

# **Mental Health Consequences Following Release from Long-Term Solitary Confinement in California**

Consultative Report Prepared for the  
Center for Constitutional Rights

Human Rights in Trauma Mental Health Lab, Stanford University



**Stanford**  
University

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## Executive Summary

In Spring 2017, members of Stanford University's Human Rights in Trauma Mental Health Laboratory (the Stanford Lab) were invited to consult with attorneys from the Center for Constitutional Rights (CCR) representing class members in the federal class action lawsuit *Ashker v. The Governor of California (Ashker)*. The Stanford Lab was asked to gather narratives from *Ashker* class members in order to glean insight into what psychiatric sequelae directly related to prolonged, indefinite isolation in the Security Housing Units (SHU) at California prisons are present, and to determine whether that harm continues to impact prisoners following their release from SHU into the general prison population (GP).

As aggregated, the class member narratives indicated that most of the men experienced severe psychological disturbances with lasting detrimental consequences as a result of their experience in SHU. The Stanford Lab's interviews revealed a range of common impairments and adverse consequences associated with long-term, indefinite incarceration. The majority of class members endorsed mood symptoms consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnosis of Major Depressive Disorder, including depressed mood, hopelessness, anger, irritability, anhedonia, anger, fatigue, feelings of guilt, loss of appetite, and insomnia. Nearly all class members also endorsed anxiety symptoms characteristic of DSM 5 diagnoses of panic disorder, traumatic stress disorders, and/or obsessive-compulsive disorders, such as nervousness, worry, increased heart rate and respiration, sweating, muscle tension, hyperarousal, paranoia, nightmares, intrusive thoughts, and fear of losing control. Psychiatric symptoms and diminished capacity for socialization continue to cause psychological suffering and problems with social function for most of the men now in GP.

Class members cited emotional numbing and desensitization as the some of the most common responses to living in SHU. This sense of emotional suppression and dysregulation continues to be problematic for prisoners following the transition to the general population. Class members also reported significant alterations in cognition and perception. Problems with attention, concentration, and memory were common, and described as persistent and worsening. Some of the most pronounced and enduring effects of long-term isolation appeared to have resulted from relational estrangement and social isolation; interviewees frequently reported losing, over time, the motivation to seek social connection.

These psychiatric and social difficulties were reported to have persisted throughout the transition to GP. Class members commonly reported ongoing anxiety and posttraumatic stress symptoms. Specific difficulties endorsed by class members include pervasive hypervigilance, worry, and nervousness; they described experiences of being on constant alert and chronically feeling under threat or danger. Many class members endorsed sensory sensitivity following their transition to GP, noting experiences of distress, anxiety, paranoia, and irritability particularly in response to

the “chaotic” environment of GP with an influx of new activities, interactions, and sounds. Furthermore, class members report that periods of lockdown in GP are triggering and re-traumatizing, and that they invoke re-experiencing symptoms of posttraumatic stress disorder. These social and psychological responses to SHU are consistent with the majority of current literature on prolonged isolation.

In considering opportunities to improve post-SHU experience and functioning for prisoners, the Stanford Lab noted that class members generally felt overwhelmed by and underprepared for the post-SHU experience in GP. Class members described the experience of GP as totally foreign and overwhelming; these experiences appeared to stem from the drastic contrast between the physical, social, and sensory environments of SHU and GP, as well as the absence of an effective transition program. The loss of routine and stability in daily functioning, and the related lack of predictability and demand for flexibility, was jarring and distressing for many interviewees, resulting in feelings of anxiety, nervousness, irritability, and a sense of isolation and disconnection, exacerbated by the lack of any transition preparation.

The mental health professionals in the Stanford Lab are well versed in treatment modalities and useful interventions for persons with mental health disorders and/or symptoms. Based on the information summarized in this report, the Stanford Lab recommends reparative services in the form educational, occupational, and social programming opportunities to help address the lasting consequence of the long-term SHU experience. Emotional and psychological support services are also needed. For transition, it is clear that improved, earnest access to mental health treatment is necessary, and that such access should come from non-CDCR sources for a number of reasons elucidated in the full report. The Stanford Lab recommends that class members be offered mental health and psychological services in the form of independent psychiatric care and/or peer-led or peer-facilitated support groups. Moreover, interviews indicate that prisoners seem to derive a sense of fulfillment and self-worth from opportunities to mentor their peers; such programming could be helpful in combatting some of the detrimental effects of time in SHU, including by diminishing anxiety and depression.

Furthermore, class members’ requests for greater access to jobs and other out-of-cell activities, to programs, and to therapeutic groups are wise interventions for their symptom profiles and are likely to improve their transitions and the long-term prospects for functioning and contribution to society. The Stanford Lab found the men interviewed to be resilient, self-educated, intellectually curious individuals, many of whom have implemented therapeutic coping mechanisms on their own. The Stanford Lab recommends that CDCR and other prison authorities seek to offer adequate and enriched programming opportunities as a means of providing reparative services and personal, community, and societal healing following long-term isolation in SHU.

## **Introduction**

In the spring of 2017, members of Stanford University's Human Rights in Trauma Mental Health Laboratory (the Stanford Lab) were invited to consult with attorneys from the Center for Constitutional Rights (CCR) representing class members in the federal class action lawsuit *Ashker v. The Governor of California (Ashker)*. The Stanford Lab is a multidisciplinary collaboration between Stanford University's School of Medicine, Law School, and the WSD Handa Center for Human Rights and International Justice, and is composed of faculty and students including academic clinicians, lawyers, and policy experts with special knowledge in the area of trauma mental health. Moreover, the team has practical experience in clinical psychiatry and mastery of the science of the effects of adverse conditions on human psychology, as well as significant experience performing interviews and qualitative research in adverse conditions. As indicated, the Stanford Lab was approached by attorneys from CCR to consult on the question of how psychological changes acquired in long-term situations of isolated incarceration affect transition into a general prison population. The Stanford Lab was asked to gather narratives from *Ashker* class members in order to glean insight into what lasting psychiatric sequelae are present and how the acquired psychological changes affect the transition from solitary confinement to the mainline, as well as to review the science of the consequences of isolation for human psychology. The focus of the endeavor was to investigate the extent of psychological harm directly related to prolonged, indefinite isolation in the Security Housing Units (SHU) at California prisons and to determine whether that harm continues to impact prisoners following their release from SHU. Of note, the experiences of class members in SHU were consistent with conceptualizations of solitary confinement, which is widely accepted as being held in isolation for 22 - 24 hours each day. Given the specific focus on class members in the *Ashker* settlement, the purpose of the current analysis and report was not to review all applications of solitary confinement (for example, the impact of isolation for periods of less than 10 years); however, the present considerations and outcomes have relevant implications for those held in the SHU or similar conditions for any duration of time.

## **Methodology**

In early 2017, *Ashker* class members received a letter (drafted by the attorneys in consultation with the Stanford Lab) via U.S. Postal Service inquiring if they would be willing to participate in an interview with Stanford Lab members. *Ashker* class members were all formerly housed in the SHU at Pelican Bay State Prison and California State Prison, Corcoran for more than 10 years (with some also spending time in similar units at additional facilities, including San Quentin State Prison).

Forty-five *Ashker* class members now housed in California State Prison, Sacramento (SAC); Salinas Valley State Prison (SVSP); and Kern Valley State Prison (KVSP) were randomly selected by the Stanford team and invited for interviews. Thirty class members accepted the invitation

and all but one of them were subsequently interviewed using a semi-structured and focused interview format. The survey instrument was carefully designed by the Stanford Lab over a period of several weeks to gain subjective, qualitative responses in three general categories of information: mental health symptoms acquired in SHU; symptoms that persist and/or new symptoms that have surfaced during the post-SHU period, in most cases while being housed in the general prison population (GP); and insights into potentially beneficial resources for prisoners following long-term isolation. The Stanford Lab also asked class members to reflect on how their fellow SHU inmates fared. Each interview was conducted during prison visiting hours with the class member, an attorney from the Plaintiffs' monitoring team<sup>1</sup>, and an interviewer from the Stanford Lab (interviewers included a licensed psychiatrist, licensed clinical psychologist, clinical psychology doctoral student, and a human rights investigator).

Stanford Lab members drafted individual reports summarizing each interview. The team then collectively reviewed the individual reports to identify common themes and notable aberrations with a focus on making informed suggestions to improve outcomes for class members' post-SHU experience. The noticeable trends, which are discussed below in further detail, reveal that the clients suffer a range of mental health consequences following their prolonged isolation, varied responses to the post-SHU experience in GP, and ongoing psychiatric, medical, social, and functional difficulties.

### *Acknowledgement of Limitations of the Consultation*

By interviewing 29 prisoners, the Stanford Lab was able to investigate and capture a fair cross-section of the class members' experiences so as to make credible generalizations of themes, while allowing nuances to highlight the diversity of experience and opinion. Patterns were detected across the class members' narratives, and sound information could be gleaned about the mental health symptoms associated with SHU, and how these symptoms hindered — and continue to hinder — clients' psychology and social capacity since release from SHU.

That said, the Stanford Lab recognizes that relying upon the consent and ability of the class members to participate in interviews likely inserts some selection bias into the grouping, meaning the perspectives and experiences of individuals interviewed do not likely represent those prisoners who faced or face the most severe challenges from their time in isolation. This project only represents narratives from class members who were able to affirmatively respond to a letter sent by the *Ashker* attorney group; this excludes narratives from men yet to be released from SHU, men who did not survive SHU, men who were transferred to a mental health unit, and/or men who were either not able to answer the invitation or unwilling to consent. While this creates a potential bias, it likely selects for persons with higher cognitive abilities and better mental health

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<sup>1</sup> Three interviews were conducted without a member of the legal team owing to an administrative complication.

states. Therefore, the current report presents a summary of the psychological impact of SHU among what are likely the most resilient and resourceful of the former SHU prisoners.

Another factor that may influence the quality and quantity of the information obtained is a general reluctance among prisoners to acknowledge mental and emotional distress. While all interviewees gave consent to participate and were willing to talk openly about their experience, their stories might not capture the entirety of what they went through in SHU and during the transition to GP, as prisoners may be hesitant to disclose the full extent of the psychological harm they have experienced for a number of reasons. Mental health stigma is a problem in the general community that appears to be exacerbated within the prison system.<sup>2</sup> Multiple class members explained that it is important to avoid appearing weak or vulnerable in front of other prisoners. They also stated that emotional expression is often considered to be a sign of weakness in prison culture. Some class members began the interviews by discussing their strengths and resilience, and only opened up about emotional difficulties after getting comfortable with the interviewer and being asked more specific questions.

Another potential challenge to using a voluntary interview format is emotional numbing and minimization of distress. Nearly all class members reported experiencing emotional numbing during their time in SHU. Many class members reported ongoing difficulties with experiencing emotions, which might affect their ability to recall their emotional state in SHU and during the transition. As noted by Stuart Grassian (2006), many prisoners view prolonged confinement as an attempt to break them down, mentally and physically. In this case, prisoners may view acknowledgement of psychological symptoms as evidence of being successfully “broken,” which could cause even greater distress and damage to their sense of self.<sup>3</sup> Finally, some class members expressed a fear of being labeled as mentally ill and subsequently forced to receive psychiatric medication or intervention from the California Department of Corrections and Rehabilitation (CDCR).

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<sup>2</sup> "Furthermore, many inmates cite an undesirable degree of social risk in identifying oneself as being in need of mental health intervention or taking psychotropic medication. They report that inmates and staff see such behaviors as evidence of a weak or broken status." (Cloyes et al., 2006, p. 762)

<sup>3</sup> "Many inmates housed in such stringent conditions are extremely fearful of acknowledging the psychological harm or stress they are experiencing as a result of such confinement. This reluctance of inmates in solitary confinement is a response to the perception that such confinement is an overt attempt by authorities to 'break them down' psychologically, and in my experience, tends to be more severe when the inmate experiences the stringencies of his confinement as being the product of an arbitrary exercise of power, rather than the fair result of an inherently reasonable process." (Grassian, 2006, p. 333)

## Mental Health Consequences of Long-term Isolation

As aggregated, the class member narratives indicated that most of the men experienced severe psychological disturbances with lasting detrimental sequelae as a result of their experience in SHU. The Stanford Lab's interviews revealed a range of common impairments and adverse consequences associated with long-term, indefinite incarceration in SHU. These include mood deterioration and depression, intense anxiety, emotional numbing and dysregulation, cognitive impairments, and modifications in perception of time. In addition, all the interviewees reported distressful relational estrangement with family and/or friends. Psychiatric symptoms and diminished capacity for socialization continue to cause psychological suffering and problems with social function for most of the men now within the GP.

"We are broken, but most of us are too proud to ask for help."

"The worst thing you can do to a person."

"There is a sense of impending doom ... [like a] tidal wave."

"I lost time as if I went to a deserted island and then came home."

"I was not even living in the world."

"I could hear them banging their heads against the walls and yelling. ... Men lose their minds, cover themselves in feces."

"I'm going to die here. I'm never going to leave this place.  
I can wake up tomorrow dead. I'm leaving this place in a box."

"It's like being buried alive under cement and steel."

"Caged animal." " [A place to] learn impatience,  
learn intolerance, and learn irritability."

"Environment designed to break people mentally and emotionally."

"Everyday is the same day. Time stands still."

"The cell is my life, while time  
goes by somewhere else."

### *Inventory of Mental Health Impairments Acquired in SHU*

**Mood** The majority of class members endorsed a number of negative mood symptoms such as irritability, intense anger, anhedonia (an inability to feel joy), hopelessness, and depression.<sup>4</sup> Class members described their emotional experience in SHU as "desolate," "stale," and "like a robot."

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<sup>4</sup> A study of 34 inmates in Kentucky by Miller and Young (1997) indicated that inmates in disciplinary solitary confinement experience greater feelings of inferiority, withdrawal, and isolation than the general prison population, and greater feelings and actions of aggression than both the general prison population and inmates held in administrative segregation.



Nearly all class members reported sleep difficulties including severe insomnia and inability to fall asleep owing to intrusive thoughts.<sup>5</sup> Class members also reported experiencing fatigue, loss of appetite, and feelings of guilt. A number of class members reported having thoughts of ending their life.<sup>6</sup> Some class members also witnessed the suicide or self-harm of others. These symptoms are consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of Major Depressive Disorder (American Psychiatric Association, 2013).<sup>7</sup> Also, while some class members were able to remain hopeful, many became despondent and believed that they would die in SHU. Class members recalled thinking that the only way they would get out of SHU prior to the *Ashker* settlement was to “debrief, parole, or die.”

“I have many daily rituals. If I can’t get them done, I get agitated.”

“Every little sound bothered me.”

“I cultivated anger and hatred.”

“I learned to watch everything, like any spider or bug that came into my cell”

“It’s easy to become a product of your anxiety.”

**Anxiety** Nearly all class members reported experiencing anxiety<sup>8</sup> symptoms characteristic of DSM-5 diagnoses of Panic Disorder, traumatic stress disorders, and/or obsessive compulsive disorders (American Psychiatric Association, 2013). Symptoms included nervousness, worry, increased heart rate and respiration, sweating, muscle tension, hyperarousal, paranoia,

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<sup>5</sup> Andersen, et al. (2000) found, through repeated measurements over four months of Danish prisoners without prior mental illness, that SHU prisoners were significantly more likely than those in general population to develop psychiatric disorders, particularly related to anxiety, depression, irritability, worrying, insomnia, difficulty concentrating, and passivity.

<sup>6</sup> Single-cell SHU housing has been found to be a significant suicide and self-harm risk factor in other studies (Kaba, et al., 2014; Kupers, 2008; Patterson & Hughes, 2008; Roma, et al., 2013; Reeves & Tamburello, 2014; Way et al., 2005).

<sup>7</sup> A longitudinal study comparing Danish prisoners in solitary confinement and those not in solitary confinement by Andersen, et al. (2003), found that scores of psychopathology (including anxiety and depression) decreased for non-SHU inmates over the first 2-3 months of imprisonment, but remained the same for SHU inmates (improvement was likely due to being removed from drugs, alcohol and treatment of withdrawal). Once inmates were moved from SHU to non-SHU their psychopathology scores improved.

<sup>8</sup> In his study of 100 Pelican Bay inmates in SHU, Haney (2003) found that 91% reported anxiety, 84% chronic lethargy, 84% difficulty sleeping, 70% impending nervous breakdown, 68% heart palpitations, 63% loss of appetite and 55% nightmares.

nightmares, intrusive thoughts,<sup>9</sup> and fear of losing control. Multiple class members reported experiencing akathisia, or the feeling of “wanting to crawl out of one’s skin.” Class members reported feeling compelled to engage in repetitive behaviors in order to reduce their anxiety. These behaviors include obsessively organizing their belongings, keeping strict daily routines, and excessively cleaning their cells.<sup>10</sup> Individuals who endorsed obsessive compulsive spectrum symptoms reported feeling highly distressed when their routine was interrupted or their belongings were disturbed. Additionally, some class members reported experiencing hyperarousal and paranoia. These individuals became increasingly suspicious of others and bothered by benign noises.

“You stop relating to anyone who isn’t in SHU.”

“I needed to disconnect and tune out emotions [to survive].  
In SHU, you can’t show emotions, you go within yourself.”

“Anger was an escape from other emotions.”

“I wasn’t able to shed a single tear – it bothered me.  
It bothers me to this day.”

“You can go through different emotions really quick. A  
happy moment will turn into despair. Even thoughts  
about your family can turn to despair.”

“Like a robot.”

“Emotions are up and down.  
You struggle to stay positive so you can survive.”

“Retreated back into my shell.”

“My mind is just out.”

**Emotional Numbing** Class members cited emotional numbing and desensitization as the most common responses to SHU living. Many class members described becoming “emotionless,” numb, or detached during their time in SHU.<sup>11</sup> They expressed a need to intentionally suppress

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<sup>9</sup> Cloyes, et al. (2006) found that 69% of those surveyed show psychosocial impairment and/or meet criteria for serious mental illness. Authors highlight “thought disturbances,” which include “conceptual disorganization, hallucinatory behavior, unusual thought content,” and are the subscale equated with with “serious psychotic illness.”

<sup>10</sup> Grassian (2006) found obsessive thoughts common and notes the prevalence of obsessive behaviors in prisoners of war held in solitary confinement and postoperative, bed-confined heart surgery patients; granted, the conditions of SHU inmates are very different.

<sup>11</sup> In their studies of social exclusion with nonincarcerated populations, subjects in Twenge, Catanese, & Baumeister (2003) displayed emotional numbness, reduced empathy, passivity, and lethargy.

their emotions in order to cope with their experience.<sup>12</sup> They reported feeling disconnected from emotional experiences (particularly for emotions involving a level of vulnerability, such as sadness or fear) and also reported an inability to control or regulate certain emotional responses, such as anger. Class members indicated that displays of emotion were considered a form of weakness in SHU culture. Additionally, many class members reported that the act of suppressing emotions was a necessary coping strategy in SHU. Many class members felt like they had to “shut everything out.” Oftentimes, the only emotion class members allowed themselves to feel was anger, which could erupt from seemingly benign encounters or interactions. This sense of emotional overcontrol and dysregulation continues to be problematic for prisoners following the transition to GP.

**Cognition** Cognitive deficits appear to be some of the most pronounced consequences of long-term isolation. Problems with attention, concentration, and memory were some of the most commonly reported responses to SHU. Most, if not all prisoners experienced changes in attention span and memory deficits during their time in SHU. Multiple class members cited a loss in ability to focus while reading and an inability to retain new learning. The class described cognitive difficulties as persistent and worsening.<sup>13</sup>

Class members reported changes in thought content throughout the duration of their stay in SHU.<sup>14</sup> Some individuals had ruminative thoughts about the past, their feelings of guilt, or the injustice of their situation. A number of interviewees also reported experiencing invasive or unwanted thoughts. Moreover, they endorsed paranoid thought processes, and described feeling anxious around and distrustful of correctional officers or any CDCR staff. Some class members reported experiencing auditory hallucinations and delusions of a paranoid nature. Only one interviewee reported visual hallucinations.<sup>15</sup>

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<sup>12</sup> This aligns with the findings of Haney (2001) that “emotional over-control, alienation, and psychological distancing” are psychological adaptations that many SHU prisoners employ, often creating a “prison mask” of emotional flatness. Emotional numbing, in combination with hyper-vigilance and suspicion, which are also common psychological adaptations, often leads to social withdrawal.

<sup>13</sup> Extrapolating from beyond the prison environment, a study of 823 elder adults by Wilson et al. (2007) found that loneliness led to significant declines in global cognition, semantic memory, perceptual speed and visuospatial ability, as well as increased risk of Alzheimer’s disease.

<sup>14</sup> In a study of 152 Danish SHU prisoners and 193 non-SHU prisoners, Sestoft, et al. (1998) found that risk of admission to the prison hospital for psychiatric problems was higher and increased in relation to amount of time spent in SHU.

<sup>15</sup> Grassian (1983) found that five of the 15 SHU inmates he interviewed reported experiencing auditory hallucinations and three experienced visual hallucinations. Additionally, there exist several studies that indicate that sensory deprivation and isolation induce hallucinations (Goldberger & Holt, 1961; Heron, Doane & Scott, 1956; Lipowski, 1975), but the test subjects were mostly college students held in brief confinement.

**Alterations in Perception** One of the most common reported responses to long-term isolation relates to lasting changes in perception. Class members consistently reported a marked shift in their perception of time while in SHU, stating that in some cases days seemed longer, while in other instances “time became a blur.”<sup>16</sup> Additionally, class members reported becoming highly sensitive to environmental stimuli, including loud noises and sudden movements.<sup>17</sup> Moreover, they reported ongoing fear of crowded spaces.

“The things that used to have meaning  
no longer have any meaning.”

“I don’t want to be close to anyone.”

“Mind would go negative without someone to talk to.”

“I don’t know if someone is going to shake my hand or attack me.”

“You can only trust yourself – your own mind and emotions.”

“I don’t want family and I don’t want friendship.

I have no desire to meet people. Family is meaningless to me.”

“[Being in SHU] ends trust with anyone who isn’t already trusted.”

“SHU made me lose all my ability to trust. You can’t imagine the hopelessness.  
If you don’t find an outlet this place will make you go insane.”

**Relational Estrangement** Nearly all class members reported losing relationships with family, friends, and significant others as a result of their isolation; several class members recalled that the deterioration of relationships with parents, partners, siblings, and children marked some of the most difficult experiences in SHU. According to most individuals interviewed, contact from their personal networks outside the prison system was often limited to notification that a family member had died. Class members reported being unable to properly grieve these losses, because they could not allow themselves to feel emotions associated with grief. One individual stated that he was unable to feel anything when his ex-wife, uncle, and nephew died within a short time period, because he “just had to keep going.”

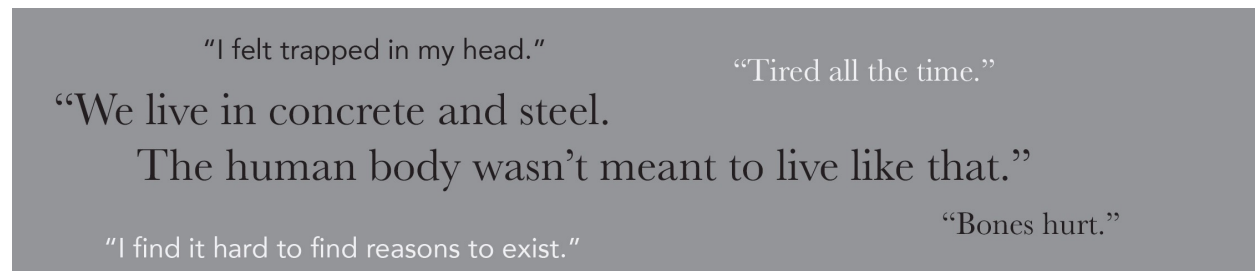
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<sup>16</sup> Drawing upon general research, Twenge, Catanese, & Baumeister (2003) found that time distortion, an indicator of being in a “deconstructed state,” which is common in suicidal individuals, increased after experiencing social rejection within the experiment.

<sup>17</sup> Solitary confinement prisoners in Maine State Prison also reported that the slightest noise, such as knocking on a cell door, resulted in feelings of uncontrollable anger. General prison population prisoners did not report such feelings (Benjamin & Lux, 1997).

**Physical Health** Several class members dealt with severe medical problems while in SHU; some were treated successfully, others less so. In some cases, these physiological problems appear to have developed as a result of the physical conditions of the SHU (for example, confinement to small spaces, lack of exercise). These include chronic pain, vitiligo, joint problems, and visual impairment, and many of these health consequences appear to continue well after transition out of SHU. There are a few environmental factors that increase the risk of health problems for people in long-term isolation. Lack of sunlight, for example, can lead to Vitamin D deficiency, which increases the risk of bone fractures (Williams, 2016). Lack of exercise also contributes to an increased risk of hypertension, arthritis, and heart disease (Williams, 2016).

Older prisoners may be particularly susceptible to chronic health problems and the health consequences of reduced quality of medical care; the average number of chronic medical conditions found in prisoners above the age of 55 is three (Williams et al., 2013). Research suggests that prisoners are more likely to be functionally impaired by health problems compared to non-prisoners. This means that prisoners have more trouble managing their illnesses and adapting to worsening health. Physical difficulties are likely to be compounded by untreated mental disorders and psychosocial impairment.



**Social Impairments** As previously noted, most class members lost contact with their personal networks while in SHU. Moreover, they frequently reported losing, over time, the motivation to seek social connection as well as a willingness to talk about their experience. Some became afraid to communicate with others because of how this might be perceived by correctional officers or Institutional Gang Investigators (IGI). Many class members expressed a belief that any personal connection could be misinterpreted as gang association, which would likely lead to longer terms in SHU. The majority of class members reported having highly negative relationships with correctional officers.

Class members who were able to maintain supportive relationships throughout their time in SHU appear to be outliers, though those who were successful in doing so seemed to show improved mental health overall. In other words, maintaining social connection appeared to be a protective factor against negative outcomes in SHU, meaning those with strong family ties demonstrated enhanced resilience to their SHU experience. Also, class members who reported having external social support or positive relationships with other prisoners, including cellmates, found themselves

better able to cope. Additionally, class members who affiliated themselves with others who shared the same political ideology, for example the New Afrikan Revolutionary Nationalism, or who created opportunities for mentorship, perhaps of younger prisoners, reported a greater sense of purpose and fulfillment.

**Functional Deterioration** It was the perception of most men interviewed that their overall functioning in multiple spheres was damaged by their time in SHU. They report the capacity for normal social interaction as the primary area of dysfunction after SHU. They also report lasting and ongoing dysfunction in mood, anxiety, and cognition.

**The Experience of Others in SHU** Class members reported that other prisoners in their SHU pods demonstrated evidence of mental disturbances, and that witnessing the suffering of others was distressing. Class members reported losing friends in SHU due to suicide, psychological deterioration, and death as a result of medical issues. Additionally, class members saw others engage in self-harm and violence at a level that was described as “heart-breaking.” Some class members reported that inmates in neighboring cells would talk to themselves, scream constantly, and speak in non-linear patterns. Some class members reported that neighbors attempted or completed suicide. Some neighbors were transferred to mental health units because they were “too crazy.”

A number of class members stated that the primary purpose of SHU “is to break you.” They reported feeling targeted by correctional officers, and being unable to communicate openly. Class members explained that it was important to “keep thoughts to yourself” in SHU. Conflict with correctional officers and IGI appeared to be a significant source of distress among class members. In a number of interviews, class members reported being treated unfairly by investigators who were seeking reasons to validate their status as members of prison gangs. For example, class members reported distress at having personal belongings, documents, and records confiscated; these items were often alleged to be evidence of gang affiliation, though class members stated that such claims were unsubstantiated and often interpreted such interactions as forms of harassment or provocation.

### *Interview Results Consistent with Existing Literature*

The social and psychological responses to SHU described above are consistent with the majority of current literature on prolonged isolation. In one of the most notable publications, Grassian (2006) described a specific syndrome associated with social isolation and sensory deprivation. Similar patterns of psychological dysfunction have been documented in empirical literature on prolonged solitary confinement. A number of researchers have observed the behavioral patterns of individuals confined long-term and found consistent detrimental outcomes (Arrigo & Bullock, 2008; Cloyes et al., 2006; Grassian, 1983; Grassian & Friedman, 1986; Grassian, 2006; Haney,

1993; Haney, 2003; Haney, 2006; and Lovell, 2008). Individuals in SHU exhibit increased risk for a wide range of psychiatric symptoms and disorders including depression, impulse control disorders, self-mutilation, and suicidal behavior (Haney, 2006). Prisoners in SHU also experience disproportionately high rates of general anxiety, symptoms of panic disorder, and difficulty with concentration, memory, and attention (Grassian, 1983; Grassian & Friedman, 1986; Grassian, 2006). Increased rates of psychotic symptoms, including paranoia, hallucination, and delusions have also been correlated with long-term isolation (Cloyes et al., 2006; Lovell, 2008; Grassian, 1983, 2006).

Additional cited outcomes of long-term solitary confinement include insomnia, intense anger, ruminations and intrusive thoughts, and social withdrawal (Cloyes et al., 2006; Haney, 2003; Grassian & Friedman, 1986; Grassian, 2006). Psychiatric symptoms have been found to vary based on the degree of sensory deprivation and social isolation (Arrigo & Bullock, 2008). The writers of this report are familiar with Grassian's concept of "SHU syndrome," which is comprised of "massive free-floating anxiety, hyper-responsivity to external stimuli, perceptual disillusion, hallucinations, derealization experiences, difficulties with thinking, concentration, memory, acute confusional states, aggressive fantasies, and paranoia" (Grassian, 1983, pp. 1452-1453). While the information obtained from the interviews does appear to align with symptoms of SHU syndrome, making retrospective claims regarding the presence or absence of SHU syndrome in *Ashker* class members is beyond the scope of the current report.

There is some conflict within the field and it is necessary to acknowledge critiques of these studies, as well as assess the validity of conflicting literature. A report by Haney and Lynch in 1997 has been criticized as being overly reliant upon interviews and self-report as opposed to scientifically rigorous experimentation (Kurki & Morris, 2001), while the reports of Grassian (1983) and Grassian and Friedman (1986) have been challenged due to their reliance upon a study population of only 14 inmates. A number of researchers contend that solitary confinement is not conclusively detrimental (Bonta & Gendreau, 1990; O'Keefe et al., 2010; Suedfeld et al., 1982; Zinger et al., 2001), but there are valid criticisms of these countering studies as well. Primarily, the literature reviewed by Bonta and Gendreau (1990) relied heavily upon studies involving volunteer subjects, short-term solitary (up to 10 days), and healthy subjects without pre-existing conditions (Kurki & Morris, 2001). The authors emphatically make clear that they are not arguing in favor of solitary confinement, and raise important questions: individual response to the conditions of solitary confinement may be different, further research is necessary to understand if solitary confinement effectively deters harmful behavior, and humane alternatives must be explored (Bonta & Gendreau, 1990). O'Keefe, et al. (2010) presented controversial findings that while both prisoners in solitary confinement and prisoners with mental illness in the general population exhibited SHU symptoms, over time, 20% of SHU inmates improved. The authors acknowledge not only that the results should not be generalized given the unique conditions of Colorado SHU, but also that the research was limited due to the utilization of

group averages and collection of psychological well being and behavior measures by prison clinicians and correctional officers (Smith, 2011). The report by Suedfeld et al. (1982) was limited by insufficient breadth of psychological measures and an inability to include subjects with severe responses to SHU due to the fact that they could no longer be interviewed (Ogloff, 2008). They did find that increased time in solitary was linked to anxiety, depression, hostility, and other negative emotions, but that it was not “overwhelmingly adverse” (Suedfeld, et al., 1982). The study is focused primarily upon the idea that responses to solitary confinement are individual and not always deleterious, which is an important area of investigation. Lastly, Zinger, et al. (2001) found that segregated inmates exhibited more depressive symptoms and anxiety than non-segregated inmates, but did not find evidence that mental health had significantly deteriorated. These longitudinal accuracy of these findings is challenged due to the fact that the experiment lasted merely 60 days (Metzner & Dvoskin, 2006), and the attrition rate proved problematic given that only 15% of 83 subjects completed all three phases of the testing and that ratios of voluntary SHU subjects to involuntary were no longer accurate (Ogloff, 2008). Overall, the literature indicates that solitary confinement negatively impacts the psychological well-being of inmates (Pizarro & Stenius, 2004).

## **Experiences in the General Population Following Release from SHU**

While the experiences and impact from time in SHU reported to Stanford Lab researchers are consistent with the previous body of evidence regarding outcomes of prolonged isolation and solitary confinement, the current analysis offers new important information regarding the lasting impact of indefinite, long-term isolation following release. Little previous research or analysis has been conducted with ex-SHU inmates following their release into GP or the general public at large.<sup>18</sup> At the time of these interviews, the amount of time elapsed since class members had been released from SHU averaged approximately 14 months (ranging from 4 months to 2 years since release). While many class members reported shock during their initial transition to GP (described in greater detail below), this transition is not a finite process, and many class members continue to experience significant difficulties up to two years post-SHU; many individuals are likely to continue to struggle with the impact of the SHU experience into the foreseeable future.

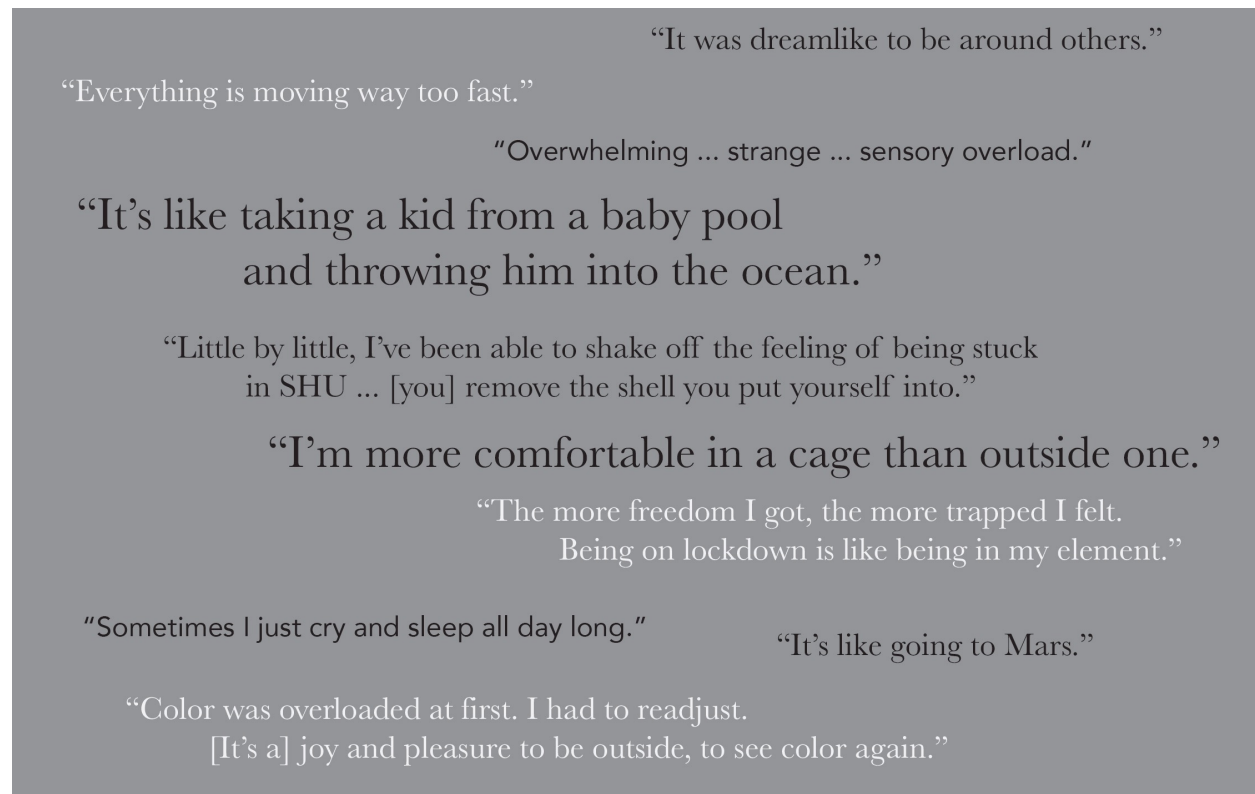
**General Responses to the Post-SHU Experience** In general, class members felt overwhelmed by and underprepared for the post-SHU experience in GP. Class members described the experience of GP as totally foreign and overwhelming (e.g., “like going to Mars”). The class members reported no preparation or information offered by CDCR to explain the

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<sup>18</sup> "Presently, there are no published studies that answer such important questions as whether prisoners who spent time in restrictive housing develop PTSD as a result of the experience. Likewise, no studies address whether restrictive housing prisoners experience long-term changes in psychosocial functioning following release into the community (e.g., getting a job, reconnecting with friends and family, finding stable housing)." (Kapoor & Trestman, 2016)



transition; many thought this would have been helpful to set expectations. Class members' reactions and adjustments to living in long-term SHU largely proved maladaptive within the context of the general prison population.



Class members reported a wide variety of transition experiences. Nearly half of individuals reported participating in the “Step Down Program” (SDP), which is designed to change attitudes and lead prisoners out of gangs. This program involves four stages that must be completed in order to earn privileges and eventually be released from SHU.<sup>19</sup> Prisoners who participated in the SDP reported few benefits, and many class members found aspects of the program to be unhelpful and disingenuous, particularly referencing the journals they were asked to keep. The majority of class members who commented on the benefits of SDP credited the improvements to increased social interaction and psychosocial education. A number of class members found learning skills such as “cognitive restructuring” and similar therapeutic tools to be useful during the transition. However, prisoners also reported problems with program implementation, including coercion and conflicts of interest with correctional officers facilitating group discussion. Prisoners did not report receiving any transitional support aimed at mitigating distress related to the overwhelming nature of the transition to GP from SHU. The great majority of class members denied any benefit of SDP in the absence of social interaction and mutual respect and understanding.

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<sup>19</sup> In CDCR, the SDP occurs entirely within the SHU, and is not a transitional housing placement.

Based on class member reports, experiences of feeling overwhelmed and underprepared appeared to stem from the drastic contrast between the physical, social, and sensory environments of SHU and GP, and the lack of an effective transition program. Class members reported being shocked and overwhelmed by the cacophony of the GP environment, and they reported hypersensitivity to the sounds and noises there. Many class members experienced distress as a result of being “overstimulated” in GP. Routines and expectations regarding periods of quiet and silence that had evolved over the many years in SHU were completely undermined in GP, resulting in discomfort and disturbance for many post-SHU prisoners. Expectations regarding cleanliness and organization were disrupted or unattainable in GP. Similarly, the highly structured and closely supervised daily procedures and transitions in SHU were found to be largely absent in GP. While many class members had developed rigid routines, daily schedules, and expectations as a means of adapting to their time in SHU, living in GP required them to re-develop greater flexibility in their daily functioning. The loss of routine and stability in daily functioning, and the related lack of predictability and demand for flexibility, was jarring and distressing for class members, resulting in feelings of anxiety, nervousness, irritability, and a sense of isolation and disconnection, exacerbated by the lack of any transition preparation. While class members overwhelmingly asserted that GP was an improvement over life in SHU, the difficulties experienced post-SHU are indicative of the impact of long-term isolation on normal functioning and the extent to which adaptations to the SHU environment prove maladaptive in other contexts, underscoring the need for programs and supports to assist in adapting to life post-SHU.

Class members also reported being unprepared for the increase in social and physical interaction in the GP environment. Many did not anticipate or realize the discomfort they would feel in having to interact with unfamiliar prisoners, and in experiencing violations in their expectation for personal space and physical contact. For example, multiple class members reported difficulty and distress in making eye contact and greeting other prisoners in GP. One class member reported feeling as though “bugs were crawling” under his skin, because he was so unfamiliar with being around people. Some found the communication styles they had developed in SHU to be problematic and maladaptive in the context of GP. Many class members also reported difficulty with a perceived change in prison culture during the time they were in SHU. In particular, they noted difficulty with the younger generation of prisoners, in which there is “no moral code.” Overall, class members described a general sense of being “out of place” and “unfamiliar” in GP, resulting in a failure to achieve a sense of belonging, security, or personal identity in their life outside of SHU.

Class members described experiences that frequently and continually created the perception that they were being targeted by prison officials, guards, and IGI, not to mention treated differently by fellow prisoners, because of their post-SHU status. Class members report that they are viewed as dangerous, treated with disrespect, watched closely and searched frequently, granted fewer privileges, and intentionally pushed to instigate an anger response (e.g., through disruption of

routines or living environment, or destruction of personal belongings). Class members reported the perception that prison officials wanted them to be back in SHU and were looking for reasons to put them there. Such themes of harassment and discrimination by prison officials were a focus of over half of the class member interviews. Class members report that their sense of being watched, scrutinized, and targeted because of their post-SHU status leads to increased anxiety, distress, anger, and paranoia.

In general, class member reports demonstrate that the post-SHU experience in itself had negative psychological consequences, contributing to experiences of irritability, hypervigilance, and anxiety (discussed in further detail below) particularly in the absence of appropriate transitional or support programs that might have mitigated these impacts. This distress experienced in GP compounded the already existing negative impact and functional impairment caused by the many years of being held in long-term isolation.

Nonetheless, class members reported some positive responses and beneficial aspects of the post-SHU experience, such as witnessing nature (seeing mountains and the moon, for example), increased social interaction, increased physical activity, and having increased contact with family. Clearly, living in GP provided an improvement in quality of life over SHU, despite class members living with the lasting psychological insult and functional impairment related to their many years in SHU. However, the lack of programming, significant restrictions, limited mobility, and repeated distress and disruptions experienced by ex-SHU prisoners in GP led some class members to describe their experience in GP as a “modified SHU.”

“We are broken, but most of us are too proud to ask for help.”

“That trepidation never leaves even when things are going well.”

“I don’t know how to write without handcuffs on.”

“I am scared about when I go out and if I will be able to work.”

**Ongoing Psychiatric Problems Post-SHU** Class members endorse lasting and ongoing psychological difficulties since being released from SHU. These include anxiety and post-traumatic stress, obsessive and compulsive behaviors in an effort to re-impose order, and continued mood dysregulation, emotional numbing, and cognitive impairment. Class members coming out of SHU also report the emergence of metacognitive reactions, which is to say they become aware of their own psychological impairments vis-à-vis others around them; this itself becomes a source of additional anxiety. Class members also report psychosomatic complaints as well as renewed substance abuse.

While some class members report that their psychiatric symptoms and psychological difficulties (including anxiety, mood instability, obsessions/compulsions, and cognitive impairment) have

gradually declined over time as they have adjusted to living in GP, others report sustained severity and frequency of such symptoms even after periods of over two years since release from SHU.

**Anxiety, Post-Traumatic Stress, and Hypervigilance** Class members commonly reported ongoing anxiety and posttraumatic stress symptoms in their post-SHU experiences. Nearly all class members reported experiences consistent with an ongoing anxiety or trauma-related psychiatric disorder (such as panic disorder, generalized anxiety disorder, and posttraumatic stress disorder (American Psychiatric Association, 2013)). Specific difficulties endorsed by class members include pervasive hypervigilance, worry, and nervousness; some described experiences of being on constant alert and chronically feeling under threat or danger. In the post-SHU experience in GP, class members report living in a perpetual state of fear, in which they feel their safety and well-being is under threat, and some report ongoing intrusive worries and re-experiencing symptoms (such as nightmares).

While such feelings may generally be expected for any inmate in GP, class members' experience of anxiety and hypervigilance appeared to be exacerbated by the SHU experience: following a prolonged period of incarceration in a highly structured and contained environment, exposure to the chaotic, disorganized, and unpredictable GP environment leads to a heightening of symptoms and distress. Class members described that, when in SHU, any time out of the cell and in common areas was associated with potential threat or danger (e.g., due to potential attack from other inmates). Therefore, the post-SHU experience involved increased exposure to contexts and environments associated with threat or danger, thereby exacerbating anxiety symptoms. Class members report particular anxiety in social situations and/or crowded settings: they report feeling uncomfortable, nervous, and jittery when around groups of people, and find themselves constantly scanning their surroundings. They avoid situations and settings in which they do not have a clear view of, or cannot closely monitor, their surroundings and the movements of others.

Many class members endorsed sensory sensitivity following their release into GP, noting experiences of distress, anxiety, paranoia, and irritability particularly in response to the noise and sounds of GP. In addition, class members report sensitivity to physical touch, which continues to elicit exaggerated startle and discomfort for many class members.

In addition, class members report that periods of lockdown in GP are triggering and re-traumatizing, and that they invoke re-experiencing symptoms of posttraumatic stress disorder (such as flashbacks in which one feels that he is reliving the traumatic experience, in this case, the experience of being held in SHU). Many class members report a pervasive and ongoing fear of returning to SHU, which is often exacerbated by their interactions with prison officials. In some cases, class members reported ongoing paranoia stemming from their anxieties and worries.

**Obsessive-Compulsive Behaviors** Class members report lasting obsessive-compulsive thoughts and behaviors, primarily related to continued desire for cleanliness, order, and organization in their living environment. The rigid routines, rituals, and compulsions that developed while in SHU were also present for many class members following their transition to GP; more than half of the class members interviewed endorsed ongoing difficulties in this area. For example, many class members endorse experiences of irritability, anxiety, frustration, and general distress when belongings are perceived to be out of order or unclean; they continue to spend significant amounts of time and effort engaged in obsessive perseveration and compulsive rituals. These obsessions, compulsions, and rigid routines sometimes result in interpersonal conflict with others (cellmates, peers, prison officials).

**Mood Dysregulation** Class members describe lasting mood difficulty, typically marked by anger, irritability, and emotional instability. Experiences of anger and aggression were often linked with feelings of heightened anxiety, nervousness, and threat that are common in the GP environment. Lasting mood impairments, which were endorsed by the majority of class members, also include symptoms consistent with depression, including negative mood, lack of motivation, anhedonia, and sense of isolation. Class members describe and exhibit continued flat affect and signs of emotional numbing that arose while in SHU. In many cases, experiences of anger, irritability, negative mood and affect, and other depressive symptoms carried over from the distress and frustration that onset while in SHU; current interviews therefore confirmed this form of distress related to the SHU experience to be lasting and pervasive following release. In addition, class members' heightened and ongoing experiences of anxiety and posttraumatic stress in GP contribute to their experience of agitation, irritable mood, despair and hopelessness.

**Cognitive Impairments** Lasting cognitive difficulties experienced post-SHU and endorsed by class members involve impairments with executive functioning, including attention, concentration, and memory. Approximately two out of every three class members report current, ongoing (at time of interview) difficulties with attention, concentration, and memory. Class members report lasting difficulty in sustaining attention (e.g., while reading or writing), comprehending information, remembering factual information and names, and the perception and estimation of time. Some class members note feeling “slow” and “disorganized” in their psychological and cognitive functioning. For some, these difficulties arose while in SHU, while others note the onset of cognitive impairment only following their release from SHU, which they attributed to the stress of being in GP and the overwhelming transition away from the highly structured SHU environment. Lasting and pervasive impairment in executive and cognitive functioning is common in response to chronic and traumatic stress exposure, due to the biochemical impact of the stress response on brain structure and function (Polak et al., 2012).

**Metacognition** Class members report varying meta-cognitive and meta-emotional reactions during their post-SHU experience.<sup>20</sup> While some class members report and demonstrate ongoing emotional numbing and limited insight regarding their cognitive and emotional experiences (which commonly onset while in SHU), others report increased awareness of their psychological distress and functional impairment as they integrated into GP. Class members' heightened awareness of their own psychological impairment proved for many to be an additional source of distress and despair, contributing to attributions that they are damaged and that their situation is hopeless.

For example, as one class member became more aware of the atypical nature and the severity of his obsessions with order and cleanliness, he became increasingly frustrated and distressed by his compulsions and behavioral tendencies. In other cases, class members report distress and concern in reflecting on their lack of emotional response to the death of close family members. In addition, many class members struggle with feelings of guilt and shame about the emotional and behavioral difficulties they experienced while in SHU. While difficulties with emotional and behavioral regulation (e.g., anger outbursts) are a common and expected reaction to living in SHU conditions, class members often internalized and personalized their difficulties. Class members' attributions of their difficulties often resulted in self-blame, rather than consideration of the context in which they were living. The meta-cognitive and meta-emotional processes described above and endorsed by class members are common core components of depression, anxiety, and posttraumatic stress disorders.

**Somatic Complaints** Class members report numerous ongoing psychosomatic complaints that are commonly associated with depression, anxiety, and posttraumatic stress. Such somatic symptoms include chronic pain, fatigue, difficulty sleeping, and nausea/digestive irritability; somatic difficulties were endorsed and discussed in nearly half of the interviews.

**Substance Abuse** Some class members report the onset or exacerbation of substance abuse and substance dependence problems following their transition to GP. Incidences of new substance abuse and addiction problems were attributed both to (1) the intensified anxiety and emotion dysregulation associated with the transition to GP, and (2) increased availability and access to alcohol and drugs in GP relative to SHU.

**Other Health Problems and Difficulties** Class members report other ongoing health difficulties during their post-SHU experience in GP. Many individuals report psychosomatic complaints including chronic pain, fatigue, insomnia, psychomotor retardation, and weakness. In addition to the psychological factors contributing to these health difficulties, the presence of such

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<sup>20</sup> Meta-cognition and meta-emotion refer to one's own awareness of one's thoughts, feelings, and ability to function.

problems may also be attributed to the limited physical activity, the nature of the physical environment, and quality of care provided in SHU. For some class members, the quality of food and health care in SHU contributed to and exacerbated existing health conditions. For example, class members with poorly managed diabetes report worsening of neuropathy, which is permanent. In addition, many class members attribute significantly elevated blood pressure and cholesterol to their diet in SHU, though the chronic stress experienced in the SHU environment is also likely to be a contributing factor with lasting consequences. Many class members reported contracting Hepatitis C while in SHU.

Over half of all class members reported deterioration in their vision during their time in SHU, which appears to be lasting and permanent. Many class members were not aware of the deterioration in their vision until they were released from SHU. A majority of class members now wear corrective lenses, and some report ongoing sensitivity to light.

**Ongoing Social Interaction Problems** A primary lasting outcome of SHU and the transition experience experienced by class members is the impairment in social functioning. Over two-thirds of the class members interviewed endorsed ongoing anxiety and difficulty functioning in social situations. As described above, class members noted difficulty and distress in social interactions both while in SHU and while in GP post-SHU. Class members reported feeling nervous and uncomfortable in social interactions, leading to behavioral avoidance of social contact. They describe themselves as newly quiet, awkward, timid, and generally overwhelmed by social experiences. They are unable to engage new relationships, as many report lasting difficulty with basic greetings (e.g., making eye contact, shaking hands). In addition, class members experience lasting anxiety and hypervigilance around social interactions, citing a distrust for others, chronic perceptions of danger, and a pervasive fear of sharing information about themselves. These fears have clear impact on their social interactions and functioning, consistent with the negative impact of social anxiety disorders.

After getting accustomed to social isolation, and as a result of social difficulties experienced post-SHU, class members demonstrate a lasting reluctance to engage or “be close with” others, preferring the simplicity and familiarity of isolation. Class members feel disconnected from others, and many prefer and envision a future in which they remain isolated and independent. Many report a lasting loss of motivation, interest, or desire to connect or socialize with others. As an exception to this common phenomenon, class members endorse an increased level of comfort and interpersonal effectiveness with other ex-SHU prisoners, relative to other inmates and/or family members and others on the outside.

Class members reported lasting impairment and dysfunction in relationships with family members and individuals outside of the prison system. The “death” of family relationships that occurred while in SHU continues for many class members, as they have been unable to repair

damaged relationships caused by long-term separation. Class members report an inability to tolerate the affective responses inherently involved in family interactions, leading to further estrangement. Class members report complex and distressing difficulties in responding to contact visits with family members, and they describe themselves as being unable to receive affection. Commonly reported reactions included nervousness, joy, shock, dissociation, and numbing/flat affect. Class members reported experiencing “sensory overload” and derealization — a sense of one’s surroundings not being real — upon meeting with visitors. They reported not knowing how to react to physical touch or displays of kindness during contact visits, and often found themselves feeling uncomfortable and rejecting physical and social contact with family members, despite having a desire to improve their relationships. Many class members are keenly aware of their social impairments, leading them to be further distressed and upset by their inability to engage with family and their lack of emotional response to family interactions.

Class members reported difficulties forming relationships with other prisoners in GP for a number of reasons. As noted above, many prisoners experience heightened anxiety around crowds of people. In order to cope with the overwhelming anxiety, some individuals described standing with their backs against the wall, or in a place where they could view everyone around them at all times. Others used self-talk to convince themselves that people would not attack them. As noted earlier, some class members report that their behavioral rigidity, mood lability, and expectations regarding cleanliness and order serves as a point of conflict and source of distress in many of their interpersonal relationships (e.g., with new cellmates) in GP. Older class members also experienced significant interpersonal stress related to cohort differences. They report feeling “out of place” and “out of touch,” they have a limited sense of belonging, and their personal identity as SHU inmates does not fit within the context of GP. These class members reported feeling anxious about blending in and communicating with the younger generation. However, some individuals relished their ability to mentor and advise younger prisoners.

In summary, class member difficulty with interpersonal and social functioning is characterized by dysfunction and impairment due to: anxiety, irritability, and mood instability impacting interpersonal interactions; emotional numbing affecting engagement; social and familial withdrawal (isolation); poor communication and lack of conflict resolution skills; lack of connection to others influencing personal identity and worldview; reduced sense of security; limited support-seeking and social engagement; and low confidence and self-esteem. While some class members report gradual reductions in social anxiety, irritability, and impairment over the course of their adjustment to GP, many report sustained severity of symptoms and impairment with little perceived prospect or hope for future improvement.

**Other Ongoing Impairment in Functioning** Class members describe alterations in their personal identity following their release from SHU. Throughout the post-SHU experience, class members continue to struggle to see their place and value in society and in the world, as they



came to view themselves only as prisoners during their time in SHU. Many class members reported that, after living in isolation for so many years and being treated only as an inmate with no value or opportunity for contribution to society, they lost their sense of self and their motivation for industry and productivity. An individual's self-concept and personal identity play major roles in his decisions and actions towards education, employment, and other contributions to society; therefore, the impairment and alteration in class members' sense of self and sense of purpose is likely to impact their functioning in GP and in the outside community if unaddressed. Additionally, the pervasive and perpetual anxiety, nervousness, and sense of threat experienced following release from SHU contributes to a sense of hopelessness and despair regarding class members' well-being and prospects for the future.

Class members' ongoing difficulties with mood instability, anxiety, depression, behavioral rigidity, and cognitive functioning are likely to impair their functioning and performance in domains of learning/education, vocation/employment, and independent functioning/self-care. Given these difficulties, some class members reported concerns and anxieties about their ability to function (i.e., obtain and retain employment) in both GP and society at large. Clearly, lasting difficulties with social interactions will impact interpersonal functioning, including family relationships, social relationships, and peer interactions in professional settings.

The impairments described above, while consistent with various forms of psychopathology and psychiatric illness, are not thought to be generally rooted in an underlying psychopathology or illness. Rather, the psychological, physical, and behavioral responses of class members represent expected adaptations to the conditions of long-term solitary confinement. Any individual living in long-term confined isolation is likely to manifest the symptoms and functional impairments endorsed and demonstrated by class members. For example, undergoing a process of emotional numbing and dampening may very likely be the best way of coping with the intense emotions associated with long-term isolation, especially given the limited resources and outlets available to class members. Or, developing rigid, highly structured routines (which eventually evolve into obsessions and compulsions) around order and cleanliness likely served as the best possible means to both maintain a sense of productivity and to exert some level of control and self-efficacy in an otherwise helpless situation. Though these adaptations helped class members survive and cope while in SHU, they proved largely problematic and maladaptive in the context of GP, as reported and demonstrated by class members following their release from SHU. Clearly, class members' psychological and behavioral adaptations to SHU will also be maladaptive in the context of general society, and are likely to impair independent functioning, social functioning, and vocational functioning.

As demonstrated by class members who had spent one to two years in GP at the time of the interviews upon which this report is based, these impairments are pervasive and ongoing, and are expected to continue, especially given the length of time that these emotional, cognitive, and

behavioral response patterns became engrained (from 10 to over 20 years). While significant and lasting, the impairments and difficulties endorsed and demonstrated by class members are not irreversible in many cases, and may be amenable to intervention or support. There remain opportunities for healing, for new learning, and for successful functional re-adaptation to the contexts of GP and larger society. While some class members may experience a natural, gradual reduction in distress and impairment, for others, if difficulties are not addressed, their impairments are likely to continue and worsen over time.

The information provided by this report aligns with current literature on long-term isolation and the subjective experience of SHU. Moreover, the trends in psychosocial and mental health responses observed by the interviewers are consistent with those identified by SHU expert Terry Kupers. Kupers (2016) developed the term “SHU post-release syndrome” to describe the behavioral patterns of people who are re-introduced to social environments after experiencing social isolation and sensory deprivation. Elements of SHU post-release syndrome that are salient to the current report include anxiety in unfamiliar places, hyper-awareness of surroundings, heightened suspicion of others, concentration and memory problems, and a sense of one’s personality having changed. As noted above, these reactions were among the most commonly endorsed by *Ashker* class members.

## **Considerations for Improving Post-SHU Experiences and Functioning**

Many class members reported experiencing multiple restrictions in their activities in GP due to their status as ex-SHU inmates. They reported limited opportunities for out-of-cell time, employment, education, and contact with families and outside supports. Such restrictions placed specifically on ex-SHU inmates are likely to be detrimental to their functioning and recovery, and may exacerbate existing psychological difficulties and related distress stemming from their experience in long-term isolation. Class members directly reported that with major restrictions and little time out of cell, symptoms similar to those experienced while in SHU remained and did not dissipate. Class members involved in out-of-cell activities and with less restriction reported a subjective sense that there was a higher possibility for psychological improvement.

Class members repeatedly emphasized the importance of having jobs and other programming opportunities in GP. Class members who are participating in jobs and educational programs reported greater satisfaction and better outcomes in GP than those who are not. Class members who are not working expressed frustration with their lack of program placement. Some individuals perceived that they were being purposefully excluded from programming opportunities due to their SHU history. Employment opportunities not only correspond with greater out-of-cell time for class members,<sup>21</sup> but they also provide class members with a greater

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<sup>21</sup> S. Miller, personal communication, September 15, 2017.

sense of purpose, industry, and productivity. Involvement in occupational and educational activities was observed to be a protective factor against distress during the post-SHU experience, and appears to promote resilience in the face of the numerous adversities described above. Class members who are denied opportunities for employment or education can be expected to demonstrate greater levels of psychiatric distress, poorer general health, and poorer outcomes with regard to functioning and performance.

“It helps to know what’s going on in the outside world.”

“We don’t see the R in CDCR.”

“Interacting with someone who is not a guard, not someone who was locked up [was] really nice.”

“I want a chance to make amends with the community.”

“It feels good to relate your experience to others. You can help someone else by recognizing patterns in your own life and preventing that for them.”

“Hearing about others’ experiences helps me to know that I’m not crazy.”

“Stigma is a major barrier to men getting mental health services here.”

“The more out-of-cell time, the better.”

Class members, particularly those without jobs, stated that they would benefit from more out-of-cell time. Numerous class members suggested that education around their transition would be exceedingly helpful in improving outcomes and functioning. As mentioned above, some class members found the group aspect of the Step Down Program to be thought-provoking and helpful, while others found it to be coercive and threatening. Those who were unhappy with the program would have preferred for the groups to be peer-facilitated or run by independent professionals rather than correctional officers. Numerous class members emphasized the value of gaining an improved understanding of their psychological reactions to living in SHU and their difficulties in the post-SHU environment (including gaining knowledge that others experienced similar difficulties), which they achieved through both formal and informal interactions with other ex-SHU inmates.

It is understandable for class members to have reservations about participating in support groups run by correctional officers, or anyone affiliated with CDCR. An overwhelming majority of class members (over three out of every four interviewed) suggested and requested services and support from non-CDCR officials. Bringing in outside facilitators to host supportive groups for prisoners

transitioning from SHU to GP would allow for more genuine reflection and communication among prisoners. Peer facilitation would be similarly beneficial.

Many class members spent the majority of their time in SHU studying, reading, and pursuing an education. This appeared to be a source of resilience in the face of the adversity of the SHU environment, as those class members that found ways to use their time productively and to extract a sense of purpose from their time in SHU appeared to be better able to cope with the psychological impact of the SHU experience. Many of these class members expressed the desire to give back to the community by mentoring others. While many of these efforts were self-directed and self-initiated, there exist ample opportunities for CDCR to offer programming and facilitate opportunities; such efforts are likely to ameliorate the negative impact of long-term isolation in SHU.

### *Concepts for Improved Post-SHU Transition*

The mental health professionals in the Human Rights in Trauma Mental Health Laboratory at Stanford University are well versed in treatment modalities and useful interventions for persons with mental health disorders and/or symptoms. Much of the mental health pathology discussed in the interviews with class members is amenable to intervention, but mental health interventions must be sensitive to the needs and wants of the individual in order to be effective.

First, occupational, educational, and social programs are needed to address the lasting consequence of the long-term SHU experience. Such services can be arranged and facilitated by CDCR. Second, emotional and psychological support services are needed. The literature on effective, evidence-based treatment for anxiety and depression is vast. Conventional medication and psychotherapeutic interventions are proven to treat symptoms and improve functioning. In addition, psychoeducation regarding psychiatric symptoms and expected reactions to adversity and trauma is an important (and sometimes the most effective) element of evidence-based intervention. Psychoeducation helps an individual to gain insight about his struggles, helps to normalize distress, and leads to empowerment in managing symptoms. The importance of psychoeducation is reflected in class member statements regarding the benefits of discussing their experiences with other post-SHU inmates.

However, the class members have expressed concerns over the administration of traditional mental health services through CDCR. Furthermore, many class members have made it clear that they would not seek services through CDCR because of the stigmatizing effects of identification with psychiatric illness. Some class members report that they would seek mental health services if they were offered through providers from outside CDCR in a way that was totally confidential. For transition, it is clear that improved, earnest access to mental health treatment is necessary, and that such access should come from non-CDCR sources. Therefore, we

recommend that class members be offered mental health and psychological services in the form of independent psychiatric care and/or peer-led or peer-facilitated support groups. As noted throughout the report, prisoners seem to derive a sense of fulfillment and self-worth from opportunities to mentor their peers; such programming could be helpful in combatting some of the detrimental effects of time in SHU, including by diminishing anxiety and depression.

Lastly, the feedback from the narratives offers greater understanding of what other interventions class members want to improve their transitions from SHU. Their requests (detailed above) for greater access to jobs and other out-of-cell activities, to programs, and to therapeutic groups are wise interventions for their symptom profiles and are likely to improve their transitions and the long-term prospects for functioning and contribution to society.

## **Conclusion**

In interviewing *Ashker* class members undergoing the transition from long-term solitary into the general prison population, members of Stanford Lab identified a number of trends related to prisoners' mental health, psychosocial adjustment, and general well-being. Class members reported experiencing a number of psychological symptoms during their time in SHU, many of which have persisted or even worsened while in GP (after being released from SHU). The sterile environments common in GP, in which prisoners spend almost all of their day in their cell with little productive activity, have contributed to many class members' continuing psychological symptoms. The most commonly reported symptoms included hypersensitivity to stimuli, anger/irritability, anxiety, insomnia, paranoia, emotional numbing and/or dysregulation, obsessive-compulsive thoughts and behaviors, and problems with concentration, attention, and memory. In addition to these symptoms, class members reported difficulties adjusting to the social environment of GP. It is clear that placing ex-SHU prisoners in GP without additional supports or programming is insufficient to remedy the outcomes stemming from long-term isolation in SHU. In addition, the transitional programming that has been previously implemented for the current class was largely ineffective and insufficient.

The majority of class members expressed a need for mental health care due to the psychological harm they endured in solitary confinement. Class members reported high levels of continuing distress and discomfort associated with social isolation and sensory deprivation. However, the majority of class members also expressed a significant level of distrust for CDCR mental health services. Interviewees recognized a stigma associated with seeking mental health care within the prison system. They worried about being labeled as mentally ill and maintaining their confidentiality. Class members expressed concerns of appearing weak to other prisoners and of being medicated against their will. Among prisoners who did receive mental health services provided by CDCR, there were mixed reports. Some reported benefitting from psychiatric medication, but did not feel comfortable engaging in talk therapy. Others expressed

dissatisfaction with the infrequency of the psychiatric care received, which was reportedly every 90 days.

Based on the information summarized in this report, the Stanford Lab recommends reparative services in the form of externally based (non-CDCR) mental health care and psychological support; meanwhile, continued and enhanced occupational and other programming should be provided by CDCR.

The *Ashker* class members interviewed for this report are resilient, self-educated, intellectually curious individuals, many of whom have implemented therapeutic coping mechanisms on their own. Class members reported benefitting from mindfulness and meditation, as well as critical thinking and other limited group-based therapeutic experiences. Additionally, class members who were involved in jobs and other programming at the time of interview appeared to adjust to GP significantly better than those who lacked similar opportunities. During the course of interviews, it became apparent that when class members are offered opportunities for supportive programming, education, and vocational training that are deemed relevant and are offered by trusted sources, they capitalize on such opportunities towards the ends of personal development and societal contribution. The Stanford Lab therefore recommends that CDCR and other prison authorities seek to offer adequate and enriched programming opportunities (including vocational, educational, and socio-emotional supports) as a means of providing reparative services and personal, community, and societal healing following long-term isolation in SHU.

## **About the Human Rights in Trauma Mental Health Lab**

The Human Rights in Trauma Mental Health Laboratory is committed to advancing and applying research on the physical and psychiatric impact of trauma on survivors of human rights abuses with an eye towards informing transitional justice and judicial processes. The Lab focuses on the science of the psychological changes and mental health pathology caused by trauma on individuals, their families, and their communities, over time and between generations. Lab affiliates and colleagues analyze and build upon the rich data available in the interdisciplinary scientific literature and developed in specific conflict situations to clearly identify the impact on human psychology of various forms of mass trauma, including genocide, mass killings, rape, and torture. This analysis is used to clarify the science and/or advocate for the survivors' human rights and mental health in a whole range of settings, including criminal trials, civil suits for money damages, and asylum proceedings. The Lab will participate in these transitional justice processes in a range of ways, including by providing expert testimony and reports and consulting with the legal teams prosecuting perpetrators or representing victims.

Learn more about the Stanford Lab at <http://med.stanford.edu/psychiatry/research/HumanRightsinTraumaMH.html>

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## References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Andersen, H. S., Sestoft, D., Lillebaek, T., Gabrielsen, G., Hemmingsen, R., & Kramp, P. (2000). A longitudinal study of prisoners on remand: psychiatric prevalence, incidence and psychopathology in solitary vs. non-solitary confinement. *Acta Psychiatrica Scandinavica*, 102, 19-25.

Andersen, H. S., Sestoft, D., Lillebæk, T., Gabrielsen, G., & Hemmingsen, R. (2003). A longitudinal study of prisoners on remand Repeated measures of psychopathology in the initial phase of solitary versus nonsolitary confinement. *International Journal of Law and Psychiatry*, 26, 165-177.

Arrigo, B. A., & Bullock, J. L. (2008). The psychological effects of solitary confinement on prisoners in supermax units: Reviewing what we know and recommending what should change. *International Journal of Offender Therapy and Comparative Criminology*, 52(6), 622-640.

Benjamin, T. B., & Lux, K. (1977). Solitary confinement as psychological punishment. *Cal. WL Rev.*, 13, 265.

Bonta, J., & Gendreau, P. (1990). Reexamining the cruel and unusual punishment of prison life. *Law and Human Behavior*, 14(4), 347-372.

Cloyes, K. G., Lovell, D., Allen, D. G., & Rhodes, L. A. (2006). Assessment of psychosocial impairment in a supermaximum security unit sample. *Criminal Justice and Behavior*, 33(6), 760-781. doi: 10.1177/0093854806288143

Goldberger, L., & Holt, R. R. (1961). *Studies on the effects of perceptual alteration*. Research Center for Mental Health New York University NY.

Grassian, S. (1983). Psychopathological effects of solitary confinement. *American Journal of Psychiatry*, 140(11), 1450-1454.

Grassian, S., & Friedman, N. (1986). Effects of sensory deprivation in psychiatric seclusion and solitary confinement. *International journal of law and psychiatry*, 8(1), 49-65.



Grassian, S. (2006). Psychiatric Effects of Solitary Confinement. *Washington University Journal of Law and Policy*, 22. Retrieved from [http://openscholarship.wustl.edu/law\\_journal\\_law\\_policy/vol22/iss1/24](http://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24).

Haney, C. (1993). Infamous punishment”: The psychological consequences of isolation. *National Prison Project Journal*, 8(2), 3-7.

Haney, C. (2001). The psychological impact of incarceration: Implications for post-prison adjustment. *National Policy Conference: From Prison to Home: The Effect of Incarceration and Reentry on Children, Families and Communities*.

Haney, C. (2003). Mental health issues in long-term solitary and “supermax” confinement. *NCCD news*, 49(1), 124-156. doi:10.1177/0011128702239239

Haney, C. (2006). Reforming punishment: Psychological limits to the pains of imprisonment. *American Psychological Association*.

Heron, W., Doane, B. K., & Scott, T. H. (1956). Visual disturbances after prolonged perceptual isolation. *Canadian Journal of Psychology/Revue canadienne de psychologie*, 10(1), 13.

Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., . . . Venters, H. (2014). Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *American Journal of Public Health*, 104(3).

Kapoor, R. & Trestman, R. (2016). Mental Health Effects of Restrictive Housing. NCJ 250321. In *Restrictive Housing in the U.S.: Issues, Challenges, and Future Directions*. Washington, D.C.: U.S. Department of Justice, National Institute of Justice.

Kupers, T. A. (2008). What to do with the survivors? Coping with the long-term effects of isolated confinement. *Criminal Justice and Behavior*, 35(8), 1005-1016.

Kupers, T. (2016). The SHU Post-Release Syndrome: A Preliminary Report. *Correctional Mental Health Report*, Volume 17, Number 06, March/April 2016 , pp.81-85(5).

Kurki, L., & Morris, N. (2001). The purposes, practices, and problems of supermax prisons. *Crime and Justice*, 28, 385-424.

Lipowski, Z. J. (1975). Sensory and information inputs overload: Behavioral effects. *Comprehensive Psychiatry*, 16(3), 199-221.

Lovell, D. (2008). Patterns of disturbed behavior in a supermax population. *Criminal Justice and Behavior*, 35(8), 985-1004.

Metzner, J., & Dvoskin, J. (2006). An overview of correctional psychiatry. *Psychiatric Clinics*, 29(3), 761-772.

Miller, H. A., & Young, G. R. (1997). Prison Segregation: administrative detention remedy or mental health problem? *Criminal Behaviour and Mental Health*, 7, 85-94.

Ogloff, J. R. P. (2008). Review of the Mental Health and Psychosocial Needs of Prisoners Detained in Restrictive Environments: Literature Review. *Justice Health & Corrections Victoria*. 1-25.

O'Keefe, M. L., Klebe, K. J., Stucker, A., Sturm, K., & Leggett, W. (2010). One year longitudinal study of the psychological effects of administrative segregation. Colorado Department of Corrections, Office of Planning and Analysis.

Patterson, R. F., & Hughes, K. (2008). Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004. *Psychiatric Services*, 59(6), 676-682.

Pizarro, J., & Stenius, V. M. (2004). Supermax prisons: Their rise, current practices, and effect on inmates. *The Prison Journal*, 84(2), 248-264.

Polak, A.R., Witteveen, A.B., Reitsma, J.B., & Olf, M. (2012). The role of executive function in posttraumatic stress disorder: A systematic review. *Journal of Affective Disorders*, 141, 11-21.

Reeves, R., & Tamburello, A. (2014). Single Cells, Segregated Housing, and Suicide in the New Jersey Department of Corrections. *The Journal of the American Academy of Psychiatry and the Law*, 42(4), 484-488.

Roma, P., Pompili, M., Lester, D., Girardi, P., & Ferracuti, S. (2013). Incremental conditions of isolation as a predictor of suicide in prisoners. *Forensic Science International*, 233. <http://dx.doi.org/10.1016/j.forsciint.2013.08.016>

Sestoft, D. M., Andersen, H. S., Lillebæk, T., & Gabrielsen, G. (1998). Impact of solitary confinement on hospitalization among Danish prisoners in custody. *International Journal of Law and Psychiatry*, 21(1), 99-108.

Smith, P. S. (2011). The effects of solitary confinement: Commentary on one-year longitudinal study of the psychological effects of administrative segregation. *Corrections & Mental Health*, 1-11.

Suedfeld, P., Ramirez, C., Deaton, J., & Baker-Brown, G. (1982). Reactions and attributes of prisoners in solitary confinement. *Criminal Justice and Behavior*, 9(3), 303-340.

Twenge, J. M., Catanese, K. R., & Baumeister, R. F. (2003). Social exclusion and the deconstructed state: time perception, meaninglessness, lethargy, lack of emotion, and self-awareness. *Journal of personality and social psychology*, 85(3), 409.

Way, B. B., Miraglia, R., Sawyer, D. A., Beer, R., & Eddy, J. (2005). Factors related to suicide in New York state prisons. *International Journal of Law and Psychiatry*, 28(3), 207-221. doi: 10.1016/j.ijlp.2004.09.003

Williams, B. A. (2016). Older Prisoners and the Physical Health Effects of Solitary Confinement. *American Journal of Public Health*, 2016 Dec;106(12):2126-2127. doi: 10.2105/AJPH.2016.303468

Williams, B. A., Goodwin, J. S., Baillargeon, J., Ahalt, C., & Walter, L. C. (2012). Addressing the aging crisis in US criminal justice health care. *Journal of the American Geriatrics Society*, 60(6), 1150-1156.

Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, Tang Y, Bennett DA. Loneliness and Risk of Alzheimer Disease. *Arch Gen Psychiatry*. 2007;64(2):234–240. doi: 10.1001/archpsyc.64.2.234

Zinger, I., Wichmann, C., & Andrews, DA (2001). The psychological effects of 60 days in administrative segregation. *Canadian J. Criminology* , 43 , 47.