MENTAL ILLNESSES

in the

FEMALE OFFENDER

(Incarcerated in the Prison for Women,
at Kingston, Ontario, Canada)

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ABSTRACT: Mental Illnesses in the Female Offender (incarcerated in the Prison for Women at Kingston, Ontario)

Retrospectively, the mental illnesses in female offenders serving a sentence of more than two years less a day were separated from the emotional disorders of behaviour disorders, character disorders or neuroses. These inmates who suffer a psychotic break have a guarded prognosis for a limited recovery due to the organic components, the antecedent psychiatric history and the basic personality disorder. The charge for conviction was not relevant to the mental illness. The previous use of non-prescribed drugs, alcohol and chemicals was relevant. A brief comment about management, therapy, environment and philosophy is made.

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INTRODUCTION

My being here to-day has come about because the program of the Female Offender reached my desk. I thought it had something to offer me in continuing education.

Now as one of the program participants I want to share some of my personal thoughts with you. My professional comments are not the official opinion of the department of the government for which I work.

I have continuing concern about the mental state of prisoners during long sentences in prison. In particular, those who suffer a major mental illness. Such men and women are rendered inarticulate to speak on their own behalf or undertake much action for their well being.

MENTAL ILLNESSES OF INMATES AT THE PRISON FOR WOMEN IN CANADA

BACKGROUND

INSTITUTION

This has been the only female federal prison. Defined as a maximum security institution, it also houses medium and minimum security inmates. A woman must receive at least a two year sentence to be incarcerated there. Certain provinces have an agreement with the Federal Government to enable them to retain certain of the women so sentenced. The sentenced offender might ask to be retained but this option was not under the control of the inmate. Near the end of her incarceration she could ask to finish her time in her home province if the agreement applied. Her request might be granted.

The total number of women at the Prison for Women has been in the neighbourhood of 140, with 20-30 being on some sort of absence; whether that be privilege or escape. Given the initial small size of the population, my personal opinion and thoughts apply only to a portion of this small total population. In addition, one must remember that the inmate retains the right to refuse medical services.

The Regional Psychiatric Centre of the Ontario Region gives a consultant service to the 7/8 penitentiaries of the region. Those women seen in consultation would have been referred by the Institutional Physician, the inmate herself: or the request reached the Medical Department from the Psychologist, the Classification Officer, the Parole Service, or the Administration. Occasionally the Sentence Administrator advised that the Sentencing Judge did recommend psychiatric treatment. This is followed through by a psychiatric consultation as soon as possible.

INMATE PROFILE

The age of the women has ranged from 16 years upward. All types of offences have been noted. Some recidivists have done shorter sentences elsewhere, including juvenile crime. It is my opinion that the violent offender appears in psychiatric consultation more frequently than the property offender. The occasional inmate may be of limited intellect; even considered retarded by reason of childhood domicile in an institution for the mentally retarded. As adults, their intellectual skills proved higher, and psychiatric consultation would be sought for reasons other than intellectual limitation.

Inmates who have asked to do their sentence at the Prison for Women have said it was more difficult to experience the earlier incarceration in their provincial institution. Their offered reasoning suggested much difficulty in coping with any structured living environments. Their past behaviour indicated impulsivity, emotional immaturity, and much hostility. Frequently, there was a long history of abusing their mental function by alcohol, drugs, chemicals. Also childhood behaviour disorder has been noted in many. It would seem that the daily responsible group living focus in the provincial program was strongly resisted by the inmate.

The women I saw in consultation had a general profile of alcohol and drug abuse. She would be a passive-agressive woman with much hostility. Frequently there was a gender uncertainty which resulted in an in-prison lesbian behaviour. On the street a heterosexual behaviour including child bearing could occur.

With rare exception, the female inmate gave a personal history of emotional and physical abuse in childhood. There was a life-long emotional deprivation, lack of security, physical hardship, and pain.

In adolescence, emotional dependency and immaturity persisted beyond the expected age range. There was much hos-

tility toward men yet a failure by these women to emancipate themselves from material and emotional need of gain through the male figure. It even lacked the degree of maturity seen in a typical love-hate bond of an adult suffering a neurosis. This amorphous hostility extended to other power figures: their own parents, one or both; their common-law or legal husband; the policeman, medical personnel, and society. As the inmate described her personal history, there seemed to be a life-long emotional deprivation. This resulted in an individual who only could care for the thing or the person (child) as an extension of herself. For example, the concept of compassion and the concept of self denial were diminished or absent. Remember that a personal historical narrative is a subjective matter. The reality is that some hostile children do have an average home life of emotional security, in contrast to the subjective recall.

Any woman who is judged insane would be sent to an appropriate psychiatric hospital on a Lieutenant Governor's Warrant to remain there until such time as she would have recovered from the mental illness: never reach any penitentiary.

My concern has focussed on two groups of female inmates:

(a) those women who could be suffering a mental illness or grave emotional disorder before, during, after the trial but not such that a Lieutenant Governor's warrant status would apply.

(b) those women whose mental health deteriorated after admission to the prison.

In my opinion, the character or personality disorders could suffer an anxiety state and a depressive state. These clinical subjective and objective conditions had qualities which tended to separate them from the conditions of major mood disorder and psychoses in these disorders.

The expression of the illnesses was through the change in quantity more than quality of psychological function.

The changes, the deterioration in mental function of the severe chronic alcoholic character disorder was, for example, more untruths, more unpredictability, more impulsivity, more hostility, more obvious inability to socialize. There was no fundamental or dramatic change in personality. Without understanding of the pattern of previous personality pattern one would be hard put to say that Alzheimer's dementia had begun. Once this diagnosis is considered, the psychological follow-up con-

firms the psychiatric diagnosis.

However, the custodial staff see it as a worsening in personal elective behaviour therefore to be handled in the manner of expecting the inmate to show responsible behaviour. It is a medical matter to advise the correctional staff when inmate self management is no longer possible. The sequel then is to consider the meaning of the role of custodial officer from then on. Their job description does not require the assumption of the role of psychiatric nursing.

At the Prison for Women there have been some examples of chronic organic brain syndromes in the inmate population. There have been other conditions in addition to the longterm effects of alcoholism.

These patients became totally rejected by the other women as their social incompetency increased. A transfer to the particular Ontario Psychiatric Hospital at St. Thomas became possible if an involuntary admission could be made. If improvement to the level of voluntary patient did occur then such a patient had to be returned to the Prison whether or not the psychiatric treatment plan was completed.

Such a return would be premature for the schizophrenic patient. With those patients whose psychosis remits under the influence of medication it would be a harsh step just at the time when the patient is becoming able to participate to consider their psychological problems in psychotherapy and the therapeutic environment to resolve the conflicts. All of this treatment would be denied to a federal female inmate. If she was a provincial prisoner, she could remain in the psychiatric hospital as a voluntary patient as long as it was thought necessary for the treatment process. The laws that govern people's activities do limit treatments.

For the psychotic unipolar or bipolar depressive, I observed the same patterns in that the behaviour of the character disorder inmate became more irresponsible in the eyes of others and more enigmatic to themselves.

Among the drug addicts there were some manic depressive disorders before incarceration as well as those with a later onset. Some of these had received Lithium therapy in the community prior to their last charge. The patient compliance, the consistency of taking any medications was as imperfect as they might take other materials indiscriminantly. There were some psychiatric relapses because they were so casual about necessary psychiatric medications.

Ordinary people in the community who experience relief of psychiatric distresses generally do take medications regularly. They have found through experience that non-compliance results in a trend toward the abnormal mental state: something they do not want. Naturally, one does exempt those whose mental illness incapacitates common sense and practical judgements.

The female inmate does tend to blame the prescribed medication for her disordered function even though that disorder is probably due to her deliberate abusive use of that medication, in fact.

However, their psychopathology does include a degree of immaturity that can result in the attitude of the environment being responsible for all that does not pleasure, the imperfections of this mortal existence. By their logic they use everything in this material world according to their inclination without personal responsibility for the consequences; in this case the prescribed psychiatric medication. From my conversations, it would seem that these women do seek a state of mind, through chemical action, that a philosopher seeks to gain through mental exercises with nirvana as the goal.

The tricyclic antidepressive medications have given emotional stability in addition to some relief from the tension

state. Lithium salts are the last resort by choice.

The method of delivery of all prescribed medications must control dosage to a higher degree than in ordinary practise. Even when a liquid or powder type of delivery is possible ingenious hoarding still occurs. This is sometimes for the individual though it can be to pass on to other inmates. Due to the nature of psychiatric drugs, this results in a hazard to the recipient. Many of the women are well read on the effects of medications. This knowledge may be for the basic purpose of altering the state of mind. Some women are unpleasantly explicit when one seeks to instill a sense of care for their body. That body exists solely to serve their immediate purposes rather than being their one abode for this temporal existence.

Certain states can benefit from an early psychiatric assessment.

The character or personality disorders suffer what they call a feeling of depression and a feeling of tension. For these feelings medication is sought, not psychotherapy. There is no personal concern about the mode of living and this mode of thinking. Psychiatric medication at dosages that relieve the psychiatric symptoms of the ordinary patient does not satisfy them. In my opinion, at higher dosages for a definite period

there has been no worthwhile improvement. I did note a degree of clinical difference that enabled the ultimate separation of the manic depressive disorder prior to Lithium therapy.

The smallness of the prison population has been beneficial. Staff and prisoners do know each other by face and by name. Also, the staff have no other institution to leave for as an advancement. Any recidivist is no stranger to the institutional staff or some of the inmates of the moment. Thus, there is considerable social interchange by either group. The anonymity of large populations is impossible. It is my opinion that the female inmate in general attempts to involve herself in other inmates' lives more than many men do in like circumstance.

The inmate attitude toward self abuse is not remarkable so long as it is just that. When it is no longer a manipulative, hostile act but rather a woman suffering depressive feelings to the degree that she seriously intends to take her life then something happens. In the population two attitudes surface. One or more inmates tell me of their watchfulness to prevent suicide because they are not her friends. They have no intention of letting her get away with committing a successful

suicide. This group is not her friendship one. Then I hear from the patient and one or more of her friends that they are watching her closely so that she may survive. The fact that I am advised by women other than the patient may be considered a type of manipulation because the actual death in a prison of any inmate is stressful. If one considers it an altruistic action then let us consider the implication that women are not identical to men in this respect. When a male prisoner's depression is suicidal the other men, including friends, consider the act of suicide a private matter. Men turn their faces away silent. In general, be they friend or foe, men do not alert any staff as a life saving action. Male populations are larger. Perhaps bonding, be it negative or positive, is unable to develop to this useful level. I know one exception in a male maximum security unit where one man supported one other in and out of psychotic depressions for a lengthy period.

The psychology of bonding is more understood in recent years. It may be that the type of architecture and nature of the population movement of the women assists the process for the women. In my opinion, from my understanding of war time units of women, it is rare in women to see strong bonding of more than a dyad beyond a time of emergency. Men make soldiers and the rules for soldiering, not women.

CARE AND CONCERN FOR THE MENTALLY ILL WITHIN THE PRISON

This consideration is complex where there is no psychiatric inpatient unit. The population and the staff tolerate the state of mental illness in much the same way as any community does when there is no annoyance factor, no danger. I have noticed that the violence of mental illness is tolerated to a surprising degree. In this prison population of so many violent women, this cardinal sign of psychotic decompensation is unreported early. Other aspects of reported behavioural change require thoughtful consideration before any decision making process. It may represent mental illness or merely more antisocial acting out behaviour quite in keeping with past occasions by the same inmate in response to frustrations. So much of the behaviour known to me is at the emotional developmental level of the nursery school age. Therefore, the quality of regression in psychosis has so little further regressive steps possible. In my opinion, it would be reasonable to consider the use of the psychiatric nursing profession.

As a staff member of the medical department of a prison the psychiatric nurse could serve the purpose of resource education for interested staff. Management of these inmates with chronic mental illness during their incarceration would assist the primary care physician and the psychiatric consultant.

The custodial staff are interacting with prisoners today when they become Living Unit Officers. However, I am concerned about the reality that custodial staff are employed to work with prisoners, just that. These staff members have yet to be asked to volunteer to work with the mentally ill. Until that is possible then one would be unfair to automatically ask them to cope with the stresses unique(?) to psychiatric management needs without special training.

The female inmate who suffers from a chronic cerebral syndrome still has a long period of competent days when her faculties seem to function reasonably well. Yet this is a person who has been a manipulative, dependent, passive, aggressive, inadequate, immature woman. How does one estimate her current behaviour in terms of competency? Does the Administration punish her for wrong doing just as any other inmate? Does one go softly and punish her not at all? What does that do for discipline morale?

The inmate I am thinking of needs special attention and special care out of the hearing of the population to permit adequate control. The chronic criminal is not altered by dementia. What does happen is loss of psychological competency, flexibility, responsivity. Therefore, discipline then is a meaningless, futile

exercise in frustration for all concerned. When the disease has progressed to need for supervision of personal hygiene, bathing, dressing, it should be done within the context of a secure unit. The hospital beds themselves are an improper locale unable to offer secure tolerance.