PSYCHOLOGICAL EFFECTS OF LONG TERM SHU (SOLITARY CONFINEMENT)

(Excerpted from the EXPERT REPORT OF TERRY A. KUPERS, M.D., M.S.P.)

Written by Dr. Kupers for the Plaintiffs in the Class Action Lawsuit of Todd Ashker et. al., Plaintiffs
v.
Governor of the State of California et.al., Defendants;
March 2015

Excerpt by Prisoner Hunger Strike Solidarity Coalition (PHSS)
Parole Committee
P.O. Box 5586
Lancaster, CA. 93539
Email: pjgriffin@gmail.com

July, 2017

TABLE OF CONTENTS

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

1. QUALIFICATIONS OF DR. TERRY KUPERS Page 1

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).

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.

2. OVERVIEW

Pages 2 – 4

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.

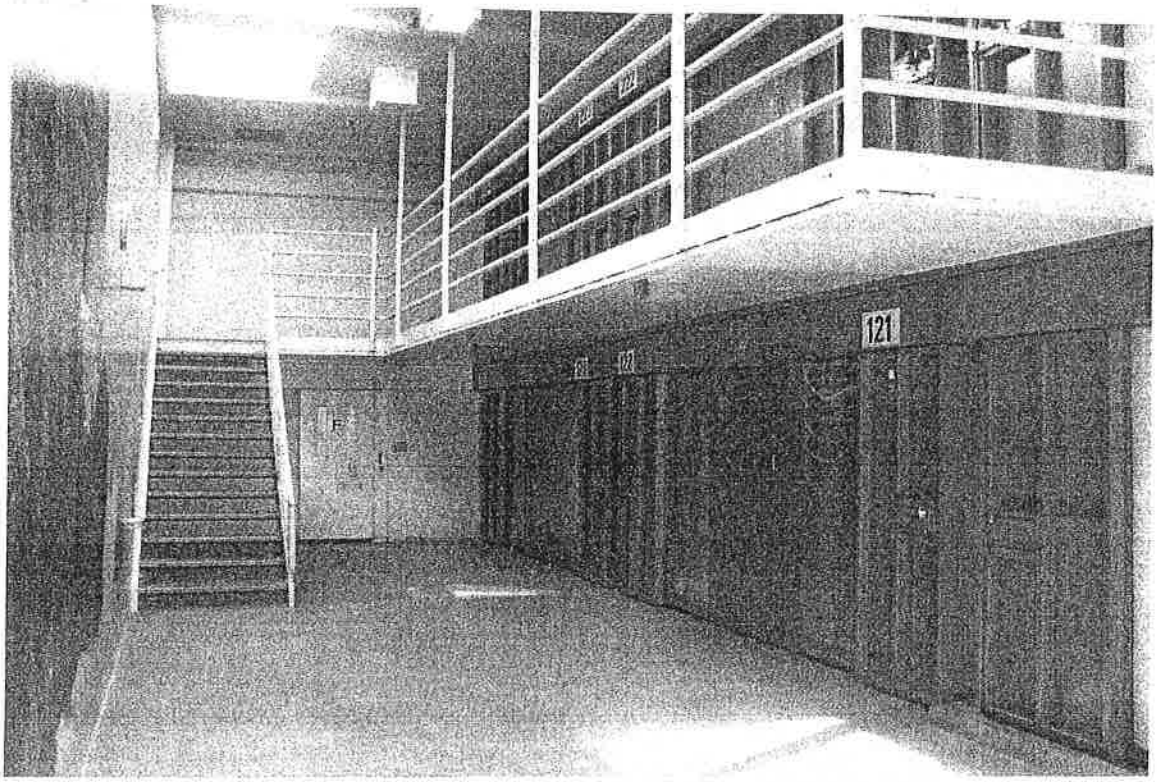
Almost all of the men I interviewed reported that they continue to avoid crowds, remain suspicious of anyone entering their vicinity, have strong startle reactions, continue to have sleep problems, and have a lot of trouble expressing themselves and their feelings, even to intimates such as a wife or 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.

3. 'LIFE' IN PELICAN BAY SHU: PHOTOGRAPHIC VISUAL

Pages 5 – 9

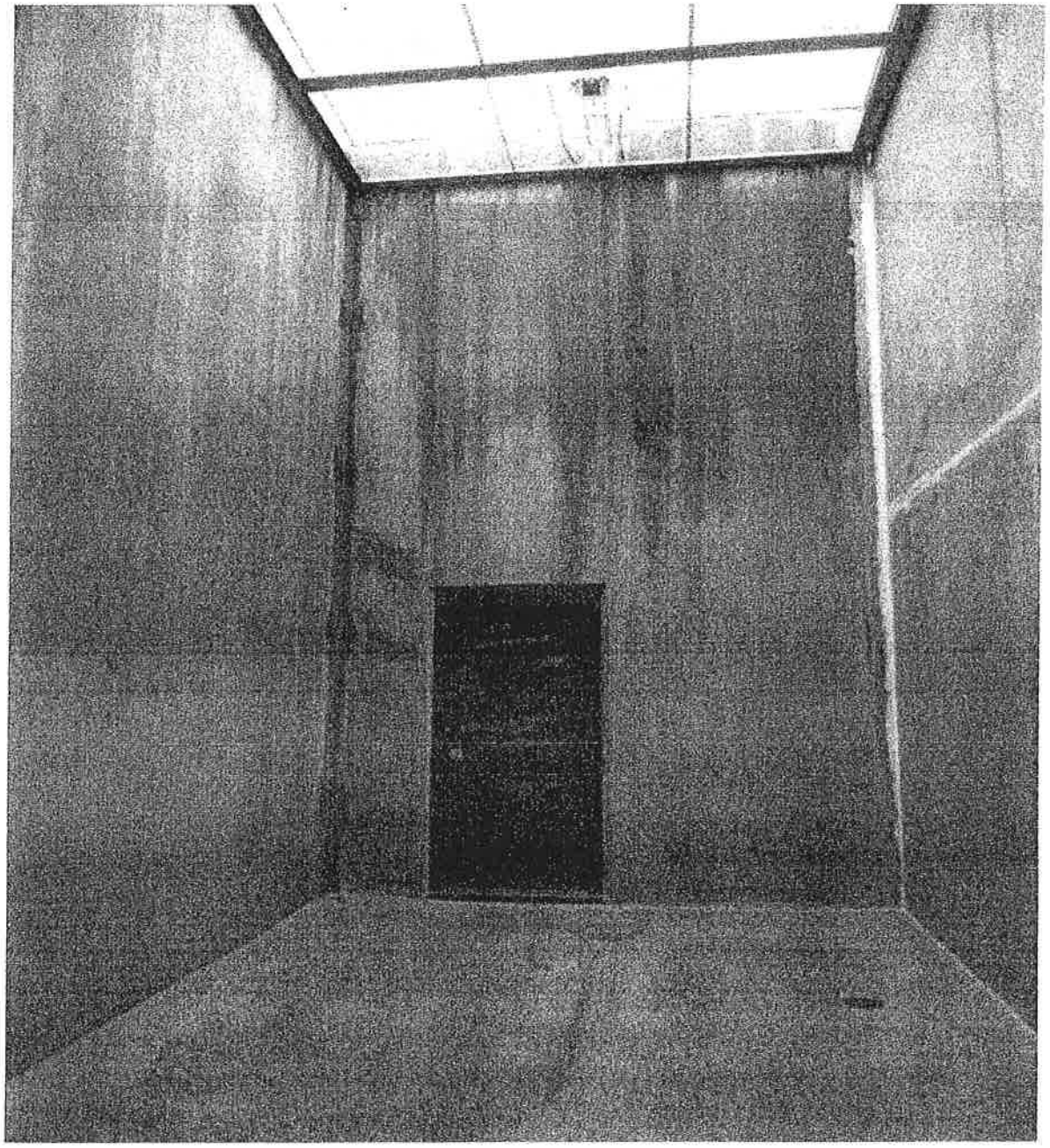


A Pod in the PB SHU[26]

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.

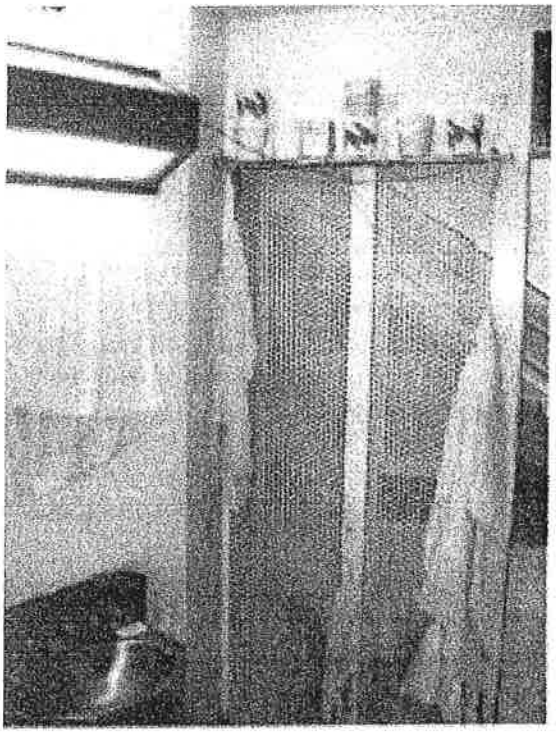


A Yard at the PB SHU[28]

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.

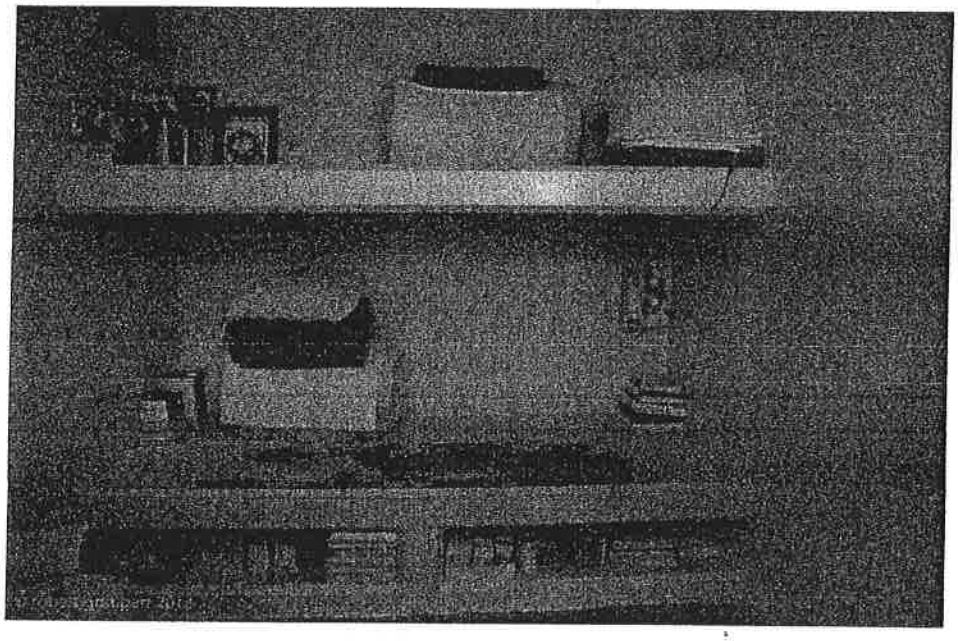


Front of a cell with perforated metal sheet, as viewed from inside cell[29]

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.

---

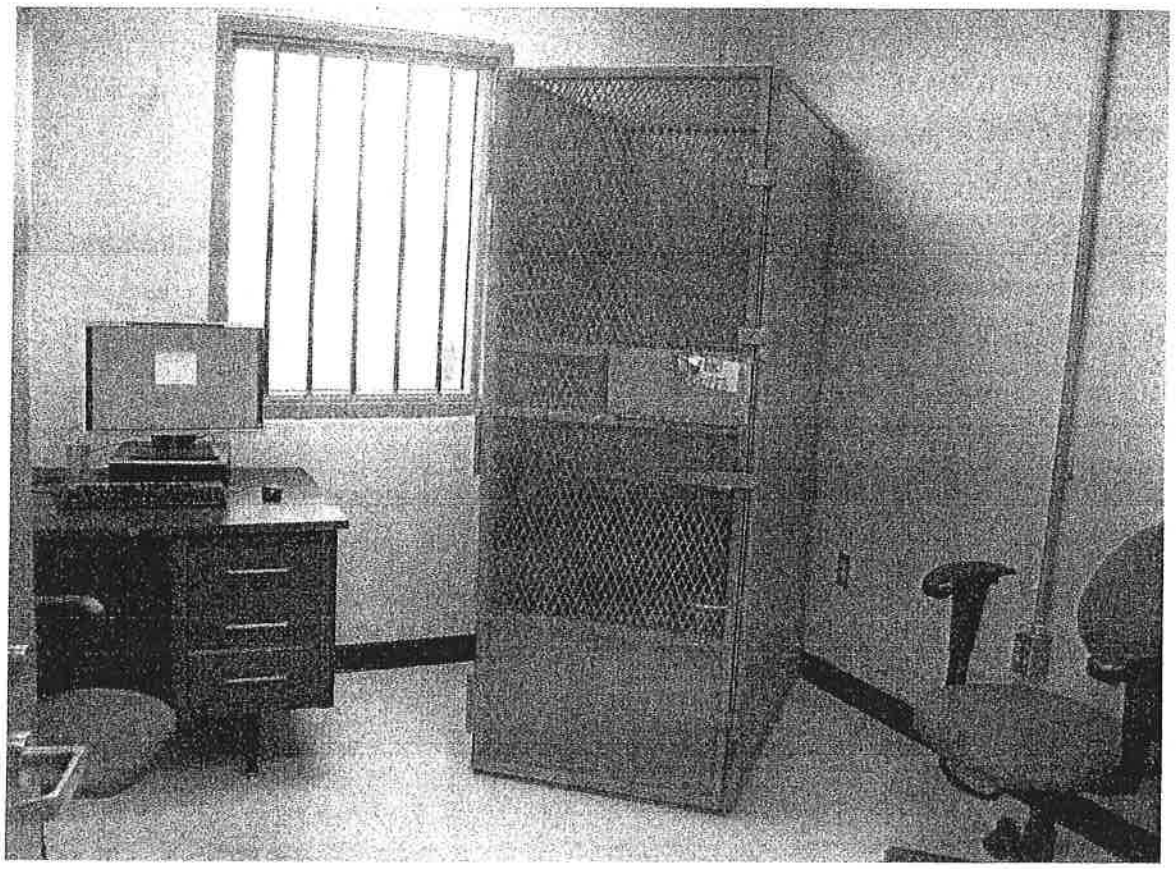
[29] Photo from Solitary Watch, available at http://solitarywatch.com/2014/07/07/worst-worst-one-year-later-whats-changed-pelican-bays-hunger-strikers/



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...

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.

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.

[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.

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

---

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.

5. SHU STORIES: (By people imprisoned over ten years)

Prisoner [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 [redacted] 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 [redacted] 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 [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.

Prisoner [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 [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.

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 [redacted] 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 [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 [redacted] 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.

6. PSYCHOLOGICAL EFFECTS OF LONG TERM SOLITARY

Pages 20 – 21

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 [redacted] 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...

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

7. SHU POST-RELEASE SYNDROME: (Stories from General Population and from Release to Community)

Pages 22 – 25

In terms of reports about what it was like to be in SHU, Prisoner [redacted] (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 . . . 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 . . .

However, in addition, over and above these symptoms and disabilities, Prisoner [redacted] 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 [redacted]'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. . .

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. . . .

. . . He reports there was a feeling of unreality when he first arrived at [redacted] from the PB SHU. He was very happy to be out of the SHU, but for months after arriving at [redacted] 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 [redacted], 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 [redacted], but are still with him as he tries consciously to remain open to new experiences and grow.

Prisoner [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 [redacted]. In fact, over a year after arriving at [redacted], 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 [redacted] was transferred to [redacted] 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 [redacted], 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.

8. SHU POST-RELEASE SYNDROME: (Stories from Release to Community and Relationships with 'Loved Ones')

Pages 26 – 31

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 [redacted] 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.

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 [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 [redacted] general population, I immediately got involved in securing whatever substance I could. Pruno, pills, marijuana. I isolated myself at [redacted], 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 [redacted] 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 [redacted] [he was in and out of SHU at [redacted] 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 [redacted] 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 [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, ..

When asked about relationships with women since his 2004 release from prison, Prisoner [redacted] 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 [redacted] 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 [redacted]. 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 [redacted] 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 [redacted] 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 [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 [redacted]. 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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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.

[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.

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 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.

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).

Perceived Fairness

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

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 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 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,) 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 [redacted], he told me that it is very upsetting to him that when his grown daughter visits him [redacted], 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 [redacted] 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,

Terry A. Kupers

Terry A. Kupers, M.D., M.S.P.