

The Forensic Column

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Who's in jail?

The incarceration rate in the United States has more than tripled since 1980. In 1998, 283,800 people with mental illness were incarcerated in U.S. prisons and jails. This is four times the number of people in state mental hospitals throughout the country.¹ Approximately 16% of male prison inmates and 57% of female inmates are reported to have suffered physical or sexual abuse or both in childhood.² More than 114,000 state prison inmates were on psychotropic medications as of June 30, 2000. There are almost 19,000 prisoners in 24-hour mental health facilities within prisons. 179,200 state prison inmates and 547,800 probationers have reported a mental illness. About 44% of men and 87% of women with abuse histories, who later were incarcerated, spent time in foster care. Thirty percent of male and 70% of female prisoners grew up with a serious substance abuser in the home. Seventy percent of State and 57% of Federal prisoners report prior regular substance abuse.³

As I do my forensic work, I am often struck that the persons I examine for court purposes have the same life histories as those I see in my trauma practice. They have led horrible lives of multiple abuse and neglect... and often turned to alcohol and other substances early in life to obtain a kind of 'substance facilitated dissociation.' I want to provide a few vignettes of some of the people I see within the criminal justice system, and then describe some opportunities-challenges-responsibilities for those of us working with severe abuse survivors.

The Case of R.R: The Combination of Substance Abuse, Family Dysfunction, Mental Disorder, and Intellectual Limits

Many would dismiss RR as merely an alcoholic and a professional thief.

He came from a family that was 'legendary' in the community; one could always find a brother or uncle in the local jail for alcohol, domestic violence, and theft related actions.

Mr. R came to the attention of the author through his public defender. The attorney called in the author because Mr. R was simply refusing to speak to her. He was mute, appeared sad and lonely and was sometimes in tears. He had been arrested for a home intrusion—he entered an occupied home and tried to steal electronics to sell in exchange for alcohol. The occupants heard him, and the male member of the couple confronted Mr. R and a physical fight ensued. In this fight, handfuls of Mr. R's hair were pulled out of his scalp. About a third of his head was a raw red bald spot. He had received special permission from the prison to wear a bandanna over it so that he would not be mercilessly teased by the other inmates, leading to fighting. Physically, he was a skinny, narrow-faced man perhaps five feet three and one hundred thirty pounds... a perfect target. His attorney reported to Dr. Kinsler that a guard said that R was 'crying over a stuffed animal.' It was unclear whether the presenting issues were depression, regressed behavior, inability to cope intellectually, or simple refusal to cooperate, with attempts to malingering mental illness or cognitive disability.

An evaluation was conducted at the regional jail, as Mr. R was considered too dangerous to be out on bail. The examination was replete with poignant moments. When Dr. Kinsler met him initially, he asked what R liked to be called. Mr. R replied he didn't care. Dr. Kinsler insisted that every person had a right to decide this. Mr. R lifted his head, previously hanging down without eye contact, and said 'Mr. R.....' He had always previously been called 'Little R,' a diminutive and somewhat insulting name for a 33 year old. He sat up a bit straighter and made a bit of eye contact.

He told Dr. Kinsler that he was refusing to talk to his attorney because he couldn't. He was 'too upset.' It turned out he was upset about the fact that not one single individual from his family had remembered his birthday while he was 'in the joint.' So, he was sitting on his bunk cuddling with the first stuffed animal he had ever owned, a Christmas gift from jail volunteers. A guard took it away from him as contraband. He sunk into sadness and withdrawal and easily becoming

emotionally upset, varying from rages to tears to elective mutism.

The Case of Ms. C.G.: The Sequelae of Trauma in the Life of the Developmentally Delayed.

In a symbolic turnabout, the state women's prison in Vermont is actually located on the grounds of the old State Hospital. Ms. G was incarcerated there on charges of burglary, forgery, and marijuana possession. She was living in a motel with a man more than double her age—a man with a long criminal history of 'uttering forged instruments.' Ms. G reported that this man would 'take her SSI checks' and 'always complain about money.' She insisted that it was her idea to steal and cash checks from a neighbor...but once she did so she was 'handing D... hundred dollar bills.' She told the examiner that 'it was her responsibility to give him money... my mother always supported all my fathers.'

The author was brought in to assess Ms. G's need for a cognitive facilitator, courtroom and probation accommodations, and to make treatment planning recommendations that were sensitive to the interface between her cognitive issues and the 'fallout' from her life history. She provided me with the following account of her family background, which was largely confirmed through documentary records:

Ms. G reported that she grew up in a chaotic and multiply abusive family; her mother had a chronic problem with alcohol and drug abuse and with 'going to the bars,' in Ms. G's words. She became involved with men from the same lifestyle. As a child Ms. G was exposed to intense and repeated family violence throughout her childhood. She reported seeing her mother 'punched, slapped, kicked' on a 'daily basis.' She said she saw her mother 'smashed in the face with bottles.' She learned to 'pretend it was a nightmare; pretend it was a bad dream.' The children often did not go to school because 'because my mom was too embarrassed by all the bruises and black eyes to take us.'

As if this was not an abusive and neglectful enough beginning, when Ms. G was eight years old, she was repetitively sexually abused over a

two-year period by a neighbor and friend of her step-father. This man also abused other neighborhood children. The police became involved, and came to Ms. G's home, informing the mother what had happened to her. Ms. G felt that her mother became enraged at her. Her life was so horrid that she 'set fire to a highchair for one of her dolls and put it under her bed, hoping to burn to death.' She was nine or ten years old.

To Ms. G's great credit, she and one other neighbor child were able to stand up to the grueling court process. Though the 'case went on for years,' eventually the 'man went to jail for twenty years.'

Not surprisingly, Ms. G has a long history of psychological struggles. In addition to chronic suicidality, she has suffered with flashbacks, nightmares, extreme agitation, and with literally clawing herself, clawing her face at night during flashbacks. She has a history of choosing older, highly exploitive men, and being used by them. And, she has always had multiple cognitive issues.

She was evaluated in another state in 1997, and found to have a Verbal IQ of 73, a Performance IQ of 72, and a Full Scale IQ of 72 on the WAIS-R, all in the 2nd to 3rd percentile. She was also diagnosed with a developmental reading disorder. She had very significant adaptive behavior deficits—she was unable to manage her own money, Ms. G's mother would have to pick out what she needed when they went shopping, and the mother also had to do her laundry. Ms. G has not been able to hold a steady job, and has felt overwhelmed when she has tried such roles as working at Burger King or in a sheltered workshop.

The evaluation Dr. Kinsler performed assessed both cognitive and trauma-based symptoms. The TSI™ [Trauma Symptom Inventory™¹] indicated that Ms. CG suffered with severe trauma symptoms; her highest peak was on the dissociation scale.

The cognitive testing occurred after what was a grueling day for Ms.

¹ Briere, J., Trauma Symptom Inventory, Psychological Assessment Resources, Odessa FL., 1995

G: she had an upset with other inmates; her cell was moved triggering feelings of not being safe; and she had just recited the extremely upsetting family history summarized above. She appeared childlike and regressed through the cognitive testing and highly self-critical. She would say 'I must be stupid' when she did not get an answer. She was accompanied to the testing by a support person; this person spontaneously asked 'Was she in a child state while she was taking those tests?' Her behavior was seen as quite suggestive of dissociative processes, with these behaviors dramatically affecting her intellectual results.

What do these statistics and vignettes mean to those of us who treat dissociative patients? Here are some basic thoughts about opportunities, challenges, and responsibilities:

1. There is a seriously underserved population within our prison systems who are not receiving services for their trauma based symptoms and behaviors. The author has had a conversation with a state director of prisoner mental health who denied the need for or efficacy of trauma therapy, and stated they were afraid of 'opening up' prisoners—as if their trauma based problems were not already splashed all over the facilities. There are opportunities to serve particularly traumatized men within these settings; to design programs that combine trauma and substance abuse treatments; and potentially to reduce domestic violence, recidivism, and enormous financial and social costs—by getting involved in the treatment of prisoners. There are jobs to be had, programs to be designed, and research to be conducted within these traditionally ignored settings. Many behavior change programs within Corrections departments are delivered by corrections officers with little training, not mental health professionals. So, don't ignore those Department of Corrections ads, and perhaps expand your vision of where you can deliver effective trauma treatment.
2. Prison settings are highly judgmental—no surprise—and it is challenging but worth it to get Corrections officers, defense attorneys, and prosecutors to look at trauma based symptomatology, not just

'bad behavior.' In the RR case above, we actually were able to convince the judge and prosecutor that what Mr. R really needed was DBT. He was transferred to the State Hospital where he went through 2 sequences of DBT treatment and is now, to the best of our knowledge, successfully completing an intense substance abuse treatment program.

3. There may well be differences in how trauma and dissociation work for people who wind up in the prison system. In evaluations of several hundred prisoners within the last 5 years, the author has seen only 1-2 cases of apparent DID—but hundreds of cases of de-realization, de-personalization, and 'substance aided dissociation.' There is a research agenda here for those with these interests.

In a recent project within the State of Vermont, we tracked all the admissions into the Public Defender system within three counties over an 18 month period. A remarkable 67% were multiple abuse survivors, most often survivors of physical abuse, witnessing family violence, and parental alcoholism. They were not screened for dissociation. Probably the last thing readers of the ISSD News need is another population that needs their help—and yet, our prisons are becoming the mental health facilities of last resort, and it is our responsibility to try to be helpful here, also.

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¹ Ditton, P., Bureau of Justice Statistics, *Special Report, Mental Health and Treatment of Inmates and Probationers, July, 1999, NCJ 174463*

² Harlow, C., *Prior Abuse Reported by Inmates and Probationers*, Bureau of Justice Statistics Selected Findings, April 1999, NCJ 172879.

³ Kinsler, P., Saxman, A., & Fishman, D., *The Vermont Defendant Accommodation Project*, *Psychology, Public Policy, and Law*, V. 10, Number 1-2, Marsh/June 2004, 134-161; see Table 1, pp. 136-137.