UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

TODD ASHKER, et al., Plaintiffs, v. GOVERNOR OF THE STATE OF CALIFORNIA, et. al., Defendants.	Case No.: 4:09-cv-05796-CW CLASS ACTION Judge: Honorable Claudia Wilken

EXPERT REPORT OF TERRY A. KUPERS, M.D., M.S.P.

I. Assignment

I am a board-certified psychiatrist. The plaintiffs have retained me to interview named plaintiffs and other prisoners, and to investigate the psychological effects of spending a decade or more in the Security Housing Unit at Pelican Bay State Prison for the purpose of testifying at trial.

II. Executive Summary

Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995), established, among other things, that keeping prisoners with serious mental illness in the harsh isolative conditions at the Pelican Bay State Prison Security Housing Unit (PB SHU or SHU) would be cruel and unusual punishment. In that case, a number of experts, I among them, examined prisoners who had been in the Pelican Bay SHU for two or three years. Since the facility had opened in 1989, and the investigations for the *Madrid* litigation occurred in the early 1990s, the experts did not at that time investigate the effects of more prolonged confinement at the SHU.

In this case, I have been asked to help determine the harm, if any, that results from keeping prisoners in isolative confinement at PB SHU for over ten years. To determine this, I interviewed 24 prisoners or ex-prisoners who spent ten or more years at the Pelican Bay SHU. These prisoners fall into three subgroups:

- Prisoners who were still at the PB SHU when I conducted interviews in 2013 and 2014;
- Prisoners who were at the PB SHU for ten years or more but in recent years have been transferred out, mostly back to general population on Step 5 of the "Step Down Program," the modified housing units that permit prisoners to take part in incrementally more productive and congregate activities as they spend more time in the program and demonstrate appropriate behavior;[1]
- Former PB SHU prisoners who have been released to the community.

I interviewed 11 prisoners from the first subgroup, ten of whom are named plaintiffs in the current matter. These prisoners suffered from very many of the

[1] See Regulations concerning Security Threat Groups, effective October 17, 2014, and Title 15, section 3378, regarding the step down program.

symptoms that are well known in the literature to be caused by isolative confinement. They reported to me a significant number of symptoms that they suffered, including anxiety reaching the level of panic; distorted thinking reaching the level of paranoia; memory and concentration problems; sadness; despair; a growing number of suicidal thoughts; compulsive actions; agitation; mounting anger; the fear that the anger will get out of control and get them into even more trouble; mood swings; and severe problems sleeping. In other words, the prisoners I interviewed while they remained in the SHU consistently reported symptoms that match those reported by prisoners in isolation in a great many settings and are documented in the literature on the psychological effects of isolative confinement.

However, they also suffered additional symptoms that go beyond those symptoms that appear in prisoners who have been in isolation only months or a few years. The prisoners I interviewed, who have remained in isolation for many more years than the average prisoner involved in earlier studies, have developed further symptoms and disabilities. I found that these varied symptoms fit into three general categories: a) symptoms related to a greatly increased urge to isolate; b) a subjective sense of "numbing," closing off all emotions that they report began as an attempt to keep a growing sense of anger at bay; and c) enlarged despair.

Inevitably, a certain number of prisoners are eventually released from their isolative confinement. All of the men I spoke to who had spent ten or more years in the Pelican Bay SHU and were then released, either to another prison setting or to the community, reported that they too experienced the list of symptoms widely reported in the literature about isolative confinement. They too had experienced a growing urge to isolate themselves, mounting despair and a numbing of all feelings during their years in the SHU. They also reported that many of the most serious problems they experience surface only after getting out of the SHU. Among the group of ex-residents of the SHU, there are universally-reported immediate experiences: a sense of being overwhelmed by sensory stimulation, massive anxiety when in crowded places, hyperawareness of every noise or change in lighting, a tendency to seek isolation in contained spaces, and difficulty expressing oneself in close relationships. That immediate reaction subsides somewhat after a period of six months or a year, but then there are residual symptoms.

Almost all of the men I interviewed reported that they continue to avoid crowds, remain suspicious of anyone entering their vicinity, have strong startle reactions, continue to have sleep problems, and have a lot of trouble expressing themselves and their feelings, even to intimates such as a wife or girlfriend. In fact, I was able to delineate a syndrome that captures the experience of the men who had been released from the PB SHU after ten years, characterized by the following symptoms:

- Disorientation immediately following release.
- Anxiety in unfamiliar places and with unfamiliar people, and the daily life events that had been ordinary prior to SHU confinement become unfamiliar events following release from SHU.
- A tendency to retreat into a circumscribed, small space, often a bedroom or cell.
- A tendency to greatly limit the number of people one interacts with, usually limited to close family members and a few friends.
- Hyperawareness of surroundings, for example a need to sit facing the door to a room or with one's back to a wall.
- Heightened suspicion of everyone who comes close, especially strangers.
- Difficulty expressing feelings.
- Difficulty trusting others, even one's spouse or first degree relative.
- Problems with concentration and memory, beginning in the period of SHU confinement and continuing after release, making it difficult to accomplish tasks and to work.
- A sense of one's personality having changed. The most often reported form of this change is a change from a relatively outgoing, friendly individual with a sense of humor prior to SHU confinement, to a more serious, guarded, and inward individual following release from the SHU.
- In some, but certainly not all, cases, there is a tendency to resort to alcohol and illicit substances to lessen emotional pain and make feelings of confusion and anxiety more bearable.

I describe this syndrome as a SHU Post-Release Syndrome.

A significant number of these problems are experienced intensely for many months after release from SHU, and then continue indefinitely in somewhat less intense fashion. This set of symptoms was consistently reported whether the prisoner had been released to the community or simply transferred to a general population or "stepdown" prison setting within the California prison system. Thus, for example, one former SHU prisoner who had been released to the community reported that he stays in his room a lot of his waking hours, while a prisoner who had been released from SHU to return to general population status in prison reported he stays in his cell most of his waking hours. Both groups appear to be trying to re-establish the conditions they experienced in the SHU. It is as if they have become so habituated to life isolated in in a small cell that exposure to any larger, more populated area seems overwhelming and frightening. Both groups are suspicious of others entering their vicinity, complain of a strong startle reaction, and report great difficulty trusting and sharing feelings with others.

In addition to reporting on the symptoms and damage discovered during my interviews with prisoners who have been in the PB SHU for ten years or more in this report, I describe the facility itself and address the following issues:

- My method for assessing the reliability of prisoners' reports;
- The way to determine whether reported symptoms and problems are in fact linked causally with SHU confinement;
- How representative of the class the prisoners I interviewed are; and
- How the issue of perceived fairness affects prisoners' psychological reactions to SHU confinement.

III. Qualifications

I am a board certified psychiatrist, an Institute Professor at the Wright Institute, a Distinguished Life Fellow of the American Psychiatric Association, and an expert on correctional mental health issues. I have testified more than two dozen times in state and federal courts about the psychiatric effects of jail and prison conditions, the quality of correctional management and mental health treatment, and sexual abuse in prison. I have served as a consultant to the U.S. Department of Justice and Human Rights Watch. I am author of *Prison Madness: The Mental Health Crisis Behind Bars and*

What We Must Do About It (Jossey-Bass/Wiley, 1998), co-editor of *Prison Masculinities* (Temple University Press, 2001), and Contributing Editor of *Correctional Mental Health Report*. I have authored three other books: *Public Therapy: The Practice of Psychotherapy in the Public Mental Health Clinic* (Free Press, 1981); *Ending Therapy: The Meaning of Termination* (NYUP, 1988); and *Revisioning Men's Lives: Gender, Intimacy and Power* (Guilford, 1993). I have authored and co-authored dozens of professional articles and book chapters, including "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs" by T.A. Kupers, T. Dronet, M. Winter, et al., *Criminal Justice and Behavior*, October 2009; and "Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?," *The Routledge Handbook of International Crime and Justice Studies*, Eds. Bruce Arrigo & Heather Bersot, Oxford: Routledge, 2013, pp. 213-232.

I have served as consultant to the departments of mental health in several jails, and to the Ohio Department of Corrections. I was the recipient of the Exemplary Psychiatrist Award presented by the National Alliance on Mental Illness (NAMI) at the 2005 annual meeting of the American Psychiatric Association, and the William Rossiter Award at the 2009 Annual Meeting of the Forensic Mental Health Association of California. My C.V. and a list of forensic cases in which I have served as an expert over the past four years are attached to this report as Exhibit A.

IV. Litigation Experience

Litigation in which I have testified at trial on similar matters includes:

- *Rutherford v. Pitchess*, Los Angeles Superior Court, regarding conditions and mental health services in Los Angeles County Jail, 1977;
- *Wilson v. Deukmejian*, Marin County Superior Court, regarding conditions and mental health services at San Quentin Prison, 1983;
- *Toussaint/Wright/Thompson v. Enomoto*, federal district court in San Francisco, regarding conditions and double-celling in California State Prison security housing units, 1983;
- *Gates v. Deukmejian*, federal district court in Sacramento, regarding conditions,

quality of mental health services and segregation of inmates with HIV positivity or AIDS at California Medical Facility at Vacaville, 1989;

- *Coleman v. Wilson*, federal district court in Sacramento, regarding the quality of mental health services in the California Department of Corrections' statewide prison system, 1993;
- *Bazetta v. McGinnis*, federal district court in Detroit, regarding visiting policy and restriction of visits for substance abuse infractions, 2000;
- *Jones 'El v. Litscher*, federal district court in Madison, Wisconsin, regarding confinement of prisoners suffering from severe mental illness in supermax isolation, 2002;
- *Russell v. Johnson* and *Presley v. Epps*, federal district court in Oxford, Mississippi, regarding conditions of confinement and treatment of prisoners with mental illness on Death Row inside supermaximum Unit 32 and regarding all prisoners in isolated confinement at Parchman, 2003 and 2006;
- *Austin v. Wilkinson*, federal district court in Cleveland, Ohio, regarding proposed transfer of Death Row into Ohio State Penitentiary (supermax), August, 2005;
- *DAI, Inc. v. NY OMH*, federal district court for the Southern District of New York, April 3, 2006, regarding mental health care in the New York Department of Correctional Services, with special attention to supermax confinement and its effects on vulnerable prisoners;
- *Presley v. Epps*, federal district court in the Northern District of Mississippi, Aberdeen, No. 4:05CV148-JAD, April 4, 2007, regarding conditions and Mental Health Care on Unit 32, Parchman, Mississippi.
- *Hadix v. Caruso*, federal district court in the Western District of Michigan, Grand Rapids, Michigan, regarding correctional mental health care, April 29, 2008.

I also serve as Monitor for the consent decree in *Presley v. Epps*, a federal class action regarding conditions in Supermax Unit 32 at the Mississippi State Penitentiary at Parchman. This case addresses the treatment of prisoners with serious mental illness who are housed in isolated confinement.

V. Compensation

I have been retained by counsel for Plaintiffs, and my rate of compensation is $175 per hour for all work except deposition and trial testimony; for deposition and trial testimony, my rate is $200 per hour.

VI. Preparation

In preparation for this report, I conducted the following interviews:

- Prisoners #1-11 for approximately 45 minutes each, during non-contact visits in the Security Housing Unit (SHU) visiting area at Pelican Bay State Prison (PBSP), on April 17 and 18, 2012. I conducted a second interview with 10 of those 11 prisoners on April 16 and 17, 2013. I also reviewed medical and custody charts when available in the Medical Facility. I interviewed Prisoner #7 a third time in general population at CSP-Sacramento on September 28, 2014, for just under two hours, after he had been placed on Step Five of the Step Down Program, and I interviewed Prisoner #9 a third time at SATF on January 14, 2015, where he had been transferred to Step Five of the Step Down Program (general population).
- Prisoner #12 at CSP-Sacramento on March 1, 2013 for approximately two hours.
- Prisoner #13 on the telephone on March 7, 2014 for approximately an hour.
- Prisoner #14 in person [redacted], on January 20, 2014, for approximately 2½ hours.
- Prisoner #15 [redacted] on July 23, 2014 for approximately 2½ hours.
- Prisoner #16 on the telephone, [redacted] on December 24, 2014, for an hour.
- Prisoner #17 and his girlfriend on the telephone, [redacted] on December 30, 2014, for approximately an hour (combined).

- Prisoners #9 and #s 18-24 at SATF/ Corcoran State Prison on January 14, 2015, for approximately 45 minutes each.[2]

Thus, I have interviewed 23 people who have been in the SHU at PBSP for at least ten years, and one (Prisoner #16) who was at PB SHU for slightly less than ten years. I had the opportunity to interview two of them, Prisoner #7 and Prisoner #9, twice while they were in the SHU and a third time after they had been transferred to maximum security general population facilities.

On April 11, 2014, I participated in a tour of the PBSP facility, including the SHU, the main yard, the Psychiatric Services Unit (PSU), and the SHU Infirmary.

Document review includes clinical and custody files of the eleven prisoners I interviewed who were in SHU at the time I first interviewed them, and one (Prisoner #12) being housed in Administrative Segregation at CSP-Sacramento for medical treatment, plus policies regarding the operation of the PB SHU.[3]

VII. Research and Literature

There is a rich literature of robust research on the effects of long-term solitary confinement or isolative confinement in prison.[4] [5] Long-term confinement (greater than three months) in an isolated confinement unit such as the supermaximum Security

[2] Of the eight prisoners at SATF, the names of seven were obtained from a list counsel received from CDCR in Feb. 2014; the eighth is a named plaintiff (Prisoner #9) who had been transferred to SATF. All have spent at least 10 continuous years at Pelican Bay SHU. In February 2014, defendants sent Plaintiffs' counsel a list of approximately 100 Pelican Bay SHU prisoners who have been placed on Step 5 of the Step Down Program. Of those, 15 had been transferred to SATF. In December 2014, Plaintiffs' counsel wrote to 14 of those prisoners (one was no longer in CDCR custody) about their willingness to be interviewed by me. Seven of those prisoners spent 10 continuous years in SHU and were English-speaking. I interviewed all those prisoners for this report.

[3] Including Regulations concerning Security Threat Groups adopted and effective October 17, 2014, amd Section 3378 of Title 15.

[4] For an overview of supermaximum security and isolated confinement, see LORNA RHODES, TOTAL CONFINEMENT: MADNESS AND REASON IN THE MAXIMUM SECURITY PRISON, (University of California Press, 2004); and SHARON SHALEV, SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT, (Willan Publishing, 2009).

[5] I employ the terms "solitary confinement" and "isolated confinement" interchangeably. Some correctional officials object to the use of the term solitary confinement because, they claim, individuals in their isolative confinement units have some contact with the officers who pass them their food trays, search them and escort them to appointments. I am not convinced this constitutes adequate human contact, so I continue to employ the two terms synonymously.

Housing Unit at Pelican Bay State Prison is well known to cause severe psychiatric morbidity, disability, suffering and mortality.[6] It has been known for as long as solitary confinement has been practiced that human beings suffer a great deal of pain and mental deterioration when they remain in solitary confinement for a significant length of time. Thus, in 1890, the U.S. Supreme Court found that in isolation units, "[a] considerable number of prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."[7]

A significant amount of research echoes the Court's findings. Prof. Hans Toch, a social psychologist and emeritus professor in the School of Criminal Justice at State University of New York at Albany, provided early narrative reports from prisoners at the highest levels of security and Isolation.[8] Prof. Craig Haney, a social psychologist and Professor of Psychology at the University of California at Santa Cruz, has researched the detrimental effects of long-term isolation.[9] More than four out of five of the prisoners he evaluated suffered from feelings of anxiety and nervousness, headaches, troubled sleep, and lethargy or chronic tiredness, and over half complained of nightmares, heart palpitations, and fear of impending nervous breakdowns. Equally high numbers reported obsessive ruminations, confused thought processes, an oversensitivity to stimuli, irrational anger, and social withdrawal. Well over half reported violent fantasies, emotional flatness, mood swings, chronic depression, and feelings of overall

[6] For reviews of this research, see Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, CRIME & JUST., 34 441, 488–90 (2006); and Bruce Arrigo & Jennifer Leslie Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What We Should Change*, INT'L J. OFFENDER THER. COMP. CRIMINOLOGY 52:, 622-640 (2008).
[7] In re Medley, 134 U.S. 160 (1890).
[8] HANS TOCH, MOSAIC OF DESPAIR: HUMAN BREAKDOWN IN PRISON, (American Psychological Association 1975, 1992)
[9] Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement,* CRIME & DELINQUENCY, 49(2), 124-156 (2003)..

deterioration, while nearly half suffered from hallucinations and perceptual distortions, and a quarter experienced suicidal ideation.[10]

Dr. Stuart Grassian, a psychiatrist and researcher, has conducted similar research.[11] He describes a particular psychiatric syndrome resulting from the deprivation of social, perceptual, and occupational stimulation in solitary confinement. This syndrome has basically the features of a delirium. Among the more vulnerable population, it can result in an acute agitated psychosis, and random violence – often directed towards the self, and at times resulting in suicide. He has also demonstrated in numerous cases that the prisoners who end up in solitary confinement are generally not "the worst of the worst"; they include, instead, the sickest, most emotionally labile, impulse-ridden and psychiatrically vulnerable among the prison population. Two-thirds of the prisoners Dr. Grassian initially studied had become hypersensitive to external stimuli (noises, smells, etc.) and about the same number experienced "massive free floating anxiety." About half of the prisoners suffered from perceptual disturbances that for some included hallucinations and perceptual illusions, and another half complained of cognitive difficulties such as confusional states, difficulty concentrating, and memory lapses. About a third also described thought disturbances such as paranoia, aggressive fantasies, and impulse control problems. Three out of the fifteen had cut themselves in suicide attempts while in isolation. In almost all instances the prisoners had not experienced any of these psychiatric reactions prior to their time in isolation. For all prisoners, long-term solitary confinement has the effect, on average, of making post-release adjustment very problematic and worsening recidivism rates.[12]

An alarmingly large proportion of prisoners consigned to supermaximum security isolation in recent decades suffer from serious mental illness. Drs. Sheilagh Hudgins and Gilles Cote, psychologists at the Centre de Recherche Philippe Pinel at Universite de Montreal, performed a research evaluation of penitentiary inmates in a Supermaximum Security Housing Unit and discovered that 29% suffered from severe

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[10] Ibid.

[11] Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, INT'L J. OF LAW & PSYCHIATRY, 8(1), 49-65 (1986).

[12] David Lovell, L. Clark Johnson, & Kevin Cain, *Recidivism of Supermax Prisoners in Washington*, CRIME & DELINQ., 52,4, 633-56 (2007).

mental disorders, notably schizophrenia.[13] Prof. David Lovell, Professor of Nursing at the University of Washington, has described typical disturbed behavior.[14] I have reported my own findings from litigation-related investigations.[15] It is stunningly clear that for prisoners prone to serious mental illness, time served in isolation and idleness exacerbate their mental illness and too often result in suicide. This is the main reason that federal courts have ruled that prisoners with serious mental illness must not be subjected to long-term isolation.[16]

The ACLU of Texas recently released a report of its research on solitary confinement. Researchers surveyed 147 prisoners and ex-prisoners who had spent significant time in solitary confinement, and summarized their findings:

> Solitary confinement can cause people's mental health to seriously deteriorate, creating or exacerbating psychiatric symptoms that persist long after their release and impede their ability to reintegrate to society. The medical consensus is that most human beings cannot withstand the prolonged isolation and sensory deprivation that solitary confinement entails, and our survey of people incarcerated in Texas prisons produced predictable results. Ninety-five percent of respondents to our survey had developed some sort of psychiatric symptom as a result of solitary confinement; thirty percent reported having oral or physical outbursts, fifty percent reported suffering from anxiety or panic attacks, and fifteen percent reported hallucinations. Solitary confinement's impact on the human brain is as brutal as a traumatic physical injury; prisoners of war who spent six months in solitary confinement had abnormal brain-wave patterns months after their release.[17]

Prisoners who are released straight out of solitary confinement to the community at the end of their prison sentence (referred to as "maxing out of the SHU") experience significant problems in adjusting to community life. The recidivism and parole violation rates for the group who "max out of the SHU," as well as for those who spent

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[13] Sheilagh Hodgins & Gilles Cote, *The Mental Health of Penitentiary Inmates in Isolation*, CANADIAN J. OF CRIMINOLOGY, 177-182 (1991).
[14] David Lovell, *Patterns of Disturbed Behavior in a Supermax Population*, CRIM. JUST. & BEHAVIOR, 35,8, 985-1004 (2008).
[15] TERRY KUPERS, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT, (Jossey-Bass/Wiley 1999)
[16] *Madrid v. Gomez* , 889 F. Supp. 1146 (N.D. Cal. 1995); *Jones 'El v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); *Presley v. Epps*, 4:05-cv-148 (JAD) (N.D. Miss. 2005 & 2007)
[17] ACLU OF TEXAS, A SOLITARY FAILURE: THE WASTE, COST AND HARM OF SOLITARY CONFINEMENT IN TEXAS (2015).

considerable time in isolation, is extremely dire.[18] Whether or not prisoners are permitted to "max out of the SHU" (the alternative in several states is to require six months of re-socialization in a general population unit prior to prisoners reaching their release date), the period of isolation and idleness has very negative effects on their chances of successfully reentering society after being released.

The Arizona Chapter of the American Friends Service Committee (AFSC) studied the post-release course of 41 men and 3 women prisoners who had spent long periods in isolative confinement. Discussing their post-release experience, the AFSC Report states:

> In describing his life on the outside, one participant who avoided old neighborhoods and contacts said that 'life is way harder out here for me than it is in there.' He is not alone in this nostalgia for prison life and for the isolation of the supermax cell. A female participant, also homeless and barely getting by at the time of the interview, said almost ashamedly, 'The worst thing that I can honestly say about trying to get back into society is I miss my cage more and more everyday. I just can't function out here.' When asked, 'Do you want to [sic] the small cage back or the big cage?' she replied, 'The smaller the better. I can control everything in it.' They make repeated efforts to avoid people, for example moving to the edge of the city or living alone in a tunnel. It is strikingly reminiscent of the social withdrawal that Craig Haney describes[19] as endemic to persons held in isolation for long periods, except now they are outside the supermax cell, in the great wide open of supposed freedom, which terrifies them.[20]

The AFSC Report points out that most of the ex-prisoners their researchers interview tended to play down the negative effects of their years in isolative confinement. Still, they report significant psychological damage, and even more telling is the fact that the interviewer observed in their behaviors and presentation of self more serious psychological disability than the interviewed ex-prisoners spontaneously

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[18] David Lovell, L. Clark Johnson, & Kevin Cain, *Recidivism of Supermax Prisoners in Washington*, CRIME & DELINQ., 52,4, 633-56 (2007).

[19] Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, CRIME & DELINQ., 48(1): 124-156 (2003).

[20] AMERICAN FRIENDS SERVICE COMMITTEE OF ARIZONA, LIFETIME LOCKDOWN: HOW ISOLATION CONDITIONS IMPACT PRISONER REENTRY, 33-34 (2012) Available at http://afsc.org/sites/afsc.civicactions.net/files/documents/AFSC-Lifetime-Lockdown-Report_0.pdf

reported. In other words, the ex-prisoners tended to downplay the damage they had incurred.

It is predictable that prisoners' mental state deteriorates in isolation. Human beings require at least some adequate or relatively normal social interactions[21] and productive activities to establish and sustain a sense of identity and to maintain a grasp on reality. In the absence of adequate social interactions, unrealistic ruminations and beliefs cannot be tested in conversation with others, so they build up inside and are transformed into unfocused and irrational thoughts. Disorganized behaviors emerge. Internal impulses linked with anger, fear and other strong emotions grow to overwhelming proportions. Sensory deprivation is not total in supermax units; there is the intermittent slamming of steel doors and there is yelling (one typically has to yell in order to be heard from within one's cell), but this kind of noise does not constitute meaningful human communication. From my interviews with prisoners and tour of the facility, it is my impression that this is very much true in the SHU at Pelican Bay State Prison. Prisoners in this kind of segregation do what they can to cope. Many pace relentlessly or clean their cell repeatedly, as if the non-productive action will relieve the emotional tension. Those who can read books and write letters do so.

The tendency to suffer psychiatric breakdown and become suicidal is made even worse by sleep deprivation, which is a frequent occurrence among prisoners in isolated confinement. All prisoners are harmed by chronic sleep problems, and it is very difficult to sleep in the PB SHU. But when a prisoner suffers from a serious mental illness or is prone to mental illness, the damaging effect is greater. Loss of sleep intensifies psychiatric symptoms by interfering with the normal diurnal rhythm (the steady alternation of day and night that provides human beings with orientation as to time), and the resulting sleep loss creates fatigue and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness. It is under these extreme conditions that psychiatric symptoms begin to emerge in previously healthy prisoners. Toch, Haney, Grassian, Lovell and I, among many others, have described serious symptoms in

[21] Of course, prisoners in the SHU can yell from their cell and be heard by other prisoners nearby, they interact with officers delivering their food trays and are accompanied by officers when they go for appointments, and when they go to the yard they pass other prisoners' cells. But these interactions do not constitute adequate social interactions.

prisoners who are relatively stable from a psychiatric perspective. In their amicus brief in *Wilkinson v. Austin*, leading mental health experts summarize the clinical and research literature about the effects of prolonged isolated confinement and conclude: "No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects" (p. 4).[22] Of course, in less healthy prisoners there is psychosis, mania or compulsive acts of self-abuse or suicide. We know that the social isolation and idleness, as well as the near absolute lack of control over most aspects of daily life, very often lead to serious psychiatric symptoms and breakdown.

It has been known for decades that suicide is approximately twice as prevalent in prison than it is in the community, and recent research confirms that, of all successful suicides that occur in a correctional system, approximately fifty percent involve the 3 to 8 percent of prisoners who are in some form of isolated confinement at any given time.[23] In California, the equivalent statistic is 60%; in other words, 60% of successful suicides occur among the 3% to 6% of the prison population confined in segregation units, including the supermax SHU at PBSP.[24] This is a stunning statistical finding, and constitutes conclusive evidence that long-term consignment to segregation is a major factor in the high suicide rate among prisoners.

A huge volume of very good research on the harm of supermax solitary confinement appears in the reports and testimony of mental health experts investigating supermax facilities in preparation for testimony in class action litigation. When I investigate a correctional system, I interview dozens or even hundreds of prisoners, many in supermax units, and I report in detail to the court the harm done by their long-term solitary confinement or the quality of their mental health treatment. Prof. Haney

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[22] Amicus Brief to the Supreme Court of the United States. (2005). Brief of professors and practitioners of psychology and psychiatry as amicus curiae in support of respondents. Supreme Court of the United States, No. 04-495.

[23] Daniel P. Mears & Jamie Watson, *Towards a Fair & Balanced Assessment of Supermax Prisons*, JUST. Q., 23,2, 232-270, (2006); Bruce Way, Richard Miraglia, Donald Sawyer, Richard Beer & John Eddy, *Factors Related to Suicide in New York State Prisons,* INT'L J. OF LAW & PSYCHIATRY, 28,3, 207-221 (2005).

[24] Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections & Rehabilitation, 1999 to 2004*, PSYCHIATRIC SERVICES, 59, 6, 676-682 (2008)

and Dr. Grassian, among others, do the same.[25] I am very familiar with the testimony provided by mental health and correctional experts in litigation, and I rely in part on that vast literature (the expert reports, testimony and trial transcripts) in arriving at my own opinions and conclusions.

In sum, we know quite a lot from research on prisoners in "long-term" isolated confinement, where "long-term" is typically defined as longer than three months. And there has been a certain amount of research and investigation of very long-term isolated confinement (greater than ten years). I have interviewed and examined dozens of prisoners who had been in isolated confinement for over ten years in numerous states, and prisoners whose solitary confinement has lasted that long are included in the research I have summarized and in the investigations of experts preparing for testimony in litigation.

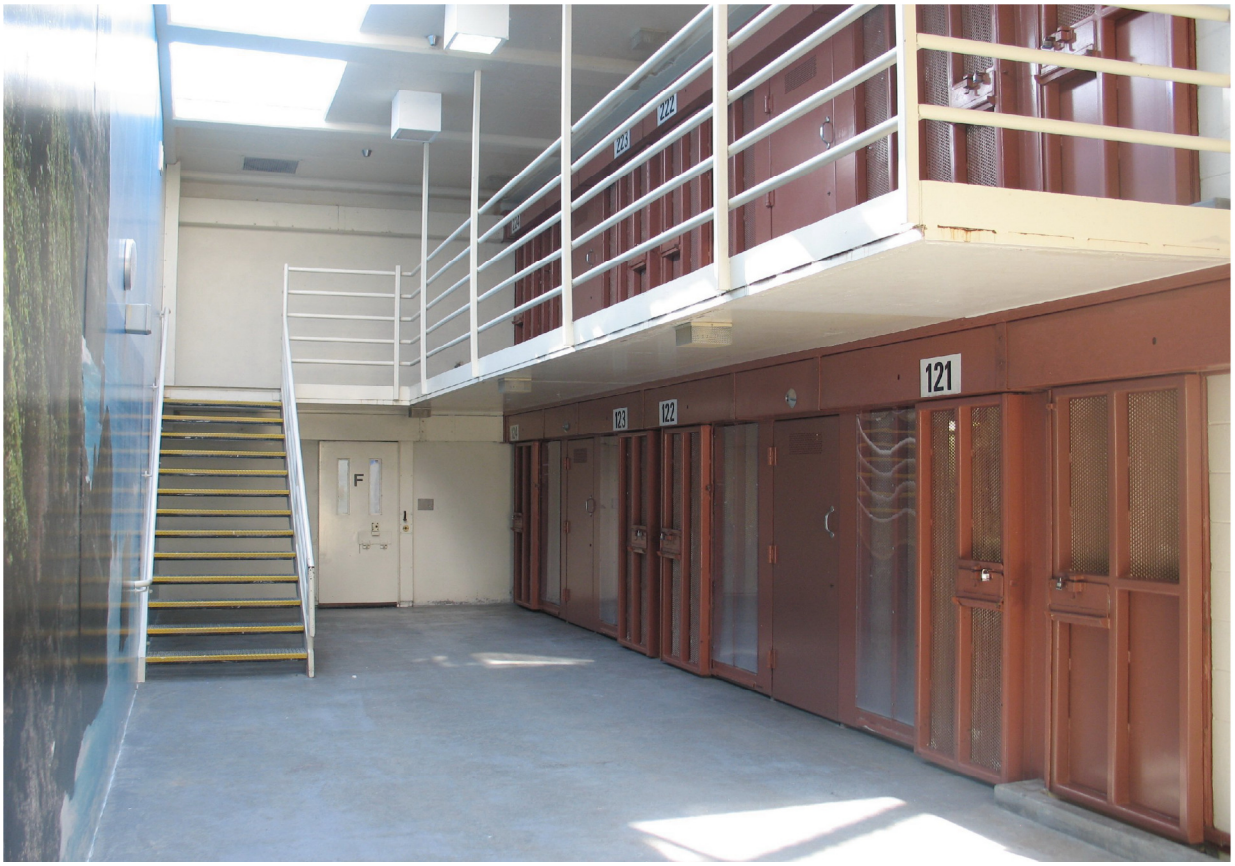
VIII. Findings

A. The Facility

On April 11, 2014, I was given a tour of PBSP, in the company of counsel for Plaintiffs and Defendants, and Prof. Craig Haney. I had previously toured the facility while preparing for my testimony in *Coleman v. Brown* in the early 1990s. Here, I present my observations from the 2014 tour. We toured the general population yard, the SHU itself, the Psychiatric Services Unit (PSU), and the medical area.

Pelican Bay State Prison, located near California's coastal border with Oregon, is a Maximum Security correctional facility with a capacity of approximately 3,000 prisoners. Approximately 1,000 or more of them are consigned to the Security Housing Unit (SHU) where most are single-celled and a small minority are double-celled. The SHU is described widely as a "Supermaximum Security Facility."

[25] Craig Haney, *Mental Health Issues in Long-Term Solitary & "Supermax" Confinement*, CRIME & DELINQ., 49(2), 124-156. (2003); Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion & Solitary Confinement*, INT'L J. OF LAW & PSYCHIATRY, 8(1), 49-65 (1986).

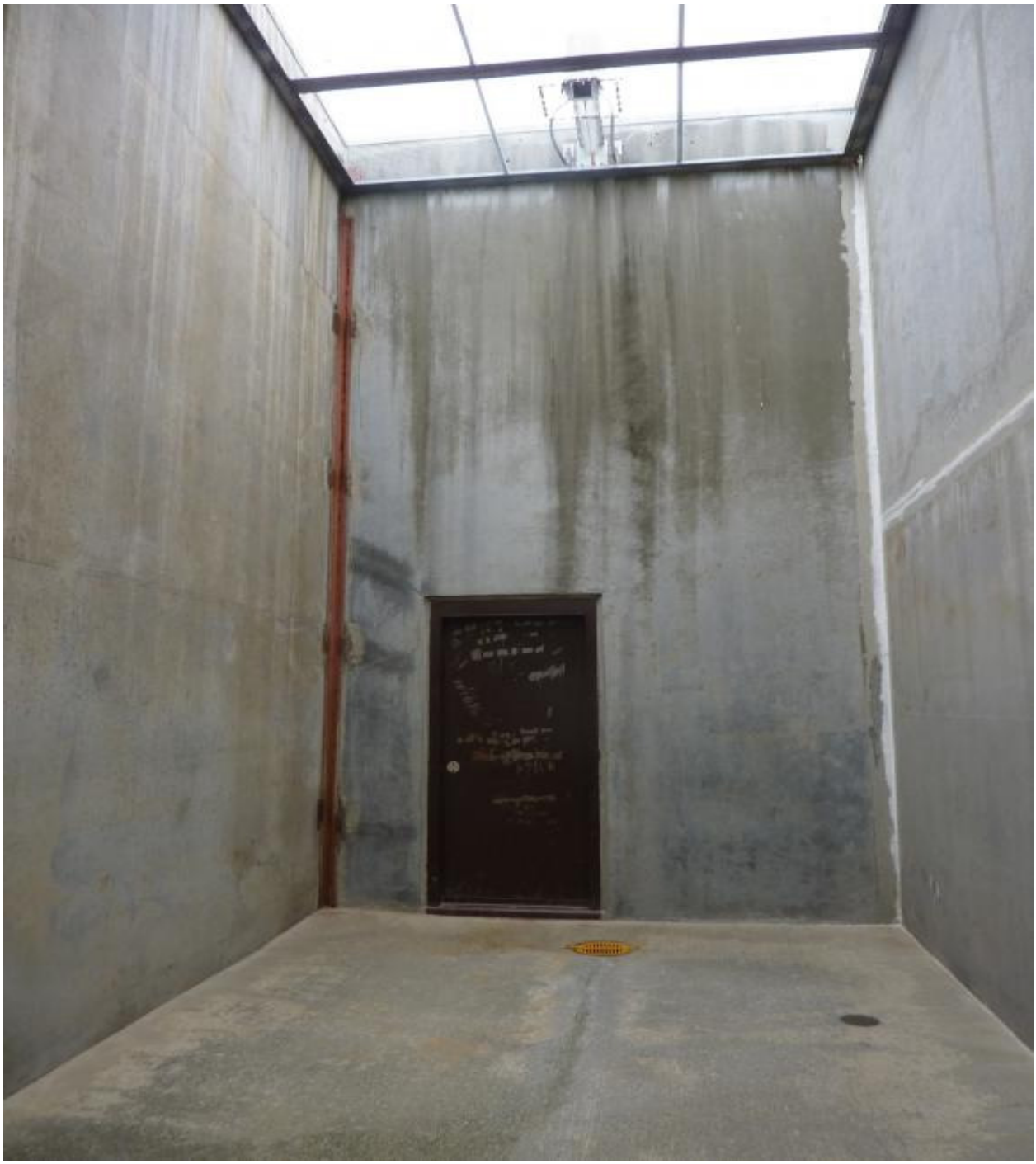


A Pod in the PB SHU[26]

Security is very strict. Prisoners remain in their cells nearly 24 hours per day. When they leave their pods, they are searched and escorted in handcuffs and/or other restraints. They are released for up to ninety minutes or less per day to go alone (or with a cell-mate) to their pod's adjacent recreation area, a room-sized space devoid of equipment except for a pull-up bar and a small ball.[27] The walls are approximately 20 feet high and there is a small space overhead left uncovered (by Lexan) through which the prisoner can see the sky. Otherwise, the prisoner has no visual connection to the outside world.

[26] Photo by CDCR staff during April 11, 2014 tour

[27] It is my understanding that the pull up bar and ball are recent amenities, improvements obtained secondary to prisoner hunger strikes beginning in 2011.



A Yard at the PB SHU[28]

The cells are approximately 8' X 10', and have no window. The front wall of the cell, including the door, is covered by a perforated (honey-comb fashion) metal sheet.

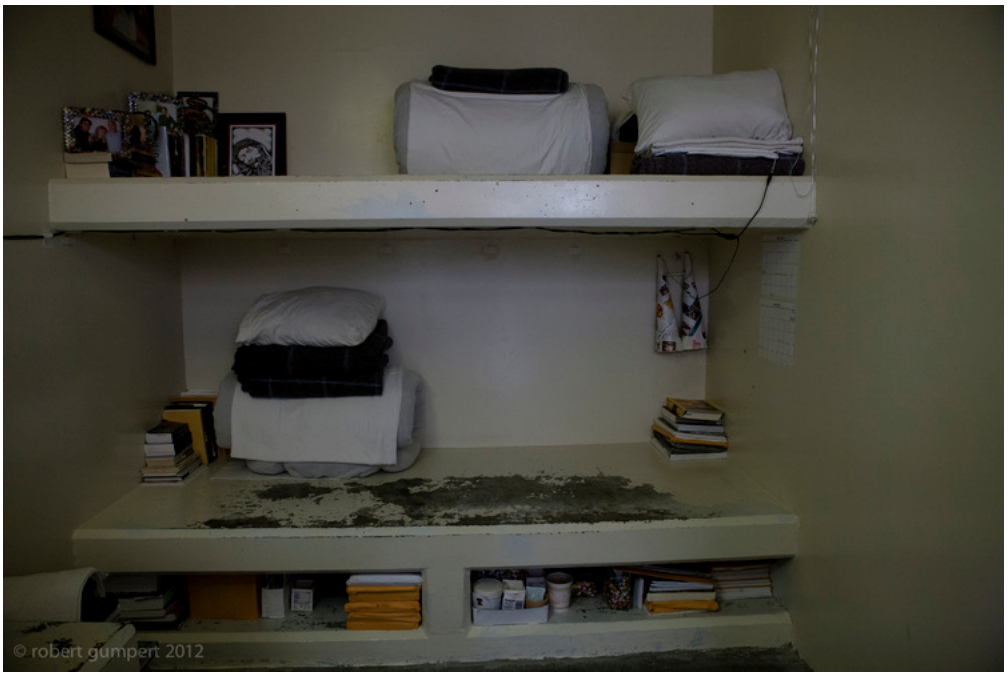
[28] Photo by Robert Gumpert available at http://www.taptas.com/pelican-bay-prison/.

The effect is to distort the prisoner's perception as he gazes out of the cell. The only thing he sees most of the time gazing out of the cell is a bare wall on the other side of the walkway, as cells do not face each other.

Front of a cell with perforated metal sheet, as viewed from inside cell[29]

Doors are opened and closed by remote control from a control booth at one end of the pod. There are four cells on each of two floors in each pod. Prisoners are cell-fed and are permitted showers where they are locked into a shower stall for a short period. Inside the cells, there is a mattress on a concrete platform, a metal toilet/sink attached to the wall, two concrete blocks for use as a seat or tabletop, and a television if the prisoner is not on restriction and can afford to purchase it. There are no areas designated for congregate activities, and the everyday practice is that prisoners are alone (a small number have cellmates) all the time.

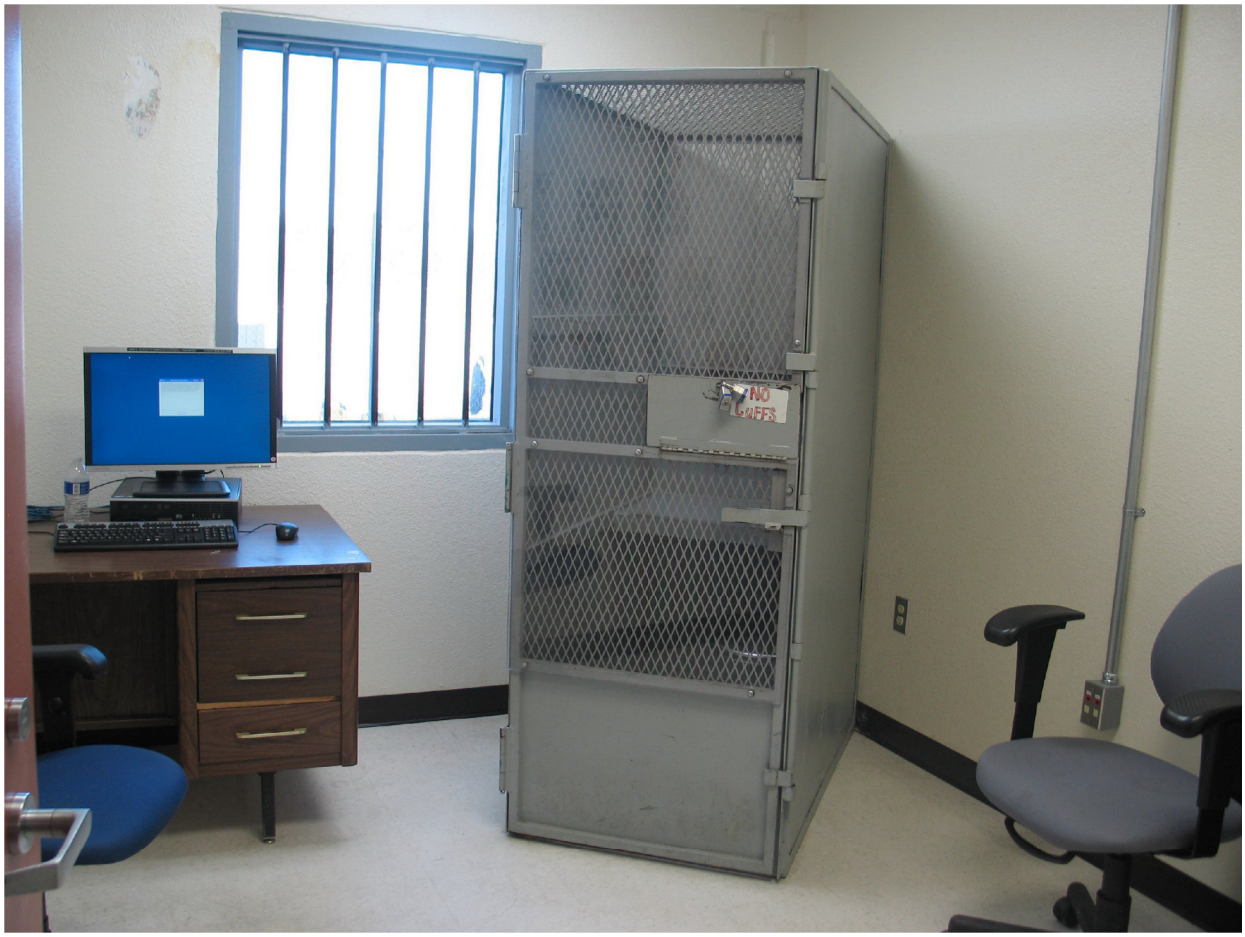
[29] Photo from Solitary Watch, available at http://solitarywatch.com/2014/07/07/worst-worst-one-year-later-whats-changed-pelican-bays-hunger-strikers/



Inside a cell in the SHU at PBSP[30]

They see mental health staff either at cell-front "rounds" or they are removed from the pod and placed in a "programming cell" or "therapeutic cubicle" to be interviewed by mental health staff. Therapeutic cubicles, called "cages" by the prisoners, are single occupancy booths wherein the prisoner is locked for the duration of a meeting with a counselor, teacher or a hearing officer.

[30] Photo by Robert Gumpert available at http://www.taptas.com/pelican-bay-prison/



A "Programming Cell" or "Therapeutic Cubicle"

We were shown the "contraband retrieval cells'" or "potty watch." The men on contraband watch are left in a special room in their shorts. They are placed in various forms of restraints including waist chains, and they are left there to defecate on a makeshift toilet. The officers check their excrement for contraband. They remain in the room through three bowel movements. We were told that during the day the people on watch sit on the floor and at night, a mattress is placed in the room.

There is a Psychiatric Services Unit (PSU) on the prison grounds. It is operated at the Enhanced Outpatient (EOP) level of mental health treatment (an intermediate level between hospital and outpatient). There are "cages" outside the PSU, with fenced in individual exercise spaces side by side. Inside the PSU there are treatment rooms where prisoners are locked alone into "programming cells," also called by some "therapeutic cubicles," four or five to a room, and a therapist or teacher can enter the

room, sit in a chair or at a desk, and work with them. There is also a room with a therapeutic cubicle for one prisoner, presumably for individual meetings with clinicians.

In PBSP's medical facility, there is a nursing station and a number of rooms for examination and housing prisoners suffering from medical illness or psychiatric crises. There are special cells/rooms for the purpose of suicide observation and crisis intervention. Evidently, prisoners from the SHU can be transferred to this medical unit, for example for suicide observation, and then transferred back to the SHU if they seem stable and are not suffering from serious mental illness. Presumably, if they are suffering from serious mental illness, they are no longer eligible for SHU housing, and would be transferred to the PSU or another EOP facility.

B. Prisoners Who Were in SHU at the Time of My Interviews

1. These prisoners suffered symptoms consistent with those identified in the literature.

The prisoners who were in the SHU when I interviewed them exhibited all the symptoms and disabilities previously reported widely in the literature. As I will report below, in Section VIII.B.3&4, they evolved additional symptoms of severe isolation and emotional numbing as the years in SHU accumulated.

Early in the course of this litigation, I interviewed eleven prisoners the PB SHU and one in SHU at CSP-Sacramento who had been in the PB SHU for over ten years but then was transferred to CSP-Sacramento for medical treatment. Some had been at the PB SHU since it opened, and many were already in segregation at another facility for some time prior to their transfer to the PB SHU. I interviewed ten of them twice, on April 17-18, 2012, and again on April 16-17, 2013. Subsequently, some of these individuals have been transferred out of the SHU to Step 5 of a "Step Down" program and general population. While this is an important subsequent development, the interviews I conducted while they were still in the SHU provide a very rich window into the experience of individuals in the SHU and the emotional impact of over ten years of SHU confinement. Even though some members of the original group are no longer in the SHU, the experiences they recounted to me are representative of the many others who have been in the PB SHU for over ten years and remain there today.

The eleven prisoners I interviewed in the SHU all report a significant number of symptoms long known to result from isolated confinement lasting longer than three months, including irritability, distorted thinking, paranoia, perceptual distortions, mounting anger, fear that they will not be able to control their anger and will get into more trouble, problems concentrating, problems with memory, compulsive and self-destructive behaviors, nightmares, lethargy and chronic tiredness, agitation, wide swings of mood, depression, despair, and emotional numbing. They report a very significant amount of hyper-alertness with startle responses (e.g. jumping when they hear a door open or a light go on because they are afraid someone will "come in on them"). Most complain of severe chronic insomnia, many of headaches. They report they often feel infantilized and humiliated by staff. Several cited the implementation of "potty watch" where, in an intrusive search for contraband, prisoners are forced to defecate three times in a makeshift toilet while being watched. Several prisoners cite the existence of this particular form of humiliation even when they have not personally been subjected to it.

These men, at the time of our interviews, were all in SHU because of gang validation. They reported that the justifications for their validation are very old (i.e. alleged associations that occurred many years before) and then they have been "re-validated," in all cases based on what they report as dubious or false evidence.[31] When these men approach six years without any disciplinary write-ups (termed "115's," the number of the form where major disciplinary write-ups are documented) and proven gang activity, they are re-validated for reasons they consider unfounded. They consider their validation entirely unfair, and believe they are denied an opportunity to show that they do not belong in the SHU. Further, their every activity is controlled by staff, who are often unfriendly and whom the prisoners consider unfair, in many cases racist. They feel they are denied adequate contact with family members (no phone calls except on rare occasions such as the death of a first degree relative, and visits are problematic because of policies as well as the geographic isolation of the facility), and some believe their mail is being destroyed. In the SHU they have little or no meaningful activities and

[31] In one case, the prisoner was re-validated for a drawing of a picture copied from a book in the PBSP library, and in another case the prisoner was re-validated for saying hello to another prisoner confined in the facility.

essentially no programs. Almost all of them complained about a lack of touching or physical contact other than being searched or transported by officers.

For these and related reasons, they all report a certain amount of anger about their situation. Earlier in their period of incarceration, many of them acted out equivalent anger by talking back to officers or getting into fights. By now, they have learned to keep their anger to themselves. Mounting anger plus dread of losing control of the anger are almost universally reported by prisoners in long-term isolated confinement.

Since all prisoners report they are under constant pressure by staff to "de-brief," they are unable to really trust their neighbors, believing that what they say could be distorted and reported to staff during the “de-briefing” procedure. They are afraid that if they say the wrong thing to someone they will be re-validated or they will suffer some type of retaliation. It is very stunning how universal this concern is among the 24 prisoners and ex-prisoners I interviewed. Quite a few told me that when they complain about poor medical care (or even about the food) they are repeatedly told by officers that they should “de-brief” if they want better medical care (or food).

All but two of the 11 prisoners I interviewed in the SHU participated in the hunger strikes in 2011. The two who did not had health problems that precluded their participation. At the time of my interviews, all of these men maintained the firm belief they would never be released from SHU because they refused, on principle, to “de-brief” and the parole board is very unlikely to approve the parole of a prisoner in SHU. They believe that there is incredible unfairness in the way they are validated and re-validated, and yet they have no opportunity to hear the evidence against them nor to rebut it (i.e. they believe there is no fair or due process). They all believe that the health care is very poor, and most report they are told that if they want better health care they should “de-brief”. These men try not to utilize mental health services, and they offer a number of explanations why that is so. Most talk about the stigma in prison towards men who seek mental health services, the dangers of being labeled a “ding” or crazy by other prisoners, and the unwritten rule that a man needs to do his time without showing weakness. Quite a few also tell me that they do not trust the mental health staff to maintain confidentiality and they do not feel that the mental health staff truly cares about them. Further, they object to the fact that they would be seen by mental health staff in a

"therapeutic cubicle" or "programming cell," which they call "a cage," and they find this kind of treatment humiliating.

For the most part, while they have been forced to endure being in a cell nearly 24 hours per day, mostly idle, for ten or more years, this group of men have not fallen victim to serious mental illness,[32] and that is a testament to their emotional strength and stability. However, it is important to note that some prisoners are prone to serious mental illness, many forms of which are clearly exacerbated by isolative confinement. These forms include psychotic disorders, severe depression, mood swings, Bipolar Disorder and suicide.

Suicide is a very important consideration. The eleven men I interviewed are not presently overtly suicidal, even though several told me they would not care if they died, for example from being on hunger strike. But this is not the group who are likely to commit suicide. Yet we know that 60% of completed suicides in the CDCR occur among the 3% to 6% of prisoners who are in isolated confinement.[33] So there is definitely a group of prisoners in the SHU who are at very high risk of suicide, and these men are not in that group. In other words, this group of eleven actually evidences relatively much less suicidal ideation and intention than would be clearly expected in the larger group of prisoners who have been in the SHU at PBSP for over ten years.

Subsequent to my interviews with the eleven men who were in SHU at the time of the interviews, I interviewed one prisoner (#12) who had been transferred to SHU at CSP-Sacramento for medical treatment, eight prisoners (Prisoner #7 at CSP-Sacramento and Prisoners #9, 18-24 at SATF) who had been transferred out of the SHU, either to Step 5 of the Step Down program (general population),[34] and five former prisoners who had been released to the community, either directly from SHU or from general population. Two prisoners (Prisoners #7 and #9) among the 24 total who I

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[32] Prisoner #12 was transferred to the Psychiatric Services Unit for treatment of major depressive disorder several years ago, and then was determined to be in remission and transferred back to SHU.

[33] Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections & Rehabilitation, 1999 to 2004*, PSYCHIATRIC SERVICES, 59, 6, 676-682 (2008).

[34] Several of the individuals I interviewed had been placed in Step 5 and subsequently "graduated" to general population status. For the purpose of this discussion, Step 5 of the Step down program is similar in programming and amenities to general population.

interviewed in all settings were seen twice in SHU, and then again after they were transferred from SHU to a general population facility. It is quite striking how all 24 of the men I interviewed averred having experienced an equivalent list of symptoms and disabilities during their tenure in SHU. In other words, these symptoms and disabilities are universally reported by prisoners who spend significant time being isolated and idle in the SHU, even if the specific list of reported symptoms varies from one individual to another.

2. Description: Prisoners' reports of symptoms identified in the literature.

Not every prisoner I interviewed avers the entire list of common symptoms I have presented above. Rather, each reports a significant number of them in idiosyncratic fashion. Thus, Prisoner #7 [redacted] with a close family, reports many of the symptoms that appear in the literature on the psychological effects of SHU confinement, including severe insomnia. He is lucky to sleep four or five hours at night. He has heard voices when nobody was talking to him, and believes that this is caused by SHU confinement. He is [redacted] He knows he should exercise, but he feels so listless all the time that he does not have the initiative nor the energy to exercise. He forces himself to go to the yard (a room-size area, see photo in previous section) for 30 minutes, five times a week, and he walks out there. He feels a lack of energy to do anything. He gets headaches. He thinks that he is frustrated about the unfairness and lack of recourse, and that adds with the effects of the dull colored walls and monotony of SHU to cause him to feel depressed and hopeless.

Prisoner #10[redacted] had been in the PB SHU for 13 years. He does not understand why, when he has been found to be "inactive," he was retained in SHU. The unfairness of his validation and SHU confinement, along with the lack of any recourse, make him despairing and resentful. He reports many psychological symptoms, including a high degree of anxiety, mood swings, and frequent bouts of depression. He has great trouble focusing, for example on something he is trying to read, and finds that his

memory is very poor. Further, he finds he is overly sensitive to stimulation (a strong startle reaction), has lost the ability to feel things, has wide swings of emotion (he is depressed much of the time, but then feels agitated and "jumpy" at other times), feels blocked in getting things done, feels lonely and feels blue. He avers perceptual distortions, for example seeing things move on the drab walls of his pod, and then he realizes he is imagining something.

Prisoner #10 has a lot of difficulty sleeping. During the nights there are repeated noises of doors being opened and closed, and the noise causes him to waken suddenly. He becomes frightened that someone is going to enter his cell and attack him. He spends his days working out and reading as much as he can (the trouble focusing and memory loss make reading very difficult, and he tends to forget what he read a few pages back). He does not talk to mental health staff because he believes they do not care about the prisoners, and besides, he tells me, whenever prisoners talk to mental health staff there are officers present and there is no confidentiality. He looks very sad as he tells me he has not shaken the hand of a human being in 13 years. He worries that he has forgotten the feel of human contact. Once, on his way to a doctor's appointment, where he was led in shackles by officers, he caught a glimpse of a tree. That was such a contrast with the monotony of looking at the windowless walls in his pod that he felt excited about the tree. He reacts strongly whenever a door is opened or closed, always afraid "someone is going to come in on me."

Prisoner #5 complains of severe eye problems. He believes the problem stems from not seeing anything but a blank wall for years. Even to see the wall across the hallway, he has to look through a metal cell door with small holes in it, and this distorts his vision (see photo in previous section). He gets headaches frequently, and when he does eventually see colors other than the monotonous color of his cell walls, his vision gets distorted. He has a television but watches it very little because he gets headaches when he sees colors. He really misses having contact with anything natural. He never sees a tree, nor a bird. When he finds an insect in his cell, he feels like finally he has company. He suffers from prostatitis and reports medical care is very poor, but when he asks staff for better care he is told he should “de-brief” and then he would get better care in another facility. He also complains of severe insomnia, loss of appetite, chronic

tiredness and lack of energy, talking to himself, confused thinking, and losing the ability to feel or know what he is feeling.

Prisoner #9, [redacted] had been in SHU for 36 years (with occasional transfers out of SHU, followed by return to SHU) at the time of our interview, arriving at PBSP around when it opened. He avers intense anxiety, sweating even without exertion, frequent "weird violent dreams," a strong startle reaction especially to the sound of doors opening, perceptual distortions which he attributes to the lack of windows in his cell and the odd experience of looking at the wall across from his cell through the small holes in his metal cell door, a sense of losing the ability to feel things, wide swings in emotion, constantly misplacing things, an inability to concentrate, memory loss, worrying about getting sloppy, and irritability. He describes irregular sleep with frequent waking whenever he hears the sound of doors opening and closing. He explains that loud noises make him jump or induce panic attacks because he is afraid someone will come into his cell and attack him. He is afraid that officers will enter his cell and beat him. He avers being hyperaware, even paranoid.

He believes his validation is entirely wrong and unfair. The unfairness makes him very resentful. He claims that far from being connected with a gang, he has served as a mediator and negotiator for peace whenever there has been discord in the general population. His wrongful consignment to SHU makes him very upset, but he constantly tries to keep his anger suppressed and maintain a positive attitude. In fact, he presents as cheerful and positive. He does not utilize mental health services. He believes the mental health staff is very uncaring and there is no confidentiality. He reports that it is very dangerous to let staff know about one's emotional problems. Also, the only way a prisoner can talk to mental health staff is to be placed in a "therapeutic cubicle," which "makes you feel like you are an animal in a cage," so he does not utilize mental health services. He suffers frequent nightmares about violence, something that he never experienced prior to being in SHU. In addition, the fact that medical staff are inattentive and uncaring causes him to be very frightened that were he to suffer a life-threatening emergency, they would fail to respond adequately and he would die. He concludes, "They want us to die in here." He becomes easily distracted, cannot concentrate, and loses the initiative and capacity for accomplishing tasks. Then he stops trying to

accomplish many tasks. He falls into a state of dampened emotions and little energy to do anything. Then he despairs because he believes he will never be released from SHU, therefore he will never be paroled, and he will die in the SHU without having meaningful contact with loved ones.

Prisoner #1 [redacted] has been in a SHU since 1986. He was transferred to the SHU at PBSP when it opened. He complains of inattention from medical staff, and he reports that the physician told him if he wants better care he needs to "de-brief" and go to general population. He suffers from severe insomnia. A part of the sleep problem is the noise that occurs throughout the night. The slamming of doors wakes him, and causes anxiety that his door will open and someone will come into his cell and attack him. He feels that he is being given just enough food and water to stay alive, but he is not actually living. He tells me: "I'm locked in a cell, powerless, I have to rely on these people (staff) for everything, and they treat me as less than human. As soon as you realize that this will never end, and that you are stuck being at the mercy of staff who hate you, then you become more depressed, hopeless and angry."

Prisoner #6 [redacted] reports many symptoms that began only since he has been in SHU. He has severe problems with concentration; for example, when he tries to read he forgets what he read a paragraph earlier, so he loses interest in the text and puts the book or newspaper down after reading only a few lines. He used to write things down to compensate for his failing memory, but he has stopped doing that because his eyes are weak (he thinks this is related to his glaucoma) and he cannot see what he is reading. This results in inactivity in his cell, and loss of contact with what is going on in the world. He lays in his bunk quite a lot each day. He also feels he is hyper-aware and has a strong startle reaction, and he experiences visual distortions. He avers wide swings of emotion, anxiety, fantasies of a violent nature, dizziness, low energy and inertia, no interest in any activities, easy crying, blaming himself for things, worrying incessantly, having to do things very slowly to insure correctness, episodes of palpitations, episodes of nausea, and difficulty sleeping. He feels that the officers taunt the prisoners, but he has learned to ignore them. He feels that he closes himself off to

others, stays to himself in his cell while not speaking to others, he feels very lonely and sad, and he is always worried that his resentment will break loose and he will get into trouble.

Prisoner #3 had been in the SHU at PBSP for 20 years at the time of our interview. He began a 15-to-life sentence in 1989. He participated in the hunger strikes in 2011, even though he knew he might die, because he felt hopeless about getting out of SHU and eventually being paroled. He felt that the hunger strike would be a way to change the policies that are currently designed to keep him in SHU until he dies. He does not believe there is any valid evidence he is associated with any gang. The pettiness and unfairness of his continuing validation upset him quite a lot. He reports that as the first few years of a prison sentence go by, you do not see your family, but you can tolerate it because you hope you will eventually be released and go home. He reported that when many years go by and it does not look like you will ever be paroled, and phone contact is not permitted and visits are extremely difficult and rare because of geography and the awful way staff treat visitors, it really gets you down. Several members of his family have passed away since he has been in SHU. He tells me: "Life just slips away." He suffers from many symptoms that are included in the literature on the effects of isolated confinement, including anxiety, problems sleeping, excessive perspiring, deteriorating eyesight, obsessive ruminations, oversensitivity to stimulation, mounting anger, and despair about ever being released from SHU. He reports deteriorating memory and progressively more trouble concentrating on anything. He thinks that thoughts about his son and his family intrude on his concentration, and then he gets sad and cannot continue.

Prisoner #4 had been in SHU for 27 years at the time of our interview. He was transferred to PB SHU close to the time it opened. The symptoms he reports include very negative thinking, severe anxiety, frequent rage, hopelessness and lethargy. He does not initiate conversations, is not motivated to do anything, and feels like he is in a stupor much of the time. He feels lightheaded when he leaves his cell. He becomes confused and disoriented; as he put it, "It's like I'm not really here." He has trouble concentrating on reading a book,

watching television programs and writing a simple letter. When he is transported by staff he becomes irritated, feels lost and becomes numb. He has lost all hope of being released from SHU and has lost interest in everything. He reports: "I wake up every morning consumed with feelings of anger and rage directed at prison staff over my continued isolation, restrictive conditions, and loss of family." He suffers from severe insomnia. He repeatedly wakes and cannot go back to sleep because of the loud opening and shutting of doors, officers stamping along the hallway all night long and pointing their flashlights at his face every few hours for "count." He says he is very depressed most of the time. He tries to suppress his sadness and not let others see it, but then he becomes "blank," out of touch with all feelings. He feels tired all the time. He has trouble reading because he cannot concentrate and cannot remember the previous paragraph or page. As he gets older, health problems multiply, and he is very worried he will not get proper medical care. He dreads getting to a stage where he cannot take care of himself. He is not suicidal, but he feels hopeless about his situation. He does not seek mental health treatment because he believes mental health staff members are uncaring and unhelpful, and besides, he believes a history of mental health treatment has an adverse effect on his chances for parole. Also, he does not believe that contacts with mental health staff are confidential. They interview prisoners at cell-front within earshot of other prisoners and staff, and if they "pull you out" (take you to an office), everyone on the pod knows about it.

Prisoner #11, [redacted] had been in the PB SHU for 15 years at the time of our interview. He believes he will never be granted parole as long as he is in SHU, and that he will never get out of SHU. This causes him to feel hopeless. He believes the main reason for his validation is that he said hello to another prisoner he passed in the hall, but feels this is ridiculous and unfair because he always says hello to everyone. Because he feels the punishments and especially his consignment to SHU are entirely unfair, he cannot trust the authorities or the staff. But since his life is totally controlled by staff and there is nobody else to ask for help, this creates a quandary for him. He has had progressively less contact with family members as the years in SHU have gone by. He suffers many symptoms. He is anxious much of the time, and has intermittent panic attacks where his heart pounds

and he has trouble breathing. He cannot sleep and gets only a few hours sleep per night. He is increasingly out of touch with his feelings. When asked how he feels he responds that he does not feel. He thinks there is no longer any purpose in life. He has severe concentration difficulties, for example he has to read paragraphs over and over in order to understand content. He cannot focus on a topic or a task. It takes an extraordinarily long time for him to write a letter, as his mind simply wanders.

Prisoner #8 [redacted] had been in the SHU for 14 years at the time of his interview. He has not been charged with any violent crimes and has received no gang-related infractions, yet he is validated and repeatedly re-validated as a member [redacted] He refuses, on principle, to “de-brief”. He participated in the 2011 hunger strike because he believes that unless something changes, he will die in the SHU. He participated in the hunger strike in spite of the fact he knew he might die from starvation. Sparse contact with family makes him very sad and lonely. He reports many symptoms that he is certain only commenced after he came to the PB SHU, including memory problems that have worsened over the years along with an inability to concentrate. The exception is his writing, which he does to stay sane. He writes about getting older, dying, his sadness about his older brother dying without his having a chance to see him, among other topics. He believes the long-term effects of SHU consignment include the bags he has under his eyes from chronic and unremitting sleep loss, extreme emotions that range widely through the day, waking up angry every day about the unfairness of it all, deep grief about not raising his son and now having his son go to prison. He avers talking to himself often and worrying that the SHU will drive him mad. He says, "I feel like I am here but not here." He suffers from ongoing severe anxiety. He is hyperaware of others' presence, cannot tolerate anyone standing behind him, and needs to see the hands of anyone he is in contact with. He has frequent flashbacks to cell extractions that happened years ago, not at PBSP. He avers a strong startle reaction. He believes he is phobic. To this day, he needs the door to the shower to remain open when he takes a shower. He becomes hyper-alert when officers approach his cell. He is anxious most of his waking hours, with only a little relief when he exercises or writes. He says, "They try to make you crazy, but I struggle to remain sane." He has

progressively isolated himself over the years in SHU, and meanwhile has found that he is less and less in touch with how he is feeling. He is saddened by the fact it becomes more and more difficult to see himself ever being in the community again.

He feels he almost died during the hunger strike, and tells me that if he died that would be okay with him because living in SHU is not really living at all. He reports being taken off of his heart and blood pressure medications during the hunger strike. He is very close to his family, especially one sister who writes to him and "keeps me going." He was close to his wife at the time he was arrested for the instant offense, but feels his being in the SHU led to their breaking up. They simply could not arrange quality visits and he is not permitted to have phone calls. If he had been in general population, visits and phone calls would have been more realizable and he believes his marriage would have remained intact. He [redacted] takes medications for his heart condition as well as for hypertension. He believes that he has had to learn to suppress his feelings in order to survive in SHU, and that were he to express much in the way of feelings in SHU he would be dead. But then the suppressed feelings come back at him during the night and that is why he cannot sleep. Then, the loss of sleep makes all of the emotional pains and symptoms worse. He does not talk to mental health staff because he finds them uncaring and objects to the lack of confidentiality when officers are permitted to overhear sessions or are told of the prisoners' personal problems.

Prisoner #2 [redacted] entered prison in 1981 and was validated as a member [redacted] in 1985. He believes that he was validated not because of any involvement with the [redacted], but because he was an advocate for peace in the troubled general population of the early 1980s. He has a severe back ailment, for which he feels he receives terrible medical care. He does not utilize mental health services because he believes they are not confidential. He avers loss of ability to feel or react emotionally, very low energy, lack of motivation to do anything, intense distrust of the administration and staff, worry that staff are watching him, self-blame for his situation, ongoing nausea and stomach pain, frequent headaches, and numbness and tingling, among other symptoms. When he complains to staff about anything, they tell him if he does not like

it he should "de-brief." He could not stop crying when his sister died a few years ago. He had not been able to see her. He reported that the separation from loved ones that is part of being in prison is magnified by the lack of phone calls in the SHU and the hardship for family members to travel to see him. Even then, no contact visits are permitted and the permitted visits are short. There are no phone calls. He has great difficulty concentrating on any task, and relates that to the loud noises in the SHU, sleep loss on account of the noise, and the general effects of isolation. He feels he has no ability to share what is on his mind with anyone, and this leads to a further sense of isolation and despair. He spends much of his time reading and writing, and feels that his optimism and continuing attempts to express himself in his writing keep him sane. He suffers from many other symptoms known to be related to long-term isolation, including trouble concentrating, memory impairment, anxiety, mounting anger, ongoing fear his anger will get out of control and he will get in trouble, fears of others attacking him and hyperawareness of sounds plus a strong startle response.

3. More than a decade in SHU results in additional symptoms that go beyond those identified in the literature.

Over the course of these interviews, it became apparent that these prisoners had symptoms and disabilities that emerged only after prolonged SHU confinement, i.e. symptoms that are mostly unique to prisoners who experience SHU confinement lasting many years, where they remain in a cell nearly twenty-four hours per day and are cell-fed, including those who have spent ten years or more in SHU. While they also aver symptoms and disabilities that are widely reported by prisoners in isolated confinement for three months and are reported in the literature, they aver additional symptoms and disabilities that are, for the most part, unique to prisoners who experience SHU confinement for many years or more than ten years.

Over and above the symptoms I have listed thus far, all eleven men still in SHU when I interviewed them report that over the years they have learned to keep quiet about their feelings and not to talk very much to others – neither staff nor other prisoners. They experience quite a lot of anger after being consigned to isolation; they fear the anger will get them into trouble if expressed; so first, they are silent about their

feelings; then they begin to suppress feelings (beginning with anger, but the suppression spreads to all feelings) to the point where they do not even know what they are feeling; and as a result they feel numb or dead. In addition, they have progressively isolated themselves more and more even within the context of SHU confinement. They give various reasons for not talking about much with their neighbors or even a cellmate. Some say it is the fear that someone will get mad at them and then inform on them in the process of "de-briefing". Others report that living so close together makes tempers flare and they would rather not have enemies. Others say that if they give expression to their anger they will lash out at officers and get into even more trouble. Thus, for various reasons, the universal experience of all eleven men I met with in the SHU is that over many years they experience progressively more emotional numbing and greater isolation. Prof. Haney has described the phenomenon as a form of "social death."[35] Meanwhile, most of the prisoners I interviewed report that their despair grew in intensity over the many years of isolated confinement.

In other words, over and above the list of symptoms from the literature about long-term isolated confinement (anxiety, perceptual distortions, mounting anger, insomnia, compulsive acts, hyper-awareness or strong startle reaction, despair, problems concentrating, memory problems and so forth), there evolves over many years a pattern of increasing self-isolation and emotional numbing as well as enlarged despair, such that the prisoner progressively shuts himself off from other human beings and loses touch with his own feelings. These men have also been living with the very serious symptoms and disabilities that I described in Sections VIII.B.1 & 2. When prisoners live with many of these serious symptoms and disabilities, the symptoms and disabilities become chronic and even more damaging. Then, in addition to the problem that they are suffering from these symptoms and disabilities for many years (here, more than ten), they also suffer from an evolving exaggerated isolation and numbing as well as enlarged despair.

As I will discuss below regarding individuals who have been released from SHU, this pattern is very long-lasting. In many, it is seemingly permanent. In that sense, it is

[35] Craig Haney, *Mental Health Issues in Long-Term Solitary & 'Supermax' Confinement*, CRIME & DELINQ., 48(1): 124-156 (2003).

similar to a personality change – that is, a chronic pattern of experience and behavior. Quite a few of the prisoners tell me that they feel their personality has been substantially changed by their years in SHU, and now their personality involves much more isolation-seeking and incapacity to express their emotions. Of course, each experiences this dual development in his own personal way, and so they each express the themes of emotional numbing and progressively more extreme isolation in idiosyncratic fashion.

Prisoners who have been in SHU for ten years or longer suffer from a number of severe symptoms, including disorientation and numbness that derive from the lack of memorable feelings and social interactions. Most report that they feel each day is the same, and they lose all sense of time. Or they simply feel "numb," "dead," or they lack motivation to do anything, even to exercise. As Prisoner #8 put it, "I am so busy suppressing feelings and isolating myself all day, and so much anger builds up in me from the conditions, that I can't sleep at night because the sound of a door opening or closing wakes me and I get anxious about someone coming in on me and I can't fall back to sleep." The lack of sleep exacerbates the irritability and anger, so they feel a need to suppress their feelings all the more and to isolate themselves further.

Thus there is a clear pattern in the stories of all eleven of these men about the psychological consequences of spending a decade or longer in the SHU. That pattern includes, in addition to the many years suffering the symptoms and disabilities I listed in Section VIII.B.1 & 2: Angry feelings about being in segregation for so long, having little or nothing meaningful to do, being deprived of fair due process and being provided no way to win their release from SHU; and the suppression of the rage, which, along with the harsh isolative conditions, leads to a numbing of all feelings so that over the ensuing years and decades the prisoner becomes less in touch with his feelings and less expressive. Meanwhile, concerns about evoking hostility in others, boredom with the monotonous conversations that occur in the SHU, concerns that others will use information they receive to lie about them when they “de-brief”, or cultural alienation cause the prisoners to progressively isolate themselves, even from cellmates and neighbors, but certainly from staff. Thus, they are isolated from family and the outside world because visits, phone calls and mail are so limited, and then they isolate themselves from the people physically nearby. They become increasingly isolated on

all levels. There is a growing feeling that there is no use doing anything, and that nothing will change, so the prisoners shut down to a great extent, become unmotivated to do anything (the memory loss and problems concentrating contribute to this phenomenon), and become listless and lacking in initiative. Some describe this state as depression, some as numbness, some as deadness. It is quite evident to this interviewer that the despair they originally experienced early in their tenure in the SHU grows more intense as the years go by. The prisoners withdraw into themselves, spending endless hours silent and alone, entirely out of touch with how they feel. They get out of practice expressing themselves. They experience intense despair, but for them suicide is not an option. They begin to feel numb, unreal, non-human, or dead. I have conducted upwards of a thousand interviews with prisoners in a variety of correctional settings, and I have never before found a pattern at this level of specificity described universally by a group of similarly situated individuals.

In the medical and psychiatric literature on the consequences of torture, a comparison is often drawn between the consequences of torture and the consequences of severe trauma (including but not limited to Post-traumatic Stress Disorder).[36] What I am describing here is a third entity, the consequences of very long-term solitary confinement as obtained in the PB SHU when prisoners remain there for over a decade. What we find is men who are a shell of their former selves, passionless and isolated. They are very disabled, but their disability is not readily apparent because, after all, they live in a cell and meals are delivered to them by staff. All 11 of the men I interviewed at the PB SHU (and all of the additional 13 men I interviewed in other settings) exhibit almost all of the characteristics that are described in the literature about survivors of torture. For example, Rona Field's list of psychological consequences of torture include, besides suicide and psychiatric breakdown requiring hospitalization (which are not the case for these men), anxiety, fear, depression, irritability, introversion, difficulties in concentration, chronic fatigue, lethargy, restlessness, communication difficulties, especially expressing emotion, memory and concentration loss, loss of sense of identity, insomnia, nightmares, hallucinations, visual disturbances, and

[36] David P. Eisenman, Allen S. Keller & Glen Kim, *Survivors of Torture in a General Medical Setting*, WEST J. MED, 172(5), 301-304 (2000).

headaches.[37] This is precisely the list of symptoms and experiences the twelve men I interviewed in SHU report.

These symptoms were reported by all 24 prisoners and ex-prisoners I interviewed, whether they were still confined in a SHU, had been transferred to a different prison setting, or had been released to the community. All these prisoners spent at least a decade in the SHU. It is quite stunning how all 24 of the men I interviewed averred having experienced the same tendency to suppress their anger and become numb (or feel "dead") in the process, and the same tendency to isolate themselves even further than the architecture and program of the SHU required. In other words, emotional numbing and self-isolation are universally reported by prisoners who spend significant time in the SHU. It is difficult to say precisely when the exaggerated self-isolation and numbing evolved. There are individual differences. What is very clear is that prisoners who have spent ten years or longer at the PB SHU present a qualitatively different picture of symptoms and disabilities than do individuals who have been in isolated confinement for much shorter periods, and the difference is encapsulated in my description of the exaggerated isolation, numbing and despair, as described above and in Section B4 below.

4. Description: Prisoners' reports of additional symptoms of self-isolation, emotional numbing and enlarged despair.

Prisoner #11, the man who had been in the PB SHU for 15 years when interviewed, gets angry about the awful deprivations and conditions, the unfairness of being in SHU so long when he did not do anything to deserve it, and the lack of recourse to have anything changed. But as much as the anger mounts, so does his fear he will "go off" again and do something dangerous. So he suppresses his anger, and that makes him entirely out of touch with all feelings. He becomes numb and listless much of the time, unmotivated to do anything. When asked how spending many years in SHU is different than spending a year or two, he says that he has progressively kept to himself more and more. He has been closing down his emotions and stopped

[37] Rona Fields, *The Neurobiological Consequences of Psychological Torture,* in The Trauma of Psychological Torture, 1555, (Almerindo E. Ojeda ed., 2008)

talking to others, even to his cellmate and prisoners in neighboring cells. He does not talk to anyone about personal things.

Prisoner #9 admits that in order to keep his anger suppressed so he will not get into trouble, he has to isolate himself from others so there will be no opportunity for him to express anger. When he gets angry, which occurs frequently (although he was not an angry person before being in SHU), he does not talk to anyone for several days until his anger cools down. But meanwhile, he feels very isolated and out of touch with all of his feelings. He sees others lash out and get in trouble. Again, his attempts to suppress his feelings lead to his self-isolation, and then he feels even more out of touch with his feelings, alone and lonely. In other words, this is a poignant personal description of what Haney terms "social death."[38] He does not want to deal with his feelings, so he becomes numb. He falls into a state of dampened emotions and little energy to do anything. Meanwhile he isolates himself from others so as not to get into any disputes or lose his temper.

For Prisoner #10, more worrisome than his anxiety, problems concentrating and intense startle reaction, is a total loss of the capacity to feel. He says he does not feel anything, and this makes him "feel dead." Days go by without him feeling anything, "as if I am walking dead." He keeps most of his thoughts to himself and says very little to other prisoners and to staff. He is afraid of sharing what he is feeling and then finding that others attack him because they disagree. He says, "You never want to say what you really feel because others will think there's something wrong with you." On account of such concerns, he ends up saying very little to others, and it frightens him when that leads to his losing touch with his feelings altogether. Increasingly he avoids talking to prisoners on his pod because he does not want anyone he is going to be forced to live closely with to get upset at him. The numbing and isolation have been building over the years he has been in SHU.

Prisoner #5, [redacted] tells me "you need to be careful what you say in here. You have to withdraw, I go silent, everyone understands silence in here." He avers working hard to suppress his mounting anger, and then

[38] Craig Haney, *Mental Health Issues in Long-Term Solitary & 'Supermax' Confinement*, CRIME & DELINQ., 48(1): 124-156 (2003).

suppressing other feelings as well, then he loses touch with what he is feeling. “I don’t want to let out what builds up in me, so I shut down completely.”

Prisoner #2 tells me he has become increasingly isolated from others as the years in SHU have progressed. He also feels one has to be careful about speaking to staff and other prisoners because harm can come from saying the wrong thing or telling something to the wrong person. So he, like others in the SHU, becomes progressively more isolated and has ever fewer opportunities to share thoughts and feelings with others. As a result, he becomes less aware of how he is feeling and less capable of expressing himself. He feels extremely cut off from family, partly because phone calls are not permitted, but also he believes staff tamper with his mail, destroying many letters so he never receives them. As the years in SHU have progressed, he has become increasingly out of touch with his feelings, and increasingly isolated, so he feels his growth has been stunted. Since he will not participate in "de-briefing" (because he is opposed to the informant system and fears retaliation toward his family), he sees no way for himself to ever leave the SHU. He believes one cannot be paroled out of the SHU. This causes great despair. He feels increasingly isolated. With contact restricted so harshly with his family, he has nobody to talk to. He stops trying even to write letters and becomes overwhelmed by sadness. He has received a 128 (minor disciplinary write-up) for saying “hi” to a prisoner in the next pod as they passed each other. So, in order to avoid disciplinary trouble, he simply does not talk to other prisoners. He is not given access to the evidence that results in his validation, and has no opportunity to dispute the charges against him. He believes that the entire process is unfair, and the unfairness and lack of justice make it much more difficult to tolerate the harsh deprivations. He has to clamp down on his mounting anger and not show it or he will get in trouble. Increasingly he keeps all his feelings to himself, and even stops knowing what he is feeling.

Prisoner #1 has been in a SHU since 1986, or 26 years. He is serving 21 years to life, and has been eligible for parole since 2004. He was transferred to the SHU at PBSP when it opened. He feels that as time passes, conversations become trivial. Nobody wants to say too much to the others because they are afraid something they say will evoke anger and then they will be stuck on a pod with someone who is mad at

them, or someone will "de-brief" and use information they shared to falsely accuse them of gang affiliation. Then the trivial conversations suppress one's intellect, and halt personal growth. Besides, he reports, 99% of one's verbal contact with other prisoners involves disembodied voices (i.e. they cannot see each other from their cells; they can only see the far blank wall). When they do see one another, for example when one of them is in transit to the "yard" and passes in front of another's cell, he gets very anxious because the experience of face-to-face contact has become so unfamiliar. This phenomenon worsens over time, and he finds he has given up trying to talk. He feels he is becoming silent and paralyzed. He has found himself increasingly out of touch with his feelings and severely isolated from others.

Prisoner #7 reports that the unfairness and absurdity of the entire validation and parole process make him very angry, and very hopeless about ever getting out of SHU. He says, "I struggle to control my emotions, my mother taught me to control my emotions." But he feels that over-control is bad for his medical condition, for example his blood pressure. He believes that suppressing anger or keeping it to himself causes a rise in blood pressure. So he is caught between his need to control his anger toward staff, which could get him in trouble, and his need to give expression to his emotions so he will not worsen the hypertension. He opts in the SHU to over-control his anger and other emotions to avoid trouble. He has learned over the years to suppress his anger, but to do so he has had to suppress all feelings to the point where he does not any longer know what he is feeling. He says that he does not want to let himself succumb to feelings. If he did, he is afraid he would cry relentlessly and roll up into a ball in the corner of his cell.

Prisoner #12, [redacted] has been in prison over half his life, and has spent much more than ten years in the PB SHU. He explained his tendency to isolate: “Not everyone is on your level of understanding, so you don’t want to let anyone see you’re angry. It might stir them up, so you withdraw and become silent.” He doesn’t feel he has totally lost touch with his feelings. It is just a matter of having to hold back his feelings around volatile people. He prides himself on his skill at not stirring people up. He is always very cautious around other prisoners, which causes him to isolate himself even more than what’s required by the isolative

conditions in SHU. He absolutely refuses to inform to staff about anybody or anything, as a matter of principle, and this makes him keep his conversations with staff to a minimum. So progressively, over the years, he has become isolated on all fronts.

C. Prisoners Who Were Released from PB SHU.

1. These interviews reveal a SHU Post-Release Syndrome

Whether they had been released to a general population or stepdown unit within the CDCR or back to the community, all of the prisoners I interviewed who had spent over ten years in the PB SHU and were no longer in the SHU reported they had experienced the same set of symptoms and problems that the 11 prisoners who were in the SHU at the time of our interviews reported to me. (See Section B, above.) They reported the same symptoms that fill the literature about long-term isolated confinement, including intense anxiety, disordered thinking and paranoia, problems concentrating, problems with memory, compulsive acts, despair, suicidal thoughts or actions, severe insomnia, nightmares, and so forth. Like the 11 prisoners who were in the SHU when I interviewed them, they also reported their prior tendency while in SHU to numb their feelings and isolate themselves even more than SHU confinement required, and their mounting despair.

In addition, however, the group of prisoners who spent a decade in the SHU but are now in a different environment, whether in the prison system or in the community, evidenced further symptoms and problems that emerged only after they were transferred out of the SHU. Their experience demonstrates that human beings survive in an isolative setting like the PB SHU, where they are alone in a cell nearly 24 hours per day and mostly idle, by shutting down emotionally and isolating themselves in exaggerated fashion, but that when they are released from SHU, the measures they took to survive within the SHU setting become detrimental and disabling in their efforts to become productive participants in the larger community.

I will begin with the report of one ex-prisoner, Prisoner #13, to illustrate the general pattern. Then I will describe the pattern. Finally, in Sections VIII.C.2 & 3, below, I will provide other prisoners' and ex-prisoners' specific reports of the problems they encountered after leaving the SHU, and in most cases, right up to the present.

In terms of reports about what it was like to be in SHU, Prisoner #13 (a [redacted] man released nine months earlier to the community where he now lives with his wife), reported on his experience while in the SHU:

> I got less social over the years. It just started happening. Nobody talks to you. There's not much to talk about. I'd ask 'how are you doing.' I saw myself changing, I didn't really want to talk. My social skills deteriorated. Slowly, with my wife's help, I am trying to talk. But mostly I don't say much. You stop talking because you've already heard everyone's stories. I didn't have anything to say. As the years go by, you are disintegrating. You don't even know what's happening. You might say 'good morning,' or you might not. There's nothing more to say. I kept saying 'good morning,' but some people stopped talking altogether. I was also afraid anything I said could be used against me in committee. They would find a drawing in my cell. I wasn't gang-related, but I drew images from the Mexican flag. I was always scared they'd say that's proof I was in a gang….. In SHU, when I got agitated, angry, I would exercise hard to keep from expressing anger and getting in trouble, so I would exercise to exhaustion. Gradually I lost touch with all feelings. You feel dead, you are dead to society, to the mainline. If you don't keep your mind occupied, you lose it. You see guys going crazy. So you clamp down on your feelings, don't talk much, and then you lose touch with what you're feeling.

It is stunning how, without exception, all of the prisoners who were no longer in SHU when I interviewed them echoed the very symptoms from their time in the SHU that the 11 men I interviewed in SHU had reported. In other words, they report that when they were in the SHU they experienced many of the short term symptoms and disabilities I have previously discussed (Section VII), as well as the self-isolation, despair and numbing symptoms that go beyond those experienced by prisoners who spend less time in the SHU and that appear in the literature (Section VIII.B.3 & 4). However, in addition, over and above these symptoms and disabilities, Prisoner #13 explained what it is like to be released into the community:

> They left me off in downtown [redacted]. I got out with no money and started walking. I waited for a ride, needed a pay phone to call my wife. I kept trying to get on my feet, get my mind back to normal. My mind is still not normal because in the SHU I started thinking I'd never get out, especially when I was denied at six year reviews. When I [first] went to the street, it was really weird. I felt all caved in. I always wanted to be in my room and sit. I did not want to go out of

> the house. I would stay in my room 4 or 5 hours. I had TV and music in my room. I didn't like going to the store – too many people. I wasn't used to being with people. I'm always hyperaware, I won't let anyone touch me. It's not easy. It's like coming out of the insane asylum. Now it's been 9 months, I still spend a lot of time in my room, that's where I'm most comfortable. I can go to the mini-market, but I can't go to the supermarket. Sometimes my wife talks me into going to a park or karaoke bar. When I got out, a lot of people came for interviews. I drank beer to relax. It's really difficult to go to new places.

Prisoner #13's report is very similar to the report of all the men I interviewed who had been released from the SHU and were either transferred to another prison setting or released from prison to the community. Their experiences amount to a syndrome that is characterized by the following symptoms:[39]

- Disorientation immediately following release.
- Anxiety in unfamiliar places and with unfamiliar people, and the daily life events that had been ordinary prior to SHU confinement become unfamiliar events following release from SHU.
- A tendency to retreat into a circumscribed, small space, often a bedroom or cell.
- A tendency to greatly limit the number of people one interacts with, usually limited to close family members and a few friends.
- Hyperawareness of surroundings, for example a need to sit facing the door to a room or with one's back to a wall.
- Heightened suspicion of everyone who comes close, especially strangers.
- Difficulty expressing feelings.
- Difficulty trusting others, even one's spouse or first degree relative.

[39] A "syndrome" is "a set of symptoms occurring together; the sum of signs of any morbid state; a symptom complex (see http://medical-dictionary.thefreedictionary.com/syndrome). My description here of a SHU Post-Release Syndrome is new; I am describing a syndrome that has not been identified in the literature about the effects of isolative confinement because there has been so little attention in the past to the post-release course of individuals confined for significant periods in harsh isolative conditions. The work of Profs. David Lovell, Craig Haney and the Arizona AFSC (op. cit.) provided some preliminary discussion of a SHU Post-Release Syndrome, but those authors did not use the term "syndrome" in their discussions.

- Problems with concentration and memory, beginning in the period of SHU confinement and continuing after release, making it difficult to accomplish tasks and to work.
- A sense of one's personality having changed. The most often reported form of this change is a change from a relatively outgoing, friendly individual with a sense of humor prior to SHU confinement, to a more serious, guarded, and inward individual following release from the SHU.
- In some but certainly not all cases, there is a tendency to resort to alcohol and illicit substances to lessen the pain and make the confusion and anxiety more bearable.

All of these problems are experienced intensely for many months after release from SHU, but then the problems continue in less intense fashion, most often right up to the present, which might be years later. This set of psychologically harmful experiences occurs in both prison and community post-SHU settings. It does not seem to matter whether the prisoner is released to the community or simply transferred to a general population prison within the CDCR.

This syndrome shares many characteristic symptoms and problems with PTSD (Post-traumatic Stress Disorder). Some of the men I interviewed do qualify for a diagnosis of PTSD (indeed, Prisoner #15 receives S.S.I. total disability for PTSD). Others have suffered multiple traumas, but their post-traumatic symptoms are not sufficiently intense and disabling to qualify them for a diagnosis of PTSD. But the diagnosis is, to a certain extent, beside the point. The picture we see in PTSD is a person who has been traumatized and then has strong emotional reactions to the trauma, but works hard at suppressing the resulting feelings and agitation. He or she isolates him- or herself, dreading social interactions, and tends to suppress feelings. Then, unwanted and dysfunctional feelings break through the individual's attempts to suppress all feelings, and erupt in irrational rageful acts or inappropriate outbursts. The reclusive Vietnam veteran who one day comes out of the house where he had been secluding himself and goes on a violent rampage is the tragic exemplar of this pattern. I do not find that the plaintiffs all suffer from PTSD, nor that confinement in SHU in itself constitutes trauma. Rather, I mention the example of the Vietnam veteran with PTSD

as a model of how certain individuals, on account of very stressful experiences, work hard at suppressing their feelings and isolating themselves. Occasionally their suppressed rage or their profound grief breaks loose and they have an emotional episode that is very upsetting to them and those close to them.

I will give examples from interviews I conducted with prisoners who leave SHU after approximately ten years or longer and go to general population (Section VIII.C.2, below), and prisoners who leave SHU and return to the community (Section VIII.C.3, below). All prisoners who have been released from SHU, to either setting, report a syndrome of very disturbing sensory and emotional experiences for months, including a strong startle reaction with loud sounds, feeling overwhelmed by lights and people moving about, feeling paranoid that someone will attack them, feeling hesitant to talk to and trust others, and so forth. A lot of these symptoms wane somewhat (never entirely) and these individuals move into a longer-term syndrome of relative isolation and numbness that they tell me they fear is permanent.

2. Description: Reports of former PB SHU prisoners released to other prison settings

Prisoner #13, in his recounting of experiences at California Correctional Institution at Tehachapi (Tehachapi) after being released from SHU to general population, identified themes that emerged in all the other prisoners I interviewed who had been released from SHU to an in-prison stepdown program or general population setting (see Section VIII.C.1, above). In fact, all of the prisoners I interviewed who had been released from SHU but remain in prison aver over half of the component symptoms and problems I have identified as the SHU Post-Release Syndrome. The difference between their reports of the syndrome and reports from prisoners who were released to the community (see Section VIII.C.3, below) is that the elements of the syndrome occur in a prison context. Thus, for example, the prisoner who left SHU but remains in a general population prison setting reports staying in his cell by himself to the extent he is permitted to do so, much like the ex-prisoner who returned home and lives in the community with family reports staying in his room by himself for many hours at a time.

Many symptoms and disabilities I have mentioned that originated during a SHU term are reported by very many of the prisoners I interviewed, including those who had been released from SHU and transferred to general population settings. For example, consider the paranoia that is widely reported by denizens of isolated confinement units including the SHU at PBSP. Prisoner #9, another man I interviewed while he was still confined at PB SHU (see Sections VIII.B.2 & 4, above), was at Substance Abuse Treatment Facility (SATF) adjacent to Corcoran State Prison when I interviewed him again. He had been transferred to SATF from PB SHU on Step 5 of the Step Down Program, but has graduated from the program and is now in General Population at this Maximum Security facility. Despite this change in his status, he remains in the same general population cell. He reports being very slow to mix with other prisoners when he was released from SHU. He tells me that in the SHU, a prisoner is locked into the shower and thus not subject to attack, but in a general population prison multiple prisoners go to the shower at once and the door is unlocked, so there is a certain danger of assault. Prisoner #9 worries that he might be paranoid, thinking whenever he goes to the group shower in general population that he is in danger of attack. He cannot determine if his fear of attack is paranoid, or whether it is a reality-based concern and he does need to be alert to signs of impending attacks in the shower. In my opinion, his fear is a combination of the two: there is a certain danger of attack in a maximum security group shower area, but he also is inclined to “ideas of reference” (a technical term for paranoid thinking), and the ideas of reference were caused by the many years he spent in the SHU.

Prisoner #9 was very anxious about that for some months after arriving at SATF. He continues to look around all the time to be certain he is not about to be assaulted. He feels he obsesses about his safety quite a lot, in ways he never did before his long stint in SHU. In the SHU, he explained, if your cell door opened when it was not supposed to be open, you always had to be ready to defend yourself: it likely meant another prisoner had arranged to have your door “popped” and was about to enter and assault you. He knows this is irrational most of the time, but he is always hyperaware of doors opening and closing at SATF. When a door opens, he has a flash of panic that he is subject to an assault. He gets very anxious whenever another prisoner comes

toward him, and explains that he never felt that in general population prior to going to SHU. He feels he became quite paranoid in the SHU, and his hyperawareness of others in his vicinity seems to him a remnant of that paranoia, though he reports it diminished quite a lot after he was at SATF for several months. He states, "I was like a hermit at Pelican Bay. Here I am adjusting to being with other prisoners, and I come out of my cell a lot." Most of the 24 prisoners I interviewed reported, or seemed on mental status examination to experience, some degree of paranoid ideation that reflected a combination of reality-based concerns and distorted ideas of reference that began during their tenure in the SHU. Prisoner #9 also avers carving out a very small space in the dayroom or yard at SATF when he first arrived at SATF and for several months. Except for the hours he worked in his prison job as a clerk at SATF, he would try to stay in his cell or only be in that particular space with other prisoners he knew. That tendency remains, but is much less intense.

Prisoner #7, [redacted] man who had been one of the original twelve prisoners I interviewed at the PB SHU, was subsequently transferred to Maximum Security General Population at CSP-Sacramento on [redacted] I interviewed him on September 28, 2014. He told me that he is no longer in SHU, this means that he is permitted out of his cell to go to the yard for 1½ hours per day. He appears depressed and lethargic, and tells me he is exhausted all the time. When he first came to the yard at CSP-Sacramento, he became dizzy, he thinks because he was overwhelmed by stimuli and people all around. He found the noise oppressive, and jumped whenever he heard a noise. He was "jumpy" for 30 days. Since then he has felt a strong startle response but it has not been as extreme. He is nervous all the time. As a result, he greatly circumscribes his activities, such as his travel around the day room and yard, and he relates only to a very few prisoners whom he knows and trusts somewhat. Since his release from SHU, his mind has been racing and he has felt very anxious. He is constantly obsessing about what any sound or sight might mean. He has trouble processing stimulation, so much so that he forced himself to stop trying to make sense of it all. Rather, he stays to himself and to the very small space he has permitted himself to be in, with the very few people he feels safe with. This means that his activities during his free time are very constricted and limited. Visits are somewhat

easier now that he is in a prison near Sacramento (his family is in Southern California, so travel to Pelican Bay State Prison was very problematic), but when his daughter comes to see him he is unable to be in touch with his feelings. He cannot cry with her, he feels very cut off and it is a difficult struggle for him to sustain a conversation. He continues to experience many of the problems that plagued him in SHU, feeling anxious, unable to concentrate, difficulty sleeping, unable to trust others, isolating himself, and so forth.

Again, as with the prisoners I interviewed who had been released from SHU and returned to the community, all nine[40] of the prisoners I interviewed who had been transferred from the PB SHU to general population in a facility within the CDCR averred a large number of the symptoms typically reported in prisoners consigned to long-term isolation (Section VIII.B.1 & 2, above); and all of them reported incrementally more severe isolation, emotional numbing and despair as the years wore on for them in the PB SHU (Section VIII B.3 & 4, above).

Prisoner #19, [redacted], spent a total of 18 years in the PB SHU. He was released in [redacted] to Step 5 of the Step Down Program, and after a year his status changed to general population, even though he remained in the same cell he had been in while on Step 5. He has been in prison since 1981. He told me: "When you first get out you're happy to be free, you enjoy inhaling air that's not in a concrete bunker; but soon all the difficult feelings hit you, the ones you'd been stuffing down while in the SHU." He always believed that his validation was wrong and unfair -- the evidence was hearsay from other prisoners who wanted to get themselves removed from SHU. Staff repeatedly told him that that does not matter; if he wants to get out of SHU he has to "de-brief". He told me: "Growing up I was taught not to inform on other people, so I wasn't going to do that." But the unfairness of his wrongful consignment to SHU weighed on him. He was very resentful all the time, and this made him irritable and made it more difficult for him to tolerate arbitrary, unfair and abusive treatment by officers. He reports that he suffered from hypertension while in the PB SHU, but since he has been at SATF his blood pressure has returned to normal. He continues to feel "very stressed" and is convinced that going to work in his job as a janitor at SATF helps

[40] Prisoners #7, #9 and Prisoners #18-24.

relieve the stress. He reports there was a feeling of unreality when he first arrived at SATF from the PB SHU. He was very happy to be out of the SHU, but for months after arriving at SATF he tended to isolate himself, choosing to stay in his cell as much as possible or in a familiar place he had staked out for himself in the dayroom. During his first few months at SATF, he experienced a very strong startle reaction, was very wary of anyone entering his space or vicinity, did not trust anyone, and was unable to share his feelings. He felt out of touch with his feelings to the extent of feeling not really alive. These problems have dwindled to a certain extent in the year and a half he has been at SATF, but are still with him as he tries consciously to remain open to new experiences and grow.

Prisoner #20, [redacted] avers a continuing tendency to isolate himself that he first noticed while in the PB SHU, but he feels he brought that problem with him to SATF. In fact, over a year after arriving at SATF, he is still very anxious in the shower: "In the SHU, you were locked into the shower alone; here there are a bunch of guys in there and you are vulnerable to attack." He reports being hyperaware of all the people in the area where he is located, and having a strong startle reaction. He describes himself as paranoid, he has a very hard time concentrating on almost any task, and he has a very hard time trusting others and letting them know what he is feeling. He is married, but says that he has trouble sharing his feelings with his wife: "I'm used to talking in the negative, about dangers lurking or people betraying me; I have to learn to talk about positive stuff. I have to learn to open up, trust my wife, and share my feelings. It's very difficult after all those years in SHU."

Prisoner #21, [redacted] was transferred to SATF from the PB SHU in [redacted] after 23 years in SHU. He described his experience in SHU becoming progressively more isolative and numbing his feelings, stating: "you had to, to survive in there." He explains that it is much better being at SATF, but he continues to isolate himself, and has a lot of trouble trusting others. He too has a very strong startle reaction.

His paranoia diminished over several months. He thinks having a job and being with other prisoners who had shared his experience in the PB SHU helped him to adjust to being in general population. He believes he has adjusted well to being in general

population. He did experience for several months when he arrived at SATF, along with quite a lot of startle reaction, paranoia, anxiety (especially when someone approached or touched him, or when he had to leave his familiar small area and move out to another section of the yard or the prison), irritability, angry outbursts that he struggled hard to suppress, problems trusting people, problems sharing his feelings with others, severe sleep problems, social isolation, and emotional numbing. He believes that all of those symptoms diminished quite a bit after several months at SATF, although all of them remain with him in much diminished form. He has a girlfriend, and now that he is in general population they have contact visits. But he feels that he is unable to share a lot of his feelings and inner experience with her – he is certain that is a result of all those years of isolation and emotional numbing while in the PB SHU. He is working very hard on opening up more with her. He thinks that SATF is a relatively small, familiar place, and the real test of his ability to adjust to current conditions and maintain a normal comfort level will come when he leaves prison altogether and re-enters the much larger and more stimulating world of the community. He is nervous about that eventuality. He reports significant hypertension while in SHU, and his blood pressure is much lower now that he is at SATF.

Prisoner #22, [redacted] spent 18 years in the PB SHU, said he felt weird and frightened when they took his handcuffs off and he was surrounded by people (both other prisoners and staff). He remembers a very strong need to stay to himself and avoid other people, which went on for many months. Gradually he started to be more friendly, but over a year after arriving at SATF, he still picks a small area of the dayroom that is his area to "hang out," and he does not go anywhere where there are more than a few people nearby. He feels he learned in SHU to be indifferent to the world and to stop interacting with other people. He avers a strong startle reaction. He is hypervigilant. He plans carefully how to respond if someone enters his area. He pays very intense attention to everything he hears within his earshot, wanting to be ready to defend himself if violence erupts. He feels he remains paranoid about the intentions of others – something he learned in SHU – and he finds it very difficult to trust anyone and let them get close. He tells me, "You normalize yourself to a kind of deadness, it starts to seem normal." Though he is very

glad to be out of SHU and tries very hard to succeed in his efforts to improve himself, that sense of deadness as normal continues to plague him.

Prisoner #23 [redacted] was in and out of the PB SHU three times, spending a total of 19 years there. When he first exited the SHU and transferred to SATF, he stayed in his cell or a small space on the yard or dayroom, and only related to a few other prisoners he already knew. He also experiences a strong startle response with hyperawareness of all others nearby. He had a huge amount of trouble trusting anyone and letting anyone get close. He experienced a great amount of anxiety and felt numb a lot of the time. All of these problems waned in degree after several months, but all remain with him. He has a great deal of trouble expressing his feelings to his girlfriend who comes to visit because he learned in SHU to suppress his feelings and share them with nobody.

Prisoner #24, [redacted] spent a total of 19 years in the PB SHU, tells me he is still not comfortable with people a year and a half after arriving at SATF and being in general population again. He states, "I am only comfortable when I am back in my house [his cell]. I get real nervous in open spaces like the dayroom or the yard, it's like a life sentence of isolation." He avers intense anxiety, severe insomnia, a strong startle reaction, panic attacks when strangers come close, problems with memory and concentration that interfere with reading and task completion, and great difficulty sharing his feelings with anyone. All of these symptoms began for him while he was in the PB SHU, worsened over the years in SHU, were very severe when he first arrived at SATF and for several months, and have waned a little since but remain very problematic. He tells me that when he knows he has to come out of his cell to use the phone or take a shower, he gets very anxious. He is very uncomfortable having people near. He fakes being friendly so he can make friends, but he says he never really lets anyone get close. He tells me, "The inside of my cell is the only place where I feel safe."

It is quite stunning how one hundred percent of the prisoners I interviewed who had been in the PB SHU and are now in general population settings reported many of the components of the SHU Post-Release Syndrome I have described, citing examples relevant to their continuing experience in prison. Again, all of these prisoners reported a

long list of the symptoms and problems that I described in Section VIII.B.1. Very much like the 12 prisoners I interviewed while they remained in SHU, they also describe suppressing their feelings and isolating themselves to survive and stay out of trouble while they existed in a cell and were cell-fed. And again, like those who returned to the community, the same behaviors that were functional in the SHU became disabling (i.e. their isolation and numbness), and they each evidence many of the problems I listed above as components of the SHU Post-Release Syndrome. They are severely damaged. Their quality of life is significantly compromised (e.g. they are not able to work up to their potential, they are relatively incapable of relaxing and enjoying social events and their primary intimacies are very problematic). The effects of their SHU confinement are relatively long-lasting if not permanent. One of the men I interviewed at SATF (Prisoner #9) shared his concern that, while he is doing relatively well adjusting to general population conditions at SATF (which is a very sheltered and contained place), he is quite worried that, when he is eventually released from prison, the relatively intense stimulation and unfamiliarity of community surroundings will cause him to have even greater problems adjusting.

3. Description: Reports of former PB SHU prisoners now in the community.

The SHU Post-Release Syndrome plays out in very particular ways when the individual is released from prison at the same time, or some time, after being released from SHU. The details of how various symptoms are experienced is different for each individual, but the general pattern or syndrome is quite clear in reports from all the individuals I interviewed. If a prisoner is housed in SHU at the time he is released from prison, he leaves prison straight out of the SHU. Prisoners call this juxtaposition of release from SHU and release from prison, "maxing out of the SHU." The prisoners I interviewed who had been released directly from SHU describe a very difficult adjustment in the community.

Prisoner #15, [redacted] was released from the PB SHU into general population, and later was released from

prison to return to the community. He describes what it was like for him to be transferred from SHU to a general population prison:

> I spent 9 years in [PB SHU], 1992 to 2000. During that time, I was 'validated,' but not 'active.' Then I got transferred to general population at Tehachapi. It was traumatic. When I got out of SHU, it was like I was brought back to civilization. I found myself caught up in a desperate reconnection with grass on the yard, and I was still hearing voices from SHU and the slamming of SHU doors, and I could appreciate seeing a bird. [He cries as he recalls the moment.] I didn't know how to act. I celled with one other guy; I went everywhere with him. I was trying very hard to figure out how to function normally. The SHU environment created a military type exterior: you had to be military to survive Pelican Bay SHU. Then I had to work on changing that exterior. I worked on not being paranoid [he reports he was paranoid in SHU, always felt under military attack]. I exercised like a soldier. In SHU, I had exercised compulsively to survive the SHU coldness. I tried to create life where it all felt totally dead. Then, when I got out, I continued the exercise to keep my feelings in check. I did this with no CDCR program in place to help us adjust. Like they said, 'You have to recover from that isolation on your own.' No therapy, no de-briefing. I probably could have gotten therapy if I'd asked for it, but I did not understand the trauma of SHU and why the need for therapy. All of my reactions were like someone who had been under attack. I didn't trust anyone. When I was released from [PB SHU] to Tehachapi general population, I immediately got involved in securing whatever substance I could. Pruno, pills, marijuana. I isolated myself at Tehachapi, would not go near a crowd. I even created a space on the big yard that approximated the space in a SHU yard. I didn't do any programs, because I was isolating myself. I didn't know why I felt I had to do that.

Eventually Prisoner #15 was released from prison and he now resides in the community. He provided me with an account of what happened after he was released from prison:

> When I got out of prison, I did everything I could to escape into euphoria. I isolated myself, I surrendered myself to drug abuse. I had several relapses. I was in and out of drug treatment. Now I've been clean and sober for 3 years, seven months. I've experienced a lot of hallucinations and delusions. The voices and delusions only happened after I left SHU. In SHU I had been hearing [only] echoing sounds. The first time they became voices and paranoia was after I left SHU in 2000. The hallucinations and delusions are always there. I still hear the kind of yelling and screaming that I was exposed to in

> the SHU. It seems like there is always someone having a mental breakdown. In Tehachapi [he was in and out of SHU at Tehachapi for short periods], I was always hearing screams of mentally ill in the SHU, and the door slamming. That door-closing sound is something that might not have bothered me in SHU, but then when I was in general population and heard a loud noise, I would jump. Then when I was released, I brought that same behavior to the streets. It interferes with every aspect of my life. Still today, if a car backfires, I jump, I'm getting prepared for combat. My heart races. I have flashbacks, always to SHU. I lay in bed now, alone in a room, wanting to urinate, it reminds me of laying in SHU watching TV from bed. I often feel like I am actually back there.

The SHU Post-Release Syndrome did not abate for Prisoner #15 when he left prison. He reports continuing SHU-induced symptoms in the community:

> I can't function in a relationship. I can't function in them because I always find a need for compatibility equivalent to having a cellie. A cellie would leave me alone in the isolation I'd become accustomed with. In SHU, I was totally detached from my feelings, I knew of the harsh environment, but refused to be sensitive, refused to cry. But since I've been out here, all of those feelings are released. I cry almost abnormally [he cries as he talks]. I came out of the SHU numb. In general population [where he was for awhile before being released from prison] I didn't allow myself to feel, but after I got out of prison, I slowly reclaimed my feelings. I had several relationships, but I couldn't break down the hard exterior from SHU.

Prisoner #14, [redacted] with his wife, was released from prison after 19 years, ten of them spent in PB SHU. He reports:

> I lost the ability to feel. I started feeling I was callous. Nothing good ever happens in SHU. I tried to hold back the anger so I wouldn't get in trouble. I'm not a disrespectful person, but I was always afraid I would badmouth a cop, so I never let them know anything was bothering me. Holding back anger leads to bottling up other feelings. The problem I have now is not feeling things now. I don't want my girlfriend to see the angry side of me. I'm just trying to do whatever 'normal' is. I try to get along, I'm not critical of other people.
>
> I don't get out a lot. I won't leave the house today. I see people, but I don't go out to dinner with anyone. In SHU I talked to neighbors. And I could hear guys in cells down the pod. I didn't isolate myself, but I saw plenty of other guys who would not talk to anyone, and I saw lots of guys deteriorate over time and go mad or isolate

> [themselves]. Part of it is they don't want to get in trouble with other guys. When you isolate, you lose coherence or sanity. I did try hard to keep my anger in check, but then that made me stop being in touch with my feelings altogether. I developed a 'who cares' attitude.
>
> My girlfriend says people are surprised how healthy I seem. But I'm always feeling inferior inside, I only 'looks normal.' I have flashbacks. Something triggers them. Maybe I feel suddenly boxed in, for example at the mall. Somehow when I'm there, I get a picture in my head of a prison setting. My girlfriend says I stare at someone and that's inappropriate. I'm always hyperaware of my surroundings. I get on guard if I see black guys around me. I stay away from crowds and cops. I try to avoid police. I'm afraid the police will harass me on account of my record, but they also just remind me of SHU and guards. SHU makes you feel you're not normal. It's not normal living in a box. I feel very bad about myself that I haven't done anything productive for all those years.

Prisoner #16, [redacted] lives [redacted] with his family. He is single and does not work. He was released from prison in 2004 after serving ten years, 9½ of them in SHU (one at Corcoran and eight at PB SHU). His sentence followed conviction for drug possession. After a relatively short time in general population at a lower security prison, he was validated as a gang member, based, according to him, on staff finding drawings in his locker that were gang-related. He was not charged with nor convicted of any illegal activities that would lead to his consignment to SHU. He was released from prison straight out of the SHU. He has four children and is currently single. He craves being alone, a craving that has been exacerbated by his long stint in solitary. He admits he tends to isolate himself, and that is very unlike how he was prior to serving those years in SHU.

He believes his personality changed in the SHU: he became more distrustful, even paranoid, and isolates himself. These tendencies have been present ever since he was released from the SHU. He remembers isolating himself in the SHU, even beyond the way the prisoners were isolated by the architecture and lack of programs. He would not even say good morning to prisoners in neighboring cells or prisoners he passed on the way to the yard. He was afraid his neighbors were hostile and playing psychological games with him. He now realizes he might have been paranoid about that, but he had no way to assess the actual safety or danger. He could not see his

neighbors; he could only talk out of his cell door to a faceless voice coming back at him if he and the neighbor yelled loud enough. He continues: "So you pull in, you isolate yourself to decrease the danger of a hostile neighbor." He tells me: "You're always so angry in the SHU, a lot because they (staff) are always investigating you to prove you're gang-affiliated so they can keep you in the hole, then what you did to control your anger stamps out all your other feelings, you become numb, I felt like I was dead – still do." He describes being out of touch with his feelings. He tells me he worked out a lot in SHU, doing calisthenics compulsively, he guesses to handle the nervousness that was always there in the SHU. He says, "I could do 1,000 push-ups in my cell – it helped bind the anger, and it numbed my feelings."

When Prisoner #16 was first released from the SHU, he was overwhelmed by sounds he heard at home and on the streets. If he took a walk, he became very nervous. It was a combination of sounds he was not used to, visual stimuli and traffic. He remains uncomfortable in crowds or even busy spaces like a restaurant. He knows intellectually that he is not in danger now, but he cannot keep his body from reacting with fear. I asked how he knows the symptoms he is describing result from time in the SHU, and not simply from being in prison. He responded:

> If you're in general population, you are relating to other guys, you get visits and phone calls, you're social, you're just in prison. But in SHU, you're the opposite of social, you don't get phone calls, you can't even look out of a window, so your social world shrinks and your visual world shrinks, and then when you get out, look-out! You can't handle all the stimuli and you don't know how to relate to people, not even your family.

He continues, "I couldn't work after getting out of the SHU. The idleness numbed me for work. I can't focus my mind to get a task done. Sometimes, with other workers, I get paranoid, I think someone is looking over my shoulder." He looked for work for quite a while after being released from prison, but was unsuccessful finding a job. By now, he has so much trouble concentrating that he is not able to carry out work assignments. This trouble began when he was in the SHU but has continued to the present. When he hears a loud noise he jumps, having an immediate fear someone is coming to attack him. He was extremely irritable and quick to anger just after being released. There is less of that now, but it's still a big problem. He says his mind never

stops, it is hyperactive, and the rapid-fire thoughts prevent his sleeping. He never had sleep problems before going to the SHU, not even in prison, but since being in SHU he has had great difficulty sleeping. He does not believe he hears "voices," meaning hallucinations, but he does aver often thinking someone is hollering at him. The hollering is vague, and eventually he figures out it is a noise or someone talking loudly, that he incorrectly interprets as a voice hollering at him.

When asked about relationships with women since his 2004 release from prison, Prisoner #16 pauses for quite some time, and then slowly and haltingly reports that he has massive trust problems:

> I can't talk about my feelings – I learned not to express them when I was alone in the SHU – now I mostly don't want to make myself vulnerable – but I am certain that's also from the SHU and all those years not practicing relating to anyone. There are no phone calls in the SHU, so you can't call someone when you're sad and tell them about it. Then, after you're out on the streets, and women want to know how you're feeling, you can't tell them. You forget how to talk to someone about feelings.

Prisoner #16 has been returned to the CDCR several times for parole violations since his release, once for a nine month stint after being found to have "dirty urine." While he has had substance abuse problems in the past, he believes that his post-release drug use has been a weak attempt to numb some of the pain of the SHU and the constricted life he has led since being released. He is afraid that he lacks sufficient concentration to do what is required at a job, and besides, he is too nervous going for an interview.

I spoke to the sister of Prisoner #16. She told me that he has lived with his mother and/or his grandmother since being released from prison in 2004. For many months after his release from prison, he stayed in his room. He would not go to the refrigerator and get food. Instead, someone had to bring it to him. If someone walked unannounced into a room where he was, he would jump and get very agitated. That reaction has calmed some, but it is still a tendency. For a few years after being released from prison, he stayed in the house most of the time and refused to go out. She found him to be uncharacteristically quiet and reserved after his release, and for a long time. He is still not himself. He avoided all levels of social interaction after leaving

prison, something that is quite different than how he was before going to the SHU. All of the symptoms she reported to me she thinks Prisoner #16 exhibited very strongly for nine months after his release, but most of them continue into the present in less intense form.

The sister of Prisoner #16 tells me he did some dating after his release from SHU, but had a lot of trouble with women. He smoked some marijuana to relax his nerves, but then he would anger quickly and this scared the women he was seeing. Before he went to prison at 20, he was very social, not gregarious but friendly and outgoing, and he had a lot of friends. As she reports, "He was bubbly and made people laugh." But she has not seen any of that kind of socializing or humor since he returned after being in the SHU. Whenever she would encourage him to meet someone or take part in an activity, he would decline, saying "You know, I did a long time in the SHU."

Prisoner #18, [redacted] tells me: "When you get out, you're happy. But then you get hit by feelings. I exercise to keep them down. Simply inhaling air is a new experience." He entered prison in 1990 and soon was transferred to the PB SHU, where he remained until 2001. He entered SHU again in 2006 and remained there until June, 2013, when he was released from SHU to Step 5 of the step down program, but by the time of our meeting he had graduated and was in General Population at SATF. He recalls many of the oft-reported symptoms while he was in the SHU, including headaches, anxiety, agitation, difficulty concentrating, anger and despair. He also recalls increasingly isolating himself in SHU, for example never starting any conversations with neighbors. He also avers emotional numbing that progressed while he was in the SHU both times. When he transferred to SATF in June, 2013, he felt a sense of unreality. He transferred with a group of men from the SHU, and he chose to remain with them much of the time and not mingle with other prisoners. He also remained in a circumscribed space rather than roaming to far reaches of the day room or yard. Gradually he felt more comfortable in his porter job, but he says "I wouldn't say I am back to normal, I know I need to be more social and I want to be more open and feel more alive than I do now."

Prisoner #17 is more disabled than the others I interviewed. This [redacted] man graduated from high school and did relatively well in school. He had

lots of friends. He was in CDCR custody from 1995 to 2014, and was in PB SHU the entire time. He was released from prison straight out of SHU. This was his second prison term. His first term was six years and he was in general population most of it, and feels he was not damaged by that earlier term. He was released from this second term on May 23, 2013. [redacted] He is trying to get SSI Disability for anxiety and panic. He reports: "I isolated myself in SHU, I went days without talking to anyone. I could have hollered down the pod, but I just didn't want to communicate. I tried very hard to suppress the anger, and that deadened all my other feelings. I couldn't concentrate. I didn't do much in that cell." When Prisoner #17 came out of the SHU, he returned home on parole:

> It was a horrible experience, I could not talk to my mother. Since being in SHU, I simply don't know what to say, and that's still going on. I do stuff I don't understand. I'm not suicidal. I didn't see the shrink in prison – too much stigma if you do that – but since being released I've gone to a therapist once a month. I try to work. I get odd jobs, and I have trouble concentrating and finishing them. I get all tangled up trying to follow orders. I think … (indecipherable)… anger about all the stupid orders I had to follow in the SHU. But right now I can't find work. I simply can't concentrate. I can't get tasks completed [because] my mind wanders. With my wife, she's supportive, but I can't really share what I'm feeling with her, and I know that hurts her. We've been together about a year. I don't share my feelings very well. I don't know what I feel, then she gets upset. I go out, I can go to a movie or the mall. I drive. But I can't get along with people, I just get irritable. All of these problems started when I was in SHU. I know I wouldn't have these problems if I'd been in general population. I would have had social interactions, communications. But in SHU I forgot how to talk to people. [Now] I get irritable. I stay to myself. I have no real friends, no other family. I think I sound crazy to my mother. I don't understand what my mother is saying, then I'm silent.[41] I can't do the things I'd need to do to get a job. I get too nervous at interviews.

Prisoner #17 tells me that prior to the time he spent in SHU, he had been a very friendly, outgoing person. During his six-year term in general population he was also outgoing and friendly. He had no difficulty talking about his feelings and he did not

[41] During a brief conversation his mother and I had on the phone, she confirmed that she is not able to talk to her son. She doesn't know what's wrong, but he just is not present in their conversations.

isolate himself. But that changed dramatically when he was consigned to SHU. Now, and while he was in SHU, he cannot talk about feelings and does isolate himself quite a lot. Sleep was very problematic in SHU – prisoners tend to wake many times during the night, and then nap during the days. He had never had sleep problems before his long stint in SHU. Since he has been out of prison, he continues to have great difficulty sleeping at night, and then he naps. He feels depressed and has low energy. He does not do much. He is able to do handyman work around the house. Since being released he has consumed a little bit of drugs and alcohol, but not much. He never used any substantial amount of substances before. He is certain that his use of substances is about easing the pain now. He continues: "Getting out, with the overwhelming stimulation all around, I got very nervous. Now, I'm not as nervous, but I simply don't know what to say." Prisoner #17 tells me:

> Sometimes I just shut down, I can't talk about my feelings, I can't really talk. I can't do chores. I just can't concentrate enough, so I procrastinate. Then my girlfriend gets upset because I haven't done the chores. I can't concentrate to finish the task. I don't trust people, and I don't want to relate to them. I'm too gullible, that might be why I avoid people. I can't tell when they are taking advantage of me. I get really nervous, and that makes concentrating on a task even harder. I don't watch TV. I don't even read the newspaper, I'm just not interested in anything. I don't think I'm mentally ill, but I sure am disabled.

I spoke to the girlfriend of Prisoner #17. [redacted] She met him after he was released from prison. She tells me he has been out 1½ years, has a lot of trouble talking to his mom – he does not know what to say. There is a lot of silence. With her, there is some of the same problem. He does not talk about feelings, or does not feel like talking except to say "hi." Often he isolates himself in the house. He will not see friends with her. He is polite, but he will not really talk. He gets very anxious in social situations and shies away from people. They do not see friends together, because it is too uncomfortable for him.

All of the prisoners I interviewed reported a long list of the symptoms and problems that I described in Sections VIII.B.1 and VIII.B.2. Very much like the 11 prisoners I interviewed while they remained in SHU, they also describe suppressing their feelings and isolating themselves to survive and stay out of trouble while they

existed in a cell and were cell-fed (as discussed in Section VIII.B.3 & 4). But then, when they were released from SHU, the same behaviors that were functional in the SHU become disabling (i.e. their isolation and numbness). They each evidence many of the problems I listed above as components of the SHU Post-Release Syndrome.

IX. Opinions

A. Harm Caused by SHU Confinement

As described in detail above, all of the 24 prisoners and ex-prisoners I interviewed suffered from very many of the symptoms that are well known in the literature to be caused by isolative confinement. They consistently reported to me an impressive number of serious symptoms that they suffered while confined in the SHU, including anxiety reaching the level of panic; distorted thinking reaching the level of paranoia; memory and concentration problems that, for example, interfere with the ability to read because one forgets what one read a few pages back; sadness; despair; a growing number of suicidal thoughts; agitation; mounting anger; the fear that the anger will get out of control and get one into even more trouble; and severe problems sleeping. In other words, all of the prisoners I interviewed told me a list of symptoms and emotional problems that fit exactly the list of symptoms reported in the literature about the damaging effects of long-term isolative confinement.

B. Additional Harm Caused by a Decade or More of SHU Confinement

There are additional symptoms that had not been noticed by investigators meeting with prisoners who had been in isolation only months or a few years. Prisoners who remain in isolation for ten years suffer from the symptoms and disabilities listed in Section IX.A above and reflected in the extant literature about the psychological effects of isolative confinement. But then, as the years pass by, they develop further symptoms and disabilities. Of course, part of the further damage is that they suffer from the first set of symptoms and disabilities for the many years they remain in isolative confinement, these problems become more chronic as the years go by, and their pain and suffering is consequently magnified. In addition, I found that the prisoners' varied personal stories of the additional ways they were uniquely affected by the decade or

more of isolation fit into three general categories: symptoms related to a greatly increased urge to isolate; those related to a subjective sense of "numbing," closing off all emotions, beginning usually with attempts to keep the growing anger at bay; and enlarged despair. Thus individuals who have spent over ten years in the SHU suffer from both longer-lasting and more chronic symptoms than those already described in the literature about isolative confinement.

C. Harm That Surfaces After Release from SHU.

Signs of some of the worst harm become evident only after the men are released following ten or more years of SHU confinement. Whether they are released from SHU to go to another, non-SHU, prison setting, or return to the community, there is an identifiable SHU Post-Release Syndrome that is reported, with some individual variation, by one hundred percent of the men I interviewed. Most did not report every single component of the syndrome, and the reports of each man were somewhat unique to his personal experience. However, they all complained of a common list of symptoms and disabilities, which I have named the SHU Post-Release Syndrome. The SHU Post-Release Syndrome is characterized by the following components:

- Disorientation immediately following release.
- Anxiety in unfamiliar places and with unfamiliar people, as daily life events that had been ordinary prior to SHU confinement become unfamiliar events following release from SHU.
- A tendency to retreat into a circumscribed, small space, often a cell (in prison) or a bedroom (in the community).
- A tendency to greatly limit the number of people one interacts with, usually limited to close family members and a few friends.
- Hyperawareness of surroundings, for example a need to sit facing the door to a room or with one's back to a wall.
- Heightened suspicion of everyone who comes close, especially strangers.
- Difficulty expressing feelings.
- Difficulty trusting others, even one's wife or first degree relative.

- Problems with concentration and memory, beginning in the period of SHU confinement and continuing after release, making it difficult to accomplish tasks and to work.
- A sense of having experienced a change of personality. The most often reported form of this change is from a relatively outgoing, friendly individual with a sense of humor prior to SHU confinement, to a more serious, guarded, and inward individual following release from the SHU.
- In some but certainly not all cases, there is a tendency to resort to alcohol and illicit substances to lessen the pain and make the confusion and anxiety more bearable.

All of these problems are experienced intensely for many months after release from SHU, but then the problems continue in less intense fashion, most often right up to the present which might be years later. The prisoners I interviewed after they were released from SHU but remained in prison, as well as the ex-prisoners I interviewed in the community, suffer from a combination of the symptoms that have been included in discussions of isolative confinement in the literature (anxiety, paranoia, insomnia, mounting anger, concentration and memory problems, compulsive acts, despair and so forth), the exaggerated self-isolation and numbing that emerged only after many years in SHU, and the symptoms I have described as the SHU Post-Release Syndrome. In other words, they experience a great many troubling symptoms and as a result the quality of their lives and their functioning are significantly impaired.

D. The Link Between Reported Symptoms and SHU Confinement.

How are we to know that the damage described in this report is not the result of traumas experienced prior to incarceration or merely to the stressful experience of prison life itself? I have concluded, to a reasonable degree of medical certainty, that there is a clear causal link between the symptoms and problems the men I interviewed reported and their tenure in the PB SHU.

As a psychiatrist, I practice a clinical science designed to fathom the etiology of reported symptoms and events. For example, the first thing a clinician asks when a person reports a symptom such as flashbacks is, “When did you first experience such

things?," and then, "Tell me more, what is the content of the flashbacks?" If the person responds that the flashbacks have been present since his teenage years and the content can be about anything (e.g. childhood, schoolyard fights, or prison events), then we conclude that, while the flashbacks might have been exacerbated by isolated confinement, the flashbacks were not triggered by the person's experience in SHU. On the other hand, if the person says, "I never experienced anything like this before I was in the SHU," and "the flashbacks are always about something that happened in the SHU," then this is evidence that the flashbacks were caused to a great extent by SHU confinement.

Similarly, a detailed psychiatric history is the main instrument we have for determining the origin and roots of various psychiatric symptoms and conditions. The source of the damage can be complicated. Thus Prisoner #15 reported to me that he never experienced flashbacks prior to his nine-year stint in SHU. It is clear that his SHU experience caused him to have flashbacks, even if the content of the flashbacks includes experiences that did not actually occur while he was in the SHU. The equivalent emergence of serious symptoms only after confinement in SHU that Prisoner #15 reported was consistently reported by all the other prisoners I interviewed. In other words, the determination can be complicated, but all of the data needs to be considered to come up with a clinical formulation.

E. Representativeness of the Prisoners.

The 25 prisoners I interviewed in all settings are entirely representative of similarly situated prisoners as a class, i.e. the class of prisoners who have been consigned to the PB SHU for ten or more years. I interviewed eleven men in the SHU and a twelfth on SHU status who had been transferred to CSP-Sacramento for medical reasons. Then I interviewed an additional 12 prisoners and ex-prisoners. Clinical research in psychiatry relies upon a number of factors to determine if a sample of affected individuals represents a larger group's shared experience. A sufficient number of representative cases is one consideration. I supervise doctoral research in the Graduate School of Psychology at the Wright Institute, an accredited graduate school granting doctoral degrees. In our dissertation manual, approved for accreditation

purposes by the American Psychological Association, it is recommended that for qualitative research, i.e. research that relies on interviews and narrative reports, a minimum of ten subjects be included to make the study valid and reliable. I have interviewed 24 individuals, some on multiple occasions, so that requirement is satisfied.

Random sampling is one of many techniques for assuring a representative study sample, but it is not always a relevant consideration. In this case, many of the prisoners I interviewed were not selected randomly. For example, the first ten were named plaintiffs in the present litigation. However, the seven SATF prisoners I interviewed were essentially randomly selected, in that I interviewed all English-speaking prisoners from a list provided by the CDCR who had served ten or more years in PB SHU and had been transferred to SATF by CDCR by February 2014.

There are additional ways to assess the degree of commonality and typicality in a larger group. First, there is the degree of shared symptomatology and the consistency of the reported symptoms and disability. Do all of the selected sample exhibit common symptomatology and functional impairment? In other words, how universal are the symptoms and disabilities in the sampled group? In the present case, it is highly significant how consistently the 24 individuals I interviewed report the same experience and resulting symptoms. In their reports, each prisoner recounts somewhat different symptoms,and none experience all of them, but so many of the prisoners report such a long list of these well-known symptoms[42] that it is clear they suffer emotional harm on account of their long-term SHU confinement. The stunning universality of their reported symptoms and problems makes it very likely that all other similarly situated individuals will evidence the same symptoms.

Then there is another list of complaints and symptoms that are reported by every single one of the 24 men I interviewed. These include a growing sense of being out of touch with their feelings to the point of numbness or deadness, a continually worsening sense of isolation accompanied by a tendency to isolate themselves even further, and a sense of despair that enlarges as the years in isolation go by. This group of complaints

[42] Anxiety, hopelessness, mounting anger, insomnia, problems with cognition and memory, exaggerated startle reaction, distorted thought processes and so forth (the list of symptoms uncovered by Drs. Toch, Haney, Grassian, myself and others in long-term isolated confinement).

and symptoms, shared by all 24 of the prisoners I interviewed, is distinct from the symptom constellation generally reported in prisoners who are in long-term (more than three months) isolated confinement, and seems clearly to result from very long-term isolated confinement, certainly including confinement in excess of a decade.

While some symptoms traditionally reported in prisoners consigned to isolated confinement (including memory loss, anxiety and paranoia) are reported by a certain proportion of the prisoners in isolated confinement, this last group of experiences and symptoms was reported universally by all the prisoners I interviewed. This is very strong presumptive evidence that this symptom complex is present in very many of the other prisoners who have been in isolated confinement for a very long time, i.e. longer than ten years. In other words, if we find a clear set of symptoms in every single one of the 24 men interviewed, it is almost certain that such symptoms and disabilities are widespread throughout the class.

Of course, ten of the men I interviewed were self-selected in the sense that they agreed to be named plaintiffs in a lawsuit. Obviously they have not committed suicide nor needed the level of mental health care that would mandate their removal from SHU per exclusion criteria established in *Madrid v. Gomez*. They also share a strong resolve not to participate in the "de-briefing" procedure because they consider it a form of "snitching," which they find morally repugnant. In terms of commonality and typicality, we must consider whether there is any reason they should logically be expected to report symptoms the other prisoners do not experience.

Malingering must be considered in this regard. Malingering is the invention or exaggeration of symptoms for secondary gain.[43] In psychiatry, we have methods for determining the authenticity of reported symptoms, and to rule out malingering and other forms of distortion and manipulation. For example, we look for internal consistency in the story reported by a person, we check for contradictions between the subjective history and our objective observations on mental status examination, we make a determination based on our psychiatric acumen whether the reported symptoms are believable and internally consistent, we check related documents and look for

[43] DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS, 683, (American Psychiatric Association, 4th Ed., 1994)

consistency versus contradiction with the record, we look for consistency between informants who do not know each other or could not have planned together to provide false answers to our questions, and so forth. I apply this methodology in my interviews and examinations. While some of the first ten men I interviewed do know each other, they are not known by and do not know most of the men I subsequently interviewed. Yet the symptoms and problems reported by the first ten men and all the others are strikingly similar and universal. This fact alone goes a long way toward proving the reliability of these prisoners' and ex-prisoners' reported symptoms and problems.

In fact, the men I interviewed are strongly inclined not to report, or to under-report emotional symptoms. This is because they share a "prison code" that discourages exhibiting weakness and emotional problems. They are very unlikely to use mental health services (many of them tell me that they do not trust that mental health staff will maintain confidentiality, and their reports of symptoms could be harmful to them). And the symptoms and disabilities I am memorializing in this report are not typical of any particular mental disorder. If a prisoner were interested in fooling me into thinking he suffer from a mental disorder in order to gain something, he would not tell me about the kinds of symptoms these men report. Rather he would tell me about symptoms out of a psychiatric textbook such as auditory hallucinations, flashbacks or suicidal inclinations, and he would be seeking some kind of psychiatric services or benefits. Further, because I am putting together the information these men provide and arriving at the conclusion that there is a pattern of numbing, isolation and despair, there is no way they would be able to concoct a false story with the consistency and integrity I discover in their oral reports. Besides, they underplay rather than exaggerate their emotional pain and disability at every turn. Thus there is no evidence of malingering in the reports of these ten men.

Further, because the first ten men are relatively articulate, willing to challenge the conditions of their confinement, and are not seeking mental health treatment, there is every indication that the remainder of the population in the PB SHU would report, on average, relatively more severe symptoms and disability than this group, would aver greater suicidal ideation and planning, and would be driven to greater levels of disability and distress by the same or equivalent symptoms than the original group of ten report. I

interviewed fourteen additional men, and found an impressive and very significant similarity between the symptoms and disabilities they reported and the symptoms and disabilities reported by the ten named plaintiffs who were in the SHU when I interviewed them. Of course, the men who had been released reported additional problems, which I have characterized as a SHU Post-Release Syndrome. The men I interviewed while they were in the SHU had not yet experienced or reported many of those symptoms and disabilities.

In arriving at the opinion that the reports of these 24 men are quite representative of the group of prisoners confined in the PB SHU, I also call on all my previous experience investigating conditions in isolation units and interviewing over a thousand prisoners in many states. I have encountered prisoners in several states who were in isolated confinement for longer than ten years, and found in many cases that they exhibited massively constricted affect, extreme isolative tendencies and significant despair. As a general tendency, I have discovered that the longer an individual remains in isolated confinement, the more severe the resultant symptoms and disability, especially symptoms related to constriction of affect, severe isolation and despair.[44] I cannot guarantee that every single prisoner similarly situated in the PB SHU suffers precisely the same emotional pain and psychiatric symptomatology and disability as these 24 men, but I can say with a reasonable degree of medical certainty that, given the severity and consistency of these men's reported suffering and symptomatology, most if not all of the prisoners in the PB SHU for ten years or more suffer from a significant number of the symptoms I have enumerated (in Section VIII.B), a significant degree of emotional numbing, social isolation and despair, resulting in severe pain, suffering and disability. And most if not all of the individuals who are released from the SHU after ten years suffer from many of the symptom and disabilities I have termed the SHU Post-Release Syndrome.

F. Perceived Fairness

Perceived fairness is a very important issue. While I will not comment directly on

[44] See Terry Kupers, *What to Do With the Survivors?: Coping With the Long-Term Effects of Isolated Confinement*, CRIM. JUST. & BEHAVIOR, Vol. 35 No. 8, 1005-1016 (2008).

the legality or constitutionality of the due process afforded these men, I will mention the psychological consequences of their subjective feeling that they are denied due process and treated unfairly. A prisoner who commits a crime and is punished feels, to a certain extent, he has "done the crime and will do the time." But if he is innocent, his resentment about being unfairly punished gnaws at him, and makes the traumas of prison life (the humiliating strip searches, the time in isolation, the lack of phone calls, etc.) much more difficult to bear. A special measure of resentment wells up inside. He feels always a bit more angry and irritable about each successive injustice, and he is all the more afraid his anger and resentment will break out and he will do something that will lengthen his sentence or his time in segregation. His feeling of betrayal by those in authority (the officers, the classification officials, etc.) makes it much more difficult for him to trust staff at the prison, and this both tends to get him into trouble and to deprive him of the help that staff should be providing him during his time behind bars.

All the men I interviewed feel that the validation process was entirely unfair – that they were never given an opportunity to defend themselves, that they were never able to cross-examine those who gave evidence against them, and that the evidence for their six year "re-validations" were entirely "bunk." These men subjectively (with varying degrees of basis in objective reality) feel that they have been treated unfairly. They consequently build up a lot of resentment about the unfairness and they are unable to trust the staff upon whom they are entirely dependent in the SHU. The anger about the unfairness of their validation and SHU confinement serves to exacerbate all the symptoms that anyone confined in isolation would feel. Secondarily, they isolate themselves and suppress their feelings all the more because of the extra measure of resentment that is swelled by their sense of the unfairness of it all. Further, the distrust they feel with staff makes it even harder for them to acquire the social skills – including but not limited to the capacity to rely on people in authority to accomplish one's goals – that they will need to succeed either in general population or in the community after their release from prison. In other words, there are very damaging effects on these prisoners due to their subjective sense that their validation and very long SHU confinement is entirely unfair and that due process is lacking.

X. Conclusion

The 24 men I interviewed who had spent ten years or more in their cells for nearly 24 hours per day in the PB SHU are representative of the class and are severely damaged by the experience. Those who remain in SHU continue to suffer from the major symptoms and disabilities I have described throughout this report, and those who are no longer in SHU find the quality of their lives is significantly compromised. They are not able to work up to their potential, they are relatively incapable of relaxing and enjoying social events, and their primary intimacies are very difficult because of the psychological damage they incurred while in the SHU. These negative effects of SHU confinement are relatively long-lasting if not permanent.

I interviewed 24 prisoners or ex-prisoners who spent ten or more years at the Pelican Bay SHU. The 24 prisoners and ex-prisoners I interviewed include 11 prisoners who were still in SHU when I interviewed them, one who was in another SHU so he could receive medical treatment, seven who had been released from SHU to other prison settings, and five who had returned to the community after being released from SHU. I described (in Section VIII.B.1 & 2) a set of symptoms experienced during their tenure in SHU that I uncovered in all 24 men I interviewed, including anxiety reaching the level of panic; distorted thinking reaching the level of paranoia; memory and concentration problems; sadness; despair; agitation; mounting anger; the fear that the anger will get out of control and get one into even more trouble; and severe problems sleeping. In other words the prisoners I interviewed while they remained in the SHU consistently reported symptoms that match those reported in the literature by prisoners in isolation in a great many settings.

Then I described (in Section VIII.B.3 & 4) a pattern of additional symptoms that evolve after many years of isolated confinement in SHU, symptoms that fit into three basic categories: an exaggerated urge toward isolation even in the context of isolated confinement; and the numbing of feelings to the point where the individual reports not even knowing what he feels, and several said they feel dead. In addition, there is the enlarging sense of despair that grows during the years of isolation.

A certain number of prisoners are eventually released from their isolative confinement. All of the men I spoke to who had been released from SHU, either to

another prison setting or to the community, reported that many of the most serious problems they experience surfaced only after they left the SHU. I was able to identify a syndrome, the SHU Post-Release Syndrome (described in Section VIII.C) that captures the experience of the men who had been released from the PB SHU after ten years. The SHU Post-Release Syndrome is characterized by disorientation; anxiety in unfamiliar places and with unfamiliar people; a tendency to retreat into a circumscribed, small space, often a bedroom or cell; a tendency to greatly limit the number of people one interacts with; hyperawareness of surroundings; heightened suspicion of everyone who comes close; difficulty expressing feelings; difficulty trusting others; problems with concentration and memory; a sense of a changed personality; and a tendency to resort to alcohol and illicit substances to lessen emotional pain. The set of symptoms that characterize the SHU Post-Release Syndrome was consistently reported, whether the prisoner was transferred from SHU to a general population or "stepdown" prison setting within the California prison system, or returned to the community. Thus, for example, one former SHU prisoner who has been released to the community reported that he stays in his room a lot of his waking hours, while a prisoner who had been released from SHU to return to general population status in prison stays in his cell most of his waking hours. Both groups appear to be trying to re-establish the conditions they experienced in the SHU. It is as if they have become so habituated to life in a small cell that exposure to any larger, more populated area seems overwhelming and frightening.

The extraordinarily painful experiences reported by all 24 prisoners I interviewed are not reflective of any particular diagnosis out of the *Diagnostic and Statistical Manual of Mental Disorders*, yet they make these men miserable and relatively dysfunctional, in and after SHU confinement. In other words, there are limits to the use of psychiatric diagnoses and standard disability assessments when it comes to the pain and suffering and long-term damage of men who have been in the SHU for a decade or more. Thus there is very little discussion in the clinical charts I reviewed of the kind of pain and suffering I discovered in the men I interviewed. Of course, these are men who are not prone to expose psychological pain and vulnerability to a prison mental health clinician they do not even know, and almost all of them tell me they do not want to be diagnosed

nor provided mental health treatment. Again, the kinds of damages they suffer do not fit into any neat diagnostic category.

Many of these men could benefit from mental health treatment, or from other interventions such as relaxation techniques, meditation or psycho-educational classes on coping with the negative effects of prolonged isolation. Treatment cannot take away past suffering, but it might help reduce present and future suffering. But no amount of treatment will eradicate the pain and suffering these men were forced to endure during their years of relative isolation and idleness in the PB SHU.

For example, when I interviewed Prisoner #7, he told me that it is very upsetting to him that when his grown daughter visits him (which occurs more easily now that he is at CSP-Sacramento), he cannot express any emotions or cry with her. Then it pains him deeply that his connection with his daughter necessarily remains superficial. He explains in detail how suppressed he feels most of the time, how he stays to himself and does not exhibit any spontaneity or initiative in his interactions with other prisoners on the yard, does not experience any enjoyment, and how he and his cellmate do not even talk to each other, but both go on about their business as if the other were not present in the cell. In these and comparable ways, he explains that he feels not really alive. Similarly, Prisoner #15, who is in the community, reports:

> I can't function in a relationship. I can't function in them because I always find a need for compatibility equivalent to having a cellie. A cellie would leave me alone in the isolation I'd become accustomed with. In SHU, I was totally detached from my feelings. I knew of the harsh environment, but refused to be sensitive, refused to cry. But since I've been out here all of those feelings are released.... I had several relationships, but I couldn't break down the hard exterior from SHU.

Of course, removing these men from isolative confinement would be a prerequisite for treatment to be effective. But no treatment will take away their immense pain and suffering.

Respectfully submitted,

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