5-2023

Embodied Escapism: Liberation Within Incarceration

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May 2023

Submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Dance/Movement Therapy
Sarah Lawrence College

Abstract

Mass incarceration in the United States disproportionately impacts Black people, poor people, and people with serious mental illnesses. The criminalization of poverty, systemic racism, and deinstitutionalization combine to create a nation in which significantly higher numbers of individuals with serious mental illnesses are receiving treatment in jails and prisons rather than psychiatric hospitals. While mental healthcare in jails and prisons has shown improvement in recent years, limited resources and negative public sentiment continue to restrict the effectiveness of mental healthcare for incarcerated individuals. There is a profound need for embodiment and empowerment in jails and prisons, and dance/movement therapy offers one avenue for integrated care. Dance/movement therapy research in jails and prisons is limited but promising, suggesting that the modality has potential for helping individuals transcend the harsh reality of incarceration. Following the framework of early dance/movement therapist Trudi Schoop, dance/movement therapists working with incarcerated individuals may facilitate joyful self-expression through the embodiment of fantasies, dreams, and desires. The experience of incarceration is antithetical to rehabilitation, but embodied escapism makes space for feelings of freedom.

Keywords: dance/movement therapy, jail, prison, fantasy, embodiment, escapism

Acknowledgments

I would like to express my sincere gratitude to the people who have guided me over the course of my graduate education.

First and foremost, to the men who have graciously, enthusiastically, and compassionately welcomed me into the spaces where they live while incarcerated, thank you for allowing me to experience your realities and witness your fantasies.

To my supervisors, Laura Raffa and Christina Clinton, and to my teachers, Elise Risher and Susan Orkand, for your empathy, encouragement, and introduction of revolutionary ways of thinking, being, and moving.

To my husband, Nathan Luttrull, for unwaveringly, unflinchingly, patiently loving me and seeing me for exactly who I am. To my parents, Michelle Herman and Glen Holland, for resolutely standing by me as I decide over and over again what I want to be when I grow up.

To my classmates, Dilara Akpinar, Rachel Alford, Ashmita Biswas, Rebekah Brown, Lauren Marcus, Iris Ridley, Johnny Stellard, and Aaron Tonaki, for the kind of connections anyone would be lucky to encounter even once in a lifetime.

To Lea Bowen, Bre Piccolotto, and Suzie Wilson, for friendship and fantasies that transcend time and space.

To Suzy PetchEam, Kira Kull, and our students, for proving to me the power of playing pretend.

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You ask what it's like here
but there are no words for it.
I answer difficult, painful, that men
die hearing their own voices. That answer
isn't right though and I tell you now
that prison is a room
where a man waits with his nerves
drawn tight as barbed wire, an afternoon
that continues for months, that rises
around his legs like water
until the man is insane
and thinks the afternoon is a lake:
blue water, whitecaps, an island
where he lies under pale sunlight, one
red gardenia growing from his hand—

But that's not right either. There are no
flowers in these cells, no water
and I hold nothing in my hands
but fear, what lives
in the absence of light, emptying
from my body to fill the large darkness
rising like water up my legs:

It rises and there are no words for it
though I look for them, and turn
on light and watch it
fall like an open yellow shirt
over black water, the light holding
against the dark for just
an instant: against what trembles
in my throat, a particular fear
a word I have no words for.

—M. A. Jones, *Prison Letter,* 2011

I drive over a bridge, onto one highway and then another, off the highway and onto neighborhood streets. I double park my car and leave the blinkers on while waiting for my pass to park properly. Back in the car, I drive past red flashing lights and oversized stop signs until the houses and yards and street signs disappear into the distance. I park in a lot whose white lines have mostly been washed away by weather and pass through a building that smells like my parents' basement. I wait half an hour for a shuttle bus, then hold onto the seat in front of me as the driver swerves past barbed wire fences, stray cats, and seagulls pecking at the desolate ground. I leave my phone in a locker, sign a book with one of the golf pencils allowed on the inside, and pull down my mask to smile at an officer who stamps my hand and mutters *be safe*.

There are still Christmas decorations in the halls, and I shake my head at the half-inflated blow-up penguin flopping miserably beside the first of six gates I will pass through to reach the people I'm here to see. It's so hot in here my skin crawls, and I move farther and farther from sunlight and fresh air, deeper into the bowels of the building.

It is strange to come here, knowing that I can leave. The landmarks of incarceration—the gates, the flashing lights, the grim stains on the ground—speak of a place designed to be entered but not left, seen but not remembered. Still, I return again and again, like the seagulls landing amidst barbed wire, finding nothing to eat, then flying away. I am an outsider, and outsiders have an obligation to learn what it's like to live on the inside.

The embodied experience of incarceration is oppressive in quiet ways and louder ones: staying still in a cell, blood and dirt, scars and stains on the matching outfits everyone is wearing.

To dance and play here is radical. To cope is a revolution.

Defining Terminology

I have never been incarcerated. Having been privileged enough to remain free for my entire life, I have entered jails only as an outsider: a teacher, an artist, a student. I first set foot in a juvenile detention center when I myself was a teenager, helping teach Shakespeare to boys my own age who were locked up for minor offenses. Years later, I taught acting classes to adult men incarcerated in general population units at a jail; now, I return to that same jail as a student of dance/movement therapy, working with individuals housed in specialized mental health units. A student in the jail once told me he looked forward to acting class because it afforded him the opportunity to imagine himself into a different reality; I return again and again as the years go by with the hope of providing that same potential for liberation in thought if not in actuality.

Throughout this paper, I will be referring to both jail and prison, which are not interchangeable terms. A jail confines individuals who have been charged with a crime but not yet sentenced, while a prison holds people who have been sentenced for a set period of time (Dvoskin et al., 2021). Understanding this distinction is critical, because individuals incarcerated in jails have not yet been convicted of a crime and may still be found innocent. The time between arrest and sentencing is often long, however, and detainees may spend years in jail awaiting the conclusion of their trials (Dvoskin et al., 2021).

Jails operate at city, county, and regional levels and are designed to confine people for short periods of time (Dvoskin et al., 2021). In addition to holding pre-trial detainees, jails also hold people who have been sentenced to a year or less of prison time and are finishing out the remainder of their sentences (Dvoskin et al., 2021). From July 1st, 2020 to June 30th, 2021, local jails in the United States admitted 6.9 million individuals; the average daily jail population was

618,000 people (Zeng, 2022). The typical jail population in the United States turns over twenty to twenty-five times per year, as individuals go to trial and are either released or sentenced and sent to prison (Dvoskin et al., 2021).

The typical prison population, conversely, turns over approximately once every two years. Prisons operate at the state and federal levels and confine individuals serving sentences longer than one year (Dvoskin et al., 2021). If a person is charged with a crime then found guilty, they will generally spend time in jail before they are sentenced and then serve the remainder of their sentence in a state or federal prison. In 2021, the prison population of the United States was 1,204,300; in other words, 350 people were sentenced to serve time in prison per every 100,000 United States residents (Carson, 2022).

Throughout this paper, I will be referring to the people confined in jails and prisons as "incarcerated individuals," "incarcerated people," or "patients" (when referring to individuals who are receiving mental health treatment while incarcerated). I will not use the word "inmate" except in direct quotations from writers who have used this term. The words we use to refer to other people and ourselves have power, and the word "inmate" is othering by nature, suggesting that there is a clear and obvious distinction between "inmates" and "the rest of us" (Hayden & Huth, 2020). It should not be necessary to consciously reinforce the humanity of people confined in jails and prisons by explicitly stating that they are people, but we are operating within a system in which individuals charged with crimes are stripped of almost all of their societal power —in which incarcerated people are often denied access to basic resources such as food, water, clean clothes, and fresh air. The culture of incarceration intentionally creates a distinction between people who are incarcerated and people who are not incarcerated: there is a sense of

safety, confidence, and condescension associated with the belief that "those people" are separate from oneself and one's own experiences (Hayden & Huth, 2020). The word "inmate" reinforces this distinction and will not be used in this paper.

The Criminalization of Mental Illness

The United States has the highest incarceration rate in the world (Widra & Herring, 2021). As of 2023, approximately 1.9 million Americans are incarcerated, with another 4.9 million Americans having previously been to jail or prison (Sawyer & Wagner, 2023). This mass imprisonment—a rate of incarceration higher than the historical norm for affluent liberal democracies—disproportionately impacts Black people, poor people, and people with serious mental illnesses (Western & Muller, 2013).

At the time of a 2017 study, approximately 16% of incarcerated individuals were estimated to have serious mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder (Lamb & Weinberger, 2021). According to this estimate, the number of people with serious mental illnesses incarcerated in jails and prisons that year would have been around 345,985 (Lamb & Weinberger, 2021). In 2021, the rate of mental illness in prisons and jails was estimated to be anywhere from three to six times higher than in the community at large (Dvoskin et al., 2021). Rates of incarceration—and specifically rates of incarceration for people with mental illnesses—were not always so high; the descent into mass incarceration in America has been steady and insidious.

Prior to the 19th century, people with mental illnesses were generally cared for by family members in the home (Dvoskin et al., 2021). Methods of care and perspectives on mental illness varied widely around the world and across cultures, but the practice of caring for mentally ill

individuals was most often carried out within communities (Dvoskin et al., 2021). The early 19th century saw the rise of "moral treatment" in Europe and then the United States: people's beliefs around mental illness shifted, and many hypothesized that kind, gentle, rational treatment could lead to recovery for people suffering from what was then called "insanity." The moral treatment era coincided with the earliest asylums, which were designed to separate mentally ill individuals from society while they received care. The first asylums were private, geared toward the wealthy, and free of punitive behavior modification methods such as restraints and periods of isolation (Dvoskin et al., 2021).

While this system of caring for people with mental illnesses proved somewhat effective at managing symptoms within a safe environment, the asylum movement also served to widen the wealth gap: people unable to afford these expensive private facilities continued to maintain themselves with varying degrees of success in the community (Dvoskin et al., 2021). Already, people with mental illnesses who had fewer financial resources were being arrested and confined to jails and prisons. At the end of the 19th century, numerous states were answering calls from mental health advocates to open large public asylums. These public hospitals, originally designed to liberate mentally ill people from jails, rapidly became overcrowded, leading to worsened care, overworked staff, increased punitive measures, and poorer overall conditions (Dvoskin et al., 2021). By the 1950s, many of these public asylums had been closed as a result of advocacy against them—and nationwide, the number of beds for mentally ill people in hospitals had decreased dramatically (Dvoskin et al., 2021).

Outrage over the poor treatment of people committed to asylums was not the only impetus for deinstitutionalization (Lamb & Weinberger, 2021). Institutionalizing people was

expensive, for one thing, and federal programs funding community treatment, such as Social Security, Medicaid, and Medicare, offered lower cost alternatives. At the same time, the first antipsychotic drugs were being tested and found effective in treating people with schizophrenia spectrum disorders in outpatient settings (Lamb & Weinberger, 2021). New treatment options—and new methods for funding them—coupled with anti-institution advocacy to create a rapid process of deinstitutionalization, which took place without adequate planning or preparation. Ideas about new mechanisms for community treatment went mostly unrealized, and the majority of people with serious mental illnesses were returned to the community without sufficient resources to seek out, obtain, and maintain care (Dvoskin et al., 2021).

For the next several decades, individuals with mental illnesses were overwhelmingly left to their own devices, because community treatment was underfunded and generally unavailable. By the 1970s, the United States' criminal justice system was becoming increasingly punitive: "tough on crime" policies, coupled with the so-called "war on drugs," resulted in the arrest and incarceration of significantly higher numbers of mentally ill individuals (Dvoskin et al., 2021). These policies targeted not only individuals with mental illnesses but Black people in particular. Mass incarceration in the United States is inseparable from the systemic racism that underlies it (Western & Muller, 2013).

During the prison boom of the late 20th century, Black Americans were six to seven times more likely than White Americans to be incarcerated; the intersection of race and class inequities combined to confine disproportionately high numbers of poor Black Americans to jails and prisons (Western & Muller, 2013). The perpetuation of racism and racist policies through incarceration has only worsened over time: in the 1970s, the chances of a Black American man

with no college education serving a prison sentence was 12%; by 2013, that likelihood had risen to 35% (Western & Muller, 2013). This hyper-incarceration of Black men with less education (a measurable marker of poverty) represents an extreme form of oppression at the intersection of race and class, effectively denying full citizenship to many of the poorest Black Americans (Western & Muller, 2013).

Recent data suggests a slight decline in imprisonment rates among Black Americans but still indicates significantly higher rates of incarceration for Black Americans compared to other racial groups (Gramlich, 2020). At the end of 2018, there were 1,501 Black Americans imprisoned for every 100,000 Black American adults—nearly twice the rate of imprisonment among Hispanic Americans and more than five times the rate among White Americans. Rates were higher for Black men and highest in certain age groups: among Black men ages 35 to 39, approximately one in twenty individuals was incarcerated. Although Black Americans represent 12% of the population, they make up 33% of the prison population (Gramlich, 2020).

Structural racism is a determinant for health outcomes as well as criminal justice system involvement, and the elevated rates of incarceration among Black people, poor people, and people with mental and physical illnesses are all interrelated (Bailey et al., 2017). Research suggests that interpersonal discrimination as a psychosocial stressor has adverse effects on psychological wellbeing (sleep disturbances, eating patterns, consumption of psychoactive substances) and various biomarkers of disease (allostatic load, inflammatory markers, hormonal dysregulation) (Bailey et al., 2017). Furthermore, residential segregation—Black and White Americans predominantly living in separate neighborhoods—predicts poor health outcomes for Black Americans by way of substandard quality of environment, exposure to pollutants, and

limited opportunities for education and employment in mostly-Black neighborhoods. Negative health effects of residential segregation include adverse birth outcomes, decreased longevity, increased risk of chronic disease, and increased rates of homicide among Black Americans. Systemic bias in the treatment of Black people by healthcare systems, coupled with inequitable distribution of healthcare resources, results in lower quality care for Black Americans, and particularly for poor Black Americans (Bailey et al., 2017).

Black Americans are less likely to receive treatment for mental disorders than other racial groups as a result of this complex constellation of inequities, and, when receiving treatment, Black Americans are more likely to be incorrectly diagnosed than White Americans (U.S. Department of Health and Human Services, 2001). Black Americans have a longstanding history of over-diagnosis with psychotic illnesses and under-diagnosis with affective disorders (U.S. Department of Health and Human Services, 2001). Black Americans are also more likely to experience trauma and its psychological effects than White Americans, resulting in higher rates of post-traumatic stress disorder (Jäggi, 2016). Exposure to trauma, in turn, increases an individual's risk of criminal justice involvement: people exposed to trauma are more likely to engage in externalizing, aggressive, and oppositional behaviors, thus attracting attention from law enforcement. A 2016 study found that Black Americans who were exposed to traumatic events were five times more likely to be incarcerated than the general population (Jäggi, 2016).

The criminalization of poverty, racist policies, and deinstitutionalization combine to create shockingly high numbers of incarcerated individuals with serious mental illnesses. Today, the United States houses over three times more people with mental illnesses in prisons than in psychiatric hospitals (Fazel & Seewald, 2012). In a 2021 paper exploring the criminalization of

mental illness, Warburton and Stahl write that “the conditions of individuals with psychotic disorders have swung, like a pendulum, from institutional neglect to community neglect and back again over the past several hundred years” (p. 1). While in 1955 there was one bed in a psychiatric hospital for every 300 Americans, in 2005 there was one bed for every 3,000 Americans. From 1983 to 2010, the number of mentally ill individuals in jails and prisons almost tripled (Torrey et al., 2010). The criminal justice system in the United States has essentially transformed into an alternative for the mental healthcare system (Lamb & Weinberger, 1998).

Community-based mental health treatment could prevent people with mental illnesses from getting arrested in the first place (Lamb & Weinberger, 1998). Warburton and Stahl (2021) propose an ideal structure for continuity of care, in which community hospitals and crisis services are adequately funded, while patients receive access to housing, vocational support, peer support, therapy, case management, and psychopharmacology (Warburton & Stahl, 2021). With further reliance on assisted outpatient treatment (AOT), increased use of mental health courts, budget reallocations on the local and federal level, and a shift in treatment standards, it could be possible to reverse some of the disastrous effects of the last few decades and provide appropriate mental health treatment to individuals in the community (Torrey et al., 2010).

At present, the success of such services is limited by lack of funding and negative public sentiment toward people who are mentally ill and people who commit crimes. Critics of Alternative to Incarceration Programs (ATIs) do not believe that “criminals” should have free and easy access to services difficult for the general population to obtain (Fagan, 2003). Furthermore, some Americans uphold that incarceration reduces crime, advocating for the

confinement of individuals who engage in antisocial behavior in order to increase safety in the community (Western & Muller, 2013).

Currently, there is no consensus regarding the effects of incarceration on crime. Two contradictory hypotheses dominate the field: one suggests that incarceration does in fact reduce crime through deterrence and incapacitation, while the other indicates that incarceration may actually increase crime in the long-term (Western & Muller, 2013). At present, most research shows a mild reduction on rates of crime associated with incarceration. The impact of deterrence —preventing criminological behavior by threat of punishment—is not large, as people do not generally appear to weigh the likelihood of punishment when engaging in antisocial behaviors (Western & Muller, 2013). Incapacitation—preventing crime by removing individuals who might engage in antisocial behavior from society—does, however, seem to reduce criminological behavior at least in the short-term (Western & Muller, 2013).

In the long-term, data does not indicate a clear positive or negative effect of incarceration on crime (Western & Muller, 2013). Research does show, however, that prison increases the "criminal propensities" of incarcerated individuals (Dvoskin et al., 2021, p. 21). Prison culture encourages isolation, threatening behavior, manipulation, and gang involvement, resulting in an overall increase in conflict within jails and prisons (Dvoskin et al., 2021). While incarceration appears to have a criminogenic effect within jails and prisons, it is not known whether that effect carries over into the community once individuals are released (Dvoskin et al., 2021).

Apart from its potential impact on criminological behavior, incarceration appears to have serious negative social and economic effects (Western & Muller, 2013). Serving time in prison reduces an individual's employment and wage prospects, negatively affects the individual's

likelihood of forming a family, and diminishes the well-being of the individual's children (Western & Muller, 2013). Furthermore, the disproportionate representation of Black and poor Americans in jails and prisons perpetuates the systemic oppression that began with slavery and continues into the present day (Western & Muller, 2013). Formerly incarcerated individuals often face discrimination on the basis of race, class, (dis)ability, mental illness, sexuality, and substance use, in addition to the stigma associated with their history of incarceration—and formerly incarcerated people with multiple stigmatized identities suffer deleterious effects on their self-esteem and mental well-being (LeBel, 2012).

These negative impacts on well-being show up in various ways: individuals previously incarcerated for at least five years, for example, are more likely to meet the threshold for a serious mental illness than those beginning their first incarceration (Bronson & Berzofsky, 2017). Many of these individuals experience numerous traumatic events over the course of their incarceration, increasing their likelihood of suffering from post-traumatic stress disorder (Tapia, 2021). In a study of 7,500 incarcerated individuals, 35% of men and 24% of women reported being physically victimized in the last six months (Tapia, 2021). Another study found that 60% of incarcerated men who had experienced physical violence in their lifetimes suffered from symptoms of PTSD, compared to just 3-6% of men who experienced a traumatic event but were never incarcerated (Tapia, 2021). In addition to increasing violent behavior, perpetuating social isolation, and exacerbating symptoms of mental illness, incarceration also dramatically increases recidivism: nearly 80% of all individuals released from prison are arrested again with six years (Stringer, 2019).

Questions about the impact of incarceration on individual and community health are moral as well as scientific. Whose health matters more: individuals suffering from mental illnesses, individuals leading "normal" lives, poor communities, rich communities, or the nation as a whole? Who has the right to decide whose health and safety will be prioritized? Individuals with serious mental illnesses are disproportionately disenfranchised and disempowered and are more likely to receive treatment in a jail or prison than a hospital. What sort of mental healthcare is currently being provided in jails and prisons, and how can it be improved?

Mental Healthcare in Jails and Prisons

Jails and prisons across the United States have varying standards and systems for mental health treatment, though in most cases resources are limited and treatment is focused on medication and behavior management (Fagan, 2003). With underfunding and understaffing in most United States jails, many patients receive only the most basic care, including psychotropic medications and the possibility of being transferred to a psychiatric hospital for restoration of fitness (Fagan, 2003).

In 1971, the National Advisory Commission on Criminal Justice Standards and Goals was established to formulate standards for mental healthcare in local jails (Comptroller General, 1980). This nationwide investigation identified a significant deficiency in funding at the local level, concluding that states lacked the necessary resources to provide reasonable mental health services within their jails (Comptroller General, 1980). A second study of the same decade found psychotropic medication programs in every jail it investigated, though only 30% of the facilities offered any form of psychotherapy apart from medications (Steadman, McCarty, & Morrissey, 1986). In general, services focusing on behavior management within the jail were emphasized,

but long-lasting treatment that might impact individuals upon release into the community was neglected (Steadman, McCarty, & Morrissey, 1986).

A 2014 report on jails in Virginia found similar problems across the board in jail mental healthcare, indicating that little progress had been made in more than forty years (Office of the State Inspector General, 2014). The review indicated that local and regional jails had insufficient resources to implement mental healthcare, increasing patients' risk of deteriorating during the course of their incarceration. Medication management was the primary form of mental health treatment offered in the jails studied, and emphasis was placed on control and safety rather than treatment during acute episodes of mental illness (Office of the State Inspector General, 2014).

In recent years, several innovations in jail mental healthcare have yielded promising results (Police Executive Research Forum, 2018). For instance, one jail in Louisiana hired a medical psychologist to provide more accurate diagnoses and comprehensive care, seeing a 67% reduction in pharmaceutical costs as a result of increased accuracy in diagnosing. In some remote areas, jails have begun implementing telepsychiatry programs, allowing clinicians to provide services to patients and offer guidance to staff members from afar. One Minnesota jail hired its first ever mental health professional, a clinician who provided psychoeducation for both incarcerated individuals and staff on misconceptions about mental illness. In several jails throughout the country, Crisis Intervention Team (CIT) training, de-escalation training, and mental health first aid courses are now mandatory for corrections officers (Police Executive Research Forum, 2018).

In New York, researchers recently piloted a boundary-spanning approach for individuals with serious mental illnesses who were psychiatrically hospitalized during their incarceration

(Bursac et al., 2018). Throughout this program, vulnerable individuals requiring acute hospitalization were followed between jail and the hospital by a clinician providing continuity of care through non-pharmacological supportive therapy. Patients receiving boundary-spanning care showed significant reductions in hospitalizations and suicide watches; this innovative approach positively impacted the mental health stability of clinically complex patients (Bursac et al., 2018).

Many jails and prisons now offer specialized units for mentally ill individuals, facilitating access to care for the most vulnerable patients (Holton, 2003). In North Carolina prisons, Therapeutic Diversion Units divert individuals with serious mental illnesses away from restrictive housing (i.e. solitary confinement), which is associated with worse mental and physical health outcomes (Remch et al., 2021). These multidisciplinary treatment units incorporate recreation, behavioral therapy, relationship-building, and social skill development. Therapeutic Diversion Units and other similar programs are a promising solution for keeping people with serious mental illnesses out of restrictive housing (Remch et al., 2021).

There are, however, numerous obstacles to classifying individuals into these specialized units (Holton, 2003). Bed space is usually limited, so only patients presenting with obvious symptoms of psychotic or major mood disorders are able to be accommodated. Furthermore, the right to move individuals in and out of different facilities often belongs to corrections officers rather than mental health staff, meaning that classifications are made based on security rather than clinical need (Holton, 2003). With limited staff and funding, patients with the most severe and apparent needs are prioritized, and individuals with less-pressing (but still urgent) needs slip through the cracks (Fagan, 2003). In fact, a 2006 report by James and Glaze found that only a

third of individuals in state prisons in the United States had received mental health treatment since admission to their facility (James & Glaze, 2006). Jails and prisons are simply not equipped to provide services to the large number of individuals with mental illnesses who are housed within them (Dvoskin et al., 2021).

The barriers to sufficient care are numerous, and may be divided into three levels: the individual level, the staff level, and the systemic level (Dvoskin et al., 2021). It is worth noting that all barriers to care are in fact systemic, rooted in oppression, stigma, and cultural perspectives on incarceration; however, in an attempt to make sense of the various processes preventing incarcerated patients from receiving care, it is useful to categorize the obstacles according to their impact.

On the individual level, patients themselves may avoid seeking mental health treatment due to the influence of prison culture. Any person housed in a jail or prison for a period of time —whether that person experiences mental illness or not—is vulnerable to the influence of "prisonization" (Dvoskin et al., 2021). In jails and prisons, people tend to take on certain behaviors in order to stay safe and appear strong, including reliance on threats and intimidation, use of manipulation tactics to achieve goals, reluctance to discuss problems, and a preference for isolation (Dvoskin et al., 2021). As in any group, individuals adjust their behavior to "belong." In jails and prisons specifically, people take on more violent and isolative behaviors in an attempt to fit in with their peers (Dvoskin et al., 2021).

As a result of prisonization, individuals may avoid taking medications or engaging with mental health services on any level: appearing weak, vulnerable, or aligned with staff is dangerous, and the risk of being singled out is high (Holton, 2003). Furthermore, many

psychotropic medications dull the senses—and since decreased reaction time could be deadly in a jail or prison, some individuals refuse medications in order to stay safe (Holton, 2003).

So-called "bad behavior" stems not only from prison culture but also from mental illness symptoms. "It is not uncommon," writes Holton (2003), "for a mentally ill inmate to receive a conduct or disciplinary report for inappropriate behavior, even though the behavior demonstrated was actually the product of a mental illness. For example, an inmate may be charged with disrupting an institutional count because he or she is talking, even though he or she is doing so in response to auditory hallucinations" (Holton, 2003, p. 103). Showing signs of mental illness may result in disciplinary measures such as punitive segregation, leading to feelings of hopelessness, desperation, and anger (Holton, 2003).

Incarcerated individuals are not the only ones susceptible to prison culture: staff members who spend much of their days behind bars will also inevitably adapt to these same unspoken, unwritten rules (Dvoskin et al., 2021). Staff are vulnerable to many of the same variables as incarcerated individuals: submitting to hierarchies, avoiding the image of weakness, and rewarding attention-seeking behaviors (Dvoskin et al., 2021). Mental health professionals who understand the impact of prison culture may, rather than grappling with it, choose to avoid the setting altogether. "Even when adequate funding is available for mental health staff," Fagan writes, "sometimes it is difficult to find mental health professionals who are willing to work within a correctional environment. Many view this environment as unwelcoming and antithetical to the objectives of treatment" (Fagan, 2003, p. 7). Many mental health professionals prefer not to work in a correctional setting because the environment itself is so hostile. The staffing shortages resulting from these attitudes, however, negatively impact the services patients receive,

further contributing to the hostile environment that so many clinicians want to avoid (Steadman, McCarty, & Morrissey, 1986).

The limited number of staff willing to work in jails and prisons, coupled with the high number of individuals with mental illnesses who are incarcerated, constitutes a serious systemic issue. Overcrowding in jails and prisons presents such a significant problem that it may overshadow all other concerns. "…No matter how important mental health care may be," write Steadman, McCarty, and Morrissey (1986), "the provision of adequate space and food necessarily assumes a greater priority" (p. 112). Without sufficient funding, space, or staff, incarcerated individuals are denied necessities such as clean spaces to sleep, access to fresh air, and even food and water. In such a crisis, mental healthcare becomes a secondary concern (Steadman, McCarty, & Morrissey, 1986).

Pervasive negative attitudes among the general public toward incarcerated individuals pose another barrier to treatment. Critics of correctional mental health suggest that incarcerated individuals may be too comfortable and privileged, receiving access to free services when they should be "punished" instead (Fagan, 2003). In actuality, the isolation and lack of control associated with incarceration are far more punishing than can be imagined by people who have never been to jail (Dvoskin et al., 2021).

The barriers to treatment operating at the individual, staff, and systemic levels contribute to a vicious cycle of incarceration, wherein mentally ill individuals experience a continual worsening of symptoms, resulting in repeat incarcerations and chronic prisonization (Fazel & Seewald, 2012). There is a profound need for funding and resources, including more beds in mental health units, staff training focusing on biases toward mentally ill incarcerated individuals,

and increased collaboration among mental health disciplines to combat the culture of incarceration and provide adequate, appropriate services (Holton, 2003). Within a system of chronic traumatization, patients deserve care that is specific, consistent, and targeted to their individual needs.

Community-building, self-expression, autonomy, empathy, and acknowledgement of individual humanity are missing from typical models for mental healthcare in jails and prisons. The need for embodiment and empowerment is profound. One modality that may offer humanistic, relational, integrated care to incarcerated individuals is dance/movement therapy.

Dance/Movement Therapy in Jails and Prisons

Dance has been a mechanism for creative expression, pleasure, celebration, and healing for thousands of years (Ritter & Low, 1996). People dance in circles and create rhythms and build community through movement all around the world. The physical, emotional, and spiritual components of dance make it organically and inherently therapeutic (Chaiklin, 2009). Dance/movement therapy is built upon the healing tradition of dance, bringing together ritual movement practices with psychological theories and a mind-body approach to understanding and treating mental illness. Dance/movement therapy is distinguished from other somatic healing practices by its emphasis on contemporary psychological theories and research; it is distinguished from other psychological fields by its emphasis on body movement as a tool for observation, assessment, and treatment (Bartenieff & Lewis, 1980).

The field of dance/movement therapy is broad, incorporating a wide array of techniques, practices, and approaches. Marian Chace, sometimes recognized as the “mother” of dance/movement therapy, stood or sat in a circle with her patients and encouraged familiar,

uncomplicated, rhythmic body movements until the patients began to move spontaneously and synchronously with one another, working toward self-awareness and emotional release (Chace, 1975). Mary Whitehouse, another early practitioner in the field, brought together psychoanalytic theory and artistic expression, using the Jungian concept of active imagination to facilitate an exploration of "depth" through improvisation (Whitehouse, 1977). A student of Whitehouse, Janet Adler formulated a process called Authentic Movement, in which a witness (often a therapist) observes a mover (often a patient) moving spontaneously with their eyes closed. Afterwards, the mover and witness verbally process the experience, bringing the mover's unconscious into conscious awareness (Adler, 1985).

Contemporary dance/movement therapists often incorporate elements of neuroscience into their practice, enhancing emotional understanding and empathy through mirroring (imitating or merging with another person's gestures and movement patterns) (McGarry & Russo, 2011). In Hong Kong, some dance/movement therapists focus on the interrelationship between psyche and soma, integrating the Chinese cultural belief in mind-body connection; in Haiti, practitioners work with Haitian movement traditions, using a ceremonial circle formation and therapeutic drumming to create a familiar, collective, culturally relevant experience for young trauma survivors; in Argentina, victims of torture use "body-in-movement integration" to rebuild their physical, emotional, cognitive, and social selves; in Japan, self-expression is inspired through the practice of ancient *shirabyoushi* court dances (Capello, 2010).

A 1996 meta-analysis by Ritter and Low remains one of the more comprehensive accounts of the effectiveness of dance/movement therapy as a psychotherapeutic practice. The paper concludes that, while well-designed quantitative experiments are lacking, qualitative

studies indicate that dance/movement therapy may be effective in treating a wide range of problems, including psychotic illnesses in inpatient settings, anxiety, motor skills in children with developmental disabilities, and range of motion in the elderly (Ritter & Low, 1996). More recent research indicates that dance/movement therapy may be effective in enhancing the development of empathy (McGarry & Russo, 2011), reducing negative symptoms of schizophrenia (Lee et al., 2015), and reducing psychological distress over time (Bräuninger, 2012).

Dance/movement therapists work in psychiatric hospitals, schools, outpatient clinics, nursing homes, addiction recovery centers, and numerous other settings (Chaiklin, 2009). Jails and prisons are among these settings; internationally, dance/movement therapists use a variety of techniques to meet the unique needs of this population.

The breadth of research on dance/movement therapy in jails and prisons is limited, but the potential for further investigation is promising. There are few quantitative findings or long-term studies (Milliken, 2008), and much of the research focuses on the subjective experiences of the authors. The goals explored are indicative of both the strengths of the field and the specific needs of the population: objectives include embracing humanity under grim conditions, building group cohesion, developing autonomy, and reducing anger and aggression.

A 2008 paper by Seibel offers one of the most compelling cases for the effectiveness of dance/movement therapy in prisons. For several years, Seibel led monthly dance/movement therapy groups in a women's prison, recording the techniques and interventions she used as well as her impressions of the participants. Over time, she witnessed the women who took part in her groups becoming comfortable with the therapeutic process and one another. "At the end of each

session," she writes, "the women seemed visibly different. They were consistently appreciative, more communicative, more related, with their muscle tone relaxed and their interpersonal skills improved. Hostility and sarcasm had melted, replaced by calm expressions of gratitude" (Seibel, 2008, p. 108). Seibel's primary goal was helping the patients "tune into themselves amidst [the] inner chaos and external rigidity of prison life" (Seibel, 2008, p. 107).

Milliken makes similar observations in a 2002 article describing her experiences leading dance/movement therapy groups with men in a jail addictions' recovery program. Like Seibel, Milliken noticed a sense of harmony and peace in her groups, suggesting that the patients may have experienced feelings of belonging otherwise absent from their lives (Milliken, 2002). Having witnessed her patients moving freely, she posits that dance/movement therapy allowed them a feeling of freedom in their bodies, although they were not "free" in any literal sense. Milliken takes note of the group's ability to "…create a movement experience that transcends the ordinary, somewhat grim reality they live in…to put aside normal, 'tough' ways of relating and to remember themselves in a world which felt different, safer, freer and for a moment open to great possibility for them" (Milliken, 2002, p. 205). She lists this potential for transcending reality as a primary objective of dance/movement therapy in jail.

Oktay explores the relationship between the harsh environment of the unit and the vulnerability within groups in a 2010 article detailing her experiences as a dance/movement therapist working with men on an inpatient forensic unit (Oktay, 2010). She notes that the forensic setting presents unique challenges, with its hostile and often punitive atmosphere and systematic deprivation of liberty, autonomy, and security. Using Marian Chace's techniques, she inspired patients to move while supporting change and natural development (Oktay, 2010). "On

the forensic unit," she writes, "physically joining the patients, moving as they move and validating their expressions, is particularly relevant because so much of their experience outside the group is about being told what to do and how to do it" (Oktay, 2010, p. 12). While creative expression in the forensic environment is challenging and often perceived as taboo, Oktay observes that profound communication occurs on a body level during dance/movement therapy groups, revealing a need to be "accepted, seen, and trusted" (Oktay, 2010, p. 19).

Dancers teaching in jails and prisons have observed similar themes: transcendence, liberation, and the emergence of group identity. In a 2017 paper, Mortimer presents three qualitative interviews with teaching artists working in New Zealand prisons, all of whom suggest that dance provides a positive and rehabilitative learning experience for their students (Mortimer, 2017). The teachers' experiences vary, but there is a general consensus that dance classes promote enjoyment, excitement, and exploration (Mortimer, 2017). Dunphy (1999) presents similar impressions from staff and participants involved in a dance program at Washington Correction Center in the United States. Participants in this program describe the process of preparing for a dance performance as transformational, turning them into a team with a clear purpose. Staff recall observing positive interactions between members of rival gangs and an overall intimate, supportive atmosphere (Dunphy, 1999). Studying dance may have offered a positive outlet for these individuals, creating the opportunity to be viewed "as multi-aspect humans and not just criminals" (Dunphy, 1999, p. 42).

While the papers discussed thus far focus on helping individuals reconnect with their humanity and forge connections with one another, additional studies identify the reduction of anger and aggression as a primary objective.

In her second paper, Milliken (2008) again reflects on her experiences in the jail addictions' program, this time focusing on participants' feelings of anger and shame. The objectives of her second study include releasing tension, re-experiencing painful memories in the present, learning how to be in relationship with others, and developing awareness of the physical components of recovery, with the ultimate goal of reducing anger and shame in the participants (Milliken, 2008). Milliken describes the transformational power of warming up, stretching, and developing awareness of self and others, concluding that the mind-body approach of dance/ movement therapy has potential to intervene in the cycle of anger and shame that accompanies addiction and incarceration (Milliken, 2008).

In a 2001 unpublished thesis, McNamara also focuses on reducing anger, aggression, and potential for violence through dance/movement therapy (2001). Like Milliken (2008), she conducts her research on dually diagnosed individuals—patients diagnosed with a substance use disorder and at least one other mental illness—who are housed in forensic hospitals (McNamara, 2001). Although she outlines numerous objectives similar to the ones found in other dance/ movement therapy research—increased impulse control, improved ability to identify and express affect, expanded movement repertoire, healthier creative expression—her conclusions focus on the reduction of anger (McNamara, 2001). She does not find a decreased potential for violence in her participants after eight weeks of dance/movement therapy, but she speculates that a longer-term intervention might address issues of impulse control and anger management (McNamara, 2001).

Sweijsters and Cleven (2006) investigate the goals, interventions, and impact of creative arts therapies in forensic institutions in the Netherlands; in the section of their paper focusing on

dance/movement therapy, they highlight its potential for behavior modification. The goals of creative arts therapy in jails and prisons as enumerated in the paper include regulation of tension, increased impulse control, regulation of aggression, planning and structuring of behavior, and development of interaction competencies (Sweijsters & Cleven, 2006). The authors suggest that dance/movement therapy specifically may be effective for modifying behavior, allowing patients to re-live past experiences within a safe and controlled environment:

> The patient can use his body to hunt the therapist or another patient into a corner of the room. The same physical, emotional and behavioral processes are evoked as have been experienced in the offensive act. But there is analogy because in therapy this is play and not a real offensive act. The dance-movement therapist by means of rules can offer the opportunity on the one hand to experience the same physical, emotional and behavioral processes, and on the other hand to put these into play where they can be controlled and where there is no harm done to others. (Sweijsters & Cleven, 2006, p. 44)

In this example, reenacting past experiences is identified as an objective of dance/movement therapy, with the ultimate goal of changing present and future behaviors.

A 2019 study by Tepper-Lewis focuses on improving self-restraint skills in incarcerated adolescents. The author relates self-restraint to recidivism and proposes the goal of reducing re-offending by increasing self-restraint through the use of dance/movement therapy (Tepper-Lewis, 2019). Tepper-Lewis conducted weekly individual dance/movement therapy sessions with participants, using the structure of Marian Chace: a warm-up followed by a thematic development phase and a closing exercise (Tepper-Lewis, 2019). One of the only forensic dance/movement therapy papers to include quantitative data, the study shows increased self-restraint

scores in two out of its three participants (Tepper-Lewis, 2019). Tepper-Lewis suggests that dance/movement therapy may have been effective for these two participants due to its potential for strengthening emotional expression and offering new behavioral choices as well as its rehabilitative nature (Tepper-Lewis, 2019).

The techniques outlined across the board in forensic dance/movement therapy research include synchronous movement, re-enacting past experiences, creating collective rhythms, mirroring, and developing group identity. Transcending a harsh reality, experiencing a sense of liberation, building prosocial relationships, and reducing anger and aggression are identified as primary goals. While these studies touch on joyful self-expression as a tool for healing under harsh conditions, conclusions more often focus on behavior modification and reducing anger than on developing coping skills and experiencing joy. Dance/movement therapy brings people closer to themselves and the world, and the facilitation of embodiment in jails and prisons may create a profound sense of liberation. One mechanism for unleashing joy, laughter, soothing, and connection is the embodiment of fantasy, a technique grounded in the theories of early dance/movement therapist Trudi Schoop.

Trudi Schoop and the Embodiment of Fantasy

Trudi Schoop's theoretical framework is based on the fundamental belief that all human beings deserve to live, dance, and be joyful: "I believe," she reflects, "that all people have a right to be here, and that being here has an important reason. I would really like to make people believe that. And I also believe that to dance is wonderful" (Wallock, 1983, p. 12). Schoop—a dancer, comedian, teacher, and early dance/movement therapist—spent the 1920s, '30s, and '40s touring Europe and receiving international acclaim for the comedic value and political power of

her performances. In the 1950s, she moved to the United States and began dancing with patients at the Camarillo State Hospital in California (Chodorow et al., 1999). She was among the first to write about dance as a technique for healing in the context of psychological theory and practice, and her 1974 book *Won't You Join the Dance?* is foundational to the field of dance/movement therapy.

Schoop was described by her friends, collaborators, and students as encouraging and energetic, with a zest for life and a deep understanding of her own fears and anxieties. In old age, she appeared full of vitality, with a desire to convey her excitement about transforming individuals' lives through dancing alongside them (Wallock, 1983).

Schoop worked primarily in psychiatric hospitals with individuals diagnosed with psychotic illnesses. She describes in vivid detail the "atmosphere of abstraction" in the hospitals where she worked: the wards, she writes, were "worlds of dreams" within which a "ballet of delusions" played out among the patients (Schoop & Mitchell, 1974, p. 24). Schoop's approach to her patients' relationship with reality was unique at the time (and perhaps even now): she engaged in reality-testing that was individualized, encouraging, supportive, and empowering. She believed in joining rather than resisting—understanding rather than dismissing her patients' fantasies (Schoop & Mitchell, 1974).

According to Schoop, it is through the body that we experience our reality: our senses tell us who and where we are, and our beliefs and ideas and thoughts and feelings are rooted in our physical beings. If a person can begin to draw connections between mind and body—between what is believed and what is experienced, between imagination and reality—then they may learn to differentiate the world around them from the world they envision. "I feel," Schoop writes,

"that rather than suppressing the fantasy of a psychotic individual, we should fly with him for a while, then descend with him for a soft landing on this earth. In giving shape to his visions, he will create a work that fuses fantasy and reality" (Schoop & Mitchell, 1974, p. 150). Schoop believed that joining her patients in their fantasies ultimately allowed them to become more grounded, more secure, and more self-aware. After all, if an individual shares their secret world with another person, they may begin to evaluate their beliefs from a different perspective and discover a healthier balance between their delusions and reality.

The goal of Schoop's work was not to push individuals deeper into psychosis but rather to establish the interactive relationship between their fantasies and the real world in order to find equilibrium. She writes:

> …My belief in the positive nature of fantasy has never diminished. It allowed me the freedom to understand a patient, who lives in his dreams, where the impossible is possible. To a certain extent, at least, I can follow him into those regions. I can show him the other side of our world: the physical and practical side. I can connect this side to his fantasies, showing that he can dream with his feet on the ground; and make him aware that both sides exist within him. My ultimate hope is to gradually bring him into balance as a 'global' or total person, in whom there is a place for both reality and fantasy. (Schoop, 2000, p. 100)

Schoop's theory may be extended to individuals outside of psychiatric hospitals and to patients experiencing all different kinds of emotions and situations and problems. Everyone dreams; everyone fantasizes. The expression and embodiment of fantasies in a dance/movement therapy context is not limited to psychosis and reality-testing; in fact, the use of fantasy and

imagery is empowering for everyone. Schoop developed thematic elements that arose in her groups through the use of imaginative play and exploration—what a child might call "let's pretend" or an actor might call "improvisation." The specific elements that arose in these explorations of fantasy related metaphorically to the real-world concerns of her patients (Wallock, 1983). She gently nudged the individuals with whom she worked toward noticing these connections and experiencing them with their bodies as well as their minds. Schoop describes the process of working with thematic imagery in a 1983 interview with Wallock:

> For example, I might work with the theme of circles. When you put a stone in water, circles form. Man sometimes goes in circles. Cooking—stirring—makes circles. So in a session I might say, 'Why don't we try to cook soup?' Then something very interesting happens with everyone: their realism is more or less out. You mad add 'salt' or just as easily, add something else that is good! You add beauty and a lot of fantasy and the soup becomes something that, in a very small way, connects those two worlds. (Wallock, 1983, p. 12)

People fantasize for different reasons—to distract, to cope, to regulate, to soothe, to stimulate, to excite, to explore—and embodying the fantasies that otherwise reside entirely inside our imaginations allows us to physicalize what is otherwise untouchable. Perhaps we realize what we desire or fear—perhaps we notice that these things are nearby or faraway, achievable or unattainable. Perhaps we draw connections between the world around us—another person in the room, the floor under our feet, the light streaming in through the windows—and our most secret reveries. Dance bridges the gap between fantasy and reality because we live in the world with our whole beings (Wallock, 1983).

Active Escapism

Trudi Schoop's concept of fantasy differs from the traditional use of the word in psychoanalytic theory. In much of dance/movement therapy literature, fantasy is situated in relation to the Jungian concept of active imagination: exploring the subconscious by embodying dreams and suppressed desires (Whitehouse, 1979). Schoop's definition may be more expansive: she writes about the fantasies of her patients not exclusively as manifestations of the subconscious, but as expressions of creativity, imagination, and identity. Fantasy as conceived by Trudi Schoop may have more in common with the concept of escapism than with psychoanalytic theory and active imagination.

Escapism as a term in popular culture has developed an almost entirely negative connotation. We associate escapism with procrastination, addiction, and avoidance. The term rarely shows up in dance/movement therapy literature; Schoop herself never uses it. Still, the concept delineates an important distinction between fantasy in the psychoanalytic sense and fantasy in the imaginative sense and may be helpful in exploring the therapeutic potential of acting out one's fantasies in a dance/movement therapy context.

For lack of research on escapism within the field of dance/movement therapy, I turn to an unexpected and apparently unrelated field: consumer marketing of video games. Escapism is an essential tenet in the academic literature about video games, and recent research highlights the potential of escapism to promote growth and change.

In video game research, escapism is broadly defined as the concept of "getting away from it all" and divided into passive and active forms (Kuo et al., 2016). Passive escapism in media includes watching television or reading a book: engaging in imaginative fantasy without actively

choosing how the story will progress. Active escapism constitutes transportation and immersion into a fictional reality wherein the individual interacts with the imaginary world (i.e. video games). Players of video games may project themselves onto characters who share a similar self-concept to their own, transporting themselves into the world of the game through the perspective of their chosen character (Kuo et al., 2016).

Kuo et al. (2016) argue that active escapism is purpose-driven. Through interviews with individuals who engage in active escapism, the authors identify similarities between the individuals' real-world stressors and the ways they choose to engage with games. Themes that emerge among the subjects interviewed include feelings of helplessness in real life coupled with feelings of control, power, and security within the worlds of their favorite games. Kuo et al. suggest that escapism through video games may be a positive coping mechanism for these individuals, allowing them to experience affirmation and empowerment in order to cope with the stressors they face in their lives (Kuo et al., 2016).

Does dance/movement therapy evoke presence and transportation in a similar way? Can active escapism be embodied as a mechanism for coping with real-world problems that are causing distress?

Embodied escapism may allow for freedom of movement and thought that is otherwise prohibited, restricted, or feared. An individual playing a video game creates a character who represents certain aspects of themselves; similarly, a dance/movement therapy patient may choose to embody aspects of their identity that please or frighten them—for instance, they may move like a god, or a king, or a warrior, or a child. They may act out desirable situations, such as driving in a race car, going to the beach, winning an award, or cooking a delicious meal. In these

fantasies, there is strength, self-awareness, and attunement to the collective unconscious that dreams of being somewhere (or someone) else. In a jail setting, a patient enacting aspects of their imagination may uncover the feelings beneath the fantasies, developing mechanisms for coping with an environment that otherwise feels inhospitable.

Jimmy Santiago Baca writes about the power of creative self-expression during his incarceration. He reflects:

> Through language I was free. I could respond, escape, indulge; embrace or reject earth or the cosmos. I was launched on an endless journey without boundaries or rules, in which I could salvage the floating fragments of my past, or be born anew in the spontaneous ignition of understanding some heretofore concealed aspect of myself. Each word steamed with the hot lava juices of my primordial making, and I crawled out of stanzas dripping with birth-blood, reborn and freed from the chaos of my life. (Baca, 2011, p. 103)

For Baca, writing offered the bridge between fantasy and reality discussed by Schoop, allowing him to heal, cope, and begin to live fully. Baca found liberation through language; others may find feelings of freedom through a process of embodiment.

Discussion

Transcending A Harsh Reality

Victor Hassine, reflecting on his incarceration at Graterford State Prison, writes:

> If I made eye contact with a stranger, I would feel threatened. An unexpected smile could mean trouble. A man in uniform was not a friend. Being kind was a weakness. Viciousness and recklessness were to be respected and admired. I could feel my habits, my personality, and even my values change. I came to view the world as a place of unrelenting fear. Oddly enough, these changes were in some ways comforting. In the struggle to survive, it was easier to distrust everyone than to believe in their inherent goodness. (Hassine, 2011, pp. 19-20)

It is difficult to convey the feeling of prison to someone who has never been behind bars, because the pervasive culture of performative masculinity, strength, and resourcefulness is so specific to the stale, suffocating atmosphere in the halls, units, and cells. When the only way to receive attention from staff is to start a fight, you will fight; when the only way to make friends is to sell your commissary, you will sell it; when the best way to avoid being assaulted is to keep to yourself, then you will be alone.

It is easy to associate violence in jails and prisons with qualities inherent to the people incarcerated there, but correlating the two reflects a narrow, superficial perspective on a nuanced situation. Fighting in jails and prisons does not necessarily have anything to do with anger or impulsivity—it may have more to do with hunger, exhaustion, and discomfort. No human being feels calm and collected when they are overstimulated and malnourished; no one is on their best behavior when they have not slept or showered. When people are denied basic resources—a safe

place to sleep, nutritious food to eat, access to fresh air and clean clothes—they will be stressed, hyper-vigilant, and reactive, all of which are symptomatic of inherent flaws in the system rather than indicative of "bad behavior."

Much of jail mental healthcare is focused on behavior management; even within the field of dance/movement therapy, addressing anger and aggression is often a primary objective. This emphasis on behavior change exposes a fundamental misunderstanding: if people knew how to express their anger, they would not commit crimes. Both inside and outside of jails and prisons, people engage in violent, antisocial behavior for a wide variety of reasons, many of which have nothing to do with aggression or impulsivity (Dvoskin et al., 2021). As a society, we deem certain behaviors antisocial and others prosocial, and our justice system distinguishes between "illegal" and "legal" according to these codes and values. But individuals differ in their moral beliefs: some behaviors deemed "illegal" may be justifiable according to certain people's values (i.e. stealing food from a wealthy corporation to feed one's family), while behaviors deemed "legal" may be considered immoral (i.e. a wealthy corporation with a billionaire CEO paying its workers minimum wage). Behaviors are grounded in context; human beings act differently when they are hungry than when they are fed, when they are tired than when they are rested, when they are sick than when they are healthy, when they are comfortable than when they are deprived, oppressed, or stigmatized. It is a vast oversimplification to assume that individuals who engage in antisocial conduct do so because they are inherently violent, immoral, or angry. A focus on anger reduction in jails and prisons fails to address the complex reality of criminological behavior.

Take, for example, the case of a composite patient, invented for the sake of this paper but born from real-world experiences: he is an adult Black man in his twenties living in the United States. He has been living on the street and has no family; he has been physically, sexually, and emotionally abused. He experiences visual and auditory hallucinations and was diagnosed with schizophrenia in his early twenties after being hospitalized for a suicide attempt. He has spent most of the last decade moving between jail, hospitals, and the street, and he has endured chronic, complex trauma in all of these settings.

Because this composite patient is incarcerated, he may receive counseling focused on managing his anger and improving his behavior. But anger is not a primary concern for him; instead, his complex trauma, schizophrenia symptoms, and unmet needs are more pressing. In therapy, he should address the intersectional traumas of poverty, homelessness, and racism, as well as stigmas associated with his incarceration and mental illness. He should engage in reality-testing and grounding to explore and manage his positive symptoms of schizophrenia, and he should co-create coping mechanisms to manage the stress associated with homelessness and incarceration. In a jail or prison, it is difficult if not impossible to address all of these needs—after all, dealing directly with traumatic memories while being consistently re-traumatized may do more harm than good. The difficulty of addressing trauma as it is occurring does not mean there is no hope for therapy within the jail environment, however; on the contrary, dealing with traumatic events as they are happening may prepare an individual to integrate and manage both past and future traumas. The incredible healing power of learning to cope should not be diminished.

Dance/movement therapy is particularly well-suited for helping individuals cope with present traumas. Embodying wishes, dreams, and desires may help patients manage their emotions in the present moment while exploring new possibilities, situations, emotional states, and ways of being. Schoop's work with fantasy offers an outline for dance/movement therapists working in all settings who want to help their patients experience both joy and grounding. While Schoop describes joining her patients in their imaginary worlds amidst the dreamlike atmosphere of the hospital ward, a dance/movement therapist working in a jail or prison may join patients in imaginative play amidst the chaotic and often oppressive atmosphere of the housing unit.

How does embodied escapism actually look in a dance/movement therapy group in a jail? At my clinical internship, I lead dance/movement therapy groups for incarcerated individuals following Schoop's framework, focusing on the collective embodiment of fantasies. While I cannot offer examples from the groups I lead out of respect for the patients' privacy, I can provide descriptions of hypothetical groups and scenarios based heavily on the themes that have emerged in reality. None of the "patients" I will describe actually exist, but the group structure, imagery, and emotions are drawn from numerous groups I have led over the course of several months working in the jail.

Group #1

It is loud on the mental health unit, with doors to cells clanging like medieval dungeons as they slide open and closed. On any given day, there is at least one individual yelling from inside his cell and perhaps several others shouting back to him. There are one or two people talking on the phone and a group of four or five playing cards at a table, which is steel and bolted to the ground. There is an individual standing in the corner and singing along to a song on the

radio. Two more men watch the news, which plays at a low volume from the television in its little cage on the wall. One of the officers laughs at a joke while another listens with a tired expression on her face. One man lies on the floor with a blanket over his head. Someone else does pushups beside him.

Dance/movement therapy includes everyone who is there that day: the individuals who choose to join the therapy group as well as the people talking on the phone or sleeping in their cells, and the officers, and the mental health staff, and the man lying with his blanket over his head. All of the noise and feelings and stress and solidarity and restlessness of the milieu make their way into the dance/movement therapy session, because therapy does not happen in a vacuum—and in jail, the environment is inescapable.

The group begins as soon as the therapist enters the unit. She greets each individual in the common area and asks if he would like to join the dance/movement therapy group; the men who decide to join follow her into the glass-walled group room and form a circle. Right away, one individual begins tapping his fingers rapidly against his leg. The therapist asks if the group can join him in this movement, and he agrees. As the group members begin tapping their legs with their hands, the gesture changes—now the group is making a rhythm together: slowing down, settling in. The rhythm is light and steady, and another patient observes that it sounds like rain. Now the idea of rain is present in the collective unconscious, and a few people begin shifting side to side as if their bodies are rocking with the wind. The therapist asks what they are imagining, and one man reflects that they are standing outside in a rainstorm together. They begin to rock more strongly, and perhaps the sounds of the milieu (the shouting, laughter, and phone conversations) come together to form a storm of human bodies, human sounds, and human

feelings. The group is moving faster now, and the rhythm grows louder and stronger. The rhythm created by the group seems to find the same cadence as the rhythm on the unit (or perhaps that rhythm is changing to mirror this one). One individual observes that he feels stressed out by all these sounds, and another shakes his head and laughs.

The laughter is contagious, and someone else laughs, kicking his feet in the air as he does so. The therapist asks whether the gesture feels familiar, and another individual observes that he appears to be kicking up water that has collected on the ground. Someone else jumps, loud and hard and suddenly, and it startles the group. He informs everyone that he's jumping in puddles; a few other people join in. It is a fantasy grounded in memory—or perhaps in the idea of a memory—and it is childlike and playful. One man sits down with his arms crossed, stating that he is too old to play around like this. His peers cajole him until he stands back up, kicking half-heartedly at an imaginary puddle on the dry ground.

The group members gather around him, and the rhythm slows and becomes more steady. The fantasy of the storm is coming to an end, and there is less tapping and shifting in the patients' bodies than there was before the storm. In the collective unconscious of the group, the rhythm of the unit and the "storm" of emotions contained within it have been physicalized, embodied, and explored. Men played like children. Some of them had fun. Was the playfulness a distraction, meaningless once the individuals have returned to their cells? Or was it a genuine exploration of deeply embedded impulses and desires?

Are the patients overstimulated by acting out the storm, which may have represented different things for each of them, or are they soothed?

After the storm ends, the unit, for once, feels quiet.

Embodied Escapism Is a Human Right

In her poem “Arrival,” Judee Norton explores the impact of incarceration on her body and spirit:

bright shiny bracelets

jangling on my arm

wide leather belt

snug about my waist

chains dangling seductively

between my legs.

I am captured

but not subdued

THEY

think they have me

but

my mind

wheels and soars and spins and shouts

no prisoner

I am free

to look to see

all that I ever have been

all that I ever may be

I hold the small and sacred part of me close

like a royal flush

my poker face

must not betray

THEY

cannot touch it

not even in their dreams

I

am light and air and fire

I

slip through their clutching fingers

like the night

even as they grasp my puny wrist

of simple bone

and blood

and flesh

body here

spirit there

I

am still

free. (Norton, 2011, pp. 22-23)

What does it actually mean to be embodied? Is it the tingling you feel on the surface of your skin when you see someone you love, or the rhythm of your heart when you're walking in

the woods, or the deep breath you take as you stand outside on a sunny day? Is it an awareness of your lungs and cells, your feet on the floor and your spine extending toward the sky? Is it the certainty that your body is your own, or the spiritual, psychological, deeply and inexplicably *known* nature of your existence?

Prisons and jails are intentionally designed to deprive the individuals confined within them of their sense of self, their agency, their empowerment, and their humanity. It is a system of disembodiment—one in which individuals are separated from all the things that make them feel like human beings. The question is not whether American jails are safe, humane, and rehabilitative—research and real-world experience indicate that they are not—but whether some individuals deserve to be dehumanized, deprived of their fundamental human rights, and separated from society. The system as it operates in America today is antithetical to a belief in the inherent value of human life.

It is a therapist's role, however, to work within the world we have, not the one we wish we had—and dance/movement therapists must not ignore the realities of incarceration, even if we believe systems should be changed, dismantled, or rebuilt from the ground up. Individuals detained in city jails, awaiting trial—and people serving life sentences in federal prisons—are systematically stripped of their right to embodiment. They wear uniforms and live in small cells or crowded dorms with wooden boards for mattresses—they are called by their last names, or by numbers—they are penalized mentally and emotionally and physically for their behavior, often unpredictably—they are denied choice and reflection and intention and individuality. As dance/movement therapists, we are uniquely positioned to offer incarcerated individuals the

opportunity to be embodied—to suggest, through imagery and mirroring and moving together, a return home to the self.

Themes that emerge in the dance/movement therapy groups I lead at my clinical internship more often deal with patients' wishes and desires than with the present realities of their lives. Patients act out cooking and eating meals together, traveling, celebrating—they embody fantasies and dreams, collectively creating a space of joy and laughter within which coping becomes possible.

In another hypothetical group based on my real-world experiences facilitating dance/ movement therapy in jail, I will offer an example of the healing potential of embodied fantasy.

Group #2

The patients are disorganized today. One man rocks steadily forward and backward while another bobs as he stands, bouncing one leg. The person closest to the door sings to himself, while the man next to him shouts to a peer on the unit. Someone else stares intensely out the door of the group room; another sits with his head in his hands. The patient bouncing his leg begins to move faster, and his rhythm captures the man beside him, who stops rocking and begins to bounce too. The shouting man picks up the rhythm, and then the singing man. Soon, the whole group is bouncing, some sitting and some standing, each moving in their own way. The therapist feels nervous energy in her own body as she joins them. She imagines a concoction of anxiety and curiosity and desire for belonging swirling in the center of the circle, fast and intense.

One person laughs, which gets a few of the others laughing. Someone asks why he is laughing, and he shakes his head.

"We're just bopping," he says. Another of the men who laughed turns the bounce into a two-step, and someone else mutters a line of a song. Two people join him, singing the next line a little bit louder. It's a familiar song, and soon most of the group is singing. They're not quite in rhythm with one another, but they are all two-stepping; even the man who is still sitting moves his feet side to side, watching his peers with alert eyes.

"Where are we?" the therapist asks. The man who started the two-step answers, without hesitation, that they are at a party.

A few people try and shoot him down—no one, they say, wants to be at a party in jail. The therapist asks where else the party might be taking place, and the man who was the first to laugh firmly and confidently states that the party is at his house.

The imagery unfurls instantaneously from this moment, as if the group has been waiting for their opportunity be transported somewhere else. The man who began the group by bouncing jumps into the center of the circle, ringing an imaginary doorbell and offering the "host" a pretend bag of chips and bottle of whiskey. Another exclaims about the host's elaborate gym and begins to demonstrate the use of a rowing machine. Two people light up imaginary cigarettes.

"What kind of party doesn't have music?" complains one man, who is still two-stepping in the corner. There is no music today—the speaker is dead, the charger cord is missing, no one is around to help—so the soundtrack for the group is jail noises: cells clanging as they open and shut, TVs in the background playing the news, feet in cheap shoes sliding over the concrete floor.

The man who has stayed sitting begins to beat box, and everyone stops for a moment to stare. Then someone hollers, and another man starts rapping to the rhythm provided by the beatboxer. The host pours imaginary drinks, and the men start to make toasts.

They toast to music, to good food, to parties, to rowing machines, to someone's favorite brand of cigarettes. One man toasts to freedom. Everyone echoes his toast, and someone observes that the circle has closed so that everyone is standing practically shoulder-to-shoulder, though without actually touching. As they lower their gazes, staring at the floor in the center of the circle, the therapist asks if they see something there.

Yes, they say. They do.

"Let's summon it," someone says. Nobody names exactly what they are witnessing—their shared energy, or a sense of belonging, or a feeling of freedom—but they all seem to see it. They extend their hands to it, palms facing out. Somebody hums.

The men stand still, summoning the energy they have created. They are here in the group room of a mental health unit in a jail, but they are also at a party, where they can be joyful and playful—where they can celebrate being together and feeling free.

When the group is over, the jail rushes back to meet them. The sounds, and smells, and stale air return, but the sensation of standing so close together lingers. It is a fantasy to be free, to be joyful, to be invited to someone's home. Some of these men have already been sentenced and will be transferred to prison soon; others have waited years for sentencing and will likely wait longer still. Some may be discharged into the community, but without homes or families waiting for them once they're released. It would be natural for disappointment and anxiety and regret to follow the enactment of such a joyful, unattainable fantasy, but that is not the way the patients respond.

Instead, they leave the group laughing. There is hope here, and it is neither superficial nor unfounded, because community and celebration and liberation and resilience have emerged even under impossible circumstances.

It is inhumane to be disembodied, and it is a unique kind of cruelty to deprive human beings of their individuality and creativity and self-expression. Embodied escapism offers the radical opportunity to connect simultaneously with the self, with others, with dreams, and with the world. In the body, there is joy and pain, suffering and hope.

"body here

spirit there

I

am still

free" (Norton, 2011, pp. 22-23).

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