefs about mental health and psychotropic medication use during incarceration. Operating within an interpretive paradigm, the researchers collected narrative data via in-depth, semi-structured interviews with currently incarcerated women ($N = 25$), a volunteer subset of the 274 women who participated in a paper and pencil survey about their experiences. A traditional thematic analysis of the interview transcripts was conducted to identify significant topics and themes which captured women's subjective perspectives about their experiences. All research protocols were approved by the Institutional Review Board at the authors' institution as well as the research review committee for the Department of Corrections in the state where the research was completed.

Setting

The research was conducted in a medium-security correctional facility in the Mid-Atlantic region of the United States. The correctional facility, where all participants were incarcerated at the time of data collection, is located in a rural area roughly 30 miles outside a major metropolitan area. The facility houses approximately 550 women whose index offenses range from larceny to homicide, with commensurate ranges in sentences. The grounds of the institution resemble a college campus, with numerous smaller buildings arrayed amid paved walkways and manicured landscaping. One peculiar feature of the institution is its lack of traditional security measures; it does not have any impassable walls or fences to prevent escape attempts, which further bolsters the illusion of a college campus for visitors to the institution.

Participants

During the time of data collection, 535 women were incarcerated at the correctional facility. Of those 535 women, 274 chose to participate in a larger survey related to the present study.

Participants for the present study were randomly selected from the 154 women who volunteered to engage in a face-to-face interview after participating in the larger survey. Of those women who volunteered to be interviewed, 125 met the inclusion criteria of (a) currently taking prescribed psychotropic medication and (b) having been incarcerated for at least two months. Thirty participants were randomly selected from the group of eligible women, and 25 women elected to engage in the interview when the appointment time arrived. Resources precluded the inclusion of additional participants; however, a sample size of 25 participants is considered more than adequate, particularly if data saturation is reached, as was the case with this study (Dworkin, 2012; Mason, 2010). Each participant was given a blank writing notebook as a token of appreciation and incentive for participation.

Interview participants ranged in age from 18 to 64 years, with the largest number of participants indicating ages between 35 and 44 ($n = 9$). The majority of participants were White ($n = 21$), with two participants identifying as African American and two participants identifying as multiracial. The amount of time the interviewees had been incarcerated during adulthood ranged from 1.25 to 18 years, with an average of 6.17 years. Participants reported a total number of incarcerations during adulthood ranging from one to five incarcerations, with an average of 2.12 incarcerations. To ensure confidentiality of responses, participants were asked to assign themselves a pseudonym that was used to identify their interview data throughout the data analysis and reporting processes. Each participant explicitly provided permission for publication of her words.

Data Collection

The semi-structured interviews were conducted in a small conference room in the administrative building of the institution and ranged in duration from 30 to 60 minutes. Audio recordings were made of the interviews and later transcribed by a professional transcriptionist. The interview guide, developed by and available from the researchers, derived from previous research and our own research questions and thus addressed the following: perceived therapeutic effects and side effects of psychotropic medication, access to mental health services and continuity of care, medication adherence and decision making, identity and meaning-making, personal beliefs about medication and mental health, experiences with stigma, perceptions of control, and feedback for improved care. Following collection of basic demographic data, each interview began with, "Tell me the story of how you came to be taking psychotropic medication," and "What has your experience of taking psychotropic medication been like?"

Data Analysis

The researchers conducted a traditional thematic analysis of the interview transcripts. NVivo 11 software was used as a tool for data storage, organization, and coding. During the initial coding phase, data were subjected to simultaneous processes of deductive coding—applying codes derived from existing literature and research questions—and inductive coding—applying codes as relevant ideas emerged from the data (Harding, 2013). The researchers utilized a mixture of process codes, emotion codes, descriptive codes, and *in vivo* codes as appropriate (Saldaña, 2015). Upon completion of initial coding, data saturation was determined to have been reached

as the collected data were both rich with nuanced detail and thick in terms of quantity (Dibley, 2011). The initial coding process yielded 841 codes. Through a process of constant comparison, codes were sorted and collapsed into 326 codes. The collapsed codes were then grouped into categories and subcategories, and themes were identified. The researchers wrote analytic memos throughout the coding process to document choices related to coding and categorization of data.

Trustworthiness

Several strategies were undertaken to maximize the trustworthiness of the research. First, the researchers conducted a code–recode procedure to ensure dependability of findings. Specifically, sections from a randomly selected subsample ($n = 5$) of the transcripts were subjected to a second round of coding, the codes from which were then compared to codes from the first coding attempt and determined to be consistent. Second, the researchers conducted a member check to increase credibility; the researchers presented their findings to a small group of women from the institution, all of whom vocalized their confidence in the veracity of the study findings. Finally, confirmability was addressed through the use of reflexive journaling throughout the data analysis process.

RESULTS

Findings from the qualitative analysis are organized around two overarching and predominant topics: women's experiences with access to psychotropic medication during incarceration and women's beliefs about medication and its impact on their lives. Within each of these categories, multiple themes emerged (see Table 1 for a summary list), which have been described in detail below along with exemplar quotations from the interviews.

Experiences with Access to Medication during Incarceration

Adverse Consequences of Limited Access to Preferred Medications

When describing their experiences with psychotropic medication, all participants highlighted the lengthy process of trial and error involved in finding the optimal medication regimen. For many women ($n = 21$), this process began prior to incarceration, sometimes as early as

TABLE 1
Thematic Findings from the Qualitative Data Analysis

Experiences with access to psychotropic medication during incarceration
Adverse consequences of limited access to preferred medications
Problematic limits on access to mental health services and psychiatric care
Disrespectful medication administration procedures
Medication misuse and abuse
Beliefs about mental health, psychotropic medication and its impact on their lives
Trauma underlies mental illness, medication use and substance use
Medication helps women be a better version of themselves
Medication offers control over life

childhood. Importantly, because the medication formulary is extremely limited within the correctional system (e.g., benzodiazepines and stimulants are disallowed), becoming incarcerated either extends or reinitiates the exhausting search for the "right"—or sometimes, "good enough"—medication. Dawn describes how incarceration has impacted access to her preferred medications:

> I've been tried on all kinds of stuff, but I think that there is a combination that works for me. I just have to figure it out what I can take in here compared to out there. I stay on Seroquel … and Xanax and I'm able to get through, but when you're locked up you can't have certain drugs that you could have out there.

Some women ($n = 8$) described withdrawing from medications that are disallowed in the correctional system. For example, Victoria recounts her experience withdrawing from Xanax—which she had been prescribed in the community—upon entering the correctional system: "I didn't have anything for, like, the first week. That was really hard. … I was physically sick from it." Being forced to withdraw from and change medication seemed to have emotional repercussions in addition to any chemical changes resulting from altering medications. Nancy explained, "I'm just tired of trying different things, and I want to get on with my life." YoYo described her experience of finding the optimal medication with vivid imagery: "it's been like being on a rollercoaster blindfolded, never knowing when a loop's gonna be there, when a big drop is gonna be there."

Problematic Limits on Access to Mental Health Services and Psychiatric Care

Feelings of exhaustion, frustration, and uncertainty around access to medications are also experienced as a result of limited access to mental health services generally during incarceration. Significantly, most women ($n = 23$) strongly emphasized the problematic nature of limited access to appointments and communication with a prescriber. Medication checks with prescribers were quick and infrequent. Indeed, Quinn described appointments with her prescriber as, "the fastest doctor appointment you'll ever go to in your life." Per institutional policy, these women could see the psychiatrist only once every 90 days, regardless of their need for care. Not surprisingly, many women ($n = 17$) bemoaned the infrequency of appointments, describing the limited access to their prescriber as particularly problematic when their medication regimen was not having the desired effect. Penelope explains:

> Waiting three months to get your medicine changed is a very long time. Especially when you are unstable, one day is a long time. … I know there's a lot of us, and they can't see us every single day, but something definitely needs to be done.

Communication with prescribers between appointments occurs via an internal mailing system using paper request forms, which typically yields a response within several days. However, in Kelly's words, "the majority of the time Dr. [X] does not get the request. It goes through someone before him and they simply write, 'You have an appointment scheduled for such and such day.'" Limited access to appointments results in women either experiencing unwanted medication side effects for as long as three months, or making self-directed changes to their

medication regimen without consulting their prescriber. Indeed, when asked for suggestions for improving mental health care in the prison system, the most frequent response ($n = 17$) was to increase access to mental health care providers including increasing the frequency of appointments with the prescriber as needed.

Not only did women experience limited access to prescribers and certain medication types specifically, but women also encountered limited access to mental health services more generally, such as individual counseling and psychotherapy. The limited psychosocial interventions that *were* delivered were provided primarily via group treatment, which a few women ($n = 4$) found anxiety-provoking or otherwise undesirable. Access to certain psychosocial treatments, such as group substance abuse treatment or individual case management, was determined by release date, meaning that women with longer sentences were often deemed ineligible. Some women ($n = 7$) noted that limitations to mental health services and a perceived overreliance on pharmacological interventions for treatment of mental health issues likely resulted from a lack of resources such as funding and personnel. Jenny explains, "There are so many people and so little mental health staff. … We finally realized we need help, but we just don't have the people there to actually help us." Rebecca reported: "It's just like, 'take your medicine' and that's it. … There's no help in prison for mentally ill people." Furthermore, some women ($n = 14$) believe medication regimens are too heavy handed or completely off base. Nancy reported, "Dr. [X] gives people these strong medicines that don't really need them. It's kinda scary. You see people walking around drooling on themselves, and just completely incoherent." Clearly, problems related to appropriate access to, and management of, mental health care, are associated with significant diminishments in quality of life for these women.

Disrespectful Medication Administration Procedures

Women described overwhelmingly negative experiences with the strict and rigid medication administration procedures in the facility. To obtain their medication, women are required to walk to the infirmary and wait outdoors until they can advance to the window, at which time a nurse administers their medication. Jenny describes the experience of going to the "pill line": "We're talking about outside, in the rain, and you're getting soaking wet and you're out there in line for God knows how long to get your medications and it's horrible." Towanda explains the security procedures intended to reduce medication misuse: security staff, "pretty thoroughly checks your mouth; you have to run your fingers inside there and check under your tongue and the roof of your mouth." Some women ($n = 12$), like Penelope, experienced these invasive mouth checks as disrespectful, not to mention ineffective at preventing medication misuse: "It doesn't matter how much they search your mouth. If somebody wants to get by with something, they're gonna do it. … You don't have to go through that level of disrespect." Similarly, Alice stated, "I don't think they could degrade me much more." Most women ($n = 20$) cited the medication administration procedure as a reason for nonadherence. For example, Kelly reported, "I did try to quit taking it due to just the hassle of going to pill line."

Medication Misuse and Overuse

On the other hand, some women ($n = 8$) perceived the restrictive medication formularies and medication administration procedures as a necessary response to rampant misuse of medication

in the prison environment. Indeed, Quinn stated, "Some people cheek them and then they take them up to the hall and they do 'em or they sell 'em and everybody's snorting this or snorting that." Several women described their own experiences misusing medication; YoYo shared, "They had me on Wellbutrin, and I ended up abusing it. I got two drug charges because of Wellbutrin." Reasons given for medication misuse included coping with the harsh realities of incarceration. Nancy explained, "I didn't take any medicine on the outside, but now I want all these high doses of these medicines that will knock me out, or I can't deal with my problems in here." Additionally, medication misuse represents an extension of substance abuse in which many women were engaged prior to incarceration. Jenny describes, "A lot of people are abusing medications here, trading their pills and it's almost like you're out on the streets all over again."

Beliefs about Mental Health, Psychotropic Medication, and Its Impact on Life

Trauma Underlies Mental Illness, Medication Use, and Substance Use

Many women ($n = 17$) emphasized the significant contribution of negative life experiences to their development of mental health symptoms and challenges. Victoria explained that her own mental illness, "stemmed from the abandonment. My mom was a drug addict." Similarly, Isabel attributed her mental illness to the fact that her "dad was abusive." Even among women who noted the roles of heredity or brain chemistry in mental illness, trauma was identified as a powerful influencing factor; as Laura reported, "I think it all kind of goes together." In addition to citing traumatic experiences as a cause of mental health difficulties, some women ($n = 10$) identified trauma itself, not the symptoms of mental illness stemming from it, as their reason for initiating psychotropic medication use. For example, when asked how she came to be taking psychotropic medication, Alice responded, "When I was married my husband used to beat me up all the time. Then I got raped by two different people." Uglaysis also identified a direct connection between negative life events and initiating medication use: "I was in foster care, and I was sexually abused by my foster dad … so I was put on mental health medication."
Intertwined with discussions of trauma and mental health problems were reflections about the unmistakable interplay between substance abuse and psychotropic medication use. That is, some women ($n = 11$) understood trauma as a primary trigger for substance abuse as well as for psychotropic medication use. As Willie describes, "I've been living my life scared and running all the time. And that's what caused me to drink. I would get drunk because of the way I felt." Furthermore, substance abuse represented an actual alternative to psychotropic medication for women with limited access to mental health care, or for women like Laura who found psychotropic medication less effective than illicit substances: "I just walked around in a fog all the time, so I just quit taking [the prescribed medication]. That's when I really turned to street drugs." Some women ($n = 12$) saw their psychotropic medication use as a form of sanctioned substance abuse. For example, Nancy was one of a small number of women who believes that using psychotropic medication in prison is unhealthy: "You're just kind of doing what you did with drugs on the outside, just numbing yourself to your problems." A few others ($n = 4$) referred to psychotropic medication pejoratively as "a crutch," inferring that both it and illicit substances allow women to cope in ways they should be able to do without assistance from external agents.

Medication Helps Women be a Better Version of Themselves

Importantly, most participants ($n = 18$) described substantial and pervasive shifts in their perceptions of themselves in the positive direction as a result of using psychotropic medication. For example, Hannah explained, "I despise myself when I'm not on my meds." Willie expressed similar shifts in her feelings about herself: "I love myself now, which I didn't like myself at the beginning." Women seemed to like themselves better when using medication because they believed medication allowed them to be a different, improved, or evolved person. Betty reported, "I feel like a person that has succeeded." Similarly, Penelope explained that psychotropic medication has "kept me from being this awful, terrible person that just never functioned." The notable caveat to women describing positive changes in themselves was that these positive changes occurred only subsequent to the lengthy trial and error process of identifying a medication regimen that satisfactorily addressed their symptoms while also minimizing unwanted side effects. One exception was Frances, who was one of a handful of participants who reported feeling overmedicated and described liking herself better when *not* on medication because "I'm clearer and more confident."

Several women ($n = 12$) understood the difference between the version of themselves on medication and the version of themselves off medication as starkly contrasting; as Yoyo stated, "It's black and white." Quinn agreed, stating, "you're like two different people." Interestingly, a couple of women ($n = 2$) expressed ambivalence about the effects of medication on their sense of self, describing the differences between versions of themselves as unsettling, even though they insist they prefer the self that is taking the medication. Rebecca explains, "It makes me feel guilty that I have to take medication … to be human or to have feelings because, without it, I'm a totally different person. I see the difference and I'm ashamed of it."

Medication Offers Control over Life

Overwhelmingly, women ($n = 22$) reported that psychotropic medications increased their sense of control over their thoughts and feelings as well as over events in their lives. For example, Alice reported, "I have all the control over [my thoughts and feelings] as long as I'm taking my meds. I don't really have much control when I'm not because [my mind] races all over the place from one thing to another." Women attributed their increased sense of control to the fact that medication helped them manage their emotions and make logical decisions, even during emotionally intense moments. Uglaysis explained that medication "helps me think before I do things. I'm a very impulsive person, so it slows me down a little bit."

For some women ($n = 5$), increased perceptions of control while on psychotropic medication correlated to their experiences with past substance use. Specifically, women described feeling out of control when abusing substances, but now, both psychotropic medication and (ironically) incarceration provide much needed stability and help them feel a greater sense of control over their lives. Frances describes this:

> I had no control over my life because drugs and alcohol had control over my life. Being incarcerated has given me absolute control over my life, even though I don't have control to do the things I want right now.

Similarly, women also understood themselves as having complete control over their decision to take or not take their prescribed medications. Marlene explained, "I feel like I have pretty much 100 percent say in it. It's not something that's forced on me at all."

DISCUSSION

The research findings highlight the positive and functional role of psychotropic medication in the lives of many incarcerated women, while also emphasizing the problematic nature of limited access to prescribers and other forms of mental health treatment. The prison environment sets up significant barriers to women's appropriate access to psychotropic medication via restrictive medication formularies and degrading medication administration procedures. Despite those negative factors within the prison environment, women still report predominantly helpful and therapeutic effects of medication, emphasizing that medication helps them to achieve stability in their lives and to "like themselves" more. According to many of these women, an apparent conundrum is that their current state of incarceration—and its concomitant restrictions—has given them opportunities to bolster a sense of control over their lives, especially through engagement in mental health services and the use of medication. The findings also demonstrate the integral and influential roles of trauma and substance abuse in women's perceptions of mental illness and medication.

The present research builds on the existing literature in myriad ways. The results certainly affirm findings from prior research (Bowens et al., 2009; Kilty, 2012) that identified issues of access—whether restrictive formularies or inhumane medication administration procedures—as particularly frustrating and problematic. Evidently, the existing protocol for the distribution of medication represents a less than desirable level of care. The findings also align with prior research reporting limited access to providers (Bressington et al., 2008) and seeming overreliance on medication in lieu of potentially life-changing psychosocial interventions (Griffiths et al., 2012; Kilty, 2012; Langner et al., 2002), a problem that may not be isolated to correctional contexts (Lacasse et al., 2016). Additionally, the present findings seem to confirm the high rates of medication misuse in correctional contexts (Baillargeon et al., 2000; Bowens et al., 2009).

Prior research has shown the high rates of substance use and trauma-based disorders among incarcerated women (Beck & Maruschak, 2001; Tripodi & Pettus-Davis, 2013), and the findings from the present study suggest that these factors are especially meaningful in terms of women's beliefs about psychotropic medication. Although, as noted earlier, most previous studies on medication use among incarcerated women have focused on medication adherence, that issue did not emerge as central in this study. Nonadherence was described simply as a "last resort" when women were unable to make contact with their prescriber, or could not tolerate side effects, as others have also found (Bressington et al., 2008; Griffiths et al., 2012). Issues of continuity of care between facilities and communities likewise did not emerge as an important issue for these women. The present study also counters findings in the existing literature suggesting that incarcerated people feel coerced into use of psychotropic medications (Bowens et al., 2009; Kilty, 2012); indeed, women in this study reported that their decision to use medication was entirely their own, a finding echoed by a larger sample in related research by the authors (Bentley & Casey, 2017).

Strengths and Limitations

The present study makes an important contribution to the literature by being among the first studies to specifically explore incarcerated women's narratives around psychotropic medication. Although the large number of participants represents another important strength of the study, a slight underrepresentation of ethnic minorities was found among participants when compared to proportions of minorities in the sampling frame of the prison, potentially limiting the transferability of findings to non-White women. Data analysis by a single coder did not allow for stepwise replication of coding procedures or other methods for increasing dependability. However, we have attempted to provide insight into the research context by employing thick description of the setting in our methods section. Other strategies were also employed to further enhance trustworthiness. For example, the achievement of data saturation and the use of member checking both bolster the credibility of findings (Guba, 1981).

CONCLUSION

The findings of the present study contribute to the small but growing knowledge base on psychotropic medication use by women during incarceration by examining their experiences with medication and their beliefs about how medication effects their lives. The portrait that emerges is one of both conundrum and complexity. Women can become exhausted and frustrated by barriers to accessing adequate psychopharmacological and mental health care, yet experience great relief and satisfaction with their medication regimens, especially regarding how they bring control and a more positive sense of self to their lives. Future inquiries should delve deeper into the role of medication and mental health treatment in shaping identity and experience among this population, especially because research has shown that incarceration can disrupt personal identity among justice-involved women (Geiger & Fischer, 2005; Hunter & Greer, 2011; Miller, 2011). Increasing our understanding of the intersections of trauma, substance use, and psychotropic medication use seems to represent another fruitful avenue for future research, as findings from this study suggest the three factors interact and influence one another in important ways.

Finally, researchers and practitioners should investigate how to reduce significant obstacles to obtaining appropriately high levels of quality mental health treatment within the correctional environment, including understanding the role of stigma and the reliance on the medical model of care in perpetuating limitations around access. Given the restrictive nature of carceral environments, particular attention must be devoted to creating more opportunities for expanding mental health care options and offering more tailored interventions that are responsive to the unique experiences and preferences of these women. Among the more obvious implications of this study is that much more timely care and more individualized care are needed. Projects which explicitly give voice to the experiences and stories of these women or implement creative innovations in the use of trauma-based care, the treatment of personality challenges, and/or the integration of interventions for both mental health and substance abuse difficulties should be especially promoted (i.e., Gee & Reed, 2013; Najavits, 2002).

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