ABSTRACT A close review of prison violence makes it obvious that a disproportionate amount of such violence is related to the mental health problems of prisoners, and that, in the U.S. at least, this appears to have become increasingly the case. One reason for the trend is that prison administrators have been routinely relegating disturbed disruptive inmates to disciplinary or administrative confinement settings that exacerbate their difficulties.

The familiar cycle of symptomatic behavior-to-punitiveness-to-symptomatic behavior-to-disruptiveness can be tracked through chronological reviews of individual prison careers; the same reviews can serve to illustrate the prospects of addressing mental health problems and interrupting violence chronicity through ameliorative interventions. doi:10.1300/J076v45n03_01

KEYWORDS Prison violence, self-mutilation, mental illness, supermax prisons, punitive segregation

Twenty years ago, one of the authors recorded some impressions about what he thought might be defined as clinical aspects of prison violence (Toch, 1989). This paper represents an effort to review and revisit the subject. Of course, in the intervening two decades much has changed in the correctional environment in the U.S.—including continuing
overcrowding—with a growing proportion of prisoners suffering from serious mental illness—and an increasing reliance on isolated confinement, especially supermaximum security units, to manage misbehaving prisoners. As a result of these and other changes, violence is taking new forms and is responded to in new ways, not always for the better. We will attempt an exploration of these developments after we have started to think about the dynamics and transactional nature of prison violence by considering the careers of two prisoners who were violent in confinement, the first towards others, the second towards himself.

**PRISONER RUIZ, THE SERIAL GUARD ASSAULTER**

Attacking a correction officer is the most feared and heavily penalized offense one can perpetrate in prisons. It is also generally viewed as coldly premeditated behavior, and is reacted to as such. In some cases, however—as with Prisoner Ruiz,¹ who was an extremely violent recidivist—this perspective becomes extraordinarily difficult to apply.

The following incidents are typical of the encounters recorded in the prisoner’s files:

The inmate spit on the wall and stairs while coming off his gallery on the way to the mess hall. A correction officer attempted to counsel him and he struck the officer in the left cheekbone, then dove into the officer and secured a bodyhold on him and attempted to bite him in the neck. The officer slammed the inmate into the bars in an attempt to free himself, also pulled the inmate’s hair to get his teeth off his neck.

The inmate later explains:

I was taking a spoon to the mess hall to eat. The officer took it away from me and threw it in the garbage. He didn’t tell me why.

[The prisoner] asked me to write the words “Lucky Strike” on a carton of cigarettes as he could not write too well in English. As I started the words, the inmate reached through the bars and slapped me across the face. I backed away from him and the inmate tried to hit me again. I then proceeded up the gallery while the inmate was hollering that I had changed his cigarettes.
After picking up trays and spoons at supper meal the inmate ... refused to let me close the plexiglass cover. The inmate was given a direct order to remove his hand from the plexiglass cover but he refused. He stated, “I want to see the psychiatrist right now.” I told him it was impossible to see the psychiatrist right now. He still refused to remove his hand. At this time I had two trays in my left hand. I set the trays down and called for [another officer] to be a witness that the inmate was refusing a direct order. When the inmate saw I had two hands on the plexiglass cover and was in the process of closing it, he removed his hand. The inmate then spat in my face. He started cursing at me calling me “a big motherucker” and “I will get you some day. You are a crazy son of a bitch. I’m not crazy. You are.” Then the inmate started beating the cell door, shouting statements that were incoherent. After this he beat his chest with his fists stating, “I am a Puerto Rican and you can’t hurt me. Me tough.” He made more verbal threats that he would get me and stated he hoped I slept good tonight because “some day I’m getting you.”

The inmate started yelling, throwing his pillow and mattress around, banging on the door and walls, and throwing water from his toilet. A nurse advised [that she proposed] to use medication by injection authorized by the doctor. When the door opened, the inmate refused to lie down and came at the officers. An officer used a shield to push the inmate to the wall. [Three other officers] held the inmate’s arms and placed him on his bed. The inmate offered little resistance as the nurse gave him an injection. He was released and the officer left the room. The inmate threw toilet water at the officers [as they were] leaving.

The officers who dealt with Prisoner Ruiz increasingly became concerned about the possibility that he might need mental health assistance, and indicated they would like to see him transferred to another setting where such assistance could be made available to him. In a request for transfer, they noted:

The subject is extremely aggressive and hostile toward correctional staff. He is reasonably civil with civilian staff but impulsive and antiauthoritarian toward correction officers. His problem has escalated to where he has [disciplinary] proceedings continuously. He has been evaluated as not psychotic and more of a disciplinary
problem by the facility doctors. There is no psychiatrist available at this facility except for parole board evaluations. . . . The inmate is presently retained in a hospital observation unit to avoid bodily harm to himself and staff members.

A consulting psychiatrist interviewed the inmate, and wrote:

He strenuously denied being crazy. I could find no evidence of any mental illness today and think from my interview and the information on his file that this man is merely an explosive psychopath. I do not think that any psychiatric treatment is likely to make any difference to his behavior. However, he is so extremely intolerant of any type of frustration he is likely to prove a continual disciplinary problem in this situation, and I would concur with the recommendation for transfer, if and when this can be arranged.

Mr. Ruiz was eventually sent to a new institution with a note from a counselor, who advised that:

If the writer may coin a phrase, this subject is suffering from a "hate the police officers" syndrome. . . . His response toward any person that might represent authority is almost pavlovian, in that the stimulus is the sight of the authority figure and the response is hate and aggressiveness. . . . He is a prime candidate for a psychotherapeutic community in the event that such a unit is established in the system. His present attitude is such that he will spend the majority of his remaining period of incarceration in special housing unless he has a very drastic change in attitude.

Mr. Ruiz indeed started by spending several months in the segregation unit of his next prison. Here the first entry recorded that "the subject has been suspected of urinating on the floor, and when he talks, he talks in mumbles and frequently to himself."

Two weeks later a segregation counselor reported:

The above subject continues to remain incoherent and incomprehensible at this time. His body appearance and cell are disgraceful at best, and he continues to request that he be transferred to Puerto Rico. He again was advised that this is relatively impossible to do, and he then stated that he would like to go down to population in this facility and participate in the programs. In view of his mental
situation it is this interviewer’s impression that he will be with me for quite some time.

Subsequently, Mr. Ruiz received another long segregation sentence for an incident that is described as follows:

An officer approached the inmate who was washing his clothes in the utility sink and told the inmate to either take his shower or lock in his cell. The inmate stated, “When I finish washing my clothes I’ll take a shower.” The officer again stated his order to the inmate. The inmate left the sink and proceeded toward his cell with the officer following him. The inmate turned quickly, and using his fist struck the officer on the right side of the face. The inmate then grabbed the officer around the neck and started choking him. The officer broke loose and the inmate attempted to strike him again. The officer defended himself, and when the inmate grabbed his coat, the officer pushed the inmate into his cell and locked the door.

The expected sequence at this juncture would be one in which the prison’s administrators—understandably tired of having their staff members assaulted by Mr. Ruiz—arranged to have him spend the rest of his term under strictly segregated confinement. They could easily accomplish this in most settings by convoking an administrative reclassification hearing, in which Mr. Ruiz’ uncontestable status as the prison’s most troublesome denizen could be handily documented.

The prison system in which Ruiz was serving his time, however, had been experimenting with “hybrid” interventions (to be discussed below) designed to accommodate prisoners who were both disturbed and disruptive. Ruiz was placed in a newly established unit for problem prisoners who had chronic mental health problems that could be handled on an outpatient basis. The staff in the unit had been trained to be tolerant of human foibles, and this tolerance was reflected in a “progress” report about Mr. Ruiz:

Since entering the unit the resident has posed certain administrative difficulties. He appears to be of limited intelligence with emotional problems of longstanding, as well as having a great deal of difficulty with the English language. The resident for the most part has demonstrated a positive attitude toward program participation. His motivation has been limited by stress from other inmates and a
difficulty with the language barrier.... He has received a number of misbehavior reports since his last parole board appearance. However, in fairness it would be advisable to evaluate the most recent reports. [On one occasion] he was written up for destruction of state property when he cut into his mattress and made a pillow from the stuffing. Destruction of state property cannot be tolerated, but one must understand that for a period of time in the block we did not have enough pillows for all our residents, and the inmate may have requested a pillow and been denied. He admitted to the adjustment committee that he did not have a pillow, and he needed one. [On another occasion] he received a misbehavior report from the recreation leader in our mandatory physical education program for refusing to participate in a floor hockey game. The inmate, according to the report, attempted to explain to the recreation leader that he doesn’t know how to play hockey. Several residents have experienced difficulty while participating in some mandatory competitive sports, while in this program. Previously the inmate received a misbehavior report for failure to follow a direct order. This order was given by the correction officer, telling the inmate that he had to go to the gym program when the inmate had informed the officer that he did not wish to go. He has received one other misbehavior report when he interfered with an officer by hollering his cell location in the presence of other inmates. A brief explanation of these misbehavior reports has been given so that the parole board may be able to see the inmate as an individual of limited intelligence with a definite communication problem who has demonstrated a difficulty following institutional procedures and processes which have resulted in misbehavior reports. . . . The inmate has been able to decrease the number of misbehavior reports and decrease the seriousness of those reports.

Actually the man’s pattern of difficulties had been tempered, and as he leaves the prison he stands transformed from an incredibly recidivistic assaulter into a clumsy and somewhat volatile individual, who is seen as having nuisance value and who invites pity from staff. It is hard to tell, of course, whether any fundamental change has occurred beyond the fact that after four or five years it has at some level dawned on the man that his pattern is self-destructive, and that the parole board could keep him in prison a good deal longer if he continued brawling with every officer who makes him feel resentful.
The term “brawling” is used advisedly, because, as this man sees it, his conflicts with officers are “fights.” In other words, they are disputes which are settled physically, as disputes must be settled among men. This view is partially shared and reinforced by the officers, who repeatedly describe in vivid detail the wrestling holds they deploy to neutralize the man, although they obviously resent his tendency to attack people without warning and the damage he does before one knows what he is about. The man is said to have “communication problems” and these are reciprocal. Observers do not know when he feels mortally affronted because they no more understand him than he understands the concerns of those around him. The central issue often appears to be that the man feels himself treated like a child, and that his version of *machismo* holds that no man must be ordered about by another man, and that it is demeaning and insulting to be told to do things, particularly when you have explained why you do not wish to do them or would have explained if you could have.

The issue of the man’s alleged reactions to uniforms does not necessarily enter the equation because the man sees encounters between himself and officers as personal, and perceives custodial instructions as originating in whims and expressions of disdain or disrespect. When the man feels disdained or disrespected in this way he reacts at the first available opportunity, which makes his behavior unpredictable, because his reaction does not necessarily coincide with the move that originates the offense to which he reacts.

In the first incident, for example, the officer does not know that the prisoner is puzzled and enraged because the officer takes the plastic spoon the prisoner thinks he will need for his meal. The officer also does not heed the prisoner’s expression of resentment, which consists of spitting on the floor, and the attack follows when the officer lectures the prisoner about prison sanitation rules, which the prisoner (who does not understand most of this lecture) perceives as adding insult to injury. In the second incident the officer is similarly oblivious to the fact that the prisoner is enraged because he has ordered one brand of cigarettes and has been mistakenly given another, an act the prisoner regards as deliberate and contemptuous. When the prisoner must rely on officers to obtain what he needs (or thinks he needs) such as cigarettes, contact with a sergeant or a psychiatrist, or permission to wash his clothes, he feels that this dependency is in itself demeaning. Thus when his requests are not immediately responded to, the humiliation becomes more serious, because not only has he had to ask for something but also those who have compromised his manliness by making him a mendicant now deny
his requests, to show him who is in charge. He also sees himself receiving the same arbitrary and demeaning messages when officers present him with forced-choice situations (such as “submit to the frisk or return to your cell”) which do not include the option (go to the yard for recreation) that he elects to exercise. Since the prisoner feels that officers make unacceptable demands and he knows that his own verbal skills are deficient, he usually concludes that there is nothing further to be said, a fight ensues and his subjection by (occasionally overwhelming) force reinforces his perspective. The fact that he keeps losing these fights because he is badly outnumbered has no bearing on the principle involved, which is that a man must fight when he must fight, and that it is better to fight and lose than to permit oneself to be belittled and emasculated by being ordered about like a child, having legitimate requests denied or having somebody else’s will prevail in a contest of will, which denotes childish subservience. To be wrestled into the ground by greatly superior forces is not to be considered unmanly and is not a cause for shame, particularly if one can indicate, by spitting at one’s retreating enemy or by otherwise declaring oneself inviolate (“You can’t hurt me. Me tough.”) that suppression is not tantamount to surrender.

It is true that the man does begin to intuit something of the authority structure of the prison, although it takes a great many months of segregation to get to the juncture where he no longer reacts with rage to what he regards as belittling and rejecting moves of officers. This does not mean, however, that even at this juncture the man accepts or understands the demands the prison makes on him, which include not skipping meals and appearing at work on days when he does not feel like working, or taking showers he feels he does not need.

The man’s violations at this stage show fewer refusals to conform, but he has learned to temper his indignation when he is admonished, because he has learned that officers enforce rules rather than invent them to humiliate prisoners. This means that a man’s honor need not be at stake when he is asked to abide by a prison rule or when he is taken to task for non-conformity.

**PRISONER GREEN, THE SELF-MUTILATOR**

Research shows that with crowding, the rates of both violence against others and suicide rise (Paulus, 1988; Thornberry & Call, 1983). One of the authors, working as a psychiatrist for over 35 years, never saw more than the rare case of self-mutilation (e.g., “cutting” or self-inflicted cuts
with either suicidal or other aims) among adult males until he began touring isolated confinement units in prisons (Kupers, 1999). Self-mutilation was previously limited mostly to adolescent females. But there is an epidemic of self-mutilation in prison isolated confinement units today, and most of the prisoners involved, men as well as women, upon reflection, say they only began injuring themselves after they were placed in segregation. Sometimes, if asked, the prisoner avers suicidal intent; at other times he or she will say the cutting behavior was driven by uncontrollable anxiety or a need to see blood to know that he or she is human—and in the non-suicidal instances, there seems to be some momentary relief from anxiety immediately after the act of self-mutilation.

Mr. Green, a 26-year-old Caucasian man, had always been viewed by others as “odd” while growing up. He had no good friends, but “hung out” at the periphery of a group of boys in an urban working class neighborhood. The other boys took note of his eccentricity, and considered him simple. He had below average grades, and after the sixth grade he tended to be absent from school too many days to receive passing grades. He left school in the eighth grade and began to get into trouble on the streets. A pattern emerged. Other boys would draw him into an illegal activity such as robbing a store. Then they would run away, literally leaving him holding the bag. Partly as a result, he was arrested for various minor crimes, and spent a large amount of time in juvenile correctional settings.

At seventeen, he stole an automobile at the behest of a group of teens he knew on the streets. He was driving when a police car spotted the stolen car. He began to speed up to get away, but his “friends” told him to slow down for a minute. They jumped out of the car and then yelled at him to hit the gas. He was pursued, arrested, and convicted of auto theft. Because of an extensive juvenile record, he was sent to an adult prison. He was terrified.

Because most of his crimes were relatively non-serious, and because he seemed quite the opposite of a tough guy, he was placed in a minimum security correctional facility. There he predictably began “hanging out” with a group of prisoners. One day the group decided to “walk away” from the facility while in a lightly guarded work platoon outside, the gates. Mr. Green dutifully “walked away” with the others, and was captured. Now, because of this escape attempt, he was sentenced to a lengthier term and sent to a supermaximum security unit to serve out the remainder of his sentence.

In isolated confinement he was forced to spend nearly 24 hours per day in his cell, eat meals in his cell, and was permitted out of his cell
only for showers and an hour five times per week for “recreation” in a fenced “yard” no bigger than a cell, which the prisoners called a “cage.” Mr. Green is functionally illiterate, so he could not even read or write and he was reduced to near total idleness. He paced incessantly in his cell. He had great difficulty sleeping, especially because several prisoners with mental illness in neighboring cells would stay up much of the night screaming and vituperating. Mr. Green became increasingly anxious, experiencing panic attacks where he had great difficulty catching his breath. He also experienced mounting anger, and began to feel aggravated by officers who would either not heed his request for help or would taunt him as they passed his cell. He had not received many disciplinary tickets prior to being confined in supermax, but soon he began to accumulate complaints at an accelerating rate.

Mr. Green began asking to see the prison psychiatrist for help with mounting anxiety and rage. Meanwhile, he was receiving more disciplinary notices, usually for obscene language or for rule violations. For example, he received a ticket for “Interfering with Observation Window and Camera” when he tried to hang a sheet up in front of the shower while showering. Each time he received a disciplinary disposition he was punished, first with loss of thirty days privileges, which could be loss of yard or commissary privileges; then he was put on “loaf” (a special diet consisting of ground-up cabbage and left-overs that is baked into an inedible loaf). The psychiatrist who made rounds and talked to prisoners at cell-front did arrange to see Mr. Green in a private office for an evaluation. In his report of that examination the psychiatrist noted Green’s anxiety, panic attacks and insomnia. He also reviewed the tickets Green had been accumulating, mostly for swearing and disobeying orders (there were no assaults). The psychiatrist diagnosed Intermittent Explosive Disorder along with Antisocial Personality Disorder. Mr. Green was not placed on the mental health caseload, and was not prescribed any medications.

Approximately a year after entering supermaximum confinement, Mr. Green began cutting himself. At first, he scratched himself on the forearm, and noticed that after he did so he felt a little less anxious. He did not tell anyone about the self-injuries. He had already tried to arrange sessions with the psychiatrist and was told several times that he merely needed to calm down and control his temper. He knew that he would get in trouble if he was discovered injuring himself, so he did not seek assistance, but began to cut himself more often, usually at night when he was unable to sleep. Eventually he was discovered by a Corrections Officer
with blood running down his arm, and was issued a ticket for the rule violation “self-mutilation.”

The psychiatrist was called to see Prisoner Green at cell-front, and decided that Green was merely “manipulating” to gain a transfer to the mental health observation unit and to receive medications. He noted that Mr. Green had tried to hang himself with a sheet prior to cutting himself. He again entered a diagnosis of Intermittent Explosive Disorder, but he also ordered that Green be placed on “strip cell status” in his cell. This meant that all of his clothes, sheets and property were taken from him, officers would record 30-minute visits to his cell-front to make certain he was not harming himself, and the psychiatrist would return each weekday to his cell-front to ask if he was still feeling like harming himself. After three days Mr. Green convinced the psychiatrist that he no longer felt like cutting himself or trying to hang himself, his property was returned to him and the 30-minute checks were discontinued. He was issued a disciplinary notice for “Self-Mutilation,” where the specific act was “Attempting to hang himself and cutting his left wrist and arm.” He was given a punishment of 30 days loss of privileges.

Subsequently, Mr. Green proceeded to slice himself repeatedly, at first once or twice a month, and then approximately weekly, and sometimes he would cut himself on a daily basis. He would receive a ticket each time he harmed himself, and accumulated a very long period of loss of privileges, including visits. But there was a new development. The supermaximum security unit where Mr. Green was confined experienced a severe staffing shortage. It was located far from any urban center, and because of the frustrations of the work and low salaries, quite a few correction officers resigned. New officers were less well trained, and because of the staff shortage were assigned to the supermax unit without much experience. Mr. Green and several other prisoners in the unit continued to express anger toward officers and Green continued to self-mutilate. The officers kept writing disciplinary notices, but they also began to spray Mr. Green in his cell with immobilizing gas (sometimes pepper spray and sometimes mace—both were permitted by policy).

The psychiatrist was called on many occasions to see Mr. Green. He did transfer him to the Observation Unit in a nearby Infirmary on several occasions. A pattern became apparent: Green would cut himself; the officers would spray him and write a disciplinary ticket, and then they would call the psychiatrist; the psychiatrist would visit Mr. Green at cell-front, and on several occasions have him transferred to the Observation Unit, where he would be in a “strip cell” where one wall was made of indestructible plexiglass (“lexsan”) so that staff passing by could
observe him and prevent further acts of self-harm. No talking therapy occurred in the Observation Unit, but after cutting himself and getting away from the noisy and isolating environment of his supermax-tier, Green would calm down and the panic attacks and urge to cut would abate; then the psychiatrist would see him for a few minutes during daily rounds and he would say he was no longer feeling like harming himself; then he would be transferred back to his cell in the supermaximum unit.

For a period of time, the psychiatrist decided that Mr. Green might be suffering from Bipolar Disorder, and began to prescribe mood stabilizing medications (Lithium, Depacote) that had the beneficial effect of modulating his mood swings. There is evidence in the clinical file that Mr. Green’s behavior problems subsided while he was receiving his prescribed psychiatric medications. However, during a cell search, it was determined that he sometimes “cheeked” pills and then hoarded them in his cell. The custody staff assumed that he was accumulating contraband pills for sale to other prisoners, and as a result he was issued a disciplinary charge for contraband and his medications were discontinued. Soon thereafter, the psychiatrist changed the diagnoses on Mr. Green’s clinical chart. He discarded the diagnosis of Bipolar Disorder that had been in place while mood stabilizing medications were being prescribed, and he reverted to the diagnosis of Intermittent Explosive Disorder, a diagnosis that has the connotation of “no serious mental illness, merely a behavior problem” in correctional facilities.

Mr. Green’s story illustrates a number of themes that will be discussed here: The vulnerabilities of prisoners suffering from a mental illness, the harmful effects that quite often result from severe isolated confinement, the kinds of psychiatric disorder that typically evolve in such units, the confusion about diagnosis that too often delays proper treatment, the dynamics of staff/prisoner interaction that too often lead to a vicious cycle wherein disturbed prisoners become aggressive toward staff and staff react with abusive disciplinary practices, and the evolution of a spiraling vicious cycle wherein all of these unfortunate occurrences become more extreme and more frequent.

**PATHOLOGY AND VIOLENCE**

Before we address the substance of patterned violence in the prison we must ask to what extent such violence falls under the purview of traditional mental health expertise and of the professionals who exercise it. The cases of Prisoners Ruiz and Green point up this issue, in that
these men had either been enthusiastically referred for mental health assistance by officers who dealt with them (in the case of Mr. Ruiz) or had requested mental health services on multiple occasions (as did Mr. Green), but were repeatedly adjudged non-disturbed. In the case of Mr. Ruiz, the only circumstance in which a formal diagnosis was entered involved a psychiatrist who diagnosed the prisoner as suffering from an antisocial personality disturbance, which, as defined by American psychiatry (American Psychiatric Association, 1994), is a category that is in theory applicable to the great majority of prison inmates. The diagnosis and its variants (such as psychopathic personality) are frequently deployed for inmates who have been involved in violence, which raise the possibility that the diagnosis is an expression of clinical disapproval. Mr. Green was also diagnosed with antisocial personality disorder, but eventually Bipolar Disorder was added to his clinical chart and then subsequently removed. We have noted elsewhere (Toch, 1998) that:

Because psychopathy is generally equated with untreatability, offenders that clinicians do not want to deal with can be turned away by adjudging them psychopathic, and hence unamenable to treatment. In other words, psychopathy is featured in what Vicky Agee (1979) has called the “diagnostic game”—the use of diagnoses to shuttle clients from one’s own turf to other jurisdictions. Psychopathy (or antisocial personality disorder) unsurprisingly becomes a salient diagnosis in the discharge summaries of hospitals who send patients back to prison after cursory review (Toch, 1982). Psychotic patients who are difficult to manage often come to carry dual diagnoses, despite provisions in DSM-IV that make this practice illegitimate. (p. 152)

As a matter of statistical fact, inmates who are emotionally disturbed or who receive mental health services are disproportionately involved in prison infractions (Ditton, 1999; James and Glaze, 2006; Toch and Adams, 2002). They are also disproportionately involved in violent incidents, given that the correlation between violent infractions and other prison misconduct is high (of the order of 0.5). Although statistics do not suggest a causal link, some patterns of conduct carry no such ambiguity. Some disturbed inmates, for example, display the same cryptic outbursts in the prison as they do in hospitals. Such outbursts frequently reflect delusional concerns or are inspired by command hallucinations. Other psychosis-related violence responds to paranoid (conspiracy-centered) concerns, or forms part of “flight-fight” patterns, in which inmates
retreat from reality but sporadically explode. In such cases the link between violence and mental illness is direct, with the former being an obvious product of the latter.

In recent years, a large number of individuals suffering from serious and persistent mental illnesses have entered prisons (Lamb, 1989; Shenson et al., 1990; James and Glaze, 2006). This is due to many interrelated factors including the deinstitutionalizing and downsizing of public mental health programs in the community; the dismantling of much of the safety net provided by welfare, housing and work programs; and the tendency for the courts to give relatively less weight to a defendant’s mental condition in determining sentences (Toch and Adams, 1987; Kupers, 1999). As a result, a growing subpopulation of mentally ill prisoners must somehow cope with the travails of imprisonment. A significant proportion of disturbed inmates withdraw into their cells to avoid trouble, and suffer from the isolation and idleness. Others are disproportionately victimized in the day rooms and on the yard. Since participants in a fight tend to be disciplined without regard to who started the fight, victim-prone inmates may find their way into punitive segregation units and may acquire a reputation for aggressivity.

To be sure, individuals suffering from mental illness often tend to behave inappropriately in varied settings, and the transcending inappropriateness of their behavior accounts for the fact that some undesirable patterns of conduct (such as Mr. Green’s fateful susceptibility to group pressures and contagion) can be imported from the streets into the prison, where the repercussions of coping failures can become increasingly serious.

**MAD AND/OR BAD?**

Disturbed violent prisoners are often shuttled between custodial personnel of the prison (who refer them for diagnosis) and mental health personnel (who classify them as management problems, manipulative, or malingeringers, or diagnose “personality disorder” and refuse to intervene). In extreme cases such staff interaction entails physically transporting the inmate from prison to mental health setting and back, a practice that is referred to pejoratively as “bus therapy” (Freeman et al., 1977; Wilson, 1980; Toch, 1982). There is the thorny issue related to the diagnosis of malingering in forensic and correctional settings (Kupers, 2004). Defined as the exaggeration or feigning of symptoms to attain personal gain, it is too often over-emphasized, as an excuse not to provide mental
health treatment. In other words, when the prisoner is deemed to be malingering, the unacceptable behaviors on the part of the prisoner are assumed not to be driven by a mental illness, and the mental health staff can safely turn the prisoner over to custody staff for predictably harsh punishment.

Often, in the process of reviewing custodial records and clinical charts, one discovers notations such as “This prisoner suffers from a chronic psychosis, but the fight that led to the current term in segregation was not a result of his psychiatric difficulty.” Yet this same prisoner evidences signs of serious acute psychopathology while segregated in near solitary confinement. Whether or not it is possible to distinguish between the unacceptable acts that are caused by a prisoner’s psychosis and those that are not directly attributable to a psychiatric condition, the confinement of such prisoners in punitive segregation units makes it that much more difficult for the mental health staff and the custody staff to collaborate in designing an individualized, secure and therapeutic management plan. And since the environment in this kind of unit often exacerbates psychiatric symptoms, the choice to turn “disturbed disruptive” prisoners over to custody staff to be placed in a lock-up unit very likely means they will receive even less mental health treatment for an increasingly serious condition. In the dozens of supermaximum security units that the two of us have seen, treatment has generally been limited to the prescription of psychiatric medications after very brief visits at the prisoner’s cell door—and within earshot of the correctional officers and the prisoners in adjacent cells.

Either/or thinking on the part of custody and mental health staff creates a humpty-dumpty problem: no one is in a position to understand the entirety of the prisoner’s pattern of violence, but both custody and mental health staff begin to believe they can separate which incidents of rule-breaking or violence are caused by a prisoner’s psychiatric condition and which merely constitute bad behavior (the old “Bad” vs. “Mad” dilemma in corrections). In effect, accusations of malingering often obfuscate or short-circuit the urgently needed search for the patterns and dynamics of the violence, and a response involving collaborative interventions on the part of both custody and mental health staff.

**PUNISHING DISTURBED PRISONERS**

*Four* questions should matter to prison authorities when a disturbed inmate faces a disciplinary sanction. In contemporary practice, all four of
these concerns tend to be largely ignored. The most obvious question the authorities could ask has to do with degree of culpability where an offense is irrationally motivated. This issue does not arise because prison disciplinarians usually display no interest in why a prisoner committed his or her transgression. The focus for the prison, however, is on the amount of damage resulting from the offense. The prisoner who sets himself on fire because voices tell him that flames will purify him can expect a hefty sentence because fires in prison are life-threatening and property-destroying.

The second legitimate but mostly un-asked question is whether the prisoner is competent, which has to do with his or her condition at the time the case is adjudicated. On the outside, defendants must be deemed capable of understanding what goes on in the courtroom. No similar requisite exists in the prison. The closest to a mandated concern is a U.S. Supreme Court ruling relating to prison hearings which says that “Where an illiterate inmate is involved . . . he should be free to seek the aid of a fellow inmate, or if that is forbidden, to have adequate substitute aid in the form of help from the staff or from a sufficiently competent inmate designated by the staff” (Wolff v McDonnell, 418 U.S. 539 (1974) at 26).

The third question prison authorities should be considering is about the vulnerability of the prisoner who is being punished. There is no rule that tells prison staff that they must think about the consequences of punitive dispositions. Disturbed prisoners are sent to settings in which they predictably fall apart. To get help, they must wait until their condition deteriorates. If a segregated inmate is sent to an observation/crisis unit or is committed to a hospital, he returns to segregation when he is discharged. Prisoner Green’s plight is in this respect illustrative.

We have already alluded to the proliferation of supermaximum punitive or administrative segregation units (or “SHUs”). In these extremely stressful settings, disturbed prisoners spend nearly twenty-four hours per day in their cells and are cell-fed. They are released, often one at a time, through remote controlled doors to an exercise yard, which is often no larger than a medium size residential living room. There is minimal contact with security staff and greatly reduced contact with other prisoners. Visits occur through a window. These units resemble “the hole” of the old days, except that a prisoner who then misbehaved was typically thrown in “the hole” for 10 days, whereas prisoners are sent to a SHU for years at a stretch. Moreover, instead of being dark, damp dungeons, most SHU’s are high tech, with lights on around the clock, doors that open and close by remote control, tinny-sounding speakers, video monitoring of prisoners, and so forth. In short, the prisoners in
these settings, irrespective how vulnerable they are, have almost no contact with other human beings, severely limited meaningful stimulation (they do hear a great amount of noise, including yelling and the slamming of doors), and nothing whatever to do to occupy their time. The psychological stress occasioned under these circumstances plausibly translates into very severe psychiatric morbidity, and in prisoners suffering from serious mental illness, there are exacerbations of the illness, a huge risk of suicide, and worsened prognoses (Grassian, 1983; Grassian and Friedman, 1986; Haney and Lynch, 1997; Hodgins and Cote, 1991; Amicus Brief to the U.S. Supreme Court, 2005; Human Rights Watch, 1997, 2003).

The fourth question prison authorities too rarely consider is the effectiveness of punitive measures. If demonstrable ineffectiveness of various punitive sanctions for unacceptable and assaultive behaviors were to become an important consideration, and were authorities to notice that an exclusively punitive approach on the part of staff transparently fails to lead to rehabilitation, then the issue whether a prisoner suffers from a serious mental illness that is driving his or her assaultive behavior, or “merely a personality disorder,” would become less important than the question whether the harsh conditions of isolated confinement make his or her tendency toward violence greater, and whether sessions with a mental health clinician might effect some reduction in the unacceptable behaviors.

**DESTRUCTIVE CYCLES**

Kupers (1999) has described a series of cycles that obtain when “disturbed disruptive” prisoners are sent to punitive lock-up units and receive very minimal mental health treatment. For example, these prisoners tend to have great difficulty controlling the kinds of impulses that others find unacceptable, and this is one reason they get into fights. They also find themselves in a situation where there is not as much room to “walk away.” The rules in punitive segregation units are more rigorously and more rigidly enforced than elsewhere in a prison, and since the prisoner is already in a cell there is nowhere for him to retreat when an officer or another prisoner begins to provoke him or make him angry. Selectively, the prisoners with the shortest fuses are concentrated in the places where there is the least opportunity for them to retreat in the face of a perceived slight or menace, so they tend to strike out, whether that means taking a swing at a guard, talking back disrespectfully or slinging excrement
(which happens with some regularity in lock-up units). Each time the out-of-control prisoner acts out inappropriately, further time is added to his sentence in the lock-up unit.

The prisoners who are housed in administrative confinement settings in prisons tend to be labeled, across the board, as “the worst of the worst.” This designation gains added credence if confinement conditions cause the prisoner to “act out.” Not infrequently, the stressed prisoner reacts to the constriction of his freedom by getting angrier, and at the slightest provocation yells insults or throws something at an officer. The staff conclude they were correct in their original assessment of the prisoner, and make no effort to understand the pattern that led to his violent reaction.

Another vicious cycle in this kind of setting involves visitation. Maximum and supermaximum security prisons tend to be located far from the urban areas from which most of the prisoners hail and, in general, it is fair to say that the more trouble a prisoner has controlling his rage and following the rules, the more important it is for him or her to maintain contact with family and friends. The visits give the prisoner something to look forward to, and the contact with loved ones serves to counter the kind of resentment that builds in total isolation (Holt and Miller, 1972; Jorgenson et al., 1986). On the other hand, isolating a disruptive prisoner in an institution that is so far from his home that his wife, mother and children can only rarely visit tends to make him more disgruntled and out of control. Yet these prisoners who have the most difficulty controlling their anger and other destructive behaviors are precisely the ones who are moved furthest from their families. Then, when they misbehave inside a supermaximum security unit, their visits can be further restricted as a form of punishment (Toch, 2003). It should be obvious that this is counterproductive because it does not take a psychiatrist to suggest that visits with loved ones might disincline the average prisoner to act out violently, toward himself and toward others.

Segregation settings also multiply occasions of “shaming” or humiliation (Gilligan, 1996) through the constant use of chains and shackles, superfluous strip searches and cell searches and other measures of custodial overkill. The shaming that occurs in the name of custody merely reinforces the prisoner’s destructive reactions to feeling shamed, he consequently acts even more aggressively to protect himself from humiliation, and the acting out leads to more humiliating forms of punishment.
LIFE AFTER SUPERMAX

When many violent inmates in a system are kept in lock-up there may be a temporary peace on the prison yard—but long-term problems for the prison system may be exacerbated. The ultimate question is what to do when the residents of confinement settings get out of lock-up. There, they have had no educational activities, no rehabilitation or job training, no social interactions, little or no quality visitation with loved ones, and no training in anger management, in ending domestic violence or in other aggression-related skills and dispositions. The inmates thus tend to emerge from lock-up acting with pent-up rage and cumulated resentments, and it is therefore not surprising that they may engage in further violence.

Of course, advocates of ever-harsher punishments can claim that the continuing crime and violence of released inmates merely proves the validity or accuracy of our criteria for incapacitation; when asked about the possibility that supermaximum control units may be generating rageful ex-felons, their response can be that we should never let chronic violent offenders out of prison. This crass and foolhardy attitude can only lead us to an ever-expanding prison population, and worsen the problem of prison violence. On the other hand, if more focus were placed on the often destructive effects of draconian sanctions such as extended time in isolation, some troublesome aspects of the contemporary correctional dilemma might be effectively addressed. One of the most urgent issues is the question, what is to be done with the prisoner who is spending his term in isolated confinement but is soon to be released into the community? The effectiveness of an appropriate decompression setting in preparing the prisoner to return to general population inside prison would certainly contribute to an effective plan to eventually return that prisoner to the community as a productive and non-violent citizen.

Contrary to claims by early advocates of supermaximum security units that they were needed to reduce violence in the prisons, evidence is accruing that the rate of violence in prison has not changed, or has risen, since the advent of the supermaximum security prison (Briggs et al., 2003). This point is even more clear when violence against the self is factored in. Recent research about the location of successful prison suicides exposes a shocking reality: close to half of all successful suicides in prison occur among the six to eight percent of the prisoner population that is in isolated confinement at any given time (Correctional Association of New York, 2004). Alison Liebling, England’s leading authority on prison suicides, has written that:
Under no circumstances should the response to a suicide attempt be punitive: isolation in stripped conditions is sometimes assumed by inmates to be punishment for their behavior... To contribute a unitary meaning to these acts (i.e., attention seeking) is potentially dangerous and misleading. Training should be aimed to encourage all staff to appreciate the complexity of such behavior and its possible causes and motivations, which are multiple. (Liebling, 1999, pp. 337-338)

Staff training of the sort that Liebling refers to has to center on the experience of individual prisoners (such as Ruiz and Green) and the first step in any such training must be to delineate the pattern of violence or self-destructiveness, a topic to which we will now turn our attention.

ADDRESSING A VIOLENCE PATTERN

With recurrent violent behavior the prime concern must be with patterned information, which covers consistencies of perspective and motive across a person's violent incidents. Such consistencies can be situational (phenotypic) or may relate to underlying (genotypic) dispositions (Allport, 1961). Phenotypic commonalities consist of inventories of the circumstances in which the person aggresses, such as the common characteristics of individuals he selects as victims (Monahan, 1981). Genotypic consistency of necessity underlies phenotypic consistency. It can accommodate situational diversity, but this does not mean that where superficial commonalities exist we need dig no deeper. Incidents in hospitals, for example, often occur at given times of the day, such as in the morning or when staff shifts change (Lion and Reid, 1983; Rice et al., 1989). This fact tells us little, however, until we translate time and place into changed levels of environmental impingement, which lead us to infer that some patients feel over-stimulated when their environment becomes enriched, making them irritable and over-responsive to trivial demands. We learn little from the fact that Prisoner Ruiz assaults prison guards until we consider the connotations the officers' interventions hold for the prisoner, which explain the intensity of the rage reactions with which he responds to seemingly innocuous instructions. Similarly, but with a different object of the assaults, Prisoner Green cuts himself often when the noise and chaos on his segregation tier reach a certain proportion.
To arrange events in chronological order, as we have done in our examples, is helpful on a number of counts:

1. Temporal patterns often call attention to the effects of environmental changes that contribute to violence or ameliorate pressures to which the person reacts. A prisoner, for example, may discontinue violent reactions when he is segregated (our two prisoners do not), which suggests that the relative isolation of confinement is paradoxically beneficial in his case (Suedfeld, 1980a). (The authors find this pattern in only a small number of repeatedly violent prisoners, the large majority of which, on average, become angrier and more prone to violence the longer they remain in isolated confinement.) Another person may be involved in a great deal of violence in an age-homogeneous prison for younger inmates, but may reduce his involvements in a prison that contains an older population, which provides clues to the peer temptations and pressures to which the prisoner has reacted.

2. Chronologies often point to time-bound internal states, such as tensions, fear and anxieties. Disturbed prisoners, for example, frequently act out at entry into the prison system or when they face impending release, transitions that typically mobilize subsurface anxieties.

3. Time-bound reductions of aggressivity can also provide clues to the therapeutic impact of serendipitous experiences, which we can only systematically mobilize once we have identified them (Bandura, 1986).

Our case studies show that motives and dispositions of even patterned offenders can change over time. In the case of Prisoner Ruiz, in fact, the change is extreme, involving an attenuation of behavior from recidivistic aggressivity to helpless confusion. Although most changes we encounter are not as significant, improvements over time are nonetheless prevalent. Young prisoners, who are most involved in violence, frequently improve their deportment over the course of their prison terms (Toch and Adams, 1989). Such changes, which at one time were regarded as anticipatory reactions to release from prison (Garabedian, 1963), are attributable to varying combinations of the effects of maturation and adaptation to the prison. Unfortunately, the advent of long-term isolated confinement in supermaximum security units has added another recognizable pattern: the isolated prisoner continues to deteriorate
even as he ages because the ongoing stress of near-total isolation and idleness perpetuates destructive patterns of behavior that might otherwise diminish with maturation. Sadly, Mr. Green's course illustrates this pattern.

**PSYCHOTROPIC MEDICATIONS**

Psychotropic medications can be a useful adjunct in managing disturbed disruptive prisoners, but as with other components of comprehensive mental health treatment, if they are employed to compensate for deficiencies in the program, medications can become more of an obstacle than an aid to proper treatment and rehabilitation. Thus warehousing mentally disordered prisoners and medicating the emergent psychosis and suicidality without providing any out-of-cell treatment and programming will predictably fail to counter the isolation-induced worsening psychosis and despair. That said, when command hallucinations lead a prisoner to act violently against himself or others, antipsychotic medications can be a crucial part of the treatment regimen (Kupers, 2005). If adequate medication can quell the voices without causing toxic side effects, the failure to prescribe constitutes inadequate management. While involuntary medicating in a prison setting is sometimes over-utilized in violation of the prisoner's right to refuse treatment, in certain instances the failure of the psychiatric staff to institute the legal procedure required to initiate involuntary medicating results in a shortsighted and inadequate treatment plan.

But if there is no underlying psychotic condition, the use of antipsychotic medications might itself constitute mismanagement. There really is no medication that diminishes violent outbursts in every clinical situation. Medications can diminish hallucinations, reduce paranoia or dampen mood swings. But in the absence of an underlying psychiatric condition that is responsive to medications, prescribing these drugs in doses high enough to reduce rage and violent acting out will merely result in sedation and toxic side effects.

To be sure, there are medication strategies that can help in the management of disturbed disruptive prisoners. When a manic state is a significant part of the picture, as in Mr. Green's case, mood regulators such as Lithium or Depacote can provide some long-term stability and decrease the tendency toward violent acting out. When violent incidents are impulsive and sporadic, the group of heart medications called beta-blockers can
reduce the frequency and severity of outbursts. The point is, when medications are prescribed as part of an individualized treatment plan that includes other treatment modalities designed to alter some of the genotypic features of a prisoner’s violence pattern, they can be beneficial. On the other hand, when tranquilizers are prescribed in strong doses simply to control aggressive behavior in the absence of a complete psychiatric examination and adequate treatment planning, they are easily abused and there is great potential for harm.

**DEVELOPING SECURE THERAPEUTIC MILIEUS**

We assume that defensible mental health service delivery in today’s prisons must include extensive collaboration between mental health staff and custody personnel in addressing the problems of disruptive inmates. Sometimes a change of jurisdiction legitimately occurs, as when a prison commits a decompensated patient to a hospital until he or she is stabilized. But even in transfers such as these, collegial links can be forged. Observations and professional inferences can be shared, and there is no excuse for the hoarding of information (invoking mantras such as “confidentiality”). Two things are very clear to the authors: (1) Cross-disciplinary collaboration is necessary if the violence patterns are to be discerned and effective interventions are to be devised; and (2) The more severe the prisoner’s pattern of violence, the more staff time, including time intervening with the prisoner and amount of staff conferencing, will be required to attain good outcomes (Toch & Adams, 1987).

Custody and mental health staff must collaborate because problems can be most effectively addressed only if those who work with an individual trust and respect each other, and get the benefit of each other’s knowledge, wisdom and expertise. All parties gain in the process, but mental health staff gain the most, because such staff see the inmate a fraction of the time that officers see him, and have limited control over the prisoner’s environment.

Collaboration and staff teaming are particularly important in specialized settings, such as the hybrid setting that was ultimately invoked for Prisoner Ruiz. This enterprise was administered by the correctional system, but there are mental health settings that are hosted by prisons and others run under joint or shared auspices.

Most effective for disturbed and disruptive inmates are prison units with a community or therapeutic-community emphasis (Bottomley and
Rich programming and staffing are required in such units, especially if they draw their clients from long-term residents of segregation settings, who tend to be self-insulating, bitter, suspicious, mistrustful and fearful. And even with the most sophisticated staff, working in a unit for disturbed-disruptive inmates tends to be a crisis-studded adventure.

Most serious are the problems that tend to arise over time. These include changes in which, the form of programs is retained while the content is abandoned. Special units become conventional prison settings, in which prisoners and staff engage in conflict, stalemates and accommodation, and no learning takes place. A second version of the process is one in which the focus of interactions is on privileges and restrictions, with prisoners testing limits imposed by staff. This results in a game of “I want,” “you can’t have,” “this is very unfair,” and can culminate with militant inmates returning to segregation in a self-destructive huff, and staff experiencing panic about having no clients to work with.

The fact that staff in prison units depend on their clients’ goodwill and cooperation compromises the use of formal power, and makes contests no-win situations for everyone concerned. It is critical, therefore, to create and sustain a culture that bridges staff and inmate roles, and centers on communal concerns that are shared by the staff and the prisoners. Prominent among these must be the therapeutic goal of assisting residents whose conduct has placed them at demonstrable risk of punitive confinement, to change their destructive and self-destructive behavior patterns. This goal must not be defined as the goal of the staff, with the inmates as passive (or resistant) recipients of ministrations. And the goal must be kept alive despite the fact that the process involves personal discomfort, much thought, and hard work.

The most important lesson to be derived from institutional experience is that a unit can in fact formally survive while abrogating its therapeutic goals. A unit with no therapy can even be said to demonstrate “success” in that prisoners may discontinue their destructive or violent behavior while residing in the unit, in exchange for being left alone. Staff, in turn, can achieve a quiescent and non-taxing (though arguably boring) sinecure.

A dramatic story was that of the renowned Barlinnie Special Unit, established by the Scottish Prison Service in 1973. This unit began life as a therapeutic community created to house the most violent prisoners in the Scottish system, who had been relegated to long-term residence in punitive segregation cells. The unit initially was able to bring about dramatic personal transformations. One of its first clients, reputed to be the
most difficult prisoner in Scotland, became a sculptor and writer (Boyle, 1977), and worked as community organizer (and wine merchant) after his release. Other residents demonstrated equally impressive changes during and following their confinement (Cooke, 1989).

Twenty years after the unit had been set up, however, it was closed down (Wozniak, 1995). The planning group that suggested abolishing the unit (Scottish Prison Service, 1994) noted that “the near universal view is that in the absence of an active and continuously developing community, the BSU has become stagnant and fossilized. Many of the current prisoners have spent lengthy periods of time (in one case, 10 years) in the unit, often actively refusing to move to another establishment, as this has been seen as a backward move, entailing too many sacrifices” (p. 17). Among other specific observations, the group reported that “community meetings have lost much of their impetus. They have become perfunctory, largely, routinized, ‘housekeeping’ meetings, in which very little challenging or exploration of unacceptable attitudes and behavior occurs and on occasion they have been used by certain groups of prisoners to exert pressure on staff” (p. 18).

An alternative to the community-based model is one in which persistently violent prisoners are placed in conventional confinement settings that are enhanced or enriched (Fox, 1958; Ventour, 1975). The model envisages the introduction of a social learning environment into segregation itself, with inmates progressively moving through stages of increased association and participation.

In California, and very recently in Canada (Vantour, 1991), settings designed for the enrichment of custodial regimes evolved into their opposite, ending up with prisoners subjected to uncompromising punitive treatment. In both cases, the co-optation occurred because the innovative concepts were not internalized, and implementation steps were shaped by an obsessive concern with the dangerousness of the prisoners and the safety of staff.

This problem cannot be addressed by underselling understandable concerns with security and safety. The challenge is one of helping staff to understand motives and dynamics in the violent behavior of offenders so that they see that one can interrupt violent careers, as opposed to locking the offenders up, leaving their predispositions inviolate. Clinicians can assist custody in this enterprise, assuming they are themselves willing to take risks by understanding, engaging, and reforming violent prisoners.
NOTES

1. Names of prisoners alluded to in this paper have been changed, and all identifying data have been altered or deleted.

2. In several states where the authors have investigated prisons, “throwing” is a felony, and throwers are prosecuted and convicted, and get years added to their prison terms. Guess where they spend those additional years!

REFERENCES


**AUTHORS' NOTES**

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