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PSYCHOSIS IN PRISON

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Psychiatric involvement in the understanding and treatment of criminals has grown rapidly in the past decade. Much of this interest has been focused upon such areas as legal responsibility, adolescent delinquency and sexual psychopathy. There are many psychiatrists who participate in the courtroom practices surrounding the determination of criminal responsibility.[1] Increasing numbers of psychiatrists are willing to work in institutions treating the young delinquent.[2] There are fewer professionals who are involved in the treatment of the sexual psychopath, but their ranks are increasing as treatment programs develop.[3] But, for the large group of adult prisoners, the availability of psychiatric resources ranges from non-existent to minimal. There are some obvious reasons for this. The punitive, gloomy atmosphere of a prison is apt to be found stultifying, limiting and depressing by psychiatrists. In most large penitentiaries the psychiatrist does not have a major impact on the prison milieu, and he is not often invited to participate in the development of an enlightened program. With rare exceptions, efforts to make such contributions are frustrated.

What avenues, then, are open for the psychiatrist who wishes to contribute to the understanding and treatment of the emotional problems of the adult criminal? Given the present state of the American correctional systems, we submit that he must compromise. He must work within existing structures that are for him strange, non-therapeutic, and which have certain built-in determinants militating against successful outcomes. Such challenges are not new to psychiatry.

As is true with any patient, therapeutic work begins where the patient is: psychologically, socially, and geographically. In this case, the setting is prison. To understand problems of mental illness in prison, one must first understand something of the social climate of such institutions. There is much in the structure of American correctional institutions that seems almost contrived to foster mental illness in the offender. If one applies the generality that a man's psycho-social adjustment can be measured in terms of love and work, a prisoner is grossly deficient on both counts. Surveying the first of these ingredients, it hardly needs pointing out that the offender is isolated from

[1] Watson, *Durham Plus Five Years: Development of the Law of Criminal Responsibility in the District of Columbia*, 116 AM. J. PSYCHIATRY 289 (1959); Hess & Thomas, *Incompetency to Stand Trial: Procedures, Results, and Problems*, 119 AM. J. PSYCHIATRY 713 (1963); Sobeloff, *Insanity and the Criminal Law: From McNaughton to Durham and Beyond*, 41 A.B.A. 793 (1955).

[2] Toussieng, *The Role of the Psychiatric Consultant in a State Training School*, 25 FEDERAL PROBATION 39 (March, 1961).

[3] Pacht, Halleck & Ehrmann, *Diagnosis and Treatment of the Sexual Offender: A Nine-Year Study*, 118 AM. J. PSYCHIATRY 802 (1962).

contacts with the opposite sex. To any of us who have listened to patients in intensive treatment, the relationship of sexual and affectional deprivation to symptom formation and emotional disturbance is obvious and clear. Looking at the broader aspects of love, the inmate is also discouraged from making close friendships. In the average prison he is repeatedly encouraged to "do his own time". Relationships between the offender and prison personnel can rarely be characterized by mutuality, positive regard, or emotional sharing. Many an inmate attempts to sustain himself with remembrance of love and friendship outside the prison. Such past relationships often assume a static quality that becomes equivalent to obsessive fantasy. In other cases the passage of time brings a slow dissolution of past relationships that is more frustating and anxiety provoking than affording nostalgic comfort.

Work, such as it is, helps sustain many a man in prison. Most inmates are subjected to an initial period of idleness upon entering prison and experience a great sense of relief when they are finally allowed to do anything that is even remotely productive. Most prisoners will affirm that idle Saturdays and Sundays are the worst parts of the prison week. Even while working hard, however, a reassuring personal sense of useful productivity is denied most prisoners. It is made clear to them that they are interchangeable parts in the prison machinery. The sense of individual achievement is, in great part, denied. The inmates themselves discourage their fellow who appears to be working too hard for his jailors. Special interests or abilities are either ignored or exploited. Thus, even when allowed to exercise special talents, the inmate is apt to feel himself used for purposes that are certainly not his own.

The offender spends much of his time just sitting. He may have an earphone so that he can listen to music via a limited choice of radio stations. He may have magazines to read. He may have limited recreational and educational privileges. By and large, however, the overall effect is one of endless time, boredom, and ennui. At its best, prison appears to be a mild form of social and sensory isolation that is chronic, insidious, and unrelenting. At its extreme, prison subjects men who will not conform to a type of sensory isolation that is almost as complete as that used to produce experimental psychosis in normal subjects.[4] The potency of solitary confinement is well known to prison administrators and is the final measure used to induce conformity.

The appropriate expression of aggression is a necessary concomitant of adequate social and psychological adjustment. Inappropriate expression of aggression is exactly what brings most men to prison. Yet, outlets for healthy assertive expression tend to be lacking in a correctional setting. Even assertive behavior of a verbal nature is often viewed as the forerunner of riot inciting provocation from a "wise guy". Unfortunately, as things now stand within prisons, this view is too often correct in that assertive behavior is dared only by the inmate who is self destructively looking for trouble.

Dependency, on the other hand, is encouraged. Forced to rely entirely on others for his food, clothing, entertainment, and the right to move about physically, the inmate may resort to passive, clinging modes of psychological gratification. Although he has been told by a court of law that he is responsible for his own behavior, the inmate finds that in prison he is responsible for almost no choices beyond strict adherence to rules and orders. The ambiguity of choice present in a free setting is largely lacking. Certain inmates will admit that this situation is peculiarly comforting. Many offenders find "escape from freedom" an easy alternative and, in effect, choose recidivism as a depressing but sustaining solution.

Finally, the offender is subjected to ruthlessly contradictory messages. He finds himself in a variant of the "double bind"[5] situation from the moment the gates close behind him. He is told repeatedly that he must learn to love his fellow man, that he can be rehabilitated, that people are out to help him rather than hurt him. Yet, with perceptual faculties that are very likely already tuned to hypocrisy and inconsistency, he looks around him and sees cruelty, institutionalized lack of concern for one's fellow man, and a situation in which he is progressively degraded by a depressing dearth of opportunity. His "double bind" is heightened by correctional systems that have not yet clearly resolved conflicts as to combining punishment and rehabilitation in their function.

Much of what passes for social adjustment in the prison setting is actually a fine attunement of pathological defense mechanisms to the artifactual structure of the institution. Some inmates may find

[4] Lilly, *Mental Effects of Reduction of Ordinary Levels of Stimuli on Intact, Healthy Persons*, 5 PSYCHIATRIC RESEARCH REPORTS 1 (1956).

[5] Bateson, Jackson, Haley & Weakland, *Toward a Theory of Schizophrenia*, 4 BEHAVIORAL SCI. 251 (1956).

a certain dependent comfort in the escape from the responsibilities of free choice in the prison milieu. Others find that certain paranoid mechanisms, which are clearly inadequate for survival in the free world, actually sustain them in prison. Similarly the withdrawn schizoid individual may be able to adjust to conditions that would totally demoralize a different man. In spite of these paradoxical advantages to the characterologically antisocial individual we believe that the experience of incarceration is for most offenders weighted in the direction of increased psychological stress. The factors militating toward emotional breakdown are prominent.

The problem of psychosis in prison is necessarily influenced by these factors. But an observer, depending on his general viewpoint and current set, can watch the stream of inmates entering and leaving a prison and be struck by diametrically opposed impressions. On the one hand, a case can be made for high levels of profound psychopathology, while with a different set an observer can be amazed at the vast similarities between an inmate and his non-criminal sociological peers. Individual histories of inmates can be used to bolster either viewpoint depending on which historical variables are emphasized.

Considering the offender from the standpoint of his previous emotional stability, the prison population can be divided into three categories. There are those who were unaware of gross internal psychic distresses; nor had their behavior been such as to have suggested the presence of emotional disturbance to others. (With regard to these individuals, one might well wonder what incidence of psychiatric disturbance might obtain if men within the range of "normal" adjustment to the outside world were experimentally thrust into prison.) A second grouping contains men who have been seriously disturbed in the past but who were nevertheless able to maintain acceptable behavior and reality testing skills sufficient to keep them out of mental hospitals. A third group consists of men who have been disturbed to an extent that was obvious to others or to themselves. These are men for whom the diagnosis of psychosis could have been easily made in the past. Their "craziness" had been so obvious to family members that accounts of delusions and hallucinations are easily obtained. Some of these men might have been seen as psychotic at the time of their criminal offense or at the time of their trial. (One might think that the rules regarding criminal responsibility would see to it that the individual with such a major disturbance would not be sent to a prison, but rather would be hospitalized. Such is not the case. The rigidity of the McNaughton rules which are utilized in most states tends to create a situation in which they are invoked only in cases of serious violence. Thus many offenders, even those who seem to have overt psychoses, are sentenced to long prison sentences without ever having the issue of their sanity raised.)

The interaction between a prison milieu and the defensive structure of each of these three groups of men leads to a situation where a percentage of each group develops psychotic symptoms. Thus the allegedly normal, the borderline and the obviously disturbed inmate are all candidates for psychosis in the prison setting.

One source of useful information for studying psychosis in prison can be found in the past histories of those inmates who eventually require hospitalization. The Wisconsin State Prison is a convenient place to examine this aspect since it is located in the same city as the state hospital for the criminally insane. Administrative routes for transfer from prison to hospital are well established and it is relatively easy to study the movement of offenders. While it is readily conceded by most of the professional staff members of both institutions that many borderline or patently psychotic individuals reside unobtrusively within the prison walls, other individuals present pressing psychiatric problems that require effective disposition. Each year approximately 25 or 30 inmates become sufficiently disturbed to warrant transfer to the State Hospital and an almost equal number are returned from hospital to prison following variable degrees of recovery. It is a common sense prediction that those individuals who had previously succumbed to psychiatric disorganization would be more vulnerable as a group to the peculiar stresses of prison life and would therefore represent a large proportion of those transferred from prison to hospital.

The histories of all currently sentenced prisoners who, as of August 1, 1962, were on transfer to the Wisconsin state hospital for the criminally insane were examined. These patients were categorized as to "positive" or "negative" histories of psychotic breakdowns occurring in a free setting prior to current arrest, conviction and sentence. Positive criteria were two: (a) history of previous mental hospitalization, or (b) descriptive accounts in the records indicating past florid psychotic behavior. The second criterion in most cases was restricted to description of delusions or hallucination, or

other "hard"signs of psychosis reported by an informant other than the inmate. Psychoneurotic symptomatology or mere hints of bizarre behavior did not qualify an inmate for the "positive" group.

A total of fifty-five prisoners were found to be on current transfer from prison to mental hospital. Thirty-seven of these men, or 67% were found to have a positive history of prior psychotic disturbance based on the above criteria. This is in sharp contrast to the 15% positive history of prior mental hospitalization for the total prison population obtained in a 1958 Wisconsin survey.[6] Approaching these figures differently, it was calculated (on the basis of a prison population of approximately 1,500) that of those inmates with a prior history of mental hospitalization, 16% were transferred from prison to hospital. Of the remaining individuals, (i.e., those with a "negative" history) only 1.4% were transferred. The high incidence of prior psychiatric disturbance in the group of inmates transferred to the mental hospital is striking. A "positive" history of previous mental illness is therefore one factor associated with eventual "breakdown" in prison. In examining other factors such as age, previous employment history, family situation and type of crime, no significant variations between those prisoners who adjust and those who become psychotic in prison were documented.

Psychotic symptomatology within prison runs the gamut of conditions seen in the "free world". Although it is always cast against the backdrop of a highly regimented, peculiarly stressful penal milieu and is therefore highly seasoned with a "prison flavor", it is not felt that "prison-specific" diagnostic labels are often needed. Confused states approximating "Ganser's syndrome"[7] or "prison psychosis" are seen on rare occasions, but "garden variety" schizophrenia is much more common.

Serious suicidal attempts and suicidal gestures are common in prison. Both seem to occur more often in schizophrenic individuals than in cases of "classical" depression. The phenomenon of repetitive self-mutilation which frequently assumes the guise of attempted suicide is perhaps seen most often in the prison setting. It is our impression that many such individuals are experiencing severe identity problems and distortions in body images. In a sense the self-mutilation may represent an attempt to feel something, anything, even pain, to re-assure oneself as to the continuation of one's own existence. For such individuals the reality of the self-inflicted pain temporarily distracts them from a more painful fear of "nothingness" and despair. Suicidal gesture in the prison setting is likely to bring down heavy penalties and controls from the authorities so that it tends to lose manipulative value. Individuals who resort to such behavior are most often as seriously disturbed as those who seem more sincerely bent on self-destruction.

The sociopaths and character disorders, who form a large proportion of a prison population, appear to develop psychotic symptomatology at a higher frequency in prison than in a free setting. This is best explained in terms of the need to develop other symptomatology, often psychosis, in the face of the marked curtailment of acting out possibilities that formerly permitted release of tensions. Malingering of psychosis poses a traditional and troublesome diagnostic problem in prison. Unfortunately, some psychiatric clinicians seem to over-emphasize this facet and to cast all diagnostic procedures in a framework of a battle with the cunning malingerer. This tends to divert the psychiatrist's energies from situations in which he can be of real help in implementing longer-range rehabilitative treatment goals. A prolonged evaluative procedure is of particular help in screening the malingerer who is often unable to sustain his facade upon observation and may, in fact, occasionally get down to considering more reasonable modes of adjustment.

The incidence of paranoid coloring in prison psychoses is high. Even the most depressed patient is not entirely overwhelmed by torturing introjects but finds readily available targets for projective mechanisms. At times it is difficult to determine the exact point at which "realistic" suspiciousness goes beyond the point of being a useful adjustment mechanism and becomes disabling. The psychiatrist often discovers that paranoid mechanisms have been present for months or years but have not been considered an adequate reason for psychiatric referral.

Acute catatonic states are not uncommon in the prison setting. These cases often take on a highly dramatic quality and are quickly referred for evaluation. A prison official who has seen a catatonic patient come close to death by starvation or ex-

[6] Wisconsin State Department of Public Welfare, Bureau of Research: STATISTICAL BULLETIN C-27 (1960).

[7] Noyes & Kolb, MODERN CLINICAL PSYCHIATRY, 555 (5th ed. 1958).

haustion learns quickly that there is little value in preoccupation with malingering.

Panic states occur with regularity and are most often related to homosexual conflicts. Homosexual panic states may be precipitated by events within or outside of the prison. The offender who is on the verge of succumbing to the temptation of a homosexual relationship is vulnerable. Likewise is the inmate who is faced with the knowledge of the loss of heterosexual loved objects on the outside. The loss of narcissistic gratification or threats to masculinity that may cause only pseudo-homosexual anxiety[8] in the free world can be devastating occurrences to the prisoner.

Transfer of the disturbed individual to a traditional psychiatric hospital is one possible result of psychiatric intervention. The prison psychiatrist should, however, be wary of this comfortable alternative. In our experiences it has not always been the best solution even for individuals easily diagnosed as psychotic. This is in keeping with the observation that hospitalization for all psychotics is not indicated in the "free world". In spite of criticisms one might level at current penal practices and in spite of psychiatrists' hope for truly rehabilitative treatment programs, it is a hard fact that society has selected each inmate as worthy of punishment. In effect, the prisoner has the assigned task of surviving his punishment and then moving forward in a constructive fashion. It is in this context that problems of individual disposition must be framed. Evasion of this societal "assignment" via removal from prison because of mental illness is not always in the long-run interest of the individual. We have previously noted that some severely disturbed offenders actually adjust more readily to the rigid prison milieu than to the more ambiguous environment of the mental hospital.

Also, the sequelae of mental hospitalization for a prisoner are not to be ignored. A few individuals are committed to the mental hospital after expiration of sentence, but most are faced with the difficult task of returning to prison prior to release. They are thereby confronted by the same stresses and same adjustment problems that were present prior to transfer. An unnecessary transfer, therefore, amounts only to procrastination. In addition, the inmate's problems on return to the prison are compounded by the potentially negative responses of his fellow inmates and of prison personnel. The consequent torment often partakes of traditional prison cruelty towards the weak and defenseless. Hence, many an inmate will directly verbalize his preference for being "bad" instead of "bugged".[9] Finally, proclivities for a defensive assumption of a helpless, sick role are apt to be reinforced by transfer to the mental hospital. Often this occurs in persons who have already been socially incapacitated by their passive-dependent stance towards the world.

It therefore appears worthwhile in all but the most emergent cases for the psychiatrist to attempt or arrange temporary supportive treatment within the prison even when eventual transfer appears likely. Supportive psychiatric treatment is a concept which is subject to a variety of definitions.[10] In the present context it is probably most useful to think of supportive treatment as an attempt at sustaining an individual in the face of the unusual stresses of prison life. To this end, many psychiatric operations can be brought into play.

The simple technique of permitting ventilation is of particular value in a prison setting where opportunities for catharsis are markedly lacking. Even the infrequent availability of a psychiatrist or other professional who will listen can be of immense use to some disturbed inmates. Chemotherapy is found to be a useful adjunct especially during crisis periods when the possible need for hospital transfer looms large. With the edge of his anxiety chemically dulled, many an individual proves capable of re-assessment of the position in which he finds himself and can proceed more realistically with the sorry task of adjusting to prison.

Most prisons and prison administrators are constituted so as to preclude the possibility of extensive environmental manipulation on the part of the psychiatrist. The possibilities that do exist should not be overlooked in appropriate cases. Even minute humanizing alterations in routine and environment, when they can be accomplished, probably impart to the inmate some ray of hope that things can change and that someone really means it when they propose rehabilitation as a goal.

At the Wisconsin State Prison opportunities for

[8] Ovesey, *The Pseudo Homosexual Anxiety*, 18 PSYCHIATRY 17 (1955).

[9] Halleck, *The Criminal's Problem with Psychiatry*, 23 PSYCHIATRY 409 (1960).

[10] Wolberg, THE TECHNIQUE OF PSYCHOTHERAPY 8 (1954); Alexander, THE SCOPE OF PSYCHOANALYSIS 280 (1961).

individual psychotherapy are sharply restricted. Group psychotherapy is somewhat more available and ranges in purpose from intensive psychiatric exploration to semi-didactic counseling. A moderate proportion of the individuals who are referred because of acute psychotic symptomatology can, with the help of prolonged supportive evaluation, become candidates for the longer range goals of the various group therapy options.

Thus, while some of the acutely psychotic individuals found in prison are best treated in a mental hospital environment there are many others for whom transfer is not needed and is even at times detrimental. The goal of "keeping a man going in prison" is perhaps parallel in some respects to the increasing tendency in American psychiatry[11] to keep psychotic individuals out of the hospitals. In the "free world" many such individuals are kept going in the face of extremely difficult and stressful environmental odds. Although the particular stresses of prison life are certainly not comparable in very many respects to the more ordinary psychological obstacles in life, some few possibilities for growth and change are available and are at times useful alternatives to risking the stagnation and procrastination that can accrue from hospitalization.

Summary

A prison environment is not a therapeutic milieu and in many respects its structure and stresses are such as to not only militate against useful change toward rehabilitation of an inmate, but also to contribute to the development of psychotic symptomatology in certain vulnerable men. As might be expected, the degree of vulnerability to psychosis in prison is related in part to history of previous breakdown. Transfer of the psychotic inmate to a mental hospital is sometimes the best treatment but is by no means the neat solution that it at first might appear to be.

Every idealized formulation of the goals of psychiatric treatment includes induction of responsibility for his own behavior on the part of the patient and the maintenance of forward movement and growth. Though many aspects of prison life tend to move a man in an opposite direction, the socially assigned task for a prisoner is the survival of his punishment in the hope that he might move forward thereafter. Abrogation of this task by psychiatry, though a tempting immediate alternative, may submerge potential for survival and change.

There is an obvious need for prisons to become truly rehabilitative institutions. Society might do well to acknowledge the lock on the prison gate as sufficient punishment to be exacted from the criminal. Then we might more easily proceed to eliminate the unnecessary waste of human potential in prison and to eradicate those facets of institutional life that perpetuate criminal behavior. More specifically, those aspects of the penal milieu that tend to push vulnerable men toward psychotic modes of adjustment should be scrutinized and modified.

[11] Glass, *Current Problems in Military Psychiatry*, 150 J.A.M.A. 6 (1952).