> **“Some eat crazy fast – they don’t digest their food. Some can’t sit or walk through a public space without their eyes rotating as if in fear of every wall and every moving thing. Some sit in meetings, but with lips sealed by ‘disqualifying’ louder thoughts. Some can’t watch TV. Some can only watch TV. Some can’t pursue love – ever.”**

A tax-paying citizen having carefully observed POST INCARCERATION SYNDROME

□ □ □ □

FAQ

What is post incarceration syndrome?

Post-incarceration syndrome (PICS) is a psychiatric disorder that affects individuals who have been incarcerated and then are released back into society. It is characterized by a range of psychological, emotional, and social difficulties that can arise as a result of being imprisoned. These difficulties can include depression, anxiety, post-traumatic stress disorder (PTSD), difficulty adjusting to life outside of prison, and difficulty forming and maintaining relationships.

PICS is not currently a recognized psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or the *International Classification of Diseases* (ICD). However, the term is used by some researchers and practitioners to describe the very real psychological challenges that people who have been imprisoned may face upon reentry.

Is post incarceration syndrome bad for society?

Post-incarceration syndrome (PICS) can have negative consequences for both the individual who has been affected by it and society as a whole. For the individual, PICS can lead to social isolation, difficulty finding and maintaining employment, and difficulty forming and maintaining relationships, which can contribute to a cycle of poverty and social marginalization. These difficulties can also increase the risk of recidivism, or returning to criminal behavior.

For society, PICS can also have negative consequences. If individuals with PICS are unable to successfully reenter society and become productive members of the community, this can lead to increased costs for social services, healthcare, and law enforcement. In addition, if individuals with PICS are more likely to engage in criminal behavior, this can have negative impacts on public safety and overall quality of life in the community. These issues are often compounding and systemic in the manner in which they lead to negative societal externalities.

Additionally, beyond the mere direct cost which may arise, the families of previously incarcerated individuals tend to suffer economically, emotionally, and mentally. For example, the estranged relationships between children, spouses, and immediate family members tend to be stressed considerably.

It is important for society to address the psychological challenges that individuals who have been incarcerated may face upon reentry into society in order to promote successful reintegration and reduce the negative consequences of PICS on a community.

What are ways to mitigate the effects of post incarceration syndrome?

There are several strategies that can be used to mitigate the effects of post-incarceration syndrome (PICS). These strategies may include:

1. Providing access to mental health treatment: Individuals with PICS may benefit from mental health treatment such as therapy and medication. Treatment can help individuals manage their symptoms and improve their overall well-being.

2. Providing support and resources during the transition back into society: This can include helping individuals find housing, employment, and connecting them with social and support services.
3. Providing education and job training: This can help individuals acquire the skills and knowledge they need to succeed in the workforce and become more self-sufficient.
4. Providing peer support and mentorship: Connecting individuals with others who have successfully navigated the challenges of re-entry can be very helpful.
5. Reducing the stigma surrounding incarceration: It can be difficult for individuals with a criminal record to overcome the negative stigma associated with incarceration. Reducing this stigma can help individuals feel more accepted and supported as they reenter society.

With that said, Post Incarceration Syndrome will likely require a varied and comprehensive approach that icludes a range of interventions at the individual, community, and societal levels.

How long does post incarceration syndrome last?

It is difficult to determine how long post-incarceration syndrome (PICS) may last, as there is limited research on the topic. However, factors that may influence the duration of PICS include the individual's pre-incarceration mental health status, the duration of their incarceration, the conditions of their imprisonment, and the level of support and resources available to them upon reentry.

Individuals who had been incarcerated are at increased risk for mental health problems, including depression and anxiety lasting up to 5 year or more based on other factor.

It is difficult to determine how long PICS may last, as it likely varies from person to person. It is important for individuals who have been affected by PICS to have access to mental health treatment and support to help manage their symptoms and improve their overall well-being.

What are the causes of Post Incarceration Syndrome?

The exact causes of PICS are not fully understood, but it is believed that a variety of factors may contribute to the development of the condition. These factors may include:

1. **Trauma:** Incarceration can be a traumatic experience, and individuals who have been imprisoned may be at risk for developing post-traumatic stress disorder (PTSD). PTSD can cause a range of psychological and emotional symptoms, including anxiety, depression, and difficulty adjusting to life outside of prison.
2. **Loss of social support:** Incarceration may lead to a loss of social support, as individuals lose contact with friends and family members during their imprisonment. This leads to social isolation and difficulty forming or maintaining relationships.
3. **Loss of skills and knowledge**: Incarceration disrupts an individual's education and employment, potentially leading to a loss of skills and knowledge. This makes it more difficult for previously incarcerated individuals to find or maintain employment.
4. **Stigma**: Incarceration is stigmatized in society, which make sit difficult for individuals with a criminal record to find employment and housing or to form new relationships. This haunting stigma contributes to a myriad of deleterious mental states, isolation, and shame.
5. **Lack of resources:** Individuals face barriers to accessing resources such as housing, employment, education, and healthcare. These barriers make it more difficult for individuals to successfully reenter society.

References:

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How Many People Suffer from PICS?

It is estimated that 40% of the 600,000 people released annually will have PICS.

However, it is difficult to determine how many people suffer from post-incarceration syndrome (PICS) since there are no widely accepted standards in medical publications. However, based on generally accessible data we can make some inferences.

Likewise, according to the Bureau of Justice Statistics, there were approximately 2.3 million people incarcerated in the United States in 2019 (Bureau of Justice Statistics, 2019). It is likely that a significant number of these individuals will experience some level of PICS, although the extent and severity of these difficulties may vary.

A significant number of individuals who have been incarcerated experience difficulties adjusting to life outside of prison.

References:

Bureau of Justice Statistics. (2019). Correctional populations in the United States, 2019. Retrieved from https://www.bjs.gov/content/pub/pdf/cpus19.pdf

What are ways to help someone with PICS?

There are several strategies that can be used to help someone with post-incarceration syndrome (PICS) which include:

1. **Access to mental health treatment**: Individuals significantly benefit from mental health treatment such as therapy and medication. Treatment help individuals manage their symptoms and improve their overall well-being.
2. **Support & resources during reentry:** This includes housing, employment, and connecting them with social and support services.
3. **Education & job training:** This helps individuals acquire the skills and knowledge they need to succeed in the workforce and become more self-sufficient. Additionally, studies have shown access to education and training while incarcerated greatly reduces the likelihood of recidivism.
4. **Peer support & mentorship:** Connecting individuals with others who have successfully navigated the challenges of re-entry can be very helpful. Firsthand knowledge passed to newly reentering individuals is paramount to outlining proper paths to follow and the pitfalls reentry proposes.
5. **Reducing the Stigma:** It can be difficult for individuals with a criminal record to overcome the negative stigma associated with incarceration. Reducing this stigma can help individuals feel more accepted and supported as they reenter society.

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Are Others impacted by PICS?

Yes, others may be impacted by post-incarceration syndrome (PICS), which can contribute to a cycle of poverty and social marginalization. These difficulties can also increase the risk of recidivism, or returning to criminal behavior.

Families, friends, governmental institutions, communities, and society as a whole all the bear the cost of previously incarcerated persons who are struggling to reenter society.

What are common signs of Post Incarceration Syndrome?

Post incarceration syndrome can be a widely varied disorder that manifests itself in numerous ways. Some commonly accepted signs of PICS may include:

1. **Depression**: People with post incarceration syndrome can experience feelings of sadness, hopelessness, and a lack of interest in activities that they previously enjoyed.
2. **Anxiety:** Individuals suffering from PICS may experience feelings of worry, nervousness, and fear that are not proportionate to the situation.
3. **Post-traumatic stress disorder (PTSD):** Experiencing symptoms of PTSD such as flashbacks, nightmares, and avoidance of triggers related to their incarceration is commonly noted with for previously incarcerated individuals.
4. **Difficulty adjusting to life:** Reentry can be difficult, and persons with PICs may strugle to adapt to the demands and expectations of life outside of prison, including finding and maintaining employment, establishing and maintaining relationships, and navigating the criminal justice system.
5. **Social isolation**: Individuals with PICS may have difficulty forming and maintaining relationships, which can lead to social isolation.

It is important to note that these signs may vary from person to person and that not everyone who has been incarcerated will experience PICS. It is also important to seek help from a qualified mental health professional if you or someone you know is experiencing these or other mental health concerns.

Does PICS lead to higher recidivism rates?

Post-incarceration syndrome (PICS) is assumed to be associated with higher rates of recidivism, and returning to criminal behavior. PICS is characterized by a range of psychological, emotional, and social difficulties that can arise as a result of being imprisoned, and these difficulties can make it more challenging for individuals to successfully reenter society and become productive members of the community.

It has been noted that individuals with mental health problems, including depression and anxiety, were more likely to reoffend after being released from prison. One study found that individuals who had a history of mental health problems prior to incarceration were at increased risk for recidivism (Fazel et al., 2012).

It is important to note that the relationship between PICS and recidivism is complex and may be influenced by a variety of factors.

References:

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. The Lancet, 359(9306), 545-550.

It's been years since I was formerly incarcerated, and I still have symptoms of PICS – what do I Do?

If you have been experiencing symptoms of post-incarceration syndrome (PICS) for an extended period of time and these symptoms are causing significant distress or impairment in your daily life, it is important to seek help from a qualified mental health professional. A mental health professional can assess your symptoms and develop a treatment plan to help you manage your symptoms and improve your overall well-being.

Treatment options for PICS may include therapy, medication, or a combination of both. Therapy can help you identify and address the underlying causes of your symptoms and learn coping skills to manage your symptoms. Medications can help to manage specific symptoms such as anxiety or depression.

It is important to be open and honest with your mental health professional about your symptoms and concerns. They will work with you to develop a treatment plan that is tailored to your specific needs and goals.

What is it like living with post incarceration Syndrome?

PICS is suffocating. Like not knowing what is wrong with you or the world - the puzzle pieces just don't seem to line up. Paralyzing depression, fear, anger, and anxiety are just words that epitomize the revolving door I seem to be stuck in. I did my time, but the lasting vestiges of a draconian punishment system never cease to torment.

Regardless of the offense, sympathy is unheard of. Nay, discouraged. The stigma that is rampant within society for previously incarcerated individuals is akin to the high school football coach telling you to "man up" and "walk it off," despite the horrific injury you may have endured.

Imagine all the doors in your life being closed - on top of that you're blind, def, and dumb. Post incarceration syndrome leads me down a path of bad choices, but to me they seem good. I don't know I'm a snowball gathering momentum down a hill. I don't know that I'm just another failed statistic. I'm just a broken version of my former self trying to reenter a world that no longer tolerates me.

My friend/spouse/family member has PICS – what do I do?

If you have a friend, spouse, or family member who has been affected by post-incarceration syndrome (PICS), it is important to provide them with support and understanding. Here are some things you can do to support someone with PICS:

1. **Listen and offer emotional support:** It can be helpful for individuals with PICS to have someone they can talk to about their experiences and feelings. Encourage your friend or family member to share their thoughts and feelings with you and let them know that you are there to listen and support them.
2. **Encourage them to seek help:** If your friend or family member is experiencing significant distress or impairment as a result of PICS, encourage them to seek help from a qualified mental health professional. A mental health professional can assess their symptoms and develop a treatment plan to help them manage their symptoms and improve their overall well-being.
3. **Help them connect with resources**: There are many resources available to help individuals with PICS manage their symptoms and reenter society. These may include therapy, medication, peer support groups, and community resources such as housing and employment assistance. Help your friend or family member connect with these resources as needed.
4. **Be understanding and patient**: Adjusting to life outside of prison and managing PICS can be a long and challenging process. It is important to be patient and understanding with your friend or family member as they navigate these challenges.

We encourage you to be supportive, but at the same time not rely solely on your own intuition to address these issues. There are experts, peer support groups, and accredited professionals with years of experience in handling these issues. Make sure to be self-aware of your own capacity to help and seek outside help as soon as possible.

Does Post Incarceration Syndrome Last forever?

It is difficult to determine how long post-incarceration syndrome (PICS) may last, as PICS is a proposed psychiatric disorder and there is limited research on the topic. PICS is characterized by a range of psychological, emotional, and social difficulties that can arise as a result of being incarcerated, and these difficulties can persist for an extended period of time.

However, it is important to note that with proper treatment and support, individuals with PICS can learn to manage their symptoms and improve their overall well-being. Treatment options for PICS may include therapy, medication, or a combination of both.

It is difficult to determine how long PICS may last, as it can vary from person to person. However, with proper treatment and support, individuals with PICS can significantly reduce the severity of their symptoms.

Is Post Incarceration Syndrome PTSD – what are the differences?

While PICS may include symptoms of PTSD, it is important to note that PICS is not the same as PTSD. PICS is a proposed disorder that is used by some researchers and practitioners to describe the psychological challenges that individuals who have been incarcerated may face upon reentry into society. PTSD, on the other hand, is a recognized psychiatric disorder that is characterized by specific symptoms that occur after a traumatic event.

In conclusion, PICS may include symptoms of PTSD, but it is important to note that PICS is not the same as PTSD.

Should Lawmakers be concerned about PICS?

Lawmakers need to be concerned about post-incarceration syndrome (PICS) due to the negative consequences of PICS for individuals who have been affected by it and for society as a whole.

For instance, if individuals with PICS are more likely to reoffend, this can have negative impacts on public safety and overall quality of life in the community. Additionally, if individuals with PICS are unable to find and maintain employment and become self-sufficient, this can place a burden on social welfare systems.

Lawmakers who are concerned about PICS may consider implementing policies and programs to address the psychological challenges that individuals who have been incarcerated may face upon reentry. For example, lawmakers may support initiatives to provide access to mental health treatment, education and job training, and peer support and mentorship for individuals with PICS.

What are the Stages of Post Incarceration Syndrome?

It can possibly be indefinite if resources are not readily available upon release.

People with PICS tend to have a 6 stage post-release symptom progression that leads to recidivism:

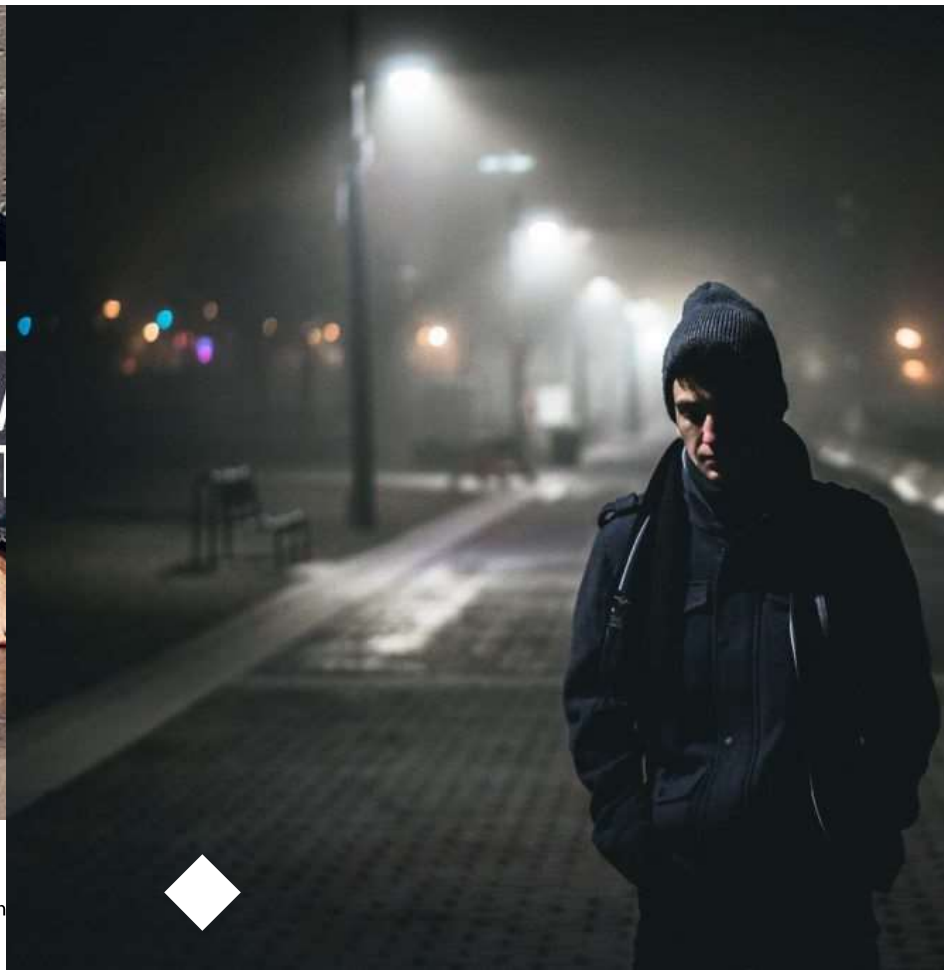
1. **Stage 1** of this Post Release Syndrome is marked by Helplessness and hopelessness due to the inability to develop a plan for community reentry, often complicated by the inability to secure funding for treatment or job training;
2. **Stage 2** is marked by an intense immobilizing fear;
3. **Stage 3** is marked by the emergence of intense free-floating anger and rage and the emergence of flashbacks and other symptoms of PTSD;
4. **Stage 4** is marked by a tendency toward impulse violence upon minimal provocation; Stage 5 is marked by an effort to avoid violence by severe isolation to avoid the triggers of violence;
5. **Stage 6** is marked by the intensification of flashbacks, nightmares, sleep impairments, and impulse control problems caused by self-imposed isolation. This leads to acting out behaviors, aggression, violence, and crime, which in turn sets the stages for arrest and incarceration.

Is Post Incarceration Syndrome Associated with mental health?

People with PICS are at high risk for developing substance dependence, relapsing to substance use if they were previously addicted, relapsing to active mental illness if they were previously mentally ill, and returning to a life of aggression, violence, and crime. They are also at high risk of chronic unemployment and homelessness.

It's incited towards disintegration of one's mental capacity. Not a natural mental health disorder occurring by chemical imbalances.

RESOURCES



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Is there a recognizable post-incarceration syndrome among released "lifers"?

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ABSTRACT

It has been suggested that released prisoners experience a unique set of mental health symptoms related to, but not limited to, post-traumatic stress disorder. We sought to empirically assess whether there is a recognizable post-incarceration syndrome that captures the unique effects of incarceration on mental health. We conducted in-depth life interviews with 25 released "lifers" (individuals serving a life sentence), who served an average of 19 years in a state correctional institution. We assessed to what extent the symptoms described by the participants overlapped with other mental disorders, most notably PTSD. The narratives indicate a specific cluster of mental health symptoms: In addition to PTSD, this cluster was characterized by institutionalized personality traits, social–sensory disorientation, and alienation. Our findings suggest that post-incarceration syndrome constitutes a discrete subtype of PTSD that results from long-term imprisonment. Recognizing Post-Incarceration Syndrome may allow for more adequate recognition of the effects of incarceration and treatment among ex-inmates and ultimately, successful re-entry into society.

1. Introduction

To date, numerous studies have shed light on the *prevalence* of mental disorders among inmates (Fazel & Danesh, 2002; Lamb & Weinberger, 1998). We know much less, however, about the influence of imprisonment on the *development* of mental disorder. The long-term effects of exposure to powerful and traumatic situations, contexts, and structures mean that prisons themselves can also bring about psychological problems resulting from prison trauma. The majority of previous studies have described these problems in terms of Posttraumatic Stress Disorder (PTSD) (Goff, Rose, Rose, & Purves, 2007). PTSD was first introduced in the third revised version of the Diagnostic and Statistical Manual for Mental Disorders (DSM-III, 1980) as an anxiety disorder and is characterized by persistent re-experiencing, avoidance, hyper arousal and emotional numbing. In a recent study on the living conditions of prisoners serving long-term (>5 years) sentences in 11 European countries, Dudeck et al. (2011) found that 14% developed PTSD subsequent to traumatic events experienced in prison (Dudeck et al., 2011). Much higher rates have been reported for prisoners of war (Lindman Port, Engdahl, & Frazier, 2001; Speed, Engdahl, Schwartz, & Eberly, 1989), wrongfully convicted and politically motivated ex-prisoners (Jamieson & Grounds, 2005) and detained asylum seekers (Ichikawa, Nakahara, & Wakai, 2006).

A major problem with the description of detention-related psychological problems in terms of PTSD is that its characteristic diagnostic features do not fully grasp the complex nature of trauma resulting from incarceration. Based on a review of the literature, Herman (1992) argued that traumatization among prisoners and other high risk groups is characterized by chronic and repeated exposure, heterogeneous symptoms, and enduring personality changes (Herman, 1992). To emphasize this complexity, Herman introduced the diagnosis *complex* PTSD.

More recently, ex-prisoners and groups working with them suggested that there may be a separate cluster of psychosocial problems, a Post-Incarceration Syndrome (PICS) that shares characteristics with PTSD, but is specific to incarcerated and released prisoners in that it is caused by prolonged incarceration.

So far, it is not known whether there exists such a recognizable and distinguishable post-incarceration syndrome. Scholarly research on this topic is nonexistent. This is particularly timely given the recent reflections on PTSD's future in DSM-V, including the discussion on allowing for PTSD subtypes (Rosen, Lilienfeld, Frueh, McHugh, & Spitzer, 2010). It is not known to what extent a specific constellation of psychosocial problems is manifested among released offenders (Bogaerts & Polak, 2012), and more specifically long-term incarcerated offenders. This is particularly relevant given the speculated causal relationship between the period of incarceration and the severity of the symptoms (Bogaerts & Polak, 2012; Gorski, 2001): Those having been incarcerated longest may be most likely to exhibit symptoms of PICS. Therefore, the aim of this study was to explore to what extent there is a recognizable post-incarceration syndrome that captures the effects of incarceration among released lifers: Individuals having

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served a minimum life sentence of 15 years before having been eligible for parole. Because of the dearth of empirical knowledge on this topic, we opted for a qualitative approach.

2. Material and methods

2.1. Procedure

This study is part of a larger international research project on the effects of long-term incarceration on the life course and criminal recidivism of homicide offenders. The larger project aims to assess the influence of criminal past, length of imprisonment, and key life events on recidivism patters among homicide offenders in the United States and Europe. The overall project combines quantitative and qualitative techniques to develop a new model through which future offending of homicide offenders can be understood. The study at hand is based on interviews with 25 released homicide offenders in Boston, Massachusetts.

Participants were selected by contacting local organizations that provide services for ex-offenders. They were given a letter that they could present to the individuals who met the following inclusion criteria: (a) committed a homicide in the Boston metropolitan area; (b) had served and completed a life sentence for this offense; (c) were released or paroled following their sentence and (d) were currently not incarcerated.

Upon the individual's consent, the researcher informed the participants about the study and gave them the choice to opt in. All individuals were given an opportunity to ask questions about the study and their participation. All gave informed consent to participate on the basis that their disclosed material would be made unidentifiable. We conducted in-depth, one-on-one, semi-structured life history interviews. Interviews took place in private at their attorney's office or at one of the local organizations for ex-offenders over the course of 10 months (November 2011–August 2012). Most research participants were interviewed once; for two participants, there was a follow-up in-person interview and for 10 participants a follow-up phone interview. The interviews were 2 to 5 h long, depending on the participant's responses. The questions were developed to obtain a thorough description of factors that characterized the individual's life before, during and after incarceration and included relations with family and friends, education, employment, physical health, mental health, and criminal behavior. A subset of questions specifically addressed the effects of imprisonment on mental health. The majority of the questions were open-ended (e.g. “Could you describe some of the challenges you initially faced after being released?”). After the interview, the participants were de-briefed. Findings were shared where this was requested. All interviews were audio-recorded and transcribed ad verbatim.

2.2. Participants

Interviews were conducted with 23 men and 2 women. Participants' ages ranged from 39 to 70 ($M = 55.8$; $SD = 9.3$). 12 participants were Black, 11 were White and 2 were Hispanic. Most committed the homicide in their twenties ($N = 17$), others in their late teens ($N = 6$) or thirties ($N = 2$). The time spent in prison for the homicide was on average 18.8 years ($SD = 8.4$). Many interviewees were exposed to the particularly harsh circumstances of confinement that characterized Massachusetts' penal climate in the 1970s. Seven individuals were re-incarcerated after having been imprisoned for a homicide. Seven interviewees reported to have been officially diagnosed with mental illness, of which four were diagnosed with PTSD.

At the time of the interviews, 20 were on lifetime parole, while 5 had never been on parole. The median time between release and first interview was 6.5 years (range: 3 months to 23 years). The majority had an extensive criminal history before the homicide, being involved in activities such as (car) theft, drug dealing and (armed) robberies. Most interviewees resided in (poor) urban and suburban housing in the Boston Metropolitan area. There was little divergence in socio-economic terms — most were unemployed at the time of the homicide or were working in manual jobs. The majority lived alone or with non-family members.

2.3. Data analyses

Following content analyses used in previous work (Appleton, 2010; Giordano, Longmore, Schroeder, & Seffrin, 2008), initial data analyses consisted of reading the text several times, and then noting connections, associations, and preliminary interpretations. We paid particular attention to the effects of incarceration on mental health, and the way in which the individual dealt with these effects. The next step consisted of identifying to what extent the psychological effects described by the participants presented overlapped with other mental disorders, most notably PTSD. Analytic conclusions were formulated by coding and then categorizing similar statements of experiences from data, replicating qualitative methodologies described in other studies on paroled offenders (Appleton, 2010). With the aid of qualitative software (NVivo 9- QSR International, 2010), these statements were grouped into categories and were then compared across all transcripts to identify connections, patterns or contradictions.

3. Results

The narratives indicate a specific cluster of mental health symptoms: In addition to chronic PTSD, effects of incarceration reported by the interviewees included institutionalized personality traits, social–sensory disorientation and social/temporal alienation.

3.1. Post traumatic stress disorder from (pre)-incarceration trauma

The most prevalent features of chronic PTSD reported by the interviewees were recurrent distressing dreams; hyper arousal (sleep disturbances), persistent avoidance of stimuli and emotional numbing. Recurrent distressing dreams mostly involved the prison experience:

> When I got out, I was tormented by nightmares that I was still in prison. I'd wake up sittin' and screamin'. Cold sweat pouring down my face, literally, and my pillow soaked […] They were all prison nightmares and some of them were me… seeing myself waking up in prison […] Those were really bad, when I [first] got out, they were almost debilitating.
>
> [Male, age 53]

> I do have nightmares about going back to jail […] that's like my nightmare, my nightmare is I'm in jail.
>
> [Female, age 60]

Signs of hyper arousal mainly included sleep disturbances, which interviewees attributed to a disturbed sleeping pattern in prison:

> Yeah every time they [the correctional officers] make rounds. 45 min to an hour […] you wakin' up, alright… To this day, I do not sleep a straight night. I wake up every 45 min to an hour.
>
> [Male, age 70]

Additionally, signs of hyper arousal included started responses, at times accumulating into full-blown panic attacks:

> Like, you know I take the ride here, and if I get into crowds or I'm in open spaces or things like that… It brings on panic attacks. And the panic attacks bring on the seizures.But, cause to me, it's like I

can't go outside, and walk around the compound because I'm in wide open spaces and there's nothing around me to like to hold onto if I start feeling panicky […].

[Male, age 64]

Almost all interviewees mentioned that they avoided places and situations, particularly crowded spaces:

Going into the subway, when the door opened and the people poured out: Instant panic attack. […] I wasn't used to people in my space. It was overwhelming; it was hard to breathe, and [I had] to get away from them.

[Male, age 41]

I don't like being with a lot of people in a small space. It distracts me. It makes me aware.

[Male, age 52]

A fourth trait that was reported by the majority of the interviewees was emotional numbing, a coping mechanism in which they had created a permanent and unbridgeable distance between themselves and other people. While 'this prison mask' may have been self-protective during incarceration, it becomes maladaptive post-release:

It's just, you, in prison, you learn not to show your emotions. You don't wanna be weak, you know, you need to be strong, you need to continue to be strong, and always strong […]. Those coping mechanisms in relationships is where I struggle. Is where I fall short. And it's like you just, you, you don't wanna show that emotion, that vulnerability, that is the damage of prison […] you're always trying to protect that vulnerability.

[Male, age 40]

Thus, each of the four characteristic PTSD feature clusters (intrusion, hyper arousal, persistent avoidance and emotional numbing) was represented in our study population.

3.2. Institutionalized personality traits resulting from incarceration

All interviewees mentioned that prison had changed them in profound ways:

I do kind of act like I'm still in prison, and I mean you [are] not a light switch or a water faucet. You can't just turn something off. When you've done something for a certain amount of time […], it becomes a part of you.

[Male, age 42]

The most common personality trait described by interviewees as a result of incarceration was "paranoia", or experiencing difficulty in trusting others and feeling vulnerable to attack:

You cannot trust anybody in the joint […]. I do have an issue with trust, I just do not trust anybody.

[Male, age 52]

Another describes:

Yeah I guess like the constant feeling of, I don't wanna say paranoia, but you're always on edge when you're in prison. You're always feeling like someone's gonna attack you. […]

[Male, age 41]

Interviewer: So what is so bad about taking the T [the subway]? The T is cramped. And you don't know anybody […] I don't trust people, period.

[Male, age 52]

The inability to trust others was also reflected in the inability to engage in social relationships post-release:

And I'm not defected to where I'm crazy. But I think that I maybe be defected socially, in some way.

Interviewer: Can you give an example of that, defected socially? Yeah just like, just me not being able to get close to people. That's what it is. Um, I'm kind of like, kind of like detached, you know?

[Male, age 37]

This inability to engage in relationships was also reflected in intimate relations:

[In prison] you have to distance yourself, so you always have to keep on putting up walls, and putting up barriers, every single day. You have to build like this shell around you, to protect you from your environment. So if you keep on doing this for so long, then once you get let out, it's kind of difficult to bring it down, because it's ingrained in you. [S]o, one of the things she [my girlfriend] has a problem with, is like […] you're unemotional. And I tell her, I'm like, listen I'm defective right now, I'm messed up right now.

[Male, age 37]

Another institutionalized personality change included hampered decision-making, and was encountered in the majority of the interviewees.

[…] [I]n prison you really don't have to think. Not about your day to day activities.

[Male, age 59]

So now I go down to the grocery store down the street: It was like crazy. It was just like millions, millions of the color, I was like, like shocked, there is so many things, so I go to the shelf, so I want this, I picked this up, and automatically I got a put down, and I grab something over here, and I put this up and put that down and then all the sudden I just started bursting crying

[Male, age 52]

As soon as you get out there's all these sort of decisions… And now your bombarded with all these decisions it's like what, what, am I supposed to do here, you know? […] You know, and that's scary […], to many men it can be daunting, you know, for many it can be frustrating and sometimes men go back to prison just because they're so frustrated they just can't handle this too much. It's just so much easier to just sit back and say "okay".

[Male, age 59]

3.3. Social–sensory deprivation syndrome

Effects of social and sensory deprivation while incarcerated were predominantly manifested in spatial disorientation post-release:

[…] for years it was very difficult on me to go somewhere and come out the other way, I'm lost. I have to turn around and come back the same way and try to figure how I got there and come back the same way 'cause I didn't have a sense of direction.

[Male, age 59]

Others emphasized difficulties in social interactions post-release, judging people's intentions. They attributed this to the lack of physical closeness and visual contact while in prison:

So when you come to my cell, this is all I see [holds hands on both sides of his face, partially obscuring cheeks]. I don't see body

> language […] [and] in the yard, we got fences between us. We talked hands down. Nobody talked with body language.
>
> [Male, age 70]

Solitary confinement was not a prerequisite to experience this syndrome: Also individuals who were not subjected to solitary confinement during incarceration reported experiencing difficulties as a result of social and sensory deprivation.

3.4. Social/temporal alienation

In addition to the features reported above, the effects of incarceration also included features not captured by PICS. These features include profound feelings of alienation, reflected in feelings of not belonging in social settings. Similarly, most interviewees reported thoughts that their current situation was only temporal, and good things can be taken away at any moment:

> Part of coming out of prison was the idea that eventually, I'll be back there […]. When I was out and good things happened to me, I always thought that 'this cannot last for long'. When good things happened to me, I always thought that: 'Eventually, this will be taken away from me.' […] I thought of freedom as a temporary thing.
>
> [Male, 50 years old]

4. Discussion

4.1. Findings and implications

Released prisoners face numerous difficulties upon re-entry in society, including poor employment prospects (Uggen, 2000), addiction, housing, and troubled family relations (Petersilia, 2003; Travis, 2005). Several studies indicate an elevated mortality rate for after release (Blokland & Nieuwbeerta, 2005; Nieuwbeerta & Piquero, 2008). Long-term incarcerated offenders constitute a group that is exposed to the pains of imprisonment over a long period of time. We sought to explore to what extent there were recognizable effects of incarceration on mental health among 25 released lifers that could be captured in a unique syndrome. Their narratives indicate that we are dealing with a specific cluster of mental health symptoms: In addition to chronic PTSD, this cluster was characterized by institutionalized personality traits (distrusting others, difficulty engaging in relationships, hampered decision-making), social–sensory disorientation (spatial disorientation, difficulty in social interactions) and social and temporal alienation (the idea of 'not belonging' in social and temporal setting).

These findings are particularly relevant in light of two recent developments: First, the findings tie in with present suggestions to modify the PTSD diagnosis in the forthcoming DSM-V (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; Rosen et al., 2010), including the incorporation of special subtypes of PTSD (such as PTSD in preschool children and PTSD with prominent dissociative symptoms). Second, in recent years Western countries have not only experienced an unprecedented growth in their prison populations, but continue to apply increasingly longer prison sentences (Lacey, 2010). This implies that more individuals will be affected by imprisonment, including long-term imprisonment. In this article, we have conducted preliminary fieldwork indicating that there is a possible discrete syndrome, or special subtype of PTSD, that merits further refinement in future developmental work on DSM-V and stress-related disorders. Whereas qualitative research provides a richness of meaning, depth of understanding, and flexibility (Geertz, 1973), further quantitative research is needed to assess to what extent our suggested features of post-incarceration syndrome are also found in other ex-offender populations, to what extent there exist differences between populations, and how traumatization while in prison is related to stresses associated with reintegration into the community post-release. A first step into this direction is the development of an inventory to quantitatively test the sensitivity and scope of the suggested PICS features, laid out in Table 1. Next, broader survey studies should be useful to further validate these findings across previously and currently incarcerated individuals.

In addition, due to the exploratory nature of this research, we cannot make definite causal inferences about the relationship between the reported features and incarceration. Future research should overcome this limitation by employing a longitudinal design in which offenders would be followed from the initial stages of confinement into their senior years and post-release. A qualitative longitudinal design also allows the study of the development of these symptoms over time. Finally, future studies should further attempt to differentiate between pre-prison traumatic effects and the impacts of routine prison experience.

Although variable between countries, prisoners suffering from mental illness do not have access to care to the same extent as non-imprisoned populations. Additionally, to the extent that mental health care *is* available and accessible, mental health professionals are often poorly equipped, both in knowledge and skill, to deal with the unique dynamics of the prison culture. Treatment staff frequently do not have direct access to actual mainline experiences, which limits their ability to prepare prisoners for transition back into society.

Another complicating factor concerns ex-offender's accessibility to counseling. Particularly interviewees who are on parole, expressed fear that seeking help could potentially send them back to prison. Simultaneously, the suspiciousness of others that is usually adaptive in prison deters prisoners from seeking help — both inside and after release (Haney, in press). The residual effects of imprisonment jeopardize the mental health of an individual attempting to reintegrate back into the free world (Haney, 2002). Without proper treatment that is focused on post-incarceration effects, these offenders run the risk of returning to prison — untreated. Recognizing the post-incarceration syndrome as a special subtype of PTSD may assist earlier recognition and more adequate treatment.

4.2. Strengths and limitations

Until now, the post-incarceration syndrome was reported as a mere hypothetical construct by clinicians, ex-prisoners and groups working with them. In this study, we have attempted to empirically assess whether there is a recognizable post-incarceration syndrome that captures the unique effects of incarceration on mental health. Drawing from in-depth life histories from 25 lifers released from prison, this is the first study of its kind.

It should be noted, however, that the interviewed participants may not be representative of the population of offenders with longer sentences, and offenders who are currently re-incarcerated were not included in this study. Currently we are underway to shed light on the nature of the effects on mental health experienced by re-incarcerated lifers.

Table 1
Proposed diagnostic criteria for post-incarceration syndrome as a subtype of ptsd in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V).

The individual meets the diagnostic criteria for PTSD and in addition experiences the following persistent or recurrent symptoms:
(i) *Institutionalized personality traits resulting from incarceration*, including (I) difficulty trusting others (II) difficulty engaging in intimate relationships (III) difficulty making decisions.
(ii) *Social–sensory deprivation syndrome*, including (I) spatial disorientation and/or (II) experiencing difficulty in interacting socially.
(iii) (iii) *Social/temporal alienation*, including (I) feeling not to belong in social settings (II) thoughts that positive events and situations can be taken away.

Second, this study relies on self-reported data. Mental health constitutes a sensitive topic (Leigey, 2010). Haney (2006) previously warned that hyper-masculine attitudes resulting from incarceration might potentially lead to the under-reporting of mental problems (Haney, 2006). Even though respondents were informed that their confidentiality would be kept and even though there is no indication that the interviewees were unable to be truthful with the interviewer, such hyper-masculine attitudes may have led to an underreporting of mental troubles. In spite of this, results suggest that respondents still suffered from a constellation of psychological symptoms.

Third, the United States typically applies longer and harsher prison sentences than other Western nations (Appleton & Grøver, 2007; Lacey, 2010) — in this study, the median time spent in prison was almost 19 years. Therefore, applying these findings to inmates in other countries that impose shorter periods of imprisonment should be done cautiously. One should also exert caution in applying these findings to so-called LWOP inmates: Those serving a life sentence without the possibility of parole (Leigey, 2010). Because of the permanency and indeterminancy of their sentences, they are in a unique situation, even among long-term inmates. It has been suggested that inmates with indeterminate sentences report higher levels of suffering (Farber, 1944; Flanagan, 1982).

5. Conclusion

The aim of this study was to explore to what extent the effects of incarceration on mental health among individuals who have been released after serving a life sentence constitute a separate cluster of symptoms. Because of the dearth of empirical knowledge on this topic, we decided on a qualitative approach. Our findings indicate that there is a specific cluster of mental health symptoms: In addition to chronic PTSD, this cluster involves three core features, including institutionalized personality traits resulting from incarceration; social–sensory deprivation syndrome and temporal and social alienation. We believe that recognizing the post-incarceration syndrome in the DSM-V as a subtype of PTSD may allow for more adequate recognition of the effects of incarceration and treatment among ex-inmates and ultimately, successful re-entry into society.

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Does PTSD occur in sentenced prison populations? A systematic literature review

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ABSTRACT

Background *A systematic review of the literature on mental disorder in prisoners, published in 2002, made no mention of post-traumatic stress disorder (PTSD), but indicators from other studies suggest that a history of serious and chronic trauma is common among offenders.*

Aims *To conduct a systematic review of the literature with the specific questions: does any epidemiological study of sentenced prisoners include data on prevalence of PTSD while in prison? If so, what is the prevalence in this group?*

Method *Literature databases EMBASE, Medline, PsychInfo, PILOTS and SIGLE were searched. The Journal of Traumatic Stress was searched manually. Preliminary screening was conducted by reading abstracts of hundreds of papers. Ten exclusion criteria were then applied to the screened selection. Reference sections of all accessed papers were searched for any further studies.*

Results *One hundred and three potentially relevant papers were identified after preliminary screening. Four met all criteria for inclusion and suffered none of the exclusion criteria. PTSD rates ranged from 4% of the sample to 21%. Women were disproportionately affected.*

Conclusions and implications for practice *All four papers suggested that the prevalence of PTSD among sentenced prisoners is higher than that in the general population, as reported elsewhere. Overall the findings suggest a likely need for PTSD treatment services for sentenced prisoners.*

Introduction

A comprehensive systematic literature review carried out by Fazel and Danesh in 2002, covering 62 studies and a total sample of 23,000 prisoners, concluded that typically one in seven prisoners in Western countries have a psychotic illness

or major depression, and that one in two male prisoners and one in five female prisoners have antisocial personality disorders. Post-traumatic stress disorder (PTSD) was not mentioned, suggesting that PTSD was not a diagnosis of interest within the prison system. There is evidence, however, that many, perhaps most prisoners have been victims of physical abuse and/or neglect as children (e.g. Weeks and Widom, 1998). High rates of childhood sexual abuse have also been found (e.g. Dutton and Hart, 1994; Weeks and Widom, 1998). Childhood abuse is an important factor in the subsequent development of PTSD (Herman, 1992). Therefore, the prevalence of PTSD in prison populations might be expected to be higher than in the general population, and the omission of reference to it in such an apparently comprehensive review of prisoners is puzzling. Failure to identify and treat PTSD among prisoners could be a factor predisposing to suicide and self-harming behaviour in prison and, indeed, to recidivism.

We decided to conduct a systematic review of the literature to examine the prevalence of post-traumatic stress disorder in sentenced prison populations worldwide.

Method

Only studies of sentenced prisoners were included in the review. The process of arrest, being charged and held on custodial remand is upsetting for most people, and we wanted to minimize diagnostic confounding by the often acute distress of individuals in this context. Studies of juveniles were excluded on the basis that treatment programmes cannot necessarily be generalized from for adults and juveniles and PTSD for the two age groups should not be considered in a single prevalence figure. Also, because our main interest was in potential indication of treatment need, reference to lifetime prevalence of PTSD was insufficient for inclusion, but rather we required clear evidence that the PTSD had been manifest during imprisonment. Where there was more than one published report from a study, results were included from only one of them to avoid double counting.

We undertook computer-based searches of the worldwide literature on sentenced prisoners, covering up to 30 years of publications. The following general databases were searched: EMBASE (1974–2004); Medline (1951–2004) and PsychInfo (1987–2004). The PILOTS database, which deals exclusively with psychological trauma, was also searched, as was SIGLE, which covers grey literature. The *Journal of Traumatic Stress* was searched manually (1994–present day). Finally, the references of identified papers were scanned for further papers that might match our criteria.

The following combinations of keywords relating to both mental illness and traumatic stress were used: mental health, mental illness, mental disorder, mentally ill, psychiatric, psychological, comorbidity, psychopath*, posttraumatic stress, post-traumatic stress, traumatic stress, PTSD, stress reaction*, traumatic neuros*.

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These keywords were used in combination with keywords relating to prisons or prisoners, which were as follows: prison*, jail*, remand*, imprison*, offend*, criminal*, detention, convict*, correctional facility*, court*, detain*, inmate*, probat*, sentenced, crime*, felon*, misdemean*, gaol, perpetrat*.

The initial search yielded 826 candidate papers. Preliminary screening was done by reading the abstracts of these papers and rating according to a checklist of 10 criteria (see Appendix 1). This yielded 103 potentially relevant papers, which were obtained in full and screened again using the same checklist. Table 1 shows the grounds on which all but four of the papers were excluded from further consideration.

Rates from the four eligible studies of PTSD contemporaneous with the imprisonment were then compared and the geographical location, year of publication, sample size, gender proportions within the sample, definition of current PTSD, qualifications/experience of the assessor, assessment tool and diagnostic tool were examined to identify any variance in the rates found.

Results

Four papers met all the criteria for inclusion (Powell et al., 1997; Simpson et al., 1999; Brink et al., 2001; Butler and Allnut, 2003). Two further papers almost reached the standard for inclusion, but one recorded 'unsatisfactory agreement' between the Diagnostic Interview Schedule and clinical assessments (Jordan

Table 1: Reasons for decisions about papers selected. Codes are included in References section following publication dates.

Code	Exclusion criteria	No.
0	None: included	4
1	Not mental health prevalence studies	17
2	Did not include prison populations	2
3	Did not measure PTSD	71
4	Did not measure PTSD while serving as a prisoner	2
5	Adolescents only or where adolescents were included inseparably in the sample	0
6	Included remand prisoners or prisoners in holding facilities or transient prisons	1
7	Prisoners incarcerated in a secure hospital setting	0
8	Used non-randomized sampling methods, or where methods were not specified	0
9	Conducted without validated instruments corresponding to DSM or ICD diagnosis, where the diagnostic instrument was not specified, or where measures were incomplete or in disagreement	2
10	Papers referring to results of a previously considered study	4

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et al., 1996). The authors attempted further assessments of PTSD, using the Impact of Events Scale, but the results of this similarly did not correspond well to the Structured Clinical Interview for DSM-III-R. The study by Singleton et al. (1998) was excluded because there was no assessment of 'criterion D' for PTSD (arousal). Arousal is one of the key symptoms of PTSD, so we considered that its exclusion invalidated the prevalence figure given.

Prevalence rates varied considerably, with one study finding that only 4% of the prisoners fulfilled criteria for PTSD (Brink et al., 2001), one that 10% did, but two finding that at least 21% of sentenced prisoners had PTSD. Further details are given in Table 2.

Discussion

All four studies of prisoners we identified seem to indicate that the prevalence of PTSD is higher among prisoners than in the general population. Stein et al. (1997), for example, found that 2% of a general population sample of 1002 from a midsized Midwestern Canadian city had a 'current' diagnosis of PTSD. Current was defined by the presence of symptoms during the month prior to diagnosis. Kessler et al. (1995) found a similar rate (2.8%) in a sample of 5877 adults from 48 contiguous states across the United States; here symptoms had to have been present for 30 days prior to diagnosis. Definition of 'current' varied across the prisoner studies, and this may in part account both for the relative overrepresentation of PTSD among prisoners and the different rates between prisoner studies. Powell et al. (1997) defined 'current' as the presence of symptoms in the six months prior to diagnosis, while Butler and Allnut (2003) defined it as the presence of symptoms 12 months prior to the diagnosis, in both cases therefore

Table 2: Prevalence of PTSD among sentenced prisoners and characteristics of the samples in studies meeting all criteria for inclusion

	Powell et al. (1997)	Simpson et al. (1999)	Brink et al. (2001)	Butler et al. (2003)
Country	USA	New Zealand	Canada	Australia
Sample size	213	802	202	566
Gender	Male	Mixed	Male	Mixed
Definition of '*current*' PTSD	6 months	1 month	1 month	12 months
Assessor's training	Basic training	Basic training	Qualified	Basic training
Assessment tool	DIS III R	CIDI-A	SCID	CIDI-A
Diagnostic tool	DSM III R	DSM IV	DSM IV	ICD 10
PTSD rate	21%	10.20%	4%	21.40%

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allowing a longer period 'at risk' for PTSD. These studies found similar and much higher rates of PTSD than the other two.

The issue of gender is also important. Brink et al. (2001) had an exclusively male sample, and the lowest rate of PTSD of all the prisoner studies. It is widely acknowledged that the prevalence of PTSD in the general population is higher for females than males, e.g. Stein et al. (1997, as above) found a rate of 3.4% for women and 0.3% for men. One of the two prisoner studies with the highest rate of PTSD (Butler and Allnut, 2003) included women in the sample, and the female : male differential was evident (F28.6% : M9.5%). Simpson et al. (1999), however, with an intermediate prevalence (10.2%) also included women in the sample. Although the differential was also evident in that study (F16.6% : M8.5%), presence or absence of women in the samples could not entirely account for the overall difference in rates.

The training background of the people evaluating the prisoners may be relevant to the threshold for diagnosis. In the study of Brink et al. (2001), which gave the lowest rate of diagnosis, only forensic psychiatrists and forensic psychologists with special training in the diagnosis of PTSD were employed. The assessment tool used was the Structured Clinical Interview for DSM-IV (SCID), and this explicitly allows the assessor to use clinical judgement. The other studies all relied on non-clinicians given basic training to carry out the assessment with no use of clinical judgement.

A variety of other factors may affect the validity of prevalence estimates of PTSD among prisoners. One is a response bias that is likely to lead to underestimates of mental illness within prisons. It is possible that men in prison have a need to present themselves as 'super-masculine' and do not wish to portray themselves as having been vulnerable or potentially remaining so within the prison setting (Toch, 1977; McCorkle, 1993). This is particularly pertinent to PTSD that follows sexual assault in prison, as implicating another prisoner as a perpetrator might feel risky given the hierarchical prison system and culture of loyalty and secrecy. Second, assessing the mental health needs of prisoners can be difficult due to the high levels of comorbidity in prisoners (Brooker et al., 2002). Third, gaining a truly randomized sample is complicated by the reliance on prisoners consenting without the expectation of personal gain.

Our paper is limited in several important respects. First, as computer-based searches produced the initial yield, results are constrained by the sensitivity and accuracy of three main search engines. The search engines appeared to produce a large number of irrelevant results. Second, a very specific and narrow group was chosen as the focus for the study. While this has the advantage of increased validity of any conclusions drawn from the results, it limits ability to generalize these to a wider prison population. Third, the validity and reliability estimates for the diagnostic tools such as the CIDI A and the DIS III R (as discussed above) were not included in the exclusion criteria, although variation across the rates in the selected papers suggests that this should have been a factor for

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consideration. A fourth limitation is the inclusion of research using either DSM-III-R (American Psychiatric Association, 1987) or DSM-IV criteria (American Psychiatric Association, 1994). The way in which PTSD is diagnosed has changed considerably between the two revisions of the DSM; the DSM III-R definition is more inclusive as is perhaps demonstrated by the comparison of the Brink and Powell papers.

Taken together, these findings nevertheless suggest that PTSD is indeed a problem in a prison population. In particular, women in prison seem to demonstrate an extremely high rate of up to 28.6% (Butler and Allnut, 2003) compared with an estimated rate of 3.4% in the general female population (Stein et al., 1997). Overall, the figures from the papers in this review suggest further investigation is warranted. Future studies should take particular account of treatment needs, to inform development of appropriate clinical services.

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Appendix 1. Ten-Item Screening Checklist of exclusion criteria

1. Papers that were not mental health prevalence studies.
2. Surveys that did not include prison populations.
3. Surveys without specific measures of PTSD.
4. Surveys that did not measure *current* PTSD.
5. Surveys which dealt with adolescents only or where adolescents were included inseparably in the sample.
6. Surveys of remand prisoners or in which remand prisoners or prisoners in holding facilities or transient prisons were included inseparably in the sample.
7. Surveys which looked at prisoners incarcerated in a medical setting (e.g. secure units).
8. Surveys that used non-randomized sampling methods or where these methods were not specified in the paper.
9. Surveys that had been conducted without validated instruments corresponding to DSM or ICD diagnosis or where the diagnostic instrument was not specified.
10. Papers referring to results of a previously considered study.

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N A T I O N A L P O L I C Y C O N F E R E N C E

**From Prison to Home:
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The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment

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The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment

Abstract

This paper examines the unique set of psychological changes that many prisoners are forced to undergo in order to survive the prison experience. It argues that, as a result of several trends in American corrections, the personal challenges posed and psychological harms inflicted in the course of incarceration have grown over the last several decades in the United States. The trends include increasingly harsh policies and conditions of confinement as well as the much discussed de-emphasis on rehabilitation as a goal of incarceration. As a result, the ordinary adaptive process of institutionalization or "prisonization" has become extraordinarily prolonged and intense. Among other things, these recent changes in prison life mean that prisoners in general (and some prisoners in particular) face more difficult and problematic transitions as they return to the freeworld. A range of structural and programmatic changes are required to address these issues. Among other things, social and psychological programs and resources must be made available in the immediate, short, and long-term. That is, modified prison conditions and practices as well as new programs are needed as preparation for release, during transitional periods of parole or initial reintegration, and as long-term services to insure continued successful adjustment.

This paper addresses the psychological impact of incarceration and its implications for post-prison freeworld adjustment. Nearly a half-century ago Gresham Sykes wrote that "life in the maximum security prison is depriving or frustrating in the extreme,"[1] and little has changed to alter that view. Indeed, as I will suggest below, the observation applies with perhaps more force now than when Sykes first made it. Moreover, prolonged adaptation to the deprivations and frustrations of life inside prison—what are commonly referred to as the "pains of imprisonment"—carries a certain psychological cost. In this brief paper I will explore some of those costs, examine their implications for post-prison adjustment in the world beyond prison, and suggest some programmatic and policy-oriented approaches to minimizing their potential to undermine or disrupt the transition from prison to home.

One important caveat is important to make at the very outset of this paper. Although I approach this topic as a psychologist, and much of my discussion is organized around the themes of psychological changes and adaptations, I do *not* mean to suggest or imply that I believe criminal behavior can or should be equated with mental illness, that persons who suffer the acute pains of imprisonment necessarily manifest psychological disorders or other forms of personal

1 Gresham Sykes, *The Society of Captives: A Study of a Maximum Security Prison.* Princeton: Princeton University Press (1958), at 63.

pathology, that psychotherapy should be the exclusive or even primary tool of prison rehabilitation, or that therapeutic interventions are the most important or effective ways to optimize the transition from prison to home. I am well aware of the excesses that have been committed in the name of correctional psychology in the past, and it is not my intention to contribute in any way to having them repeated.

The paper will be organized around several basic propositions—that prisons have become more difficult places in which to adjust and survive over the last several decades; that especially in light of these changes, adaptation to modern prison life exacts certain psychological costs of most incarcerated persons; that some groups of people are somewhat more vulnerable to the pains of imprisonment than others; that the psychological costs and pains of imprisonment can serve to impede post-prison adjustment; and that there are a series of things that can be done both in and out of prison to minimize these impediments. Each of these propositions is presented in turn below.

I. The State of the Prisons

Prisoners in the United States and elsewhere have always confronted a unique set of contingencies and pressures to which they were required to react and adapt in order to survive the prison experience. However, over the last several decades —beginning in the early 1970s and continuing to the present time—a combination of forces have transformed the nation's criminal justice system and modified the nature of imprisonment.[2] The challenges prisoners now face in order to both survive the prison experience and, eventually, reintegrate into the freeworld upon release have changed and intensified as a result.

Among other things, these changes in the nature of imprisonment have included a series of inter-related, negative trends in American corrections. Perhaps the most dramatic changes have come about as a result of the unprecedented increases in rate of incarceration, the size of the U.S. prison population, and the widespread overcrowding that has occurred as a result. Over the past 25 years, penologists repeatedly have described U.S. prisons as "in crisis" and have characterized each new level of overcrowding as "unprecedented." By the start of the 1990s, the United States incarcerated more persons per capita than any other nation in the modern world, and it has retained that dubious distinction for nearly every year since. The international disparities are most striking when the U.S. incarceration rate is contrasted to those of other nations to whom the United States is often compared, such as Japan, Netherlands, Australia, and the United Kingdom.

2 For a more detailed discussion of this issue, see, for example: Haney, C., "Riding the Punishment Wave: On the Origins of Our Devolving Standards of Decency," *Hastings Women's Law Journal*, *9*, 27-78 (1998), and Haney, C., & Zimbardo, P., "The Past and Future of U.S. Prison Policy: Twenty-Five Years After the Stanford Prison Experiment," *American Psychologist*, *53*, 709-727 (1998), and the references cited therein.

In the 1990s, as Marc Mauer and the Sentencing Project have effectively documented—the U.S. rates have consistently been between four and eight times those for these other nations.[3]

The combination of overcrowding and the rapid expansion of prison systems across the country adversely affected living conditions in many prisons, jeopardized prisoner safety, compromised prison management, and greatly limited prisoner access to meaningful programming. The two largest prison systems in the nation—California and Texas—provide instructive examples. Over the last 30 years, California's prisoner population increased *eightfold* (from roughly 20,000 in the early 1970s to its current population of approximately 160,000 prisoners). Yet there has been no remotely comparable increase in funds for prisoner services or inmate programming. In Texas, over just the years between 1992 and 1997, the prisoner population more than doubled as Texas achieved one of the highest incarceration rates in the nation. Nearly 70,000 additional prisoners added to the state's prison rolls in that brief five-year period alone. Not surprisingly, California and Texas were among the states to face major lawsuits in the 1990s over substandard, unconstitutional conditions of confinement. Federal courts in both states found that the prison systems had failed to provide adequate treatment services for those prisoners who suffered the most extreme psychological effects of confinement in deteriorated and overcrowded conditions.[4]

Paralleling these dramatic increases in incarceration rates and the numbers of persons imprisoned in the United States was an equally dramatic change in the rationale for prison itself. The nation moved abruptly in the mid-1970s from a society that justified putting people in prison on the basis of the belief that incarceration would somehow facilitate productive re-entry into the freeworld to one that used imprisonment merely to inflict pain on wrongdoers ("just deserts"), disable criminal offenders ("incapacitation"), or to keep them far away from the rest of society ("containment"). The abandonment of the once-avowed goal of rehabilitation certainly decreased the perceived need and availability of meaningful programming for prisoners as well as social

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3 Mauer, M., "Americans Behind bars: A Comparison of International Rates of Incarceration," in W. Churchill and J.J. Vander Wall (Eds.), *Cages of Steel: The Politics of Imprisonment in the United States* (pp. 22-37). Washington, D.C.: Maisonneuve Press (1992); Mauer, M., "The International Use of Incarceration," *Prison Journal*, *75*, 113-123 (1995).

4 In California, for example, see: *Dohner v. McCarthy* [United States District Court, Central District of California, 1984-1985; 635 F. Supp. 408 (C.D. Cal. 1985) (examining the effects of overcrowded conditions in the California Men's Colony); *Coleman v. Wilson*, 912 F. Supp. 1282 (N.D. Cal. 1995) (challenge to grossly inadequate mental health services in the throughout the entire state prison system). In Texas, see the long-lasting *Ruiz* litigation in which the federal court has monitored and attempted to correct unconstitutional conditions of confinement throughout the state's sprawling prison system for more than 20 years now. Current conditions and the most recent status of the litigation are described in *Ruiz v. Johnson* [United States District Court, Southern District of Texas, 37 F. Supp. 2d 855 (S.D. Texas 1999).]
But these two states were not alone. According to the ACLU's National Prison Project, in 1995 there were fully 33 jurisdictions in the United States under court order to reduce overcrowding or improve general conditions in at least one of their major prison facilities. Nine were operating under court orders that covered their entire prison system. National Prison Project, *Status Report: State Prisons and the Courts* (1995).

and mental health services available to them both inside and outside the prison. Indeed, it generally reduced concern on the part of prison administrations for the overall well-being of prisoners.

The abandonment of rehabilitation also resulted in an erosion of modestly protective norms against cruelty toward prisoners. Many corrections officials soon became far less inclined to address prison disturbances, tensions between prisoner groups and factions, and disciplinary infractions in general through ameliorative techniques aimed at the root causes of conflict and designed to de-escalate it. The rapid influx of new prisoners, serious shortages in staffing and other resources, and the embrace of an openly punitive approach to corrections led to the "de-skilling" of many correctional staff members who often resorted to extreme forms of prison discipline (such as punitive isolation or "supermax" confinement) that had especially destructive effects on prisoners and repressed conflict rather than resolving it. Increased tensions and higher levels of fear and danger resulted.

The emphasis on the punitive and stigmatizing aspects of incarceration, which has resulted in the further literal and psychological isolation of prison from the surrounding community, compromised prison visitation programs and the already scarce resources that had been used to maintain ties between prisoners and their families and the outside world. Support services to facilitate the transition from prison to the freeworld environments to which prisoners were returned were undermined at precisely the moment they needed to be enhanced. Increased sentence length and a greatly expanded scope of incarceration resulted in prisoners experiencing the psychological strains of imprisonment for longer periods of time, many persons being caught in the web of incarceration who ordinarily would not have been (e.g., drug offenders), and the social costs of incarceration becoming increasingly concentrated in minority communities (because of differential enforcement and sentencing policies).

Thus, in the first decade of the 21st century, more people have been subjected to the pains of imprisonment, for longer periods of time, under conditions that threaten greater psychological distress and potential long-term dysfunction, and they will be returned to communities that have already been disadvantaged by a lack of social services and resources.

II. The Psychological Effects of Incarceration: On the Nature of Institutionalization

The adaptation to imprisonment is almost always difficult and, at times, creates habits of thinking and acting that can be dysfunctional in periods of post-prison adjustment. Yet, the psychological effects of incarceration vary from individual to individual and are often reversible. To be sure, then, not everyone who is incarcerated is disabled or psychologically harmed by it. But few people are completely unchanged or unscathed by the experience. At the very least,

prison is painful, and incarcerated persons often suffer long-term consequences from having been subjected to pain, deprivation, and extremely atypical patterns and norms of living and interacting with others.

The empirical consensus on the most negative effects of incarceration is that most people who have done time in the best-run prisons return to the freeworld with little or no permanent, clinically-diagnosable psychological disorders as a result.[5] Prisons do not, in general, make people "crazy." However, even researchers who are openly skeptical about whether the pains of imprisonment generally translate into psychological harm concede that, for at least some people, prison can produce negative, long-lasting change.[6] And most people agree that the more extreme, harsh, dangerous, or otherwise psychologically-taxing the nature of the confinement, the greater the number of people who will suffer and the deeper the damage that they will incur.[7]

Rather than concentrate on the most extreme or clinically-diagnosable effects of imprisonment, however, I prefer to focus on the broader and more subtle psychological changes that occur in the routine course of adapting to prison life. The term "institutionalization" is used to describe the process by which inmates are shaped and transformed by the institutional environments in which they live. Sometimes called "prisonization" when it occurs in correctional

5 For a more detailed discussion of these issues, see, for example: Haney, C., "Psychology and the Limits to Prison Pain: Confronting the Coming Crisis in Eighth Amendment Law," *Psychology, Public Policy, and Law*, *3*, 499-588 (1997), and the references cited therein.

6 Among the most unsympathetic of these skeptical views is: Bonta, J., and Gendreau, P., "Reexamining the Cruel and Unusual Punishment of Prison Life," *Law and Human Behavior*, *14*, 347 (1990). However, even these authors concede that: "physiological and psychological stress responses… were very likely [to occur] under crowded prison conditions"; "[w]hen threats to health come from suicide and self-mutilation, then inmates are clearly at risk"; "[i]n Canadian penitentiaries, the homicide rates are close to 20 times that of similar-aged males in Canadian society"; that "a variety of health problems, injuries, and selected symptoms of psychological distress were higher for certain classes of inmates than probationers, parolees, and, where data existed, for the general population"; that studies show long-term incarceration to result in "increases in hostility and social introversion… and decreases in self-evaluation and evaluations of work and father"; that imprisonment produced "increases in dependency upon staff for direction and social introversion," a tendency for prisoners to prefer "to cope with their sentences on their own rather than seek the aid of others," "deteriorating community relationships over time," and "unique difficulties" with "family separation issues and vocational skill training needs"; and that some researchers have speculated that "inmates typically undergo a 'behavioral deep freeze'" such that "outside-world behaviors that led the offender into trouble prior to imprisonment remain until release." Bonta & Gendreau, pp. 353-359.

7 Again, precisely because they define themselves as skeptical of the proposition that the pains of imprisonment produce many significant negative effects in prisoners, Bonta and Gendreau are instructive to quote. They concede that: there are "signs of pathology for inmates incarcerated in solitary for periods up to a year"; that higher levels of anxiety have been found in inmates after eight weeks in jail than after one; that increases in psychopathological symptoms occur after 72 hours of confinement; and that death row prisoners have been found to have "symptoms ranging from paranoia to insomnia," "increased feelings of depression and hopelessness," and feeling "powerlessness, fearful of their surroundings, and… emotionally drained." Bonta & Gendreau, pp. 361-362.

settings, it is the shorthand expression for the negative psychological effects of imprisonment.[8] The process has been studied extensively by sociologists, psychologists, psychiatrists, and others, and involves a unique set of psychological adaptations that often occur—in varying degrees—in response to the extraordinary demands of prison life. In general terms, the process of prisonization involves the incorporation of the norms of prison life into one's habits of thinking, feeling, and acting.

It is important to emphasize that these are the natural and normal adaptations made by prisoners in response to the unnatural and abnormal conditions of prisoner life. The dysfunctionality of these adaptations is not "pathological" in nature (even though, in practical terms, they may be destructive in effect). They are "normal" reactions to a set of pathological conditions that become problematic when they are taken to extreme lengths, or become chronic and deeply internalized (so that, even though the conditions of one's life have changed, many of the once-functional but now counterproductive patterns remain).

Like all processes of gradual change, of course, this one typically occurs in stages and, all other things being equal, the longer someone is incarcerated the more significant the nature of the institutional transformation. When most people first enter prison, of course, they find that being forced to adapt to an often harsh and rigid institutional routine, deprived of privacy and liberty, and subjected to a diminished, stigmatized status and extremely sparse material conditions is stressful, unpleasant, and difficult.

However, in the course of becoming institutionalized, a transformation begins. Persons gradually become more accustomed to the restrictions that institutional life imposes. The various psychological mechanisms that must be employed to adjust (and, in some harsh and dangerous correctional environments, to survive) become increasingly "natural," second nature, and, to a degree, internalized. To be sure, the process of institutionalization can be subtle and difficult to discern as it occurs. Thus, prisoners do not "choose" do succumb to it or not, and few people who have become institutionalized are aware that it has happened to them. Fewer still consciously decide that they are going to willingly allow the transformation to occur.

The process of institutionalization is facilitated in cases in which persons enter institutional settings at an early age, before they have formed the ability and expectation to control their own life choices. Because there is less tension between the demands of the institution and the autonomy of a mature adult, institutionalization proceeds more quickly and less problematically

8 A distinction is sometimes made in the literature between institutionalization—psychological changes that produce more conforming and institutionally "appropriate" thoughts and actions—and prisonization—changes that create a more oppositional and institutionally subversive stance or perspective. Here I use the terms more or less interchangeably to denote the totality of the negative transformation that may place before prisoners are released back into free society.

with at least some younger inmates. Moreover, younger inmates have little in the way of already developed independent judgment, so they have little if anything to revert to or rely upon if and when the institutional structure is removed. And the longer someone remains in an institution, the greater the likelihood that the process will transform them.

Among other things, the process of institutionalization (or "prisonization") includes some or all of the following psychological adaptations:

A. Dependence on institutional structure and contingencies.

Among other things, penal institutions require inmates to relinquish the freedom and autonomy to make their own choices and decisions and this process requires what is a painful adjustment for most people. Indeed, some people never adjust to it. Over time, however, prisoners may adjust to the muting of self-initiative and independence that prison requires and become increasingly dependent on institutional contingencies that they once resisted. Eventually it may seem more or less natural to be denied significant control over day-to-day decisions and, in the final stages of the process, some inmates may come to depend heavily on institutional decisionmakers to make choices for them and to rely on the structure and schedule of the institution to organize their daily routine. Although it rarely occurs to such a degree, some people do lose the capacity to initiate behavior on their own and the judgment to make decisions for themselves. Indeed, in extreme cases, profoundly institutionalized persons may become extremely uncomfortable when and if their previous freedom and autonomy is returned.

A slightly different aspect of the process involves the creation of dependency upon the institution to control one's behavior. Correctional institutions force inmates to adapt to an elaborate network of typically very clear boundaries and limits, the consequences for whose violation can be swift and severe. Prisons impose careful and continuous surveillance, and are quick to punish (and sometimes to punish severely) infractions of the limiting rules. The process of institutionalization in correctional settings may surround inmates so thoroughly with external limits, immerse them so deeply in a network of rules and regulations, and accustom them so completely to such highly visible systems of constraint that internal controls atrophy or, in the case of especially young inmates, fail to develop altogether. Thus, institutionalization or prisonization renders some people so dependent on external constraints that they gradually lose the capacity to rely on internal organization and self-imposed personal limits to guide their actions and restrain their conduct. If and when this external structure is taken away, severely institutionalized persons may find that they no longer know how to do things on their own, or how to refrain from doing those things that are ultimately harmful or self- destructive.

B. Hypervigilance, interpersonal distrust and suspicion.

In addition, because many prisons are clearly dangerous places from which there is no exit or escape, prisoners learn quickly to become hypervigilant and ever-alert for signs of threat or personal risk. Because the stakes are high, and because there are people in their immediate

environment poised to take advantage of weakness or exploit carelessness or inattention, interpersonal distrust and suspicion often result. Some prisoners learn to project a tough convict veneer that keeps all others at a distance. Indeed, as one prison researcher put it, many prisoners "believe that unless an inmate can convincingly project an image that conveys the potential for violence, he is likely to be dominated and exploited throughout the duration of his sentence."[9]

McCorkle's study of a maximum security Tennessee prison was one of the few that attempted to quantify the kinds of behavioral strategies prisoners report employing to survive dangerous prison environments. He found that "[f]ear appeared to be shaping the life-styles of many of the men," that it had led over 40% of prisoners to avoid certain high risk areas of the prison, and about an equal number of inmates reported spending additional time in their cells as a precaution against victimization. At the same time, almost three-quarters reported that they had been forced to "get tough" with another prisoner to avoid victimization, and more than a quarter kept a "shank" or other weapon nearby with which to defend themselves. McCorkle found that age was the best predictor of the type of adaptation a prisoner took, with younger prisoners being more likely to employ aggressive avoidance strategies than older ones.

C. Emotional over-control, alienation, and psychological distancing.

Shaping such an outward image requires emotional responses to be carefully measured. Thus, prisoners struggle to control and suppress their own internal emotional reactions to events around them. Emotional over-control and a generalized lack of spontaneity may occur as a result. Admissions of vulnerability to persons inside the immediate prison environment are potentially dangerous because they invite exploitation. As one experienced prison administrator once wrote: "Prison is a barely controlled jungle where the aggressive and the strong will exploit the weak, and the weak are dreadfully aware of it."[10] Some prisoners are forced to become remarkably skilled "self-monitors" who calculate the anticipated effects that every aspect of their behavior might have on the rest of the prison population, and strive to make such calculations second nature.

Prisoners who labor at both an emotional and behavioral level to develop a "prison mask" that is unrevealing and impenetrable risk alienation from themselves and others, may develop emotional flatness that becomes chronic and debilitating in social interaction and relationships, and find that they have created a permanent and unbridgeable distance between themselves and other people. Many for whom the mask becomes especially thick and effective in prison find that the disincentive against engaging in open communication with others that prevails there has led

9 Richard McCorkle, "Personal Precautions to Violence in Prison," *Criminal Justice and Behavior*, *19*, 160-173 (1992), at 161.

10 Paul Keve, *Prison Life and Human Worth.* Minneapolis, MN: University of Minnesota Press (1974), at 54.

them to withdrawal from authentic social interactions altogether.[11] The alienation and social distancing from others is a defense not only against exploitation but also against the realization that the lack of interpersonal control in the immediate prison environment makes emotional investments in relationships risky and unpredictable.

D. Social withdrawal and isolation.

Some prisoners learn to find safety in social invisibility by becoming as inconspicuous and unobtrusively disconnected from others as possible. The self-imposed social withdrawal and isolation may mean that they retreat deeply into themselves, trust virtually no one, and adjust to prison stress by leading isolated lives of quiet desperation. In extreme cases, especially when combined with prisoner apathy and loss of the capacity to initiate behavior on one's own, the pattern closely resembles that of clinical depression. Long-term prisoners are particularly vulnerable to this form of psychological adaptation. Indeed, Taylor wrote that the long-term prisoner "shows a flatness of response which resembles slow, automatic behavior of a very limited kind, and he is humorless and lethargic."[12] In fact, Jose-Kampfner has analogized the plight of long-term women prisoners to that of persons who are terminally-ill, whose experience of this "existential death is unfeeling, being cut off from the outside… (and who) adopt this attitude because it helps them cope."[13]

E. Incorporation of exploitative norms of prison culture.

In addition to obeying the formal rules of the institution, there are also informal rules and norms that are part of the unwritten but essential institutional and inmate culture and code that, at some level, must be abided. For some prisoners this means defending against the dangerousness and deprivations of the surrounding environment by embracing all of its informal norms, including some of the most exploitative and extreme values of prison life. Note that prisoners typically are given no alternative culture to which to ascribe or in which to participate. In many institutions the lack of meaningful programming has deprived them of pro-social or positive activities in which to engage while incarcerated. Few prisoners are given access to gainful employment where they can obtain meaningful job skills and earn adequate compensation; those

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11 For example, see Jose-Kampfner, C., "Coming to Terms with Existential Death: An Analysis of Women's Adaptation to Life in Prison," *Social Justice*, *17*, 110 (1990) and, also, Sapsford, R., "Life Sentence Prisoners: Psychological Changes During Sentence," *British Journal of Criminology*, *18*, 162 (1978).

12 Taylor, A., "Social Isolation and Imprisonment," *Psychiatry*, *24,* 373 (1961), at p. 373. See, also, Hanna Levenson, "Multidimensional Locus of Control in Prison Inmates," *Journal of Applied Social Psychology*, 5, 342 (1975) who found not surprisingly that prisoners who were incarcerated for longer periods of time and those who were punished more frequently by being placed in solitary confinement were more likely to believe that their world was controlled by "powerful others." Such beliefs are consistent with an institutional adaptation that undermines autonomy and self-initiative.

13 Jose-Kampfner, *supra* note 10, at 123.

who do work are assigned to menial tasks that they perform for only a few hours a day. With rare exceptions—those very few states that permit highly regulated and infrequent conjugal visits—they are prohibited from sexual contact of any kind. Attempts to address many of the basic needs and desires that are the focus of normal day-to-day existence in the freeworld—to recreate, to work, to love—necessarily draws them closer to an illicit prisoner culture that for many represents the only apparent and meaningful way of being.

However, as I noted earlier, prisoner culture frowns on any sign of weakness and vulnerability, and discourages the expression of candid emotions or intimacy. And some prisoners embrace it in a way that promotes a heightened investment in one's reputation for toughness, and encourages a stance towards others in which even seemingly insignificant insults, affronts, or physical violations must be responded to quickly and instinctively, sometimes with decisive force. In extreme cases, the failure to exploit weakness is itself a sign of weakness and seen as an invitation for exploitation. In men's prisons it may promote a kind of hypermasculinity in which force and domination are glorified as essential components of personal identity. In an environment characterized by enforced powerlessness and deprivation, men and women prisoners confront distorted norms of sexuality in which dominance and submission become entangled with and mistaken for the basis of intimate relations.

Of course, embracing these values too fully can create enormous barriers to meaningful interpersonal contact in the free world, preclude seeking appropriate help for one's problems, and a generalized unwillingness to trust others out of fear of exploitation. It can also lead to what appears to be impulsive overreaction, striking out at people in response to minimal provocation that occurs particularly with persons who have not been socialized into the norms of inmate culture in which the maintenance of interpersonal respect and personal space are so inviolate. Yet these things are often as much a part of the process of prisonization as adapting to the formal rules that are imposed in the institution, and they are as difficult to relinquish upon release.

F. Diminished sense of self-worth and personal value.

Prisoners typically are denied their basic privacy rights, and lose control over mundane aspects of their existence that most citizens have long taken for granted. They live in small, sometimes extremely cramped and deteriorating spaces (a 60 square foot cell is roughly the size of king-size bed), have little or no control over the identify of the person with whom they must share that space (and the intimate contact it requires), often have no choice over when they must get up or go to bed, when or what they may eat, and on and on. Some feel infantalized and that the degraded conditions under which they live serve to repeatedly remind them of their compromised social status and stigmatized social role as prisoners. A diminished sense of self-worth and personal value may result. In extreme cases of institutionalization, the symbolic meaning that can be inferred from this externally imposed substandard treatment and

circumstances is internalized; that is, prisoners may come to think of themselves as "the kind of person" who deserves only the degradation and stigma to which they have been subjected while incarcerated.

G. Post-traumatic stress reactions to the pains of imprisonment.

For some prisoners, incarceration is so stark and psychologically painful that it represents a form of traumatic stress severe enough to produce post-traumatic stress reactions once released. Moreover, we now understand that there are certain basic commonalities that characterize the lives of many of the persons who have been convicted of crime in our society.[14] A "risk factors" model helps to explain the complex interplay of traumatic childhood events (like poverty, abusive and neglectful mistreatment, and other forms of victimization) in the social histories of many criminal offenders. As Masten and Garmezy have noted, the presence of these background risk factors and traumas in childhood increases the probability that one will encounter a whole range of problems later in life, including delinquency and criminality.[15] The fact that a high percentage of persons presently incarcerated have experienced childhood trauma means, among other things, that the harsh, punitive, and uncaring nature of prison life may represent a kind of "re-truamatization" experience for many of them. That is, some prisoners find exposure to the rigid and unyielding discipline of prison, the unwanted proximity to violent encounters and the possibility or reality of being victimized by physical and/or sexual assaults, the need to negotiate the dominating intentions of others, the absence of genuine respect and regard for their well being in the surrounding environment, and so on all too familiar. Time spent in prison may rekindle not only the memories but the disabling psychological reactions and consequences of these earlier damaging experiences.

The dysfunctional consequences of institutionalization are not always immediately obvious once the institutional structure and procedural imperatives have been removed. This is especially

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14 The literature on these issues has grown vast over the last several decades. For representative examples, see: Dutton, D., Hart, S., "Evidence for Long-term, Specific Effects of Childhood Abuse and Neglect on Criminal Behavior in Men," *International Journal of Offender Therapy & Comparative Criminology*, 36, 129-137 (1992); Haney, C., "The Social Context of Capital Murder: Social Histories and the Logic of Capital Mitigation," 35 *Santa Clara Law Review* 35, 547-609 (1995); Craig Haney, "Psychological Secrecy and the Death Penalty: Observations on 'the Mere Extinguishment of Life,'" *Studies in Law, Politics, and Society*, *16*, 3-69 (1997); Haney, C., "Mitigation and the Study of Lives: The Roots of Violent Criminality and the Nature of Capital Justice," in James Acker, Robert Bohm, and Charles Lanier, *America's Experiment with Capital Punishment: Reflections on the Past, Present, and Future of the Ultimate Penal Sanction* (pp. 343-377). Durham, NC: Carolina Academic Press (1997).Huff-Corzine, L., Corzine, J., & Moore, D., "Deadly Connections: Culture, Poverty, and the Direction of Lethal Violence," *Social Forces 69*, 715-732 (1991); McCord, J., "The Cycle of Crime and Socialization Practices," *Journal of Criminal Law & Criminology*, *82*, 211-228 (1991); Sampson, R., and Laub, J. *Crime in the Making: Pathways and Turning Points Through Life*. Cambridge, MA: Harvard University Press (1993); and Widom, C., "The Cycle of Violence," *Science*, *244*, 160-166 (1989).

15 Masten, A., & Garmezy, N., Risk, Vulnerability and Protective Factors in Developmental Psychopathology. In F. Lahey & A Kazdin (Eds.) *Advances in Clinical Child Psychology* (pp. 1-52). New York: Plenum (1985), at 3.

true in cases where persons retain a minimum of structure wherever they re-enter free society. Moreover, the most negative consequences of institutionalization may first occur in the form of *internal* chaos, disorganization, stress, and fear. Yet, institutionalization has taught most people to cover their internal states, and not to openly or easily reveal intimate feelings or reactions. So, the outward appearance of normality and adjustment may mask a range of serious problems in adapting to the freeworld.

This is particularly true of persons who return to the freeworld lacking a network of close, personal contacts with people who know them well enough to sense that something may be wrong. Eventually, however, when severely institutionalized persons confront complicated problems or conflicts, especially in the form of unexpected events that cannot be planned for in advance, the myriad of challenges that the non-institutionalized confront in their everyday lives outside the institution may become overwhelming. The facade of normality begins to deteriorate, and persons may behave in dysfunctional or even destructive ways because all of the external structure and supports upon which they relied to keep themselves controlled, directed, and balanced have been removed.

III. Special Populations and Pains of Prison Life

Although everyone who enters prison is subjected to many of the above-stated pressures of institutionalization, and prisoners respond in various ways with varying degrees of psychological change associated with their adaptations, it is important to note that there are some prisoners who are much more vulnerable to these pressures and the overall pains of imprisonment than others. Either because of their personal characteristics—in the case of "special needs" prisoners whose special problems are inadequately addressed by current prison policies[16]—or because of the especially harsh conditions of confinement to which they are subjected—in the case of increasing numbers of "supermax" or solitary confinement prisoners[17]—they are at risk of making the transition from prison to home with a more significant set of psychological problems and challenges to overcome. The plight of several of these special populations of prisoners is briefly discussed below.

16 For a more detailed discussion of these issues, see, for example: Haney, C., & Specter, D., "Vulnerable Offenders and the Law: Treatment Rights in Uncertain Legal Times," in J. Ashford, B. Sales, & W. Reid (Eds.), *Treating Adult and Juvenile Offenders with Special Needs* (pp. 51-79). Washington, D.C.: American Psychological Association (2001), and the references cited therein.

17 See Haney, C., & Lynch, M., "Regulating Prisons of the Future: The Psychological Consequences of Supermax and Solitary Confinement," *New York University Review of Law and Social Change*, *23*, 477-570 (1997), for a discussion of this trend in American corrections and a description of the nature of these isolated conditions to which an increasing number of prisoners are subjected.

A. Mentally Ill and Developmentally Disabled Prisoners

Perhaps not surprisingly, mental illness and developmental disability represent the largest number of disabilities among prisoners. For example, a national survey of prison inmates with disabilities conducted in 1987 indicated that although less than 1% suffered from visual, mobility/orthopedic, hearing, or speech deficits, much higher percentages suffered from cognitive and psychological disabilities.[18] A more recent follow-up study by two of the same authors obtained similar results: although less than 1% of the prison population suffered visual, mobility, speech, or hearing deficits, 4.2% were developmentally disabled, 7.2% suffered psychotic disorders, and 12% reported "other psychological disorders."[19] It is probably safe to estimate, then, based on this and other studies,[20] that upwards of as many as 20% of the current prisoner population nationally suffers from either some sort of significant mental or psychological disorder or developmental disability.

As my earlier comments about the process of institutionalization implied, the task of negotiating key features of the social environment of imprisonment is far more challenging than it appears at first. And it is surely far more difficult for vulnerable, mentally-ill and developmentally-disabled prisoners to accomplish. Incarceration presents particularly difficult adjustment problems that make prison an especially confusing and sometimes dangerous situation for them. For mentally-ill and developmentally-disabled inmates, part of whose defining (but often undiagnosed) disability includes difficulties in maintaining close contact with reality, controlling and conforming one's emotional and behavioral reactions, and generally impaired comprehension and learning, the rule-bound nature of institutional life may have especially disastrous consequences. Yet, both groups are too often left to their own devices to somehow survive in prison and leave without having had any of their unique needs addressed.

Combined with the de-emphasis on treatment that now characterizes our nation's correctional facilities, these behavior patterns can significantly impact the institutional history of vulnerable or special needs inmates. One commentator has described the vicious cycle into which mentally-ill and developmentally-disabled prisoners can fall:

> The lack of mental health care for the seriously mentally ill who end up in segregation units has worsened the condition of many prisoners incapable of understanding their condition. This is especially true in cases where prisoners are placed in levels of mental health care that are not intense enough, and begin to refuse taking their medication. They then enter a vicious cycle in which their mental disease takes over, often causing hostile and aggressive behavior to the

18 Veneziano, L., Veneziano, C., & Tribolet, C., The special needs of prison inmates with handicaps: An assessment. *Journal of Offender Counseling, Services & Rehabilitation*, *12*, 61-72 (1987).

19 Veneziano, L., & Veneziano, C., Disabled inmates. In M. McShane & F. Williams (Eds.), *Encyclopedia of American Prisons* (pp. 157-161). New York: Garland (1996). See, also, Long, L., & Sapp, A., Programs and facilities for physically disabled inmates in state prisons. *Journal of Offender Rehabilitation*, *18*, 191-204 (1992).

20 For example, according to a Department of Justice census of correctional facilities across the country, there were approximately 200,000 mentally ill prisoners in the United States in midyear 2000. This represented approximately 16% of prisoners nationwide. Bureau of Justice Statistics, *Mental Health Treatment in State Prisons*, 2000. (NCJ 188215), July, 2001.

> point that they break prison rules and end up in segregation units as management problems. Once in punitive housing, this regression can go undetected for considerable periods of time before they again receive more closely monitored mental health care. This cycle can, and often does, repeat.[21]

B. Prisoners in "Supermax" or Solitary Confinement

In addition, there are an increasing number of prisoners who are subjected to the unique and more destructive experience of punitive isolation, in so-called "supermax" facilities, where they are kept under conditions of unprecedented levels of social deprivation for unprecedented lengths of time. This kind of confinement creates its own set of psychological pressures that, in some instances, uniquely disable prisoners for freeworld reintegration.[22] Indeed, there are few if any forms of imprisonment that produce so many indicies of psychological trauma and symptoms of psychopathology in those persons subjected to it. My own review of the literature suggested these documented negative psychological consequences of long-term solitary-like confinement include: an impaired sense of identity; hypersensitivity to stimuli; cognitive dysfunction (confusion, memory loss, ruminations); irritability, anger, aggression, and/or rage; other-directed violence, such as stabbings, attacks on staff, property destruction, and collective violence; lethargy, helplessness and hopelessness; chronic depression; self-mutilation and/or suicidal ideation, impulses, and behavior; anxiety and panic attacks; emotional breakdowns; and/or loss of control; hallucinations, psychosis and/or paranoia; overall deterioration of mental and physical health.[23]

Human Rights Watch has suggested that there are approximately 20,000 prisoners confined to supermax-type units in the United States.[24] Most experts agree that the number of such units is increasing. In many states the majority of prisoners in these units are serving "indeterminate" solitary confinement terms, which means that their entire prison sentence will be served in isolation (unless they "debrief" by providing incriminating information about other prisoners). Few states provide any meaningful or effective "decompression" program for prisoners, which means that many prisoners who have been confined in these supermax units—some for considerable periods of time—are released directly into the community from these extreme conditions of confinement.

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21 Streeter, P., "Incarceration of the mentally ill: Treatment or warehousing?" *Michigan Bar Journal*, *77*, 166 (1998), at p. 167.

22 For a more detailed discussion of these issues, see, for example: Haney, C., & Lynch, M., "Regulating Prisons of the Future: The Psychological Consequences of Supermax and Solitary Confinement," *New York University Review of Law and Social Change*, *23*, 477-570 (1997), and the references cited therein.

23 See Haney & Lynch, *supra* note 21.

24 Human Rights Watch, *Out of Sight: Super-Maximum Security Confinement in the United States*. Feburary, 2000.

IV. Implications for the Transition From Prison to Home

The psychological consequences of incarceration may represent significant impediments to post-prison adjustment. They may interfere with the transition from prison to home, impede an ex-convict's successful re-integration into a social network and employment setting, and may compromise an incarcerated parent's ability to resume his or her role with family and children. The range of effects includes the sometimes subtle but nonetheless broad-based and potentially disabling effects of institutionalization prisonization, the persistent effects of untreated or exacerbated mental illness, the long-term legacies of developmental disabilities that were improperly addressed, or the pathological consequences of supermax confinement experienced by a small but growing number of prisoners who are released directly from long-term isolation into freeworld communities. There is little or no evidence that prison systems across the country have responded in a meaningful way to these psychological issues, either in the course of confinement or at the time of release. Over the next decade, the impact of unprecedented levels of incarceration will be felt in communities that will be expected to receive massive numbers of ex-convicts who will complete their sentences and return home but also to absorb the high level of psychological trauma and disorder that many will bring with them.

The implications of these psychological effects for parenting and family life can be profound. Parents who return from periods of incarceration still dependent on institutional structures and routines cannot be expected to effectively organize the lives of their children or exercise the initiative and autonomous decisionmaking that parenting requires. Those who still suffer the negative effects of a distrusting and hypervigilant adaptation to prison life will find it difficult to promote trust and authenticity within their children. Those who remain emotionally over-controlled and alienated from others will experience problems being psychologically available and nurturant. Tendencies to socially withdraw, remain aloof or seek social invisibility could not be more dysfunctional in family settings where closeness and interdependency is needed. The continued embrace of many of the most negative aspects of exploitative prisoner culture is likely to doom most social and intimate relations, as will an inability to overcome the diminished sense of self-worth that prison too often instills. Clearly, the residual effects of the post-traumatic stress of imprisonment and the retraumatization experiences that the nature of prison life may incur can jeopardize the mental health of persons attempting to reintegrate back into the freeworld communities from which they came. Indeed, there is evidence that incarcerated parents not only themselves continue to be adversely affected by traumatizing risk factors to which they have been exposed, but also that the experience of imprisonment has done little or nothing to provide them with the tools to safeguard their children from the same potentially destructive experiences.[25]

25 Greene, S., Haney, C., and Hurtado, A., "Cycles of Pain: Risk Factors in the Lives of Incarcerated Women and Their Children," *Prison Journal*, *80*, 3-23 (2000).

The excessive *and* disproportionate use of imprisonment over the last several decades also means that these problems will not only be large but concentrated primarily in certain communities whose residents were selectively targeted for criminal justice system intervention. Our society is about to absorb the consequences not only of the "rage to punish"[26] that was so fully indulged in the last quarter of the 20th century but also of the "malign neglect"[27] that led us to concentrate this rage so heavily on African American men. Remarkably, as the present decade began, there were more young Black men (between the ages of 20-29) under the control of the nation's criminal justice system (including probation and parole supervision) than the total number in college.[28] Thus, whatever the psychological consequences of imprisonment and their implications for reintegration back into the communities from which prisoners have come, we know that those consequences and implications are about to be felt in unprecedented ways in these communities, by these families, and for these children, like no others. Not surprisingly, then, one scholar has predicted that "imprisonment will become the most significant factor contributing to the dissolution and breakdown of African American families during the decade of the 1990s"[29] and another has concluded that "[c]rime control policies are a major contributor to the disruption of the family, the prevalence of single parent families, and children raised without a father in the ghetto, and the 'inability of people to get the jobs still available' . "[30]

V. Policy and Programmatic Responses to the Adverse Effects of Incarceration

An intelligent, humane response to these facts about the implications of contemporary prison life must occur on at least two levels. We must simultaneously address the adverse prison policies and conditions of confinement that have created these special problems, and at the same time provide psychological resources and social services for persons who have been adversely affected by them. Both things must occur if the successful transition from prison to home is to occur on a consistent and effective basis.

There are three areas in which policy interventions must be concentrated in order to address these two levels of concern:

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26 Lois Forer, *A Rage to Punish: The Unintended Consequences of Mandatory Sentencing.* New York: W. W. Norton (1994).

27 Michael Tonry, *Malign Neglect: Race, Crime, and Punishment in America*. New York: Oxford University Press (1995).

28 Mauer, M. (1990). More Young Black Males under Correctional Control in US than in College. Washington: The Sentencing Project.

29 King, A., "The Impact of Incarceration on African American Families: Implications for Practice," *Families in Society: The Journal of Contemporary Human Services*, *74*, 145-153 (1993), p. 145..

30 Chambliss, W., "Policing the Ghetto Underclass: The Politics of Law and Law Enforcement," *Social Problems*, *41*, 177-194 (1994), p. 183.

A. Prison Conditions, Policies, and Procedures

No significant amount of progress can be made in easing the transition from prison to home until and unless significant changes are made in the normative structure of American prisons. Specifically:

- The goal of penal harm must give way to a clear emphasis on prisoner-oriented rehabilitative services.
- The adverse effects of institutionalization must be minimized by structuring prison life to replicate, as much as possible, life in the world outside prison. A useful heuristic to follow is a simple one: "the less like a prison, and the more like the freeworld, the better."
- Prisons that give inmates opportunities to exercise pockets of autonomy and personal initiative must be created.
- Safe correctional environments that remove the need for hypervigilance and pervasive distrust must be maintained, ones where prisoners can establish authentic selves, and learn the norms of interdependence and cooperative trust.
- A clear and consistent emphasis on maximizing visitation and supporting contact with the outside world must be implemented, both to minimize the division between the norms of prison and those of the freeworld, and to discourage dysfunctional social withdrawal that is difficult to reverse upon release.
- Program rich institutions must be established that give prisoners genuine alternative to exploitative prisoner culture in which to participate and invest, and the degraded, stigmatized status of prisoner transcended. Prisoners must be given opportunities to engage in meaningful activities, to work, and to love while incarcerated.
- Adequate therapeutic and habilitative resources must be provided to address the needs of the large numbers of mentally ill and developmentally disabled prisoners who are now incarcerated.
- The increased use of supermax and other forms of extremely harsh and psychologically damaging confinement must be reversed. Strict time limits must be placed on the use of punitive isolation that approximate the much briefer periods of such confinement that once characterized American corrections, prisoners must be screened for special vulnerability to isolation, and carefully monitored so that they can be removed upon the first sign of adverse reactions.

B. Transitional Services to Prepare Prisoners for Community Release

No significant amount of progress can be made in easing the transition from prison to home until and unless significant changes are made in the way prisoners are prepared to leave prison and re-enter the freeworld communities from which they came. Specifically:

- Prison systems must begin to take the pains of imprisonment and the nature of institutionalization seriously, and provide all prisoners with effective decompression programs in which they are re-acclimated to the nature and norms of the freeworld.
- Prisoners must be given some insight into the changes brought about by their adaptation to prison life. They must be given some understanding of the ways in which prison may have changed them, the tools with which to respond to the challenge of adjustment to the freeworld.
- The process must begin well in advance of a prisoner's release, and take into account all aspects of the transition he or she will be expected to make. This means, among other things, that all prisoners will need occupational and vocational training and pre-release assistance in finding gainful employment. It also means that prisoners who are expected to resume their roles as parents will need pre-release assistance in establishing, strengthening, and/or maintaining ties with their families and children, and whatever other assistance will be essential for them to function effectively in this role (such as parenting classes and the like).
- Prisoners who have manifested signs or symptoms of mental illness or developmental disability while incarcerated will need specialized transitional services to facilitate their reintegration into the freeworld. These would include, where appropriate, pre-release outpatient treatment and habilitation plans.
- No prisoner should be released directly out of supermax or solitary confinement back into the freeworld. Supermax prisons must provide long periods of decompression, with adequate time for prisoners to be treated for the adverse effects of long-term isolation and reacquaint themselves with the social norms of the world to which they will return.

C. Community-Based Services to Facilitate and Maintain Reintegration

No significant amount of progress can be made in easing the transition from prison to home until and unless significant changes are made in the way ex-convicts are treated to in the freeworld communities from which they came. Specifically:

- Clear recognition must be given to the proposition that persons who return home from prison face significant personal, social, and structural challenges that they have neither the ability nor resources to overcome entirely on their own. Post-release success often depends of the nature and quality of services and support provided in the community, and here is where the least amount of societal attention and resources are typically directed. This tendency must be reversed.
- Gainful employment is perhaps the most critical aspect of post-prison adjustment. The stigma of incarceration and the psychological residue of institutionalization require active and prolonged agency intervention to transcend. Job training, employment counseling, and employment placement programs must all be seen as essential parts of an effective reintegration plan.

- A broadly conceived family systems approach to counseling for ex-convicts and their families and children must be implemented in which the long-term problematic consequences of "normal" adaptations to prison life are the focus of discussion, rather than traditional models of psychotherapy.
- Parole and probation services and agencies need to be restored to their original role of assisting with reintegration. Here too the complexity of the transition from prison to home needs to be fully appreciated, and parole revocation should only occur after every possible community-based resource and approach has been tried.