

# Role Conflicts of the Prison Psychiatrist

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Practicing psychiatry in a prison is a complex experience characterized by doubts and frustrations as well as challenges and rewards. Lack of conviction about such work is reflected by the presence of relatively few psychiatrists in this field despite enormous demand for them. Such aversion has several possible explanations. I propose that an important reason is the great potential for role ambiguity to which the psychiatrist is subjected in the prison atmosphere. This ambiguity is promoted by conflicting demands and expectations from inmates and staff as well as by social critics who question the validity of the mental health approach to criminality. These issues will be illustrated and examined.

## The Prison Setting

The observations to follow were stimulated by my experience for nine months as a U.S. Public Health Service psychiatrist at a medium security Federal Correctional Institution (FCI) housing 600 male offenders 18 to 26 years old. I also had the opportunity to visit and compare a minimum security youth facility and a federal penitentiary. My primary task at the FCI was to help organize and run a 100-man drug-abuse program comprised mostly of ex-heroin addicts.

As a new prison psychiatrist I soon became aware of a basic conflict inevitable in this setting. Essentially, in this role one cannot easily be his inmate-client's advocate without being viewed suspiciously by officials and guards. Conversely, if inmates suspect that a psychiatrist feels allegiance to the administration, they avoid him. Both inmates and staff attempt to mold him into their self-serving role projections which usually bear no resemblance to his own role image.

Though authors differ in opinion about the role of prison psychiatry and the validity of the treatment model, all agree on the deplorable conditions of prisons and the need for reform. Such criticism is as ancient as prisons themselves. Current literature is creating greater public awareness of these totalitarian environments characterized by fear, suspicion, intimidation, uncertainty, bitterness, racism, loss of privacy, homosexual pressure and overt violence.<sup>1,2</sup> It was such an atmosphere which so strongly influenced the attitudes and behavior to be described.

## Relationship with Inmates

Prisoners generally hold no special reverence for psychiatrists or physicians, who are considered just some more authority figures with whom to contend. Most inmates did not know what a psychiatrist was and initially made no distinction between my functions and those of psychologists, caseworkers, correctional counselors or custodial officers. We were seen collectively as the oppressive bureaucracy. Although I considered myself a helping person in the medical and mental health tradition, inmates were naturally disbelieving. Some contended I was an FBI agent who would eventually betray their confidence.

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As the drug unit formed I organized and led two six-man groups which met weekly. About a dozen other inmates eventually came for weekly individual sessions and many others for sporadic crisis-type problems. Nevertheless, more than three months passed before they really began to speak openly with me. It took somewhat longer for this to occur with poor urban black inmates, a class whose needs in prison have been particularly neglected.<sup>3</sup> These blacks would agree to meet only in groups where they formed a cohesive alliance against any perceived confrontation with myself or white inmates. They were especially class and race conscious, tending to see themselves as political prisoners of an oppressive white society.

Early sessions, especially groups, consisted almost entirely of attacks on the prison system and the staff. The inmates maintained that since the system paid my salary, they found it difficult to confide anything in me. Suggestions of reflection and objectivity were strongly resisted. One group told me to stop trying to be a therapist and gave me the options of sitting quietly, joining them as a non-leader or ending the group. Initially they preferred to confront me on such topics as whether I would shoot them if they tried to escape and to inquire about my personal experiences with drugs and illegal behavior. They were primarily interested in my loyalty to them vs. the system.

Any approach by staff designated as "treatment" or "therapy" was dreaded by inmates as "behavior modification," which they considered tyranny over their free will. Extremes of mind-control were represented by psychosurgery and phenothiazines (slang: "zeen") which many inmates were convinced the prison system was using to stifle nonconformity. After reassuring them that this fear was false, I learned that chlorpromazine had been advocated and used precisely for that purpose at this FCI (details in next section). Since I was treating two overtly psychotic inmates with fluphenazine injections, many inmates suspected that I was part of such a conspiracy.

In order to remain in communication with these men and to gain some of their trust, I had to be as open and non-evasive as possible about my thoughts and feelings. If I had misgivings about the system and ideas about desirable changes, I would share these opinions with them. To overlook or defend the system would have undermined our working relationship, yet care had to be taken not to scapegoat the system for all their difficulties. Most of all I felt I had to present myself as someone believable with whom they could identify. Because of the uncertain prison atmosphere, I could do this only through consistent openness. I believe that a psychotherapeutic approach of pensive, noncommittal reflection is guaranteed to fail in this setting.

Since my employment here was an alternative military service obligation, I intended to leave and explained this to the inmates six months in advance. Curiously this resulted in their trusting me more. Some expressed that my intention to leave indicated detachment from the system, which made identification with me easier.

After my probationary period with them, some inmates began to make regular appointments to discuss recognized intrapsychic conflicts. But the majority came primarily to earn a good recommendation to the parole board, a clearly understandable motivation. They openly admitted to seeing me as a possible influence for their freedom. Therefore, neither they nor I felt I was being "conned" into "treating" someone pretending to "rehabilitate" himself. With this mutual understanding they felt free to speak as they desired. The payoff was that many spontaneously began discussing dynamic conflicts which they sometimes ended up resolving. The lesson perhaps is that in prison one may be a more effective therapist if he does not claim to be one. The prison psychiatrist may cope with this functional ambiguity as long as he correctly identifies the process to himself.

### **Relationship with Staff**

It is my opinion that prison administrators in general have limited awareness of psychiatric functions and potential. Also there is likely to be wide divergence between what the psychiatrist offers and what the administration desires or will accept. The psychiatrist

before long realizes the obstacles of entrenched custodial tradition. In such an atmosphere, expressive, emotionally liberating techniques with inmates are considered threatening, and attempts are made to turn psychiatrists into what Rundle terms the "new custodians."<sup>4</sup> The following experiences, though perhaps unique, portray the nature of these obstacles and how they affect the psychiatrist's attempts to establish a comfortable role in relation to staff.

The most basic and essential atmosphere to work, an office in which to see clients and keep notes, was not available when I arrived, since I was not expected to see inmates privately. Instead the administration suggested I spend all my time consulting with unit staff members in conference rooms. Through persistence I nevertheless managed to locate an office.

While they were unhappy about my desire to be a clinical psychiatrist in addition to being a staff consultant, the directors were insistent that I abandon my identity as a physician. They explained the day I arrived that I should stay away from the medical staff in the hospital-clinic annex, since they might detract from my total immersion in the drug unit. To discourage fraternization, I was denied a key to the annex until I firmly pointed out the necessity and appropriateness of these professional contacts. Though purposely excluded from the medical on-call schedule, I was expected to assume duty as the equivalent of a custodial dorm officer one night a week. Thus, from the start my most important professional identities, physician and psychiatrist, were ignored while my role was made thoroughly ambiguous.

The few times my medical authority was sought were under unusual circumstances. For instance, I was asked to sedate an inmate with a chlorpromazine injection because he defiantly refused to come out of his isolation cell. I declined, suggesting instead a behavioral approach. Later that day, without my knowledge, 75 mg. of the drug were ordered for him by a non-physician and forcibly injected so that he could be showered without resistance. On a separate occasion the medical staff was unsuccessfully petitioned to order such an injection for an inmate who threatened to resist transfer to a county jail. This illustrates the coercion, sometimes not even subtle, that may be directed at prison psychiatrists to use their skills for custodial and police functions. Lundy and Breggin<sup>5</sup> have more extensively documented such inappropriate use of psychiatry in prisons.

Another role conflict, namely that of therapist vs. judge, involves the psychiatrist's communications to staff concerning progress reports and recommendations for inmates. The fact that staff requests this information may threaten the inmate's willingness to confide personal information which he feels might meet with staff disapproval. Therefore, my stated policy was to relate to staff non-detailed progress reports which would not violate confidentiality. This proved to be readily acceptable to all parties.

Because there were a few inmates I saw regularly whose prison experience I felt to be particularly counterproductive or destructive, I would strongly recommend them to staff for increased privileges or even parole. Though I realized that this policy would complicate inmates' and staff's perceptions of my role, certain glaring injustices demanded that I occasionally become an inmate's outspoken advocate. The harsh realities of prison life often make the neutral, uninvolved therapist role irrelevant.

Rewarding contacts with staff involved sitting in team meetings and speaking with custodial officers, counselors and caseworkers to discuss inmate problems. Initially, they were almost as suspicious and threatened by me as were the inmates, but in time welcomed the opportunity to learn about inmate psychology and to share their own anxieties and frustrations about their work.

## **Discussion**

The ambiguous role and professional identity problems of prison psychiatrists are magnified and illustrated by the controversial question of whether or not psychiatrists should even be working in prisons. Therefore this issue should be briefly examined.

Denying that criminality implies mental illness, Rubin<sup>6</sup> cautions against imposition of a "psychiatric bureaucracy" on a captive population, citing hospitals for the criminally insane as an example. Similarly, Torrey<sup>7</sup> warns that attempting treatment of social problems such as crime and drug abuse overextends the profession's authority and may lead to "psychiatric fascism." Wootton<sup>8</sup> extensively reviews the question of criminal culpability and punishability vs. illness and treatability. Though concluding that "criminality is obviously not in itself a disease and can have no valid claim to medical attention on that ground," she credits psychiatry for being a humanizing force, having "probably done more to mitigate the harshly punitive attitude of the criminal law than any other influence of the past half century."

As for differing views, Roth and Ervin<sup>9</sup> emphasize the need for more prison psychiatrists based on their findings of 15 to 20% diagnosable psychiatric problems among incarcerated criminals, with overrepresentation of alcoholism, drug abuse, epilepsy and schizophrenia. Yet they show that less than 1% of all inmates are seen by psychiatrists while imprisoned. Some authors maintain that criminality is a phenomenon of mal-adjusted individuals in need of psychiatric attention.<sup>10</sup> They lament the secondary and minimal roles psychiatrists have played in prisons, contending that "no total program for rehabilitation of offenders can be successful unless it is under the direction and guidance of psychiatrists."<sup>11</sup> Satten<sup>12</sup> concurs, pointing to the uniqueness of psychiatrists in bringing to prisons administrative know-how, the healing tradition and technical knowledge of thinking, feeling and behavior.

In the middle of the controversy are those who believe prison psychiatrists are desirable but that they should play only a consulting role, advising officials and guards about personality conflicts between inmates and staff and instructing them in human behavior principles.<sup>13</sup> If nothing else, I would agree that psychiatrists could contribute greatly by promoting staff interest in prisoner psychology and encouraging understanding and helpfulness in contrast to custodial and punitive attitudes. Even this task is a formidable one, however, making a close working alliance with wardens, chief custodial officers and caseworkers essential.

If a psychiatrist resolves to undertake full or part-time work in a prison, he will be faced repeatedly with various ethical decisions, many of which have been touched on earlier. The most important such issue to be stressed, and recently reviewed by Halleck,<sup>14</sup> entails resistance to social demands for imposition of behavior control against better psychiatric judgment. Thus it is particularly important to maintain a secure professional identity with its ethical code, despite subtle and overt attempts to erode this identity for support of custodial tradition.

The prison psychiatrist's likely alternatives to facing and solving the conflicts outlined above are to become overwhelmed and leave or to lapse into caretaker functions. Such reactions were described by two residents rotating through a county jail as part of their training.<sup>15</sup> They developed feelings of alienation, disillusionment, despair of being able to change things, and a tendency to flee. Their answer: "We coped with the environment by avoiding it."

Despite the conflictual nature of this work, I come to the conclusion that prisoners have a great deal to gain by contacts with psychiatrists. This impression, I believe, is supported by the comments of the inmates in one of my groups near termination. I asked their opinion of the appropriateness and potential effectiveness of psychiatrists in the prison environment. All concurred that, while they did not consider themselves "mentally ill," they had become aware of how deficient their expressive and communicative skills had been before this group experience. Many suggested that much of their prior antisocial acting-out had resulted from never having learned to verbalize or communicate frustrated needs.

Such personal observations lead me to agree with Halleck<sup>16</sup> that prisoners do benefit from group therapy, at least with experienced leaders. I believe other types of therapy

can be effective as well and have recently described encouraging therapeutic encounters with a similar population of young institutionalized narcotic addicts.<sup>17</sup>

In summary, the prison psychiatrist must become comfortable with frequent challenges to his role and professional identity if he is to work effectively in this setting. Once this is accomplished, the positive impact he can bring about on behalf of his inmate-clients make the antecedent frustrations and conflicts worthwhile.

### References

1. Menninger K: *The Crime of Punishment*. New York, Viking Press, 1968
2. Mitford J: *Kind and Usual Punishment: The Prison Business*. New York, Alfred Knopf, 1973
3. Sutker PB, Moan CE: A psychosocial description of penitentiary inmates. *Arch Gen Psychiatry* 29:663-667, 1973
4. Rundle FL: Prisons: The crime of no treatment. *Psychiat Opin* 11:17-21, 1974
5. Lundy P, Breggin PR: Psychiatric oppression of prisoners. *Psychiat Opin* 11:30-37, 1974
6. Rubin S: Psychiatry and the prison: a negative report. *Int J Psychiat* 6:214-218, 1968
7. Torrey EF: The preventive road to psychiatric fascism. Presented at the American Psychiatric Association, 127th annual meeting, Detroit, 1974
8. Wootton B: The place of psychiatry and medical concepts in the treatment of offenders: a layman's view. *Can Psychiatr Assoc J* 17:365-375, 1972
9. Roth LH, Ervin FR: Psychiatric care of federal prisoners. *Am J Psychiatry* 128:424-430, 1971
10. Fink L, Derby WN, Martin JP: Psychiatry's new role in corrections. *Am J Psychiatry* 126:542-546, 1969
11. Fink L, Martin JP: Psychiatry and the crisis of the prison system. *Am J Psychother* 27:579-584, 1973
12. Satten J: The psychiatrist's function in the correctional setting, in *Crime, Law and Corrections*. Edited by Slovenko R. Springfield, Ill, Charles C Thomas, 1966, pp 595-604
13. Alexander F, Staub H: *The Criminal, the Judge and the Public*. Glencoe, Ill, The Free Press and the Falcon Wing's Press, 1956, p 236
14. Halleck SL: Legal and ethical aspects of behavior control. *Am J Psychiatry* 131:381-385, 1974
15. Cumming RG, Soloway HJ: The incarcerated psychiatrists. *Hosp Community Psychiatry* 24:631-632, 1973
16. Halleck SL: Rehabilitation of criminal offenders: a reassessment of the concept. *Psychiatric Annals* 4:61-85, 1974
17. Ketai R: Peer-observed psychotherapy with institutionalized narcotic addicts. *Arch Gen Psychiatry* 29:51-53, 1973