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Research Article

Psychiatrists' Attitudes and Perspectives Towards Incarcerated Patients: Biases, Ethical Dilemmas, and Clinical Challenges

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ABSTRACT

Objective: This study aims to evaluate the attitudes, biases, ethical dilemmas, and clinical challenges faced by psychiatrists in Türkiye towards incarcerated patients.

Methods: This is a cross-sectional, descriptive, quantitative study. A total of 234 psychiatrists, including psychiatry specialists, academics, and residents from across Türkiye, participated in the study via an online survey. The survey included questions regarding sociodemographic information, experience working with incarcerated patients, attitudes toward incarcerated patients, level of empathy, ethical dilemmas, safety concerns, and therapeutic nihilism, as well as opinions about available services.

Results: The majority of participants had worked with incarcerated patients in the past or currently. This group identified several factors that make providing psychiatric services challenging in the prison environment: personality disorders, addiction, safety concerns, inadequate resources, and ethical dilemmas. Those who struggled to empathize with incarcerated patients were younger and less experienced, and this group had lower hope for recovery, lower confidence in treatment, and higher fear for their safety. The majority of participants perceived prison psychiatric services as inadequate and emphasized the importance of post-release psychiatric support. The importance of family and social support systems was also highly recognized.

Conclusion: The findings reveal that psychiatrists face significant professional and ethical challenges in the prison environment and may develop biases. To effectively treat incarcerated patients, prison mental health services must be strengthened, staff training increased, safe working conditions ensured, and supervision and empathy-focused training supported for young clinicians. These steps will improve the quality of care for incarcerated patients, and contribute to the provision of higher-quality healthcare services by reducing burnout and stress among psychiatrists.

Keywords: Incarcerated patients, prison psychiatry, psychiatrist attitudes, ethical dilemmas, therapeutic nihilism, difficulty in empathy

INTRODUCTION

The prevalence of mental disorders in prisons is significantly higher than in the general population. However, providing mental health services in correctional settings poses significant challenges and limitations.[1]

During hospital-based evaluations of incarcerated patients, several ethical dilemmas arise, including the inability to ensure privacy, conducting assessments while the patient remains handcuffed, and the presence of security personnel in the examination room. These factors further complicate the psychiatric evaluation process.[2] The conditions within correctional facilities also significantly hinder the psychiatric evaluation process for both incarcerated patients and psychiatrists. The overriding emphasis on maintaining security can undermine the development of a therapeutic alliance

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between the patient and the clinician.[3] Psychiatrists may struggle with the dual responsibility of safeguarding the mental health of incarcerated patients while simultaneously adhering to institutional rules. This dynamic also makes it more difficult for incarcerated patients to trust their psychiatrist, thereby limiting effective communication.[4]

Some of the most challenging aspects of the physician-patient relationship in correctional settings involve concerns about the reliability of incarcerated patients and concerns about attempts at manipulation.[5] Such situations may lead, over time, to the development of bias, excessive caution, or increased emotional distancing. Psychiatrists' perceptions and attitudes toward incarcerated patients can negatively impact diagnostic and treatment planning processes. Prescription drug misuse, in particular, remains a significant concern in correctional facilities. Overall, the suspicion of manipulation, ethical dilemmas, and lack of trust may contribute to heightened stress and an increased risk of burnout among psychiatrists working in correctional settings.[6] During this process, psychiatrists may develop certain biases toward incarcerated patients, such as the belief that those convicted of severe crimes exaggerate their symptoms or are malingering. Over time, such beliefs may give rise to a countertransference reaction known as "therapeutic nihilism", characterized by the perception that treatment is futile.[7] Therapeutic nihilism denotes a skeptical or pessimistic stance toward the effectiveness of medical interventions, often leading clinicians to limit or avoid treatment. This perspective influences clinical decision-making, at times contributing to undertreatment or neglect of patient needs.[8]

Psychiatrists must remain attuned to a range of challenges when working with incarcerated patients, including the regulation of empathy, managing personal biases, resolving ethical dilemmas, addressing safety concerns, and detecting malingering or manipulative behavior. Although prior studies have explored ethical dilemmas and factors affecting the therapeutic relationship in correctional settings, there is a notable lack of research that systematically examines psychiatrists' attitudes, biases, and approaches toward incarcerated patients, particularly regarding determinants such as prior experience with this population. Moreover, the impact of correctional psychiatry experience on empathy, attitudes, and bias during clinical evaluations remains underexplored in the literature.

This study aims to assess psychiatrists' attitudes and perceptions toward incarcerated patients, as well as the ethical dilemmas they encounter. By doing so, it seeks to offer meaningful recommendations for improving psychiatric assessment processes, reducing bias, enhancing access to mental health care, and drawing attention to the unique challenges faced by both incarcerated patients and the psychiatrists who work with them. Additionally, the study highlights the value of clinical exposure, supervision, and awareness of correctional psychiatry during psychiatric training. It also aims to contribute to the development of more effective mental health services and policies within correctional settings, ultimately helping to improve care delivery for incarcerated patients and support psychiatrists in providing treatment under more appropriate conditions.

MAIN POINTS

- Psychiatrists who were younger and had fewer years of experience were significantly more likely to report difficulty empathizing with incarcerated patients.
- More than 60% of psychiatrists believed that incarcerated patients are prone to lying or manipulation, reflecting high levels of distrust and therapeutic nihilism.
- The majority of psychiatrists considered prison-based mental health services inadequate and highlighted the importance of continued psychiatric care after release.
- Nearly all psychiatrists supported the need for specialized training, regular supervision, and improved safety protocols in correctional mental health settings.

MATERIAL AND METHODS

Study Design and Data Collection

This study is a cross-sectional and descriptive quantitative research that examines the attitudes, biases, and ethical dilemmas of psychiatrists in Türkiye toward incarcerated patients. Data were collected through an online survey.

The sample consisted of psychiatrists, including specialists, academic faculty members, and residents working across Türkiye. A total of 234 psychiatrists, recruited through a convenience sampling method between April and July 2025, participated in the study. The online questionnaire was distributed via professional email groups, social media platforms, and personal professional networks. Participants were provided with detailed information about the study and gave informed consent. The survey was completed anonymously and on a self-administered basis.

The inclusion criteria were actively working in the field of psychiatry in Türkiye, completing the survey fully and validly, and voluntarily participating in the study. Exclusion criteria included incomplete or invalid responses and being employed in a non-psychiatric medical specialty.

The data collection tool was a questionnaire developed by the research team based on relevant literature. The survey consisted of 45 items, covering the following themes: sociodemographic characteristics (6 items), attitudes and perceptions toward incarcerated patients (11 items), general views on the prison environment and treatment process (16 items), areas in need of improvement in prison-based psychiatric services (6 items), and perceived usefulness of support mechanisms for psychiatrists working in correctional settings (6 items).

The study was approved by the Ethics Committee of Giresun Training and Research Hospital (decision no.: 16.04.2025/19, date: 16.04.2025) and conducted in accordance with the principles of the Declaration of Helsinki and current ethical guidelines.

Statistical Analyses

Data were analyzed using IBM SPSS Statistics version 27. Descriptive statistics included means, standard deviations, medians, and interquartile ranges for continuous variables, and frequencies and percentages for categorical variables. Normality assumptions were assessed using histograms. For non-normally distributed continuous variables, the Kruskal-Wallis test was used for comparisons across multiple groups, and the Mann-Whitney U test for two-group comparisons. To control for type I error in multiple non-parametric comparisons, Bonferroni correction was applied where appropriate. Associations between categorical variables were evaluated using the chi-square test. One-way analysis of variance was applied to assess the variance between certain continuous variables. A significance level of $P < 0.05$ was accepted for all analyses.

RESULTS

A total of 234 psychiatrists participated in the study. Of these, 167 were female (71.4%) and 67 were male (28.6%). Regarding professional groups, 157 (67.1%) were specialists, 32 (13.7%) were residents, and 45 (19.2%) were academic physicians. The mean age of participants was 37.1 ± 7.6 years. Most participants were employed in institutions located in urban centers (83.8%). The most common workplaces were training and research hospitals (33.3%) and state hospitals (31.2%), followed by university hospitals (16.2%).

A total of 81.2% of participants reported that they had worked with incarcerated patients either currently or in the past. Among those with such experience, psychiatrists reported evaluating an average of 31 incarcerated patients per month, spending approximately 13 minutes per patient. The perceived difficulty of working with this group was rated as 6.3 out of 10 on average. Most evaluations were conducted in outpatient hospital consultation rooms (78.4%), followed by prison-based examination rooms (40.5%). Incarcerated patients were most commonly assessed in the presence of law enforcement personnel, with the most frequent method being evaluation while handcuffed (45.3%), followed by unrestrained evaluations under security supervision (33.7%). The most common reasons for referral were requests for psychiatric medication (68.0%) and psychiatric symptom evaluation (67.9%). Willingness to continue working with incarcerated patients was relatively low (21.1% Yes, 45.3% No). Key challenges identified in working with incarcerated patients included a high prevalence of comorbid personality disorders (89.5%) and risk of substance misuse (84.2%). Other frequently reported issues were substance use disorders (67.4%) and the impact of prison conditions on treatment (50.5%). When more time was needed for evaluation, over half of the participants (56.8%) reported extending the interview, while 18.9% preferred to conclude with symptom-oriented treatment. Pharmacological treatment was the most commonly used therapeutic approach (56.3%), while no participant reported using psychotherapy alone in this population.

A significant proportion of participants reported disagreement with certain statements reflecting prejudicial attitudes toward incarcerated patients. Most participants reported that incarcerated patients had relatively low expectations of recovery. The majority (approximately 56%) reported no difficulty empathizing with incarcerated patients, while only 18% agreed with the statement indicating such difficulty. According to participants, the most frequently reported reason for difficulty in empathizing with incarcerated patients was the belief that the individual might be manipulative. More than half of the participants reported experiencing safety-related fear during face-to-face interviews with incarcerated patients. The most commonly cited reason for this fear, based on multiple response options, was perceived security vulnerabilities within the prison setting. On average, the perceived effectiveness of pharmacological treatment in this population was around 50%, whereas the effectiveness of psychotherapy was perceived to be approximately 30%. The distribution of participants' attitudes and perceptions towards incarcerated patients is shown in Table 1.

The vast majority of participants agreed that the prison environment has a negative impact on the mental health of incarcerated patients. Similarly, most participants believed that existing psychiatric services in prisons are insufficient and that access to these services is limited. Most participants acknowledged facing ethical challenges when working with incarcerated patients and noted the difficulty of balancing public safety with patients' rights. Psychiatrists' general views on the prison environment and treatment process are shown in Table 2.

The vast majority of participants indicated that improvements are needed across nearly all aspects of mental health services in correctional settings (Table 3). There was broad agreement that most of the proposed support mechanisms would be beneficial (Table 4).

Among all participants, several notable differences emerged when groups were compared according to their responses to the statement "I have difficulty empathizing with incarcerated patients." Participants who reported difficulty empathizing (either "agree" or "strongly agree") were younger. Similarly, the median number of years working in psychiatry was lower among those who reported difficulty empathizing. Participants who had difficulty empathizing were also more likely to believe that incarcerated patients have a lower potential for recovery. Additionally, nearly all participants in the empathy-difficulty group agreed with the statement "I generally feel distrustful of incarcerated patients due to the likelihood of lying or manipulative behavior." The proportion of participants who reported experiencing fear during interviews with incarcerated patients was also significantly higher in the empathy-difficulty group. Furthermore, participants who reported difficulty empathizing rated the effectiveness of pharmacological treatment in incarcerated patients significantly lower than other groups. The comparison of participants based on difficulty in empathizing with incarcerated patients (full sample) is shown in Table 5.

Among psychiatrists who had previously worked with incarcerated patients, several differences were observed between those who reported difficulty empathizing and those who did not. Willingness to work with this population

Table 1. Participants' Attitudes and Perceptions Toward Incarcerated Patients

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The type of crime committed by the incarcerated patient consciously or unconsciously affects my clinical approach or treatment plan.	76 (32.5%)	54 (23.1%)	40 (17.1%)	54 (23.1%)	10 (4.3%)
News coverage or public opinion influences my general perceptions and expectations regarding incarcerated patients.	101 (43.2%)	56 (23.9%)	37 (15.8%)	34 (14.5%)	6 (2.6%)
I believe that incarcerated patients have a lower potential for recovery compared to others.	27 (11.5%)	64 (27.3%)	33 (14.1%)	94 (40.2%)	16 (6.8%)
I have difficulty empathizing with incarcerated patients.	49 (20.9%)	83 (35.5%)	60 (25.6%)	39 (16.7%)	3 (1.3%)
I generally feel distrustful of incarcerated patients due to the likelihood of lying or manipulative behavior.	51 (21.8%)	61 (26.1%)	15 (6.4%)	121 (51.7%)	27 (11.5%)
				n	**%**
What do you think are the reasons for difficulty in empathizing with incarcerated patients? (you may select more than one)					
The fact that the patient is incarcerated				49	23.2
Safety concerns				69	32.7
Feelings of anger toward the patient				70	33.2
Suspicion that the patient is manipulative				179	84.8
Other				18	9
Do you experience fear for your safety when interviewing incarcerated patients?					
Yes				123	52.6
No				111	47.4
What are the reasons for your safety-related fears during interviews with incarcerated patients? (you may select more than one)					
The fact that the person is a convicted offender				93	38.7
Risk of lying or manipulative behavior				104	44.4
Security vulnerabilities in the correctional setting				169	72.2
Other				17	6.8
				Mean	**SD**
In your opinion, what percentage of incarcerated patients' psychiatric conditions and treatment needs are influenced by legal processes and prison conditions?				39.7	21.0
In your opinion, what is the effectiveness rate (%) of pharmacological treatment in incarcerated patients?				48.8	18.1
In your opinion, what is the effectiveness rate (%) of psychotherapy in incarcerated patients?				29.8	19.0

n, sample size; SD, standard deviation.

varied significantly between groups. Similarly, participants who experienced empathy difficulties were more likely to rank incarcerated patients among the most challenging or least preferred patient groups. A substantial portion of those with empathy difficulties believed that incarcerated patients have a lower potential for recovery. Nearly all in the empathy-difficulty group expressed distrust regarding the likelihood of lying or manipulation by incarcerated patients, whereas this view was much less common in the comparison group. Fear during face-to-face interviews with incarcerated patients was also significantly more frequent in the empathy-difficulty group. A comparison of psychiatrists with and without empathy difficulties among those with experience working with incarcerated patients is shown in Table 6.

Psychiatrists with prior experience working with incarcerated patients and those without such experience generally exhibited similar attitudes and beliefs. There were no significant differences between the two groups in agreement with the statements "Incarcerated patients have a lower potential for recovery" (P = 0.955), "I have difficulty empathizing with incarcerated patients" (P = 0.637), or "I generally feel distrustful of incarcerated patients" (P = 0.378). However, a significant difference emerged regarding safety-related concerns. Among psychiatrists without prior experience, 79.5% reported that they would feel fearful during face-to-face interviews with incarcerated patients, compared to 46.3% of those with experience, a statistically significant difference (X^2 = 14.517, P < 0.001). Perceptions of the effectiveness of pharmacological and psychotherapeutic treatments in incarcerated patients were similar between the two groups (P > 0.05).

DISCUSSION

The reported mean difficulty level of working with incarcerated patients (6.3/10) is consistent with findings in the literature

Table 2. General Views on the Prison Environment and Treatment Process

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The prison environment negatively affects the mental health of incarcerated patients.	2 (0.9%)	31 (13.2%)	29 (12.4%)	145 (62%)	27 (11.5%)
The effects of the prison environment on mental health depend on individual circumstances.	15 (6.4%)	35 (15%)	49 (20.9%)	124 (53%)	11 (4.7%)
Psychiatric services in prisons are sufficient.	116 (49.6%)	52 (22.2%)	48 (20.5%)	17 (7.3%)	1 (0.4%)
Access to psychiatric services in prisons is easy.	83 (35.5%)	61 (26.1%)	57 (24.4%)	26 (11.1%)	7 (3%)
Psychiatric services in prisons need to be improved.	5 (2.1%)	12 (5.1%)	35 (15%)	124 (53%)	58 (24.8%)
Psychiatric support is important for the reintegration of incarcerated patients after release.	1 (0.4%)	10 (4.3%)	20 (8.5%)	130 (55.6%)	73 (31.2%)
Families and other support systems play an important role in the treatment of incarcerated patients.	2 (0.9%)	2 (0.9%)	10 (4.3%)	127 (54.3%)	93 (39.7%)
Ethical difficulties are encountered when working with incarcerated patients.	7 (3%)	14 (6%)	44 (18.8%)	131 (56%)	38 (16.2%)
It is difficult to balance public safety with the individual rights of incarcerated patients.	11 (4.7%)	27 (11.5%)	41 (17.5%)	124 (53%)	31 (13.2%)
Stigma and prejudice play a significant role in the treatment of incarcerated patients.	7 (3%)	21 (9%)	34 (14.5%)	141 (60.3%)	31 (13.2%)
I believe prison conditions negatively affect the treatment process.	9 (3.8%)	27 (11.5%)	31 (13.2%)	133 (56.8%)	34 (14.5%)
There are inequalities in access to treatment and quality of care for incarcerated patients.	12 (5.1%)	19 (8.1%)	50 (21.4%)	122 (52.1%)	31 (13.2%)
Legal processes and the prison environment affect psychiatric diagnoses.	9 (3.8%)	20 (8.5%)	33 (14.1%)	146 (62.4%)	26 (11.1%)
A history of trauma and abuse plays an important role in the treatment of incarcerated patients.	4 (1.7%)	12 (5.1%)	24 (10.3%)	149 (63.7%)	45 (19.2%)
Substance use disorders and addiction are major challenges in the treatment of incarcerated patients.	1 (0.4%)	1 (0.4%)	8 (3.4%)	97 (41.5%)	127 (54.3%)
Suicide risk and self-harming behaviors are significant problems in the treatment of incarcerated patients.	0 (0%)	7 (3%)	11 (4.7%)	105 (44.9%)	111 (47.4%)

that associate correctional psychiatry with high levels of stress, professional burnout, and safety concerns.[9] The frequent use of mechanical restraints such as handcuffs may undermine trust between patient and clinician, trigger aggressive behavior, and negatively affect the quality of the therapeutic relationship.[10]

Nearly half of the participants indicated reluctance to work with incarcerated patients, underscoring the high-stress and burnout-prone nature of correctional psychiatry. This finding aligns with the existing literature.[11] The prevalence of burnout among general psychiatrists has been reported at approximately 26%, and this figure is even higher in forensic or correctional settings.[12] Similarly, frequent reports of stress and trauma among correctional staff are thought to contribute to limited interest and high levels of reluctance toward working in this field.[13]

An examination of participants' treatment strategies revealed that the majority relied primarily on psychopharmacological interventions, and none reported using psychotherapy alone. This finding may reflect the limited availability of psychotherapy in correctional settings, as well as the practical preference for shorter-term solutions, like pharmacotherapy, due to the characteristics of the patient population.[14] The high prevalence of personality disorders, substance use, and low treatment motivation among incarcerated individuals also presents barriers to psychotherapy, such as these, and may contribute to the prioritization of pharmacological approaches.[15]

A considerable proportion of participants disagreed with statements reflecting prejudicial attitudes toward incarcerated patients and stated that the type of crime committed by the patient did not influence their treatment planning. This suggests that efforts are being made to uphold ethical standards in correctional psychiatry and to maintain a clinical approach that is independent of the offense. The literature similarly emphasizes that adherence to ethical principles should remain consistent regardless of the nature of the crime, and that allowing the offense to shape the psychiatric treatment plan is inconsistent with professional integrity.[16] Likewise, the majority of participants rejected the idea that media narratives or societal prejudices influence their clinical attitudes, which may reflect an effort among psychiatrists to preserve the independence of their evaluations.

Table 3. Areas in Need of Improvement in Prison-Based Psychiatric Services

	Yes	No	No opinion
The number of psychiatrists and other mental health professionals in prisons should be increased.	193 (82.5%)	22 (9.4%)	19 (8.1%)
Correctional staff should be trained in mental health.	228 (97.4%)	3 (1.3%)	3 (1.3%)
More diverse treatment options should be offered.	209 (89.3%)	13 (5.6%)	12 (5.1%)
Follow-up appointments should be scheduled for after release.	208 (88.9%)	8 (3.4%)	18 (7.7%)
Incarcerated patients should be provided with information about community resources and support groups.	224 (95.7%)	5 (2.1%)	5 (2.1%)
Communication with family members should be supported.	219 (93.6%)	4 (1.7%)	11 (4.7%)

Table 4. Perceived Usefulness of Support Mechanisms for Psychiatrists Working in Correctional Settings

	Useful	Partially useful	Not useful
Regular supervision and peer support.	191 (81.6%)	37 (15.8%)	6 (2.6%)
Adequate training and resources.	189 (80.8%)	43 (18.4%)	2 (0.9%)
Safe working environment and security protocols.	219 (93.6%)	15 (6.4%)	0 (0%)
Formation of specialized psychiatric teams for treating incarcerated patients.	189 (80.8%)	40 (17.1%)	5 (2.1%)
Establishing a distinct training area or subspecialty in correctional psychiatry.	144 (61.5%)	54 (23.1%)	36 (15.4%)
Increasing opportunities for working with and researching incarcerated patients.	177 (75.6%)	50 (21.4%)	7 (3%)

Table 5. Comparison of Participants Based on Difficulty in Empathizing with Incarcerated Patients (Full Sample)

Mean ± SD / Median (Q1-Q3) / n (%)	Strongly disagree / disagree	Neutral	Agree / strongly agree	Statistic	*P*
Age (years)	36 (33-41.8)	34 (32-39)	33.5 (31-37.3)	KW = 9.539	**0.008**
Years of experience in psychiatry	10 (7-14.8)	8 (6-12)	7.5 (5-12.3)	KW = 8.763	**0.013**
I believe incarcerated patients have a lower potential for recovery than others.				X^2 = 51.095	**< 0.001**
Disagree	73 (55.3%)	14 (23.3%)	4 (9.5%)		
Neutral	18 (13.6%)	13 (21.7%)	2 (4.8%)		
Agree	41 (31.1%)	33 (55%)	36 (85.7%)		
I generally feel distrustful of incarcerated patients due to the likelihood of lying or manipulative behavior.				X^2 = 43.818	**< 0.001**
Disagree	59 (44.7%)	11 (18.3%)	1 (2.4%)		
Neutral	10 (7.6%)	4 (6.7%)	1 (2.4%)		
Agree	63 (47.7%)	45 (75%)	40 (95.2%)		
Do you experience fear for your safety during interviews with incarcerated patients?				X^2 = 14.764	**< 0.001**
No	76 (57.6%)	24 (40%)	11 (26.2%)		
Yes	56 (42.4%)	36 (60%)	31 (73.8%)		
What is your estimate of the effectiveness (%) of pharmacological treatment in incarcerated patients?	49.9 ± 18.0	51.0 ± 18.0	42.62 ± 17.8	F = 3.159	**0.044**

n, sample size; *P*, significance level; Q1, first quartile; Q3, third quartile; KW, Kruskal-Wallis test; F, statistic; ANOVA, analysis of variance; SD, standard deviation; X^2, chi-square test.

Table 6. Comparison of Psychiatrists with and Without Empathy Difficulties Among Those with Experience Working with Incarcerated Patients

Median (Q1-Q3) / n (%)	Strongly disagree / disagree	Neutral	Agree / strongly agree	Statistic	*P*
Would you prefer to work with incarcerated patients?				X^2 = 18.180	**0.001**
Yes	31 (28.2%)	10 (21.7%)	1 (3.1%)		
No	40 (36.4%)	17 (37%)	23 (71.9%)		
Undecided	39 (35.5%)	19 (41.3%)	8 (25%)		
If you ranked the most difficult or least preferred patient groups to work with, where would incarcerated patients fall?	6 (5-8)	6 (5-7)	8 (6-8)	KW = 9.142	**0.010**
I believe incarcerated patients have a lower potential for recovery than others.				X^2 = 41.600	**< 0.001**
Disagree	59 (53.6%)	11 (23.4%)	3 (9.1%)		
Neutral	16 (14.5%)	10 (21.3%)	1 (3%)		
Agree	35 (31.8%)	26 (55.3%)	29 (87.9%)		
I generally feel distrustful of incarcerated patients due to the likelihood of lying or manipulative behavior.				X^2 = 38.415	**< 0.001**
Disagree	49 (44.5%)	8 (17%)	1 (3%)		
Neutral	8 (7.3%)	2 (4.3%)	0 (0%)		
Agree	53 (48.2%)	37 (78.7%)	32 (97%)		
Do you experience fear during interviews with incarcerated patients?				X^2 = 12.708	**0.002**
No	70 (63.6%)	22 (46.8%)	10 (30.3%)		
Yes	40 (36.4%)	25 (53.2%)	33 (69.7%)		

n, sample size; *P*, significance level; Q1, first quartile; Q3, third quartile; KW, Kruskal-Wallis test; SD, standard deviation; X^2, chi-square test.

The study found a relatively high proportion of psychiatrists who believed that incarcerated patients have a lower potential for recovery. In the literature, this attitude has been described as a common phenomenon among professionals working in forensic and correctional psychiatry, and is conceptualized as "therapeutic nihilism".[17] Contributing factors may include high psychiatric burden, difficulties with treatment continuity and follow-up, poor adherence, comorbid psychiatric disorders and personality pathology, substance use, behavioral disturbances, risk of violence, limited resources, and the moral weight of the offense. Previous studies have noted that psychiatrists working in prisons may develop a belief that meaningful change is unlikely in incarcerated patients, which can lead to reduced empathy and diminished motivation to treat patients.[18] Such attitudes have been recognized as a major barrier to providing adequate mental health care for stigmatized populations like incarcerated patients.[19] Taken together, our findings suggest that therapeutic nihilism remains a noteworthy tendency in correctional psychiatry. To address this, it is essential to promote access to research and clinical experiences with incarcerated populations, share evidence demonstrating positive treatment outcomes, enhance staff training, and reinforce ethical awareness.

While more than half of the participants reported no difficulty in empathizing with incarcerated patients, 18% indicated agreement with the statement "I find it difficult to empathize with incarcerated patients." This finding suggests that a substantial proportion of psychiatrists working in correctional settings are not prone to stigmatizing attitudes and can maintain their empathic capacity as part of their professional role. Indeed, a recent meta-analysis found that despite the prevalence of stigma in correctional settings, the empathic capacity of prison mental health professionals can be preserved to a certain degree within the framework of professional identity.[20] However, the fact that a subset of participants reported difficulties in empathizing aligns with concepts such as negative countertransference and therapeutic nihilism.[21] This may be related to perceptions of incarcerated individuals as inherently "dangerous" or "untreatable" due to their criminal history, which in turn may impede the formation of an empathic therapeutic stance.

The statement "Incarcerated patients are more likely to lie or manipulate" was endorsed by 63.2% of participants. This high rate may reflect a general mistrust among psychiatrists working in correctional environments toward their patients. This finding is consistent with previous research demonstrating that a significant proportion of healthcare professionals in forensic settings tend to interpret incarcerated patients'

behaviors through the lens of secondary gain, manipulation, and dishonesty.[21]

A large majority of participants believed that the prison environment negatively affects the mental health of incarcerated patients. This finding is consistent with the existing literature emphasizing that the physical conditions of prisons, social isolation, and control-oriented approaches contribute to both the onset and exacerbation of psychiatric morbidity.[22] These findings align with studies demonstrating that prison mental health services have historically remained insufficient due to systemic shortcomings, lack of resources, and staffing shortages.[23] Contributing factors include the lack of training among personnel, high caseloads, and the prioritization of security concerns over therapeutic goals.[19]

More than two-thirds of participants indicated that prison psychiatric services need improvement, and the vast majority emphasized the importance of post-release psychiatric support for successful reintegration. This supports the need for continuous mental health care to ensure rehabilitation and social reintegration of incarcerated individuals. Furthermore, the majority of participants emphasized the importance of family and social support systems in treatment and highlighted the ethical challenge of balancing public safety with the rights of the individual. This reflects a central dilemma frequently discussed in forensic psychiatry literature, namely, the tension between risk management and patient-centered care.[24] Mental health professionals working in forensic settings are tasked with safeguarding both individual well-being and the broader public interest.

The near-unanimous responses from participants regarding the need to improve mental health services in prisons highlight that prison psychiatry continues to face substantial structural and organizational shortcomings. Systematic reviews have shown that prison personnel often lack adequate knowledge and sensitivity regarding inmates' mental health problems, which negatively impacts both patients' access to care and the overall atmosphere within correctional facilities.[23]

The strong support (95.7%) for providing incarcerated individuals with information about community resources and support groups aligns with contemporary rehabilitation models aimed at social reintegration. One of the most significant risks faced by formerly incarcerated individuals upon release is the lack of social support, which can lead to recidivism and psychiatric decompensation.[25] Likewise, the high level of agreement (93.6%) on the importance of supporting communication with family members is consistent with robust evidence indicating that social support systems are critical protective factors for the mental health of incarcerated individuals. This finding suggests that psychiatrists prioritize patient well-being beyond ethical dilemmas, biases, or stigmatizing attitudes.

Participants' emphasis on the need for more diverse treatment options and post-release follow-up planning reflects the limitations of current services and the lack of continuity in care. Mental health services in prisons often remain restricted to crisis management, brief psychiatric evaluations, and pharmacotherapy. Psychotherapy, group therapy, addiction treatment, or rehabilitative approaches are frequently unavailable or extremely limited.[23] Given the heterogeneous burden of psychiatric illness in prison populations, treatment approaches should extend beyond medication to include diverse and individualized interventions such as cognitive behavioral therapy, substance use programs, and trauma-informed psychotherapy.[14,23] Therefore, mental health services for incarcerated patients must be expanded not only to ensure treatment but also to promote rehabilitation and reintegration.

One of the prominent findings of our study is that the majority of proposed support mechanisms in prison psychiatry were rated as highly beneficial by participants. This aligns with the literature highlighting frequent exposure of prison-based psychiatrists to violence risk, threats, emotional exhaustion, and burnout.[26] Systematic reviews have shown that regular supervision not only enhances clinical competence but also strengthens the ability to manage ethical dilemmas and improves self-efficacy.[27] The support expressed by 80.8% of participants for adequate training, resources, and the establishment of a dedicated psychiatric team for incarcerated patients reflects growing recognition that prison psychiatry requires specialized knowledge and skills. Evidence suggests that mental health services in correctional settings are more effective when delivered through multidisciplinary teams, which improve treatment continuity, crisis management, and patient satisfaction.[22] Furthermore, 75.6% of participants supported increased opportunities for working with and conducting research on incarcerated populations, indicating that prison psychiatry remains a neglected field that requires empirical development. However, the proposal to establish prison psychiatry as a formal subspecialty was the most divisive among respondents. Some experts advocate for formalizing prison/forensic psychiatry as a distinct specialty to enhance service quality, improve clinicians' ability to manage ethical dilemmas, and increase professional satisfaction.[28] Others argue that further fragmenting an already limited mental health workforce may weaken overall service capacity and, instead, recommend integrating forensic competencies into general psychiatric training.[29]

Our findings also provide key insights into how empathy capacity interacts with individual characteristics and perceptions in psychiatric practice with incarcerated patients. Notably, participants who reported greater difficulty in empathizing tended to be younger and less experienced, an association previously observed in other studies.[30]

The belief that incarcerated patients have a "low potential for recovery" and concerns about "manipulation" were also found to be more prevalent among clinicians reporting difficulty empathizing with this population. The literature indicates that overestimating psychopathic traits in individuals with criminal backgrounds can negatively impact treatment motivation and the therapeutic alliance, as noted in reference.[31] On the contrary, as the therapeutic alliance strengthens, positive behavioral change becomes more likely. This suggests that as motivation for recovery increases, perceived manipulativeness may decrease.[32] The significant association between heightened security concerns and empathy difficulty is noteworthy. Prior studies have emphasized that elevated perceived threat levels in prison environments can diminish both empathy and the

capacity to deliver patient-centered care.[33] Among clinicians working in high-security units, the generalization of patient behaviors and the dominance of "offender identity" are frequently observed phenomena.[34]

It is also notable that clinicians experiencing empathy difficulties reported significantly lower confidence in the effectiveness of pharmacotherapy for incarcerated patients. Studies suggest that clinicians working in correctional settings often demonstrate low treatment optimism, particularly regarding biological interventions.[35] Negative perceptions of biological treatments among clinicians with low empathy may undermine both the therapeutic relationship and patients' treatment expectations and engagement.

Among those with prior experience working with incarcerated individuals, clinicians reporting empathy difficulties were significantly less willing to work with this population, more likely to consider them an undesirable and challenging group to treat, and held more pessimistic views about their recovery potential. These clinicians also exhibited higher levels of distrust regarding inmates' honesty and manipulation potential, as well as increased security-related concerns during clinical encounters. Moreover, both experienced and inexperienced psychiatrists scored relatively high on key attitudinal items such as "low recovery potential" and "general distrust," suggesting that direct experience alone may not fully mitigate stigmatizing views. Previous studies have highlighted that even psychiatrists without prison experience can develop similar prejudiced attitudes, indicating that such perspectives are shaped more by broader educational and societal influences than by individual clinical exposure.[36]

Study Limitations

This study has several strengths. First, it includes a relatively large and diverse sample of psychiatrists from across Türkiye, which enhances the representativeness of the findings. Second, to our knowledge, this is the first nationwide study systematically examining psychiatrists' attitudes, biases, ethical dilemmas, and empathy-related difficulties when working with incarcerated patients in Türkiye. Third, the study provides a novel contribution by linking empathy difficulties with factors such as age, clinical experience, and therapeutic nihilism, offering important insights for psychiatric training and practice. Finally, the findings highlight actionable areas for policy development and clinical improvement, particularly the need for post-release support, staff training, and strengthened correctional mental health services. However, it has several limitations. First, as the data were collected via a self-report online survey, responses may have been subject to social desirability bias. Second, the questionnaire was developed by the researchers and did not include standardized scales for assessing complex psychosocial constructs such as attitudes and empathy. Third, the cross-sectional design of the study prevents the establishment of causal relationships. The sample was based on voluntary participation, which may have introduced selection bias and limited representativeness. Specifically, psychiatrists who do not work in correctional settings or who are less involved in forensic psychiatry may be underrepresented. Lastly, since the study was conducted solely in Türkiye, the cross-cultural generalizability of the findings is limited. Future research is recommended to address these limitations by employing mixed methods, longitudinal designs, and cross-national samples.

CONCLUSION

The findings of this study demonstrate that psychiatrists encounter significant challenges, resource limitations, and ethical dilemmas when working with incarcerated patients. Participants reported that prison conditions negatively affect mental health and that current psychiatric services are inadequate. The results underscore the urgent need to improve and diversify mental health services in correctional facilities, particularly by enhancing education, supervision, and safety protocols. To reduce prejudicial attitudes and the tendency toward "therapeutic nihilism," it is recommended that prison-based experiences be integrated into psychiatric training and that support mechanisms be provided to clinicians. Ultimately, the insights gained from this study may contribute to improving the quality and continuity of mental health care for incarcerated individuals while also enhancing professional satisfaction and ethical competence among psychiatrists working in this challenging field.

Ethics

Ethics Committee Approval: The study was approved by the Ethics Committee of Giresun Training and Research Hospital (decision no.:16.04.2025/19, date: 16.04.2025)

Informed Consent: Informed consent was obtained from all participants who participated in this study.

Footnotes

Author Contrbutions

Concept Design – U.K., F.G.H.Ç.; Data Collection or Processing – U.K., F.G.H.Ç., M.H.Ş.; Analysis or Interpretation – U.K.; Literature Review – U.K., F.G.H.Ç., M.H.Ş.; Writing, Reviewing and Editing – U.K., F.G.H.Ç., M.H.Ş.

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