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Bridging the Gap: Utilizing Buddhist Techniques to Treat Poverty Centered Trauma

Kessy Evina Love
Religious Studies
The University of North Carolina Asheville
One University Heights
Asheville, North Carolina 28804 USA

Faculty advisor: Dr. Rodger Payne

Abstract

In 2021, about 37.9 million Americans reported living in poverty. Living in poverty puts individuals at a greater risk to experience trauma and develop conditions such as C-PTSD (Complex Post Traumatic Stress Disorder), depression, and anxiety. With the large number of Americans living in poverty, the access to mental health resources is scarce despite impoverished communities being the most in need of such resources. This paper will examine the lack of mental health resources in low-income infrastructures, the impact of the lack of sources, and how Buddhist techniques can be used as an affordable, accessible, and effective resource to treat symptoms of trauma.

1.Introduction

In 2021, about 37.9 million Americans reported living in poverty. Living in poverty in America affects multiple aspects of one's life. It affects resource accessibility, the quality of school's children will be attending, the quality of medical care received. Even within the judicial system, the difference between living in poverty and not could be the difference between staying in a jail cell or staying in one's own bed. With a system built against those in impoverished communities, it becomes nearly impossible to work within the standard welfare resources provided.

People living in poverty are unequally affected by mental illness. According to the CDC, nearly 10% of people living below the poverty line reported psychological distress[1]. Many

people who experience poverty stay within this cycle or end up in prison due to the slippery slope of poverty being linked to an increased risk of mental illness coupled with a lack of resources for mental health treatment. Therefore, people within these low resourced communities have begun to find alternatives to combat the lack of aid. Community centers, schools, and prisons have turned to utilizing Buddhist techniques in place of traditional Western counseling. This paper will examine the lack of mental health resources in low-income infrastructures, the impact of the lack of sources, and how Buddhist techniques can be used as an affordable, accessible, and effective resource to treat symptoms of trauma.

2. Psychology

2.1 Definitions

Trauma itself is an emotional response to a tragic event, often with lasting effects on an individual's functioning: mental, physical, social, and emotional[2]. Within the context of this paper trauma will be defined with inclusion of PTSD and Complex PTSD (CPTSD). PTSD, which is recognized by the DSM-5 is “intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of a traumatic event”[3]. C-PTSD is not formally recognized by the DSM-5 but is by the National Institution of Mental Health and the International Classification of Diseases[4]. As defined by researcher, Phillip Hyland, “PTSD is conceptualized as a fear-based disorder, whereas C-PTSD is conceptualized as a broader clinical disorder that characterizes the impact of trauma on emotion regulation, identity and interpersonal domains.”[5].

C-PTSD is also identified as Type II trauma disorder or Developmental Trauma Disorder. A key factor in the difference between C-PTSD and PTSD is the prolonged or chronic nature of the trauma: “Complex trauma is a varied and multifaceted phenomenon, frequently embedded in a matrix of other psychosocial problems (e.g., neglect, marital discord, and domestic violence) that carry ongoing threat”[6]. Due to the nature of C-PTSD, it is more often developed as a result of childhood trauma, but it can be developed as an adult. When discussing low-income communities or impoverished communities, this is in reference to singular families as well as larger groups who live in underfunded areas. Typically, these areas do not exceed 80% of the median income for the area, and experience a genuine threat of losing basic needs: access to food, clean water, safety, shelter, transportation, and medical care[7].

Lastly, as defined by the American Psychological Association, the medical model is “the concept that mental and emotional problems are analogous to biological problems…and are amenable to cure or improvement by specific treatment”[8]. The opposition to the medical model is the social model. The social model views the environment as malleable and capable of change, rather than the individual being responsible for adapting their comfortability to fit the environment's lack of support. For example, if an individual struggle with becoming overwhelmed in public the medical model would propose therapies and coping strategies to aid the individual in being able to cope with these struggles in an undetectable way as to blend in with others who do not struggle in those ways. The social model, however, would propose that the individual uses noise canceling headphones when going out or to seek out establishments which participate in low-stimulation environments (dim lights, softer sounds, etc.). In the social model the individual is not expected to be uncomfortable to conform or expected to be “cured”.

2.2 Trauma in Poverty

In general, there is an agreed consensus regarding living in poverty and its effects on a person's mental health. Living in poverty limits access to basic needs such as food, stable shelter, clean water, and safe environments. Without basic survival needs, let alone other needs such as medical assistance, mental health resources, or even leisure time become so far out of reach they are often viewed as luxury in these communities. But is living in poverty truly "traumatic"? Trauma is often thought to be one distinct and significant event that shakes someone's reality or a long string of deeply jarring events: physical abuse, sexual abuse, etc. However, trauma is more complex and the human response to events, or lack of events, is equally complex.

Neurologist Robert Scaer opposes the DSM-5 definition of trauma, or a traumatic event, as it removes the individual from their experience. The DSM-5 defines a trauma as a feeling of 'intense fear, hopelessness or horror' after experiencing an 'actual threat of death' to oneself or others. Scaer presents his issues with this definition, explaining that the parameters of an event cannot determine whether or not they were traumatic: "What makes a negative life event traumatizing isn't the life-threatening nature of the event, but rather the degree of helplessness it engenders…"[9]. In other words, an individual's perspective on an event tends to determine its traumatic impact. While there are events that would be considered universally traumatic, other events may affect people differently. Despite the impact of an event being subjective, the damage that can be done to one's brain and mental health remains similar when experiencing traumatic events.

Those living in poverty are at a significantly higher risk to suffer from mental and physical illness. Living in poverty results in an individual living in 'fight-or-flight' mode more often than not, which the human brain and body are not designed for. This exposure to long-term trauma is defined as toxic stress: "Toxic stress is an emotional and/or physical response that occurs when a person experiences strong, frequent, and/or prolonged adversity without adequate support"[10]. Additionally, the factors that come with living in poverty align with the events depicted in the Adverse Childhood Experience (ACE) Study[11]. The more events in the ACE study that a person experiences before the age of 18, the more health issues they are likely to develop[12]. Some ACEs include witnessing or being the victim of physical abuse, emotional neglect, exposure to mental illness, exposure to substance abuse, and having an incarcerated relative. All of these experiences are significantly more likely when living in low-income communities[13]. Being born into, and living within poverty results in an early exposure to traumatic events and having to live in a constant state of fight-or-flight. At a young age this has detrimental effects on the child's brain development due to the exposure to various stressful contexts such as fighting within the family, early exposure to mental illness, exposure to substance abuse, exposure to violence within the community, overcrowding, food insecurity, and many other stressors which cause a hindrance in development. In a 2022 study looking at the lasting developmental effects of poverty-related stress (PRS), researcher Chelsea Mayo states,

> [C]onsistent with modern psycho-biological models of stress adaptation, it is the pressure of all of these challenging circumstances (i.e., PRS) that together require psychological and biological responses aimed at maintaining homeostasis, thereby placing "stress" on the developing child in an effort to better capture the totality of inputs that culminate in stress on a child's brain and body[14].

Mayo's research highlights the detrimental effects of PRS on child development and criticizes the lack of resources available to those in poverty.

Within the brain, the limbic system is the main player when thinking about trauma and trauma responses. The limbic system houses the amygdala, described by psychologist Rick Hanson as the 'smoke-detector' in the brain as it processes sensory data and stimuli to assess the threat level[15]. If the amygdala determines there is a threat, the body will go into fight-or-flight. The limbic system is also known for being the 'emotional' brain, as the limbic system assigns fear responses to situations, can inhibit our social interactions, and our attachment[16]. The limbic system can be thought of as The Mom of the brain. The limbic systems will tell you when it thinks you are in danger, will tell you if someone or situation is unsafe, and in general will try to keep you safe when it believes the person is in danger. While these are important aspects of the brain to be firing, it is not intended to be firing all of the time. In the smoke detector analogy, if every day someone has a fire in their house the battery on the smoke detector is going to run out significantly faster than in a house that does not. Same with the limbic system, if the limbic system is constantly in overdrive this over-activation results in anxiety, rage, mania, and panic. Additionally, these aspects of the brain turning on also results in areas such as the prefrontal cortex, the part of the brain responsible for empathy, morality, and response flexibility, turning off to have the brain focus on survival[17]. This constant focus on survival can also be defined as hyper-vigilance, a heightened sense of alertness, which puts developmental processes at risk, as stated in the NCTSN:

> In relation to the symptoms affecting attention, concentration, and memory, these children often experience disruptions in academic learning and skill development. Their hypervigilance, heightened sense of alert, and posttraumatic play may set them apart from peers, restrict the normalcy of their social interactions, and place them at risk for delays in social competence. Childhood victims of chronic trauma risk development of a lack of basic trust in the ability of others to protect them, a view of the world as threatening, a lack of self-confidence, and a dysregulated nervous system[18].

Due to the constant hyper-vigilance that comes with living in poverty, many children develop C-PTSD as a result of their environment[19]. The presence of ACEs in one's life puts them at a higher risk for destructive behaviors such as abusing substances. Prolonged hyper-vigilance has detrimental effects on crucial development and emotional regulation, and prolonged exposure to the same traumas is the defining characteristic of C-PTSD as opposed to PTSD. Symptoms of C-PTSD include issues regulating anger, aggression, dissociation, memory loss, difficulty with relationships, depression, and anxiety. If left untreated, C-PTSD often leads to substance abuse, financial struggles, legal problems, and suicide[20].

Unfortunately, due to the circumstances of living in poverty, under-resourced communities often do not have access to mental health resources that they need. Less than 20% of children who need mental health treatment receive any service at all, and of these 20% only 50% receive appropriate service[21].These numbers are based purely on pediatric mental health. When considering the discrepancy of aid between low-income communities and higher-class communities, it is chilling to consider the lack of resources in communities where it is needed the most. Children in low-income communities are at a significant disadvantage in that they are 4 times more likely to be exposed to violent crimes and receive the least amount of resources. Many of the resources that are provided are done so by the community: after school programs, community center support groups, community members creating their own support systems for struggling people. Low-income communities tend to depend on each other as the resources provided by government welfare do not support them effectively[22].

3. Buddhism

3.1 History

Modern Western psychology dates back about a century and a half ago to German psychologist Wihelm Wundt. Wundt studied human consciousness and used experimental methods to study the inner workings of the human psyche. As the field developed, concepts such as the ego, the conscious and unconscious mind, and types of conditioning begin to emerge and solidify a foundation for psychology as a discipline[23].

Similar approaches to the psyche can also be found in India during the *Sramana* movement (800-600 BCE), a philosophical and religious movement in which *sramanas (*"seekers") moved away or reframed from the dominant Vedic traditions at the time[24]. This movement stemmed from the opposition to Brahminic authority and the Vedic theology of the self being identical to the divine Brahman. *Sramanas* sought out their own understanding of self through aesthetic practices. They entertained curiosities of the human condition utilizing practices such as meditation, yoga, and focused on cultivating bodily strategies of awareness in order to better understand their own body and mind. These *sramanic* traditions gave rise to new religious systems, Buddhism by far being the most popular of them[25].

As Buddhism developed, so did notable key concepts such as *dukkha* (suffering), anica (impermanence), and *anatta* (non-self). Early Buddhist texts hold strong parallels to western psychological concepts explored by Wundt and Freud centuries later, notably strategies aimed at alleviating suffering that share strikingly similar aspects with modern behavioral therapeutic approaches such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Rational Emotive Behavior Therapy (REBT), and the Trauma Resiliency Model (TRM).

3.2 Buddhism and Psychology: Suffering and Healing

Where does the sense of self, soul, spirit, or consciousness reside? Biomedical science attempts to place this aspect somewhere within the brain as a physical understanding, psychologists place it within the subconscious, and some religions place it somewhere between our physical body and within the hands of a respective god[26] The Buddha pondered the same ideas surrounding the inner workings of one's mind and how to interpret the immeasurable force of the consciousness to relieve suffering. Buddhism recognizes three aspects of existing: everything is changing, everything is unsatisfactory, and there is no-self (*anatta*). With that, suffering (*dukkha*) is inherent within existing as a person due to attachments and clinging (*tanha*) to permanence.

The Buddha found that people refused to accept the three aspects of existing and often clung to attachments, specifically attaching ideas of ourselves, our sense of self, to anything that is going to change and is not permanent. This attachment is where suffering comes from and is also where Buddhist opposition to Brahmanic cosmologies comes in: the self cannot be identified with any object of experience and cannot be attached to an idea of a perfect identity or perfect control[27]. Sickness, aging, and death cannot be stopped, there is no control of the mind, and there is no control of the world around us, therefore any doctrine of self, even if the self is within the universe or within the divine, will lead to dissatisfaction and suffering. The understanding, however, of *anatta* is not as annihilationist as it is often interpreted. Non-self is not 'there is no self'. Non-self is focusing on oneself as one's own authority, "oneself indeed is one's own protector. What

another protector could there be? With self-control one gains a protector hard to obtain."[28] Another explanation given to understand how there is a self, yet no-self, is comparing the self to a chariot. A chariot, like the self, is only an assembly of parts interworking together. There is no actual chariot: there are wheels, axels, a carriage, and a drawbar all assembled together to create the chariot. The Buddha viewed the self as a compilation of different interworking parts that are called the Five Aggregates.

Within the Five Aggregates the self is broken into the physical form, feeling, perception, volition, and consciousness and each of these are broken into six possible filters: mental, visual, auditory, taste, smell, and touch. The purpose of the Five Aggregates is to be able to sit with one's self and examine one's suffering to identify from where the feeling is stemming. Buddhist psychologist, Andrew Olendzi, comments on the parallels between the Five Aggregates and the Western understanding of psychology.

> The study of reality becomes the study of the human construction of experience, and this is why early Buddhism is so thoroughly psychological in nature. Each of us is constructing our own reality, and understanding how we do this becomes crucial to our ability to experience happiness and meaning in our lives. Some of the principles we must follow in the process are universal, and the Buddhist tradition has much to say about these. Other aspects of the construction process are personal and arise out of unique conditions for each of us, and understanding these forms the basis for personal spiritual development and self- understanding[29].

Deconstructing this quote through a trauma-informed lens, the study of the human experience and how reality is altered due to each person's unique experiences would entail, more so, studying those who are deeply impacted by events from their past which actively warps their reality: this is the impact trauma has on a person. Trauma, especially in children, completely alters one's perception of reality. Partially what classifies an event to be considered traumatic is the lasting effect the event has on a person's life and ability to function in the world around them[30]. The focus in Buddhism to understand one's own experiences and identify how, and when, these experiences affect one's perceived reality in order to achieve a sense of peace is essentially the same goal of CBT to have patients identify their triggers from past trauma, identify how those triggers impact their reality, and how to heal those aspects to reduce stress in the body.

Buddhism creates this framework; which centuries later was used to build common therapeutic techniques within CBT. CBT and the Five Aggregates encourage practitioners to examine their negative feelings through a deconstructed lens to find the root of the pain. CBT even utilizes a grounding technique, often simplified to the '5-4-3-2-1 technique' in which participants focuses through their senses to find peace in their mind and body by identifying five things they can see, four things they can touch, three things they can hear, two things they can smell, and one thing they can taste, which is not unlike the Five Aggregates that also utilize these senses in the practice of grounding. Buddhism also acknowledges many aspects which create suffering for an individual based on personal experiences and that must be identified through self-exploration. In modern day therapy, this identification of a personal suffering especially in regard to the experienced external reality, would be referred to as a trigger. Triggers are automatic responses in an individual which derive from personal experiences, often trauma. As Olendzi summarizes, "There is a dramatic parallel between the models of mind being developed by contemporary Western theorists who are studying the nature of higher mental processes and the Buddhist core doctrine of anatta, or 'non-self'"[31].

Contrary to the Western model of medicine, the biomedical model, early Buddhism understood the patience and time healing takes. Within the biomedical model there is an

unstated assumption that healing has a deadline of sorts, it must be completed within a certain amount of time, and thus 'cured'. Practitioners of Buddhism recognize the process of training the brain to be present to begin a process of healing automatic responses that takes constant practice and is not an overnight success, with each small step being a success in itself. In Western psychology it was not until relatively recently that the focus on mental health began to shift from trying to conceal and hide the symptoms of mental health to exploring the roots of the suffering in patients with focused therapies and meditation. This approach takes patience and has no 'end goal', similar to the Buddhist view towards alleviating suffering. In his article comparing clinical psychology to Buddhist practices researcher Paul Fulton encourages therapists to indulge in Buddhist practices for the benefit of their patients: "[A] therapist who understands that well-being does not depend on the need to gain or eliminate anything may be better positioned to offer the same possibility to clients in the form of radical acceptance"[32]. In other words, if a therapist understands they cannot 'cure' their patient, and releases their own attachment to healing, they will better be able to help their patient accept the same thing.

3.3 Buddhism and Trauma

When it comes to treating people with trauma, especially people who live within ongoing trauma, such as people living in poverty, people living in toxic households, people living with chronic sickness, it can be more harmful than helpful to have a 'curing' approach.

Thinking back to the idea of clinging (*tanha)* to impermanence (*anicca)* being the root of suffering (*dukkha),* but shifting it to a modern therapeutic perspective, treating someone with trauma under the impression that the person will at some point be 'cured' is setting the patient up for failure and suffering. Instead, CBT focuses on training patients how to identify triggers in their body and gives them coping strategies to move past the trigger. This is not unlike Buddhists who follow the Five Aggregates to identify suffering within their body and utilize their meditative practices to continue upon the Eight-Fold Path (right action, right speech, etc.). The fourth Aggregate, volition or action, also identifies skillful and unskillful actions rather than good or bad. Actions done out of a triggered volitional aggregate are understood to be an impulsive reaction yet a person can train one's mind to identify reactive triggers faster before engaging in unskillful behavior[33]. The Buddha's understanding of actions out of an emotional reaction is strikingly similar to the explanation of a trauma response, which is important to not label as 'bad' or 'good'. Fulton explains growth in acceptance as "[L]earning to 'let things be.' With continued practice, we find ourselves surprised when we find we are not upset by something that formerly caused a predictable reaction in us. We gradually discover we don't relate to the world as a reflection of our needs, but take things as they are."[34]. Both the Buddha's use of the 4th aggregate and Fulton's use of acceptance show healing within a person congruent with learning to identify and calm a trauma response.

It is not fair to consider traumas, such as poverty, as a responsibility of the individual to detach from. Chronic trauma is not able to be detached from in the ways one may think when understanding detachment in Buddhism. One would not need to focus on detaching themselves from poverty, but instead harmful cognitions in place arising from classism and capitalism. These include, but are not limited to, attaching to an idea that happiness can only be achieved once someone has reached a certain level of financial status, the attachment to what success looks like, or attachment to other people's ideas of what one should be capable of doing. Fulton critiques the notion of needing to change conditions to achieve peace stating, "[T]his conception of freedom from suffering goes beyond adjustment or the removal of symptoms, suggesting a happiness that is not dependent

on changing the conditions we formerly identified as obstacles to peace. This represents a radical departure from the medical model of psychotherapy."[35]. If someone who is stuck in a systematic oppressive cycle of poverty is set in an attachment to achieving financial freedom as part of their own happiness, the reality is that may not be possible. It is not due to the person's laziness or inabilities, but due to larger oppressive forces outside of their control. This idea circles back to one of the Buddha's oppositions to Vedic theology: discovering the self could lead to a locus of perfect control[36]. The Buddha argued that attaching to ideas of one day having perfect control would only lead to suffering. Applying this to the idea of escaping poverty, it is unrealistic to attach one's happiness to a goal which would entail dismantling a deeply rooted social hierarchy which thrives on those in poverty[37].

This is not to say those in poverty, or other types of chronic trauma, are unable to receive benefit or relief from Buddhism, quite the contrary. One such resource which is deeply unavailable to those in poverty is access to mental health resources[38]. Mental health resources are often unavailable due to financial strain as well as the lack of accessibility. The lack of mental health resources directly benefits classist social structures by ensuring people in poverty stay in poverty and do not receive the help they need to thrive. However, many low-income areas have begun to utilize Buddhist techniques to help those suffering in poverty from chronic stress, C-PTSD, addiction, depression, anxiety, and more. Seeing as CBT, which is the modern Western treatment therapy for those suffering with many of these same issues, overlaps with Buddhist theories and practices, the research conducted utilizing Buddhism to help those in low-income communities has shown irrefutable benefits.

4. Clinical Mindfulness

4.1 Therapy Models

A study in 2014 explored the parallels between Buddhist meditation practices and the Trauma Resiliency Model (TRM) approach to counseling developed by Elaine Miller Karas[39]. The purpose of the TRM is to help patients return from states of system dysregulation, or survival mode, into a calmer state. The model is broken down into nine parts. Jane Compson identified these parts and placed them within aspects of Buddhist meditations. For example, what is called "tracking" within the TRM follows the same rules as 'grounding' when studying Buddhist meditations[40]. Contrary to the popularized idea of meditation, this study compared TRM to Theravada Buddhist meditations from the Pali Canon which allows for negative thoughts to be present within mindfulness. A common misconception about meditation, mainly due to popular media, portrays mediation and mindfulness with an absence of hindrances: anger, lust, pain, delusion, etc. However, the Pali canon recognized mindfulness of all minds, "the second foundation of mindfulness is mindfulness of pleasant, unpleasant and neutral feelings. The third is mindfulness of mind states, including negative mind states…"[41]. The allowance of negative feelings and mind states is crucial when doing trauma-informed care.

In 1979 Jon Kabat-Zinn developed Mindfulness-Based Stress Reduction (MBSR), followed by Mindfulness-Based Cognitive Therapy (MBCT) in the 1990s developed by John Teasdale and Zindeel Segal. These developments led to the wider use of clinical mindfulness, informed almost fully if not explicitly by Buddhist traditions[42]. In 2014, a different study using the MBCT and MBSR methods of clinical mindfulness held a five-part mindfulness class at community centers across the United States for local low-

income residents. The course was led by a trained Buddhist graduate student and covered topics such as stress, anger, self-judgment, chronic pain, financial hardships, and racism. The classes were one-hour long, once a week and the participants received paper handouts to take home. Every participant by the end of the course rated the class as helpful (4/5) or very helpful (5/5). Many reported a decrease in stress and anger as well as an improvement with their relationships[43].

Looking back to the areas of the brain affected by prolonged complex trauma, when the amygdala is on high alert and the prefrontal cortex inhibited, neuroimaging shows mindfulness combating these exact area responses:

> [F]unctional neuroimaging methods found that trait mindfulness was associated with reduced bilateral amygdala activation and greater widespread prefrontal cortical activation during an affect labeling task. There was also a strong inverse association between prefrontal cortex and right amygdala responses among those who scored high on mindfulness, but not among those who scored low on mindfulness, which suggests that individuals who are mindful may be better able to regulate emotional responses via prefrontal cortical inhibition of the amygdala"[44].

According to this study, not only do mindfulness-based treatments focus on the exact areas in the body and mind often affected by trauma, due to the nature of mindfulness treatments its accessibility far surpasses that of clinical mental health counseling or even recovery facilities. While some studies are performed by those with extensive mindfulness training or Buddhist training, there is still a high success rate for community center practices, practices in schools, practices in prisons, and the individual practice for reducing symptoms of C-PTSD.

4.2 Applications

In order to highlight the need for a change regarding the mental health resources available to those in impoverished communities, I will be examining the intersection of poverty and trauma within the contexts of the education system and the prison system within the United States, and how Buddhist techniques have been used to heal trauma symptoms within these infrastructures.

4.2.1 Context I: Education

4.2.1.1 Counseling in Schools

The American School Counseling Association recommends a ratio of 250 students per every one school counselor available. This counselor should also be spending about 80% of their time working directly with the students. In 2019, the average student to counselor ratio across all schools was 464 students to one counselor, this being applicable only to schools that have a counselor on staff. About one in five students do not have access to a counselor in their school and of the group with no counselors available, over 30% of those children have no access to school support staff, a school psychologist, or social worker[45]. Breaking down those numbers, about eight million students have no access to a counselor in school and about three million have no access to any official support system of any kind within their school setting.

In America, less than 10% of the funding for public schools comes from the federal government, nearly 70% of public school funding comes from the state and the remainder from each individual county. While each state's funding formula is different, in most states

the local property taxes make up the majority of school funding[46]. With this in mind, those living in poorer states, or even just poorer areas of states, will have significantly less funding put towards their public education. Across all schools in America, thirty-eight states show evidence of providing disproportionate funding to schools with a high percentage of low-income students and students of color. As noted by Melanie Hanson in her data report regarding the U.S. public education spending discrepancies, “Students of color and students from low-income families have been overlooked and underserved for far too long. If anything, they deserve more access to school counselors than their peers- not the same, and certainly not less. And yet, the schools serving the most students of color or the most students from low-income families are shortchanged when it comes to school counselors.”[47] Research done in 2018 by Dr. Richard T. Lapan found that within low-income schools when resources such as free lunches and access to counseling were provided, attendance improved, fewer disciplinary incidents occurred, and graduation rates improved. In general, the study was able to link a lower student to counselor ratio with overall academic improvement in schools and higher graduation rates[48].

4.2.1.2 Application of Buddhist practices in schools

Unfortunately, despite the research, schools across the country remain underfunded and without needed resources. As earlier stated, children who live in poverty are at a substantially higher risk for mental health issues and with no resources to aid in the trauma faced, many of those in poverty develop conditions such as C-PTSD. If schools cannot get the funding they need, what options are available? Oftentimes, community members will come together and create resources for families, after-school programs created from extra efforts of teachers and parents, and teachers taking on the role of counselor within their classrooms. Teachers in low-income schools began to learn about mindfulness practices and integrating these activities into their classrooms, working as a substitute for the lack of mental health resources in the school.

A study in 2018 took eight teachers at an elementary school and trained them to lead mindfulness practices for ten to fifteen minutes a day for six weeks. The teachers underwent one hour of training and were provided with a simple study format worksheet, which listed some mindfulness practices to complete with the students. The study was conducted with 124 elementary school students, with about 50% of the children participating had already experienced one or more ACE[49]. By the end of the six weeks the teachers reported overwhelming positive results from their students as well as their own improvement. The study concluded that “Diffusing mindfulness programs more broadly as part of a preventative, trauma-responsive, resilient community initiative has the potential to universally lessen the effects of ACEs and improve community-wide resilience”[50]. This is one of many studies done showing the positive effects of mindfulness practices being implemented within the school setting, especially in schools where the students are more likely to have high ACE scores. In studies such as these, the teachers undergo a short training and are given simple tasks to include in their curriculum that have been proven to benefit the students’ academic performance as well as behaviors directly correlated with high ACE scores, C-PTSD, and hypervigilance. The benefits derived from implementing these practices could bridge the gap between the lack of mental health resources available to underfunded schools and the children in need of support.

4.2.2 Context II: Prison Systems

4.2.2.1 Counseling in Prisons

In 2014 a nonprofit journalism organization was founded that focuses on the United States criminal justice system and its urgent need for reform. Led exclusively by formerly incarcerated people, the Marshall Project publishes journals on numerous subjects regarding the inhumane conditions inmates endure at the hands of the unjust justice system. the Marshall Project has won two Pulitzer Prizes for the organizers' work and has had a hand in multiple investigations which have led to improvement in the treatment of inmates. In 2018 the Marshall Project published an article titled, "Treatment Denied: The Mental Health Crisis in Federal Prisons" that highlighted a distortion from the Federal Bureau of Prisons (BOP) just a few months prior. In 2014, the BOP reportedly implemented new policies for better mental health care and treatment for their inmates. In 2018 the BOP reported a 35% decline in patients' need for treatment and that only 3% of inmates suffer from serious mental illness. This report, however, is not due to a significant improvement of conditions, but due to prisons denying patients actual mental health treatment and underdiagnosing inmates as they enter the prison, as the Marshall Project made aware, "Patients who were admitted with diagnosed mental illness were later determined, by the prison staff, to have no signs of mental illness and not require treatment"[51]. A survey done on access to mental health counseling reported 66% of federal prison inmates and 74% of state prison inmates received no mental health care, yet the same study reported that one in four inmates experienced "serious psychological distress" at least once. Even after being released, there are psychological effects that remain with the formerly incarcerated person, most commonly: post-traumatic stress, anxiety, and major depressive disorder[52]. The damaging effects of incarceration on inmates is so common, some researchers argue for a subsection of PTSD referred to as Post-Incarceration Syndrome (PIS). PIS shares many characteristics of C-PTSD, likely due to the similar prolonged nature of the trauma and the denial of basic needs or safety[53]. Despite the insinuation of improved mental health from the BOP, suicides, suicide attempts, and self-inflicted injuries increased by 18% since 2015[54].

While each state regulates their prisons differently, across all states and federal prisons there is a concerning lack of qualified mental health professionals. During a trial regarding the improvement of mental health resources in South Carolina prisons, the South Carolina Department of Corrections agreed with the expert witness that the appropriate ratio for counselors to inmates was about 1:40. At that time, the ratio was about 1:575. Additionally, 55% of the mental health counselors were deemed unqualified and unsatisfactory[55]. A study published in 2021 provided quotes from twenty-two inmates regarding the treatment they have access to and receive from within the prison. In reference to the interaction with the prison health care providers, one inmate explains that the staff has "no loyalty" to the inmates because they do not pay them and will do whatever is the cheapest option, even if it's not the best. Another inmate expressed her frustration with prison psychiatrists diagnosing inmates: "Yeah, you're depressed', and gave me some pills that didn't agree with me.…I do think a lot of the women are not diagnosed right and they end up coming home crazy….They may have needed just counseling, or somebody that was concerned, and would sit down and talk with them to see where they're at"[56]. On top of employing unqualified staff for mental health, many prisons utilize the limited resources earmarked for mental health treatment to fill other positions around the prison. Russ Wood, a former prison psychologist stated, "The psychologists were getting pulled off to work gun towers and do prisoner escorts. We're not really devoted to treating."[57]

Another common practice within prisons is placing inmates in solitary confinement

when there is concern for their mental health. An article titled “You Shouldn’t Have Used the D-Word” recounts a previously incarcerated man’s experience when he disclosed feeling depressed to the prison therapist:

> [H]e told me I shouldn't have used “the D-word” and put me on suicide watch. I was led to an empty cell, stripped naked and handed a smock. They told me this was to prevent me from using my clothing, shoe laces and sheets to fashion a noose. The isolation was torturous, and it made me think even more about suicide. In the nearly twelve years that I’ve been incarcerated, I have never talked to a mental health professional.[58]

Many states also have safe-keeper laws in which the state has the ability take an inmate currently located in a local jail and move them to a state prison to be held in solitary confinement if the local jail is deemed ‘ill-equipped’ to hold the inmate. A study done looking at jail detainees in Tennessee from over the course of six years found 41.5% of safe-keepers were transferred into solitary confinement for no specified reason, 21% for mental health, and 10% had the reasonings redacted after compilation of the solitary confinement data. Over the six years, the average stay in solitary was 328 days[59]. Despite the numerous national studies that detest solitary confinement for its detrimental effects on inmates, mentally and physically, it remains a common ‘solution’ when an inmate needs mental health treatment.

4.2.2.2 Application of Buddhists practices

In 1973, Bo and Sita Lozoff started the Prison-Ashram Project. This project introduces inmates to yoga, meditation, and Buddhist thought as a form of healing and preservation from within the prison. Bo comments on the unfortunate reality in which most political leaders view inmates as less than human and undeserving of kindnesses, noting that “That rhetoric has resulted in the steepest rise of prison population history, housed in buildings that are so anti-life that they defy all reason, logic, and morality”[60]. As earlier mentioned, the access to professional, adequate, and consistent mental health treatment is nearly impossible for inmates, yet they are in dire need of it. Many inmates arrive in prison with trauma and have had little to no prior access to counseling or therapeutic intervention of any kind. The prison system is intended to be a place of rehabilitation and reform, yet most inmates leave more traumatized than when they arrived[61]. CBT is proven to be the best form of treatment for reliving trauma and recidivism, unfortunately due to the lack of resources and denial of treatment, it is unrealistic to believe inmates would have access to the support needed to begin CBT. In an effort to survive mentally, emotionally, and spiritually some inmates begin looking to Buddhism as a way to make sense of their daily life. Inmates have reported finding their own liberation and freedom through Buddhist meditations and regaining a sense of peace they had lost or, often, a sense of peace they had never known[62]. Bo Lozoff created a three-part practice for inmates which he called “the Great Recovery: a regular practice of meditation, a commitment to ethical behavior, and the practice of open, accepting compassion for all our neighbors”[63]. The Prison-Ashram Project continues to be the largest interfaith prison ministry.

Due to the nature of Buddhist practices, many inmates find a more consistent comfort and relief in it than relying on more Western approaches to healing. Buddhist practices are malleable and can be done anywhere at any time. The practices can be learned from books and do not require another person (i.e. a therapist, a psychiatrist, a counselor) to

coach the individual, and utilizes similar methodologies to CBT which allows for an actual shift in the inmates' mental health. Konami Scott Whitney, author of *Sitting Inside: Buddhist Practices in America's Prisons,* and former Buddhist chaplain of Washington's Department of Correction, theorizes that inmates' pull towards Buddhism and the profound effects of the practice is likely related to the emphasis on suffering, how one holds onto it, and how to release it, rather than emphasizing the inmates mistakes or creating a situation in which they are labeled more for their choices than as a person who has made a mistake[64]. In the Buddhist text, the *Angulimala Sutta,* the Buddha sits with and helps a notorious murderer who is brought to tears by the Buddha's compassion for him despite his crimes. The man studies the *sutras* with the Buddha and is later ordained as a monk. Within Tibetan Buddhist history is a highly revered yogi and poet, Jetsun Milarepa, who experienced many hardships in his early life which led to him seeking revenge on those who had hurt him and his mother. Though Milarepa successfully obtained his revenge through violent acts, he was still suffering and sought out Buddhist teachings. After years of practice, Milarepa is able to be released from his sufferings. Despite his crimes, Milarepa is honored in Tibetan Buddhism. Whitney explains, "The importance of [these] stories for us is that it makes it quite clear that criminals were not to be excluded from…the possibility of awakening."[65] Furthermore, these stories rely on the practitioner's commitment to themselves and the teachings for peace, not on external forgiveness, punishment, or shame. Buddhist teachings allow for inmates to find peace and forgiveness in themselves, something every person deserves regardless of choices made. An example of the healing power Buddhism can have on inmates is shown in the documentary The *Dhamma Brothers*[66]*.* In this film, twenty inmates completed a 10-day intensive Vipassana meditation practice. Some inmates had been sentenced to life without parole, some had committed violent crimes, and some were leaders of gangs from within the prison. By the end of the meditation all twenty inmates were dedicated to their newfound peace. The documentary, and the book published afterwards, share the words of the prisoners and how they felt after completing the Vipassana meditation. One inmate feared facing his anger, but during the course was able to find self-forgiveness and settle with his grief, noting that "Now I don't have to make excuses to myself anymore. I pulled some of my masks off. In my other treatments, I never have been able to do that"[67]. Another inmate, after the meditation, began pursuing poetry as an outlet and was still actively practicing Vipassana four years after the original course had ended. Inmate Willie Carroll, incarcerated at sixteen, and age forty-four at the time of the documentary, had attempted multiple times to escape, but eventually surrendered to the reality of his prison sentence. After accepting this reality, Carroll spent years in the prison system seeking available treatment to help him heal, yet did not find stable and helpful relief until the Vipassana meditation, expressing that "To this date, Vipassana has offered and continues to bring peace of mind to me…especially in times of seemingly total despair"[68].

In 2014, the *Official Publication of the American Correctional Association* published an article regarding the effectiveness of mindfulness-based intervention (MBI) and Vipassana meditation (VM). The article included five different research studies from various correctional facilities. One such study looked at the use of VM with substance-

abuse related inmates prior to parole. The study group followed a ten day silent VM program, similar to that used in *The Dhamma Brothers, while* the control group participated in their regular treatment provided by the prison: group counseling once a week, dependency treatment, and psychoeducation. A follow-up was conducted three months after the completion of the VM. When compared to the regular treatment group, the group which participated in the meditation reported a drastic reduction of substance use: 87% reduction in alcohol use, 66% reduction in crack cocaine use, 89% reduction in cannabis use, and 60% reduction in alcohol related consequences[69]. Another study done at 6 facilities in Massachusetts studied 1,953 inmate's improvement after six to eight weeks in a mindfulness-based course. The control group continued with regular treatment: smoking cessation training, literacy education, and exercise. The MBI group reported an 8% reduction in hostility, 5% increase in self-esteem, and a 31% decrease in mood disturbances while the control group showed no significant changes[70].

Across multiple sources, the use of MBI and VM in American prisons shows a strong correlation to a development in self-control, a reduction in anger and hostility, an increase in self-esteem and optimism, increased relaxation capacity, and an increase in compassion for the individual and for others[71].

5. Conflict

Despite the parallels in Western therapeutic approaches to Buddhist practices, the research done to show the positive effects Buddhist practices can have in different contexts, and the overwhelming lack of mental health resources available, integrating these practices into contexts that are in need has met with much backlash.

5.1 Poverty to Prison Pipeline

Recent years have highlighted the foundational corruption and prejudice within the United States justice system, which has gone unnoticed far too long by those privileged enough to be unaffected. Those affected the most by this corruption are people living in poverty and people of color. Unfortunately, the judicial system is one large moving part of a much larger oppressive structure, which relies on exploiting those in poverty and inmates in order for the United States economy to thrive. Prior to the Great Recession, the U.S. economy more than doubled, yet poverty rates remained the same while incarceration rates increased by 342%[72]. The poverty to prison pipeline (PTPP) is a cycle created to funnel those in poverty into the prison system by withholding resources and creating legislation that criminalizes being poor[73]. This cycle is very hard to break as it requires access to opportunities often unavailable to those in poverty, and due to this many people stay in the cycle of poverty or enter the prison system.

Broadly, if starting the cycle as a person living in poverty, a person is already at a disadvantage due to their lack of resources. If the person has no access to materials needed to survive, they are more likely to commit a crime to obtain food, shelter, or safety. Once this crime is committed and the person is taken to jail they are introduced to the cash bail system where they can either pay bail and leave or they cannot pay the bail and must stay in jail. The cash bail system allows for those with more money to be relatively unaffected by some laws or fines[74]. In areas with disproportionately high rates of people in poverty, such as Chicago, Atlanta, and Nashville, there are bondsmen who trap minor

offenders into debt by offering to pay their bail and placing interest rates so high it is nearly impossible for people to pay them off. These bondsmen usually have a political or economic advantage, making it very hard to displace them, especially when they prey on impoverished people who could not afford representation either way[75]. After being unable to pay bail, the person must stay in jail until their court date. In this time, they are unable to work and earn money, depending on the time between being arrested and the court date, the person could have lost their job. Once released from jail, almost 50,000 people will enter homeless shelters and they are five times more likely to be unemployed. Due to the lack of resources available for those in poverty, it is likely the person would need to commit a crime in order to survive, thus continuing the cycle[76].

Maintaining the cycle of poverty is also prominent in the United States medical industry. In William Sage's article regarding the medicalization of poverty he states, "It may be largely coincidental that America's two "sovereign professions"- medicine and law- control the medicalization and criminalization narratives."[77]. In the PTPP, the medical industry falls within the 'No Opportunities' and 'Poverty' categories by privatizing vital resources such as mental health treatment, addiction treatment, physical therapy, gynecologists, and obstetricians as well as increasing co-pays to see the doctors which are covered[78]. Similar to the bail bonds who prey on impoverished people, there are "Medicaid mills" within the medical industry. These are medical professionals who perform unneeded services on their poorer patients so they can charge and receive more money from Medicaid[79]. Additionally, due to the framing of the medical model with the medical industry, particularly in regards to mental health, every issue is thought to be diagnosable and, in turn, curable. However, mental health treatment is very rarely a 'one-and-done' fix, but due to the privatization of therapists and psychiatrists, those who rely on Medicaid are often charged and prescribed for multiple medications from their primary care physician as their only means of mental health treatment[80]. As earlier stated, the medicalization of poverty aids in the cycle by requiring steep copays and privatizing access to certain medical cares. The privatization, specifically to mental health, can be seen in the prison system as well as the public school system. Those in the impoverished communities are deliberately withheld from receiving mental health treatment which directly benefits the PTPP. People suffering from untreated mental illness are more likely to be targeted, oppressed, and taken advantage of by the medical and justice system. A common "Medicaid mill" strategy is to force patients in mental hospitals to stay against their will to be able to bill for extended treatment[81]. The PTPP also thrives on people with unresolved trauma. In prisons and schools, those who act out from a place of unresolved trauma are not treated with compassion but with punishment. Children are suspended or expelled and inmates are placed in solitary confinement. No resources are provided for people in poverty to learn to cope with trauma.

Despite the use of Buddhist techniques within privatized medical disciplines (e.g. CBT) being acceptable, when used in areas such as prisons or low-income schools to aid those lacking resources the programs are often dismantled. Despite the overwhelming amount of evidence which proves the use of Buddhist techniques aiding in stress reduction, anger management, self-control, higher graduation rates, lowered disciplinary actions in both schools and prisons, improved self-esteem, lowered revisitation in prison, higher attendance rates in school, improved academic performance, and a decline in nearly all symptoms congruent with C-PTSD, programs that incorporate these techniques are repeatedly rejected and the communities are left with nothing to bridge the gap left by a lack of funding, resources, and care.

5.2 Religious Prejudice

Utilizing the same foundation as the PTPP, those who hold the power within social structures abuse this power to maintain control and avoid implementing anything which could go against their values. With that, both the U.S. prison system and the school system are deeply rooted and influenced by a predominantly unexamined Christian cultural context. Furthermore, as also seen in the PTPP, the U.S. power structures are also deeply racist.

In the 1970s the case *Cruz v. Beto* made its way to the Supreme Court after an inmate was placed in solitary confinement for several months with only two pieces of bread a day to eat. Cruz was being punished for practicing "exotic religions" after he began corresponding with a Buddhist prison ministry. Cruz wrote his lawsuit entirely on pieces of toilet paper, but in 1977 the Supreme Court favored Cruz to be able to continue his practice[82]. Despite this, prison administrations have continued to reject implementing Buddhist practices within the prison or having representation for those who practice Buddhism as their religion. Due to the nature of the judicial system, state legislation was able to reinterpret the Supreme Court ruling and begin to prohibit religious practice if those in charge in the prison deemed it "rational", which leads to those in power abusing their authority to impose their own beliefs onto the inmates[83]. Since the 1970s there have been numerous Buddhist prison outreach programs, nonprofit organizations mainly, developed to expose inmates to Buddhist practices due to its benefits for the inmates. Despite many of these programs being volunteer based and at no cost to the prison itself, many of the prison outreach groups are denied entry or if programs are established they are quickly dismantled[84]. Lastly, particularly in schools, a problem arises from a blatant misunderstanding of Buddhism. One can practice Buddhism or use Buddhist techniques and still remain faithful to a separate religion. Whitney states, "At the core of Buddhism is the practice of sitting still and observing one's own mind. The practice can, of course, be taken up by Catholics, Jews, Muslims with no need to convert to a new religion. Meditation can become part of anyone's life."[85]. Despite Whitney's quote being in reference to prison practice, the sentiment remains true. Much opposition to Buddhism in schools is the hypocritical presence of one religion and not others, or fear of attempting to convert children to a specific religion outside of their families; however, people from a variety of religions utilize Buddhist techniques for their healing purposes without sacrificing their own religious affiliations[86]. The purpose of these practices is to provide a substitute for the lack of mental health resources within the school, using them in place of traditional counseling does not distance students from their faith any more than having access to proper counseling would, which would utilize the same Buddhist techniques but under the label of CBT. Based on research mentioned earlier, implementing mindfulness in the school curriculum has deeply beneficial results on grade improvement, rise in attendance, less behavioral disturbances, increased mood, and higher graduation rates. When considering the students in deeply underfunded schools who are exposed to significantly more trauma than others, the benefits of having access to coping strategies outweighs the potential for the misperception of being exposed to a new religious system.

6. Conclusion

A study published in 2019 found that about 10% of children between the ages of five and sixteen suffer from mental illness, half of those before the age of fourteen. Factors such as low socioeconomic status, adverse childhood experiences, and a lack of stable support systems were some of the key factors to the presence of mental illness in young

people, all factors directly related to living in poverty[87]. The lack of resources consistent with living in poverty directly supports the PTPP and maintaining oppressive structures within the foundations of the United States government and economic system. When faced with adversity, people become resilient and find a way to cope and to thrive. Underfunded schools have turned to Buddhist techniques to help their students to succeed. Former inmates and those opposed to the prison system have seen its deliberate failings in rehabilitation and have built non-profit organizations utilizing Buddhist techniques to aid inmates achieving peace within themselves. In both contexts, those using these techniques have shown significant declines in behaviors synonymous with C-PTSD and hypervigilance.

Utilizing Buddhist techniques within underfunded communities can help those struggling with trauma and other mental illnesses. Additionally, it is malleable and fits the complex schedules one may have if navigating a life in poverty, the allotted free time of an inmate, or the small spaces within a teachers' curriculum. These techniques are also cheap, they require very little. Whitney's book *Sitting Inside*, while it does make comments on the prison system's racist and classist structures, is actually a book created for inmates to be able to craft their own meditation practice from just one source. It does not require a teacher or therapist to engage with these tools. In schools, teachers who do utilize these techniques can undergo as short as one hour of training, and still the effects on their students have been shown to have a profound improvement.

By bridging the gap between those in poverty and their access to mental health, there could be a viable possibility at reducing incarceration rates, poverty rates, as well as increasing graduation rates in low-income schools and in general a possibility at improving quality of life for those in poverty. Bridging this gap could lead to a significant breakage of the poverty cycle for many children and families.

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8. References

1.“Low-Income Communities: Anxiety and Depression Association of America, ADAA,” Anxiety and Depression Association of America, ADAA, last modified in 2022, https://adaa.org/find-help/by-demographics.

2.“What Is Trauma? Trauma-Informed Care Implementation Resource Center,” Center for Health Care Strategies Trauma (CHCS), last modified July 8, 2022, https://www.traumainformedcare.chcs.org/what-istrauma/.

3.Saundra K. Ciccarelli and J. Noland White, *Psychology: DSM 5* (MA: Pearson, 2014).

4.“The ICD-11: International Statistical Classification of Diseases and Related Health Problems,” World Health Organization (WHO), last modified February 11, 2022, https://www.who.int/news/item/11-02-2022-icd-11-2022-release.

5.P. Hyland, et al, “Validation of Post-Traumatic Stress Disorder (PTSD) and Complex PTSD Using the International Trauma Questionnaire,” Acta Psychiatr Scand, no. 3 (2017): 313–22, https://doi.org/10.1111/acps.12771.

6.K. Collins, et al*, Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions*, (MD: Family Informed Trauma Treatment Center, 2010), 1-120.

7.“U.S. Department of Housing and Urban Development (HUD),” U.S. Department of Housing and Urban Development (HUD), accessed April 3, 2023. https://www.hud.gov.

8.“American Psychological Association (APA).” American Psychological Association, accessed April 3, 2023, https://www.apa.org/.

9.Jane Compson, “Meditation, Trauma and Suffering in Silence: Raising Questions about How Meditation Is Taught and Practiced in Western Contexts in the Light of a Contemporary Trauma Resiliency Model,” *Contemporary Buddhism*, no. 2 (2014): 1-32, https://doi.org/10.1080/14639947.2014.935264.

10.CHCS, “What is Trauma?”

11.“What are ACEs?,” Joining Forces for Children, last modified March 29, 2018, https://www.joiningforcesforchildren.org/what-are-aces/.

12.Joining Forces, “What are ACEs?”

13.Collins, *Understanding the impact of trauma*, 13.

14.Chelsea O. Mayo, et al., “Coping with Poverty-Related Stress: A Narrative Review,” *Developmental Review*, no. 64 (2022): 1-27, https://doi.org/10.1016/j.dr.2022.101024.

15.Rick Hanson, *Buddha's Brain: The Practical Neuroscience of Happiness, Love, and Wisdom* (CA: New Harbinger Publications, 2011), 1-272.

16.Compson, “Meditation”, 4.

17.Compson, “Meditation”, 5-6.

18.Collins, *Understanding the impact of trauma*, 12.

19.Hyland, “Validation”, 320.

20.“Complex Post-Traumatic Stress Disorder,” United Brain Association, last modified June 30, 2022, https://unitedbrainassociation.org/brain resources/complex-post-traumatic-stress-disorder.

21.Marc Atkins, “School-Based Mental Health Services in Urban Communities,” *Handbook of School Mental Health Advancing Practice Researchers*, (2006): 165-178.

22.Atkins, “School-Based”, 169-171.

23.Laura Harold, “Health Benefits of Mindfulness-Based Stress Reeducation,” Very Well Mind, last modified January 3, 2022, https://www.verywellmind.com.
24.Seth Robert Segall, *Encountering Buddhism: Western Psychology and Buddhist Teachings* (NY: State University of New York Press, 2003), 9-10.
25.Segall, *Encountering Buddhism*, 10-11.
26.Segall, *Encountering Buddhism*, 12.
27.Douglass Smith, “The Buddha on Self and Non-Self,” filmed 2018, video, 20:07, https://youtu.be/gSZjKKuvHEQ.
28.Max F. Müller, *Dhammapada*, (SC: CreateSpace, 2014), 160.
29.Segall, *Encountering Buddhism*, 17.
30.Matthew J. Friedman, "Trauma and Stress-Related Disorders in DSM-5," National Center for PTSD, 2013, https://istss.org/istss_main/media/webinar_recordings.
31.Segall, *Encountering Buddhism*, 2.
32.Paul R. Fulton, “Contributions and Challenges to Clinical Practice from Buddhist Psychology,” *Clinical Social Work Journal 42*, no. 3 (2013): 211.
33.Smith, “Non-Self”.
34.Fulton, “Contributions”, 211.
35.Fulton, “Contributions”, 214.
36.Smith, “Non-Self”.
37.Federica Durante and Susan T Fiske, “How Social-Class Stereotypes Maintain Inequality,” *Current Opinion in Psychology*, no. 18 (2017): 43.
38.Compson, “Meditation”, 2.
39.Compson, “Meditation”, 2.
40.Compson, “Meditation”, 7.
41.Compson, “Meditation”, 20.
42.Harrison A Blum, “Mindfulness Equity and Western Buddhism: Reaching People of Low Socioeconomic Status and People of Color,” *International Journal of Dharma Studies 2*, no. 1 (2014): 2.
43.Blum, “Mindfulness”, 8.
44.Blum, “Mindfulness”, 2.
45.“Ethical Responsibilities,” American School Counselor Association (ASCA), last modified February 2019, https://www.schoolcounselor.org/About School-Counseling/Ethical-Legal-Responsibilities.
46.Melanie Hanson, “U.S. Public Education Spending Statistics: Per Pupil + Total,” Education Data Initiative, last modified August 24, 2022, https://educationdata.org/public-education-spending-statistics.
47.Hanson, “U.S. Public Education”.
48.Richard T Lapan, et al, “Missouri Professional School Counselors: Ratios Matter, Especially in High- Poverty Schools.” *Journal of Professional School Counseling 16*, no. 2 (February 15, 2018).
49.Kurani, et al, “Area-Level Deprivation and Adverse Childhood Experiences among High School Students in Maryland.” *BMC Public Health 22*, no. 1 (2022).
50.F. A. Huppert, “Psychological Well-Being: Evidence Regarding Its Causes and Consequences,” *Applied Psychology: Health & Well-Being*, no 1 (2009): 137–64.

51.Christie Thompson, “Why so Few Federal Prisoners Get the Mental Health Care They Need,” The Marshall Project, last modified November 21, 2018, https://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health.

52.“Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health,” Prison Policy Initiative, https://www.prisonpolicy.org/mentalhealth.

53.Prison Policy Initiative, “Research”.

54.Thompson, “Federal Prisoners”.

55.Jonathan D LeCompte, “When Cruel Become the Usual: The Mistreatment of Mentally Ill Inmates in South Carolina Prisons.” Scholar Commons, last modified 2015, https://scholarcommons.sc.edu.

56.Ashley Wennerstrom, et. al, “’You Have to Be Almost Dead before They Ever Really Work on You in Prison’: A Qualitative Study of Formerly Incarcerated Women’s Health Care Experiences during Incarceration in Louisiana, U.S.” *Health & Social Care in the Community 30*, no. 5 (2021): 1763–74. https://doi.org/10.1111/hsc.13556.

57.Thompson, “Federal Prisoners”.

58.Nicholas Brooks, “'You Shouldn't Have Used the D-Word’,” The Marshall Project, last modified July 8, 2022, https://www.themarshallproject.org/2022/07/08/you shouldn-t-have-used-the-d-word.

59.Arthur Allen and Dave Boucher, “Too Sick for Jail? Tennessee Will Send You to Solitary Instead,” The Marshall Project, last modified February 15, 2018, https://www.themarshallproject.org/2018/02/15/too-sick-for-jail-but-not-for-solitary.

60.Kobai Scott Whitney, *Sitting inside: Buddhist Practice in America's Prisons*, (Massachusetts: Prison Dharma Network, 2017), 9-10.

61.Kevin Ring Gill, *Using Time to Reduce Crime* (WA: Families Against Mandatory Minimums, 2017), 9-13.

62.Whitney, *Sitting Inside*, 9-10.

63.Whitney, *Sitting Inside*, 11.

64.Whitney, *Sitting Inside*, 19.

65.Whitney, *Sitting Inside*, 19.

66.Jenny Phillips, *The Dhamma Brothers* (April 11, 2008, Boston, MA: Northern Lights Productions), Film.

67.Jenny Phillips, *Letters from the Dhamma Brothers: Meditation Behind Bars* (WA: Pariyatti Publishing, 2008), 35.

68.Phillips, *Letters from the Dhamma Brothers*, 37.

69.Edo Shonin, “Mindfulness Meditation in American Correctional Facilities,” *Corrections Today*, 2014. 49.

70.Shonin, “Mindfulness”, 49.

71.Shonin, “Mindfulness”, 50.

72.Tishawna Jones, “Poverty to Prison Pipeline”, Seton Hall University, last modified May 2019, https://scholarship.shu.edu/petersheim-exposition/51

73.There are many pipeline titles which focus on various starting points in the process in this paper this phenomenon will be referred to as the poverty to prison pipeline (PTPP).

74.Jones, “Poverty”.

75.William M. Sage and Jennifer E. Laurin, “If You Would Not Criminalize Poverty, Do Not Medicalize It,” *Journal of Law, Medicine & Ethics 46*, no. 3 (2018): 577.

76.Jones, “Poverty”.
77.Sage, “Criminalize Poverty”, 573.
78.Sage, “Criminalize Poverty”, 573.
79.Sage, “Criminalize Poverty”, 579.
80.Sage, “Criminalize Poverty”, 575.
81.Sage, “Criminalize Poverty”, 575.
82.Scott, *Sitting Inside*, 9.
83.Scott, *Sitting Inside*, 11.
84.Paul McIvor, “Outside Buddhism: A Study of Buddhism and Buddhist Education in the U.S. Prison System” (Masters of Arts diss., University of South Africa, 2011), 81-86.
85.Scott, *Sitting Inside*, 15.
86.Scott, *Sitting Inside,* 15.
87.Sapthiang Supakyada, William Van Gordon, and Edo Shonin. “Health School-Based Mindfulness Interventions for Improving Mental Health: A Systematic Review and Thematic Synthesis of Qualitative Studies*,” Journal of Child and Family Studies 28*, no. 10 (2019): 50.