IMPRISONMENT & MENTAL HEALTH & SOLITARY CONFINEMENT "PART 1 OF 3 PART ESSAY"

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PSYCHIATRIC EFFECTS OF SOLITARY CONFINEMENT

My name is Dr. Stuart Grassian. I am a Board Certified Psychiatrist and have been on the faculty of the Harvard Medical School since 1974. I have very substantial experience in evaluating the psychiatric effects of solitary confined, and have been retained in class action suits concerning this issue in the states of Massachusetts, New York, Kentucky, and California, and have also evaluated and testified regarding the effects of such conditions in other lawsuits in Massachusetts, Texas, Georgia, and Florida.

I have been on the teaching staff of Beth Israel Hospital continually since 1977, and have been from time to time on the faculty of major medical meetings, including the American Academy of Psychiatry and Law, and the American Psychiatric Association Institute on Hospital and Community Psychiatry. I have lectured on the subject of the psychiatric effects of solitary confinement in various settings, including Beth Israel Hospital/Harvard Medical School. I have published two articles on the subject of the psychological effects of solitary confinement, and am in the process of preparing a third article on this subject, based upon clinical data compiled as part of my involvement as a psychiatric expert in Madrid v. Gomez, a class action suit concerning conditions at Pelican Bay State Prison, California's "supermax" prison facility.

In addition to my involvement in these cases concerning the effects of solitary confinement, I have also been retained as an expert in other areas of civil litigation, especially involving the psychological effects of trauma and childhood sexual abuse. In the past several years, I have been involved in continuing research regarding the effects of childhood sexual abuse and the manner in which memory of such abuse is maintained over the years; one paper stemming from this research has been submitted for publication, and a revised version will be incorporated as a chapter of a book, Trauma and Memory, to be published by Harvard University Press. I have also lectured on these subjects at various academic conferences. I am Board subspecialty certified by the ABPN in Forensic Psychiatry.

The information which follows is based upon my experience, research, and testimony. All of it has appeared either in previously published material and/or in court testimony and opinions of various State and Federal courts.

I. SUMMARY OF OPINIONS

In my opinion, solitary confinement - that is confinement of a prisoner alone in a cell for all or nearly all of the day, with minimal environmental stimulation and minimal opportunity for social interaction - can can cause severe psychiatric harm. This harm includes a specific syndrome which has been reported by many clinicians in a variety of settings, all of which have in common features of inadequate, noxious and/or restricted environmental and social stimulation. In more severe cases, this syndrome is associated with agitation, self-destructive behavior, and overt psychotic disorganization.

In addition, solitary confinement often results in severe exacerbation of a previously existing mental condition, or in the appearance of a mental illness where none had been observed before. Even among inmates who do not develop overt psychiatric illness as a result of confinement in in solitary, such confinement almost inevitably imposes significant psychological pain during the period of isolated confinement and often significantly impairs the inmate's capacity to adapt successfully to the broader prison environment.

Moreover, although many of the acute symptoms suffered by these inmates are likely to subside upon termination of solitary confinement, many -- including some who did not become overtly psychiatrically ill during their confinement in solitary -- will likely suffer permanent harm as a result of such confinement. This harm is most commonly manifested by a continued intolerance of social interaction, a handicap which often prevents the inmate from successfully readjusting to the broader social environment of general population in prison and, perhaps more significantly, often severely impairs the inmate's capacity to reintegrate into the broader community upon release from imprisonment.

In my experience, many inmates housed in such stringent conditions are extremely fearful of acknowledging the psychological harm or stress they are experiencing as a result of such confinement. This reluctance of inmates in solitary confinement is in substantial measure a response to the perception that such confinement is an overt attempt by authorities to "break them down" psychologically, and in my experience, tends to be more severe when the inmate experiences the stringencies of his confinement as being the product of an arbitrary exercise of power, rather than the fair result of an inherently reasonable process. Furthermore, in solitary confinement settings, mental health screening interviews are often conducted at the cell front, rather than in a private setting, and inmates are generally quite reluctant to disclose psychological distress in the context of such an interview, since such conversation would inevitably be heard by other inmates in adjacent cells, exposing them to possible stigma and humiliation in

front of their fellow inmates.
Lastly, the adverse impact of punitively imposed solitary confinement will often be more severe than the effect of such confinement when it is imposed for administrative purposes, since by intent, punitive solitary confinement imposes stringencies and deprivations which are in excess of those which are minimally required to maintain an inmate in segregated confinement; such stringencies often include limitations on programming, occupational and education opportunities, visitation, use of telephone, television and radio access, and access to reading materials, among others. Conversely, inmates housed in segregation for administrative reasons - such as for the protection of the inmate himself from possible harm by other inmates - will often retain access to many of the same opportunities and privileges which are provided to inmates in congregate housing.
Indeed,the institutional policies which create different conditions in administrative segregation, as opposed to punitive segregation, reflect an important underlying reality - that "institutional security" actually is employed to mean two very different things. The narrower usage of the terms reflects concerns about the safety of the individual inmate being housed, as well as the safety of those with whom he has contact. The broader use of the term, however, is fundamentally unbounded - or at least, has boundaries which are not really distinguishable from the broad purposes of any system of criminal justice. The harsh stringencies which are employed in punitive segregation reflect institutional assumptions that the harshly painful deprivations associated with a sentence to punitive solitary confinement, will serve as a deterrence to other in mates who might be tempted to break institutional rules. This rationale for imposing pain on an offender - the rationale that the punishment of this offender might deter other possible offenders - is simply a rationale for any system of criminal justice and punishment. A multiyear sentence of punitive solitary confinement is an imposition of pain of staggering proportions, and it is imposed without the due process safeguards which anchor our system of criminal justice.
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II. SOLITARY CONFINEMENT CAN CAUSE SEVERE PSYCHIATRIC HARM
A. Solitary Confinement Can Cause a Specific Psychiatric Syndrome
During the course of my involvement as an expert, I have had the opportunity to evaluate the psychiatric effects of solitary confinement in well over 100 prisoners in various state and federal penitentiaries. I have observed that for many of the inmates so housed, incarceration in solitary caused either severe exacerbation or recurrence of preexisting illness, or caused the appearance of an acute mental illness in individuals who had previously been free of any such illness.
I became aware of the particular toxicity of solitary confinement when I first had the opportunity to evaluate prisoners in solitary confinement as a result of my involvement in a class action lawsuit in Massachusetts, Libby v. Hogan, which challenged conditions in solitary confinement at the maximum security State Penitentiary in Walpole, Massachusetts. The clinical observations I made in the course of my involvement in that lawsuit, coupled with my research into the medical literature concerning this issue, have formed the basis of two articles I have since published on this topic in peer-reviewed journals. These are: 1. Grassian, S. (1983). "Psychopathological Effects of Solitary Confinement." American Journal of Psychiatry, 140, 1450-1454. 2. Grassian, S., & Friedman, N. (1986). "Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement." International Journal of Law and Psychiatry, 8, 49-65. My subsequent professional experience has included observations of similar phenomena in many other solitary confinement settings.
When I initially agreed to evaluate the Walpole prisoners, I had not yet reviewed the literature on the psychiatric effects of solitary confinement and, indeed, I was somewhat skeptical; I expected that inmates would feign illness and exaggerate whatever psychiatric symptomatology they suffered. I discovered, however, something very different. Contrary to my expectations, the prisoners appeared to be extremely defensive about the psychiatric problems they were suffering in SHU; they tended to rationalize away their symptoms, avoid talking about them, or deny or distort their existence, all in an apparent effort to minimize the significance of their reactions to isolation. Numerous interviews began with statements such as "solitary doesn't bother me" or "some of the guys can't take it -- not me", or even with the mention of a symptom and a simultaneous denial of its significance: "As soon as I got in I started cutting my wrists. I figured it was the only way to get out of here."
As my interviews progressed, these facile accounts gave way to descriptions of experiences which were very worrisome. For example, one inmate was unable to describe the events of the several days surrounding his wrist-slashing, nor could he describe his thoughts or feelings at the time. Similarly, the prisoner who said he could "take it" eventually came to describe panic, fears of suffocation, and paranoid distortions which he suffered while in isolation. Moreover, the specific psychiatric symptoms reported were strikingly consistent among the inmates:
1. The Specific Psychiatric Syndrome Associated With
Solitary Confinement.

a.. Hyperresponsivity to External Stimuli
More than half the prisoners reported a progressive inability to tolerate ordinary stimuli. For example, "You get sensitive to noise -- the plumbing system. Someone in the tier above me pushes the button on the faucet . ... It's too loud, gets on your nerves. I can't stand it. I start to holler."
b. Perceptual Distortions, Illusions, and Hallucinations
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Almost a third of the prisoners described hearing voices, often in whispers, often saying frightening things to them. There were also reports of noises taking on increasing meaning and frightening significance. For example, "I hear noises, can't identify them -- starts to sound like sticks beating men, but I'm pretty sure no one is being beaten . . . I'm not sure." These perceptual changes at times became more complex and personalized: "They come by with four trays; the first has big pancakes. I think I am going to get them. Then someone comes up and gives me tiny ones -- they get real small, like silver dollars. I seem to see movements -- real fast motions in front of me. Then seems like they are doing things behind your back -- can't quite see them. Did someone just hit me? I dwell on it for hours."
c. Panic Attacks
Well over half the inmates interviewed described severe panic attacks while in SHU.
d. Difficulties With Thinking, Concentration and Memory
Many reported symptoms of difficulty in concentration and memory; for example, "I can't concentrate, can't read . . . Your mind's narcotized. Sometimes can't grasp words in my mind that I know. Get stuck, have to think of another word. Memory's going. You feel like you are losing something you might not get back." In some cases this problem was far more severe, leading to acute psychotic, confusional states. One prisoner had slashed his wrists during such a state and his confusion and disorientation had actually been noted in his medical record.
e. Intrusive Obsessional Thoughts: Emergence of
Primitive Aggressive Ruminations
Almost half the prisoners reported the emergence of primitive aggressive fantasies of revenge, torture, and mutilation of the prison guards. In each case, the fantasies were described as entirely unwelcome, frightening and uncontrollable. For example, "I try to sleep 16 hours a day, block out my thoughts -- muscles tense -- think of torturing and killing the guards -- lasts a couple of hours. I can't stop it. Bothers me. Have to keep control. This makes me think I'm flipping my mind . . . I get panicky -- thoughts come back -- pictured throwing a guard in lime -- eats away at his skin, his flesh -- torture him -- try to block it out, but I can't."
f. Overt Paranoia
Almost half the prisoners interviewed reported paranoid and persecutory fears. Some of these persecutory fears were short of overt psychotic disorganization. For example: "Sometimes get paranoid -- think they meant something else. Like a remark about Italians. Dwell on it for hours. Get frantic. Like when they push buttons on the sink. Think they did it just to annoy me." In other cases this paranoia deteriorated into overt psychosis: "Spaced out. Hear singing, people's voices, 'Cut your wrists and go to Bridgewater and the Celtics are playing tonight.' I doubt myself. Is it real? . . . I suspect they are putting drugs in my food, they are putting drugs in my cell . . . The Reverend, the priest -- even you -- you're all in cahoots in the Scared Straight Program."
g. Problems With Impulse Control
Slightly less than half of the prisoners reported episodes of loss of impulse control with random violence: "I snap off the handle over absolutely nothing. Have torn up mail and pictures, throw things around. Try to control it. Know it only hurts myself." Several of these prisoners reported impulsive self-mutilation; "I cut my wrists many times in isolation. Now it seems crazy. But every time I did it, I wasn't thinking -- lost control -- cut myself without knowing what I was doing."
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2. This Syndrome has the Characteristics of an Acute Organic Brain
Syndrome -- a Delirium.
Clearly, these symptoms were very dramatic, and they moreover appeared to form a discreet syndrome -- that is, a constellation of symptoms occurring together and with a characteristic course over time, thus suggestive of a discreet illness. Moreover, this syndrome was strikingly unique -- some of the symptoms described above are found in virtually no other psychiatric illness: Acute dissociative, confusional psychoses are a rare phenomenon in psychiatry; random, impulsive violence in the context of such confusional state is exceedingly rare. But the most unique symptoms in this cluster are the striking and dramatically extensive perceptual disturbances experienced by the isolated person. Indeed, these disturbances are almost pathognomonic of the syndrome, meaning they are symptoms virtually found nowhere else. For example, loss of perceptual constancy (objects becoming larger and smaller, seeming to "melt" or change form, sounds becoming louder and softer, etc.) is very rare, and when found is far

more commonly associated with neurologic illness (especially seizure disorders and brain tumors affecting sensory integration areas of the brain) then with primary psychiatric illness. (When seen in primary psychiatric illness, it is basically only seen in especially severe, insidious, early onset schizophrenia -- the kind of schizophrenic illness which has always been thought to clinically "feel" like a fundamentally biological/neurologic disease.)
In addition, functional psychiatric illness very rarely presents with such severe and florid perceptual distortions, illusions, and hallucinations simultaneously affecting multiple perceptual modalities -- auditory, visual, olfactory, tactile, kinesthetic. (In fact, in the more common psychotic illnesses such as schizophrenia and psychotic depression, auditory hallucinations are by far the most common type, visual hallucinations come a distant second, and hallucinations in all other modalities are actually very uncommon; moreover, combined modality hallucinations -- other than the combination of auditory with visual -- are exceedingly rare.)
Similarly, hyperresponsivity to external stimuli with a dysesthetic (subjectively painful) response to such stimuli, is likewise rare; in fact it is exceedingly rare, so rare that appearance of this symptom also might suggest an organic -- brain dysfunction -- etiology. (This symptom is similar, for example, to the experience many people have during a febrile illness of finding any touching of their body exceedingly unpleasant or the inability of a patient with a headache to tolerate an even ordinary volume of sound, or the inability of some pregnant women to tolerate even ordinary smells without becoming nauseated.)
Thus, the fact that all of these quite unusual symptoms ran together in the same syndrome was itself a clear confirmation of the distinct nature of this syndrome. While this syndrome is strikingly atypical for the functional psychiatric illnesses, it is in fact quite characteristic of an acute organic brain syndrome -- that is, delirium, a syndrome characterized by a decreased level of alertness, EEG abnormalities, and by the same perceptual and cognitive disturbances, fearfulness, paranoia, and the same agitation and random, impulsive and self-destructive behavior which I observed in the Walpole population.
Moreover, delirium is a syndrome which is known to result from the type of conditions -- including restricted environmental stimulation -- which are characteristic of solitary confinement; even the EEG abnormalities characteristic of delirium have been observed in individuals exposed to conditions of sensory deprivation. By now, the potentially catastrophic effects of restricted environmental stimulation have been the subject of a voluminous medical literature; annual international symposia are being held on the subject, and the issue has even found its way into the popular media. (The literature is summarized in the appendices to this statement.)
B. Psychiatric Disturbances Occurring in Other Settings of Restricted Environmental Stimulation.
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My involvement in class-action lawsuits in New York State, California and Kentucky has yielded observation of the effects of solitary confinement which are quite parallel to my observations at Walpole. (These findings are discussed later in this statement.)
In addition, Earlier published reports on the effects of solitary confinement describe findings which are quite similar to my observations at Walpole. In addition, a pattern of psychiatric disturbances similar to those I found at Walpole have been seen in a variety of other -- non-prison -- settings, all of which, however, share in common features of restricted environmental stimulation:
These latter have included observations of prisoners of war, of hostages, of patients with impairment of their sensory apparatus (for example, hearing or visually impaired patients), of patients confined in the intensive care unit, of patients undergoing long term immobilization in hospital (e.g. spinal traction patients), of observations of psychiatric difficulties suffered by explorers (for example, Arctic and Antarctic exploration by individuals and small groups) and of observations of difficulties encountered by pilots during solo jet flight.
In all of these situations, despite the multiple differences which exist between them, the very same syndrome emerges. The literature documenting this fact is well-known, rich and detailed. It is reviewed in the Appendices to this declaration.
C. The Historical Experience With Solitary Confinement:
The Nineteenth Century Experience.
1. The Origin of the American Penitentiary and the Nineteenth Century German Experience
Preindustrial societies had often not made any fundamental distinction between deviant behavior seen as the product of "criminal intent" as opposed to behavior seen as stemming from "mental illness." For such societies, deviant behavior -- whatever its origins -- was a social evil that was deeply feared and cruelly punished.
In Colonial America, the Salem witch trials were but one example of a continuing tendency to equate "lunacy" with "demonic possession" and, ultimately, with "evil." Deviant behavior was naturally feared and hated; the instinctive response was to punish it cruelly, lock it away, banish it, or kill its perpetrator. Thus,