Chapter 4 | CUSTODY AND TREATMENT AT THE DIVIDE

> [The] analysis of violence should be limited to demystifying the contradiction between custody and rehabilitation, so basic to asylums and prisons.
>
> FRANCO BASAGLIA, *Psychiatry Inside Out*, p. 213

One day after going out to lunch with a prison mental health worker, I returned with him to the main gate of his institution. A buzz of movement and intensity signaled that something had happened: the prison was locked down in the immediate aftermath of an escape attempt. No one, not even someone making a delivery, was allowed to leave the grounds.

My companion tried to walk me into the interior of the prison but was stopped at a gate by the booth officer, who barked, "What the hell do you think you're doing, escorting someone through here right now?" I turned back, sat on a bench, and tried to make myself as inconspicuous as possible. After a while I realized that I was watching two parallel worlds. The uniformed staff—officers and their commanders—moved briskly through the gates, tense, talking tersely on their radios, checking with each other about the status of the lockdown. At the same time other workers in the administrative part of the prison near my bench—mostly women wearing civilian clothes—carried paper to copy machines and spoke casually to one another. Delivery people, maintenance staff, and religious volunteers walked in, looked around, and found places to sit and wait it out. These people could have been in the front office of an insurance company.

Finally I saw someone I knew from the mental health unit and went with her to my original destination. Along the way we heard that an officer had been injured and taken to the hospital—third- and forth-hand ac-

counts in anxious, hurried fragments: "Who was it?" "I heard there was a lot of blood," "I heard that he's gonna be all right." When I got to the unit, an officer told me that the "mental health folks" were having a meeting. I knocked at a locked door and was admitted to a windowless conference room where half a dozen people in civilian clothes had just heard a presentation on schizophrenia. The speaker was packing up a large bound volume of diagnostic information. As soon as he left, the mental health workers began a tense debate among themselves.

One man argued that "treatment people" needed to maintain a stance of emotional detachment. "People [that is, mental health workers, ourselves] need help so that their feelings [about the inmates] don't get involved.[1] They need to be professional and *clean*, instead of getting angry and getting their feelings into it. Otherwise it creates an atmosphere of manipulation. We need to make the rules perfectly clear." "Heil Hitler!" said a co-worker sitting across the table. He added defiantly, "A few individuals are slugs. If we couldn't make [negative, angry] comments away from inmates we'd go nuts." The first mental health worker returned to his theme undeterred. "I'd like to see a clean environment where this [discipline] happens [to the inmate], boom, boom." "We might as well create a perfect computer to deal with it," retorted the second man. "The inmates have got us figured out. They *expect* a capricious system. It's OK to be natural with them."

Unable to resolve this obviously much-visited issue, the group moved on to why people are in prison in the first place. "We need to start at the juvenile level," one said. Someone else countered, "We need to get rid of the war on drugs." "No," said the first worker, "they're [just] gonna find something else [illegal to do]. These are youths with fathers and brothers in prison." "The taxpayers *want* all of them here," added another. The man who had just argued for being natural with the inmates complained, "But we just help people adapt to prison. Do we want them to be better prisoners? Or are they *citizens*? Can we help them learn how to live with integrity?"

The first thing that struck me about this incident was the disconnection between the mental health workers, encapsulated with their visiting expert, and the custody workers outside who were engaged in the defining moment of their work. The closeted treatment workers seemed to symbolize the position of mental health as an outpost within the prison. Prison workers take this view themselves when they maintain that custody and

treatment entail inherently contradictory structural positions. But although descriptions of custody as hard-nosed and treatment as warm and fuzzy are important to workers' self-definition, this conversation suggests immediate complications. It appears that this small group of mental health workers has subdivided along custody/treatment lines. One man takes a position for a controlling, "boom, boom" approach to inmates, while the other argues for being natural and attending to social/psychological causation. The discussion does not lend itself to simple description as the "mental health perspective." Similar arguments and cross-alignments occurring within custody suggest a corresponding complexity on the other side of what is often called the "divide." One officer, speaking in a different context of how less experienced officers took the "tough" side of the job too literally, took a stance opposite that of the more "custodial" mental health worker: "I banter with these guys [inmates] a lot . . . Out here [on the control unit] there's just about nothing that isn't discussed. If you don't have any interaction with them you're not doing your job."

In the previous chapter I described the treatment context in terms of encircling attention to inmates' vulnerabilities. But that gesture is always in relationship to the complicated borderland formed at the conjunction of treatment and its custodial other. While the most obvious questions at this border concern the kind of attention impaired prisoners should receive, other, corresponding questions are asked by prison workers about themselves: Are treatment workers in possession of knowledge that reveals the true capacities of prisoners? Should—or must—custody workers punish those whose awareness of what they are doing seems limited, but not entirely absent? What about the dangers of responding empathically in the prison context?

For both custody and treatment workers it is axiomatic that friction between them results from their differential possession of power and knowledge. Custodial staff state as a brute fact of their capacity to inflict punishment: "It's about power." Treatment workers take their stand on psychiatric categories and approaches—specialized forms of knowledge—that sometimes skirt and sometimes support, but are always enmeshed in, custodial power. Sharing historical roots and a fundamentally similar method for locating individuals in institutional space, custody and treatment are united in mutual dependence. But this very interdependence also positions custody and treatment workers as one another's most vigorous

critics. In this chapter I explore the "shifting and tentative alliance" through which custody and treatment—power and knowledge—thrash out their relationship. Individual workers are necessarily caught up in the available terms, but they are not docile subjects of their job descriptions. Rather, as in the moment that followed the escape attempt, staff work out their relations to one another's projects on the shifting ground of their interpretation of prisoners' behavior. They are constrained on all sides by the structures and logic that hold custodial power in place. But their most fundamental argument—taking as its object the will of the prisoner—remains unsettled, an ongoing contradiction between custody and rehabilitation, in Basaglia's apt phrase, that is "indeed basic to prisons."[2]

CLASSIFICATION

> When John Howard, [the inventor of the penitentiary, visited prisons and jails in the 1770s] what offended him was the evidence of disorder and inattention, the failure to post rules, the indiscriminate mixing of inhabitants, and the unregulated boundary between the prison and the community.
>
> RANDALL MCGOWAN, "The Well-Ordered Prison: England, 1780-1865," *Oxford History of the Prison*, p. 78

> Classification and segregation of prisoners have been preached for over a hundred years. Officialdom has turned a deaf ear to both projects. We have arrived at last at a classification stage.
>
> WARDEN LEWIS LAWES, *Twenty Thousand Years in Sing Sing*, 1932, p. 176

> Bureaucratic professional administrators now attempt to control prisoners through increasingly formal and rational systems.
>
> JAMES AUSTIN AND JOHN IRWIN, *It's about Time*, 2001, p. 99

The centrality of classification to prisons has been repeatedly stressed by reform-minded wardens and officials. At many points historically it was probably little more than a dream of order.[3] Better, more scientific or more practical classification systems have been—and still are—the major offering of many efforts to change prisons. As Irwin notes, they have an attractive

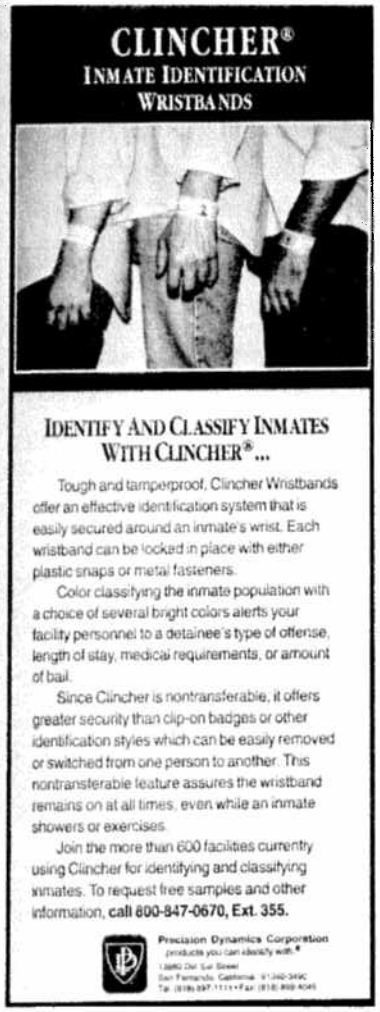

Figure 19. Correctional trade journal advertisement: "Identify and Classify Inmates."

formality and rationality; thus they can be misunderstood as descriptions both of individuals, and of what takes place in the actual interaction of individuals with "systems." But classification is in fact a set of practices, one of the primary areas where the abstraction of management meets the concrete facts of prisoners' lives. As an ad for wristbands suggests (Figure 19), the purpose is to fix a "nontransferable" identity to the inmate. Made up of type of offense, length of sentence, and many other elements, this identity should, as the ad promises, "remain on at all times," indissoluble

and "tamper-proof." Thus identified, the inmate can be "placed"—located and managed—within the security system of the prison.

During classification hearings the prisoner is brought before correctional counselors, unit managers, and mental health workers. Correctional counselors are responsible for determining where inmates are housed, calculating the effects of infractions, balancing available beds against inmate needs and wants, separating inmates from specific friends or enemies, and planning for release. They are also the inmates' link to the outside world, with the authority to arrange contacts with families and courts.[4] Sometimes the result of a hearing is curt dismissal at the hands of unsympathetic staff, with the prisoner, who must represent his own interests, having no real recourse. As one prisoner said, "[When you] bring me in for a five-minute interview . . . I know how you're looking at me . . . All you're doing is making a determination based on the paper in front of you."

But hearings can also allow for negotiation and offer a rare opportunity for self-advocacy.

> At one hearing the hearing officer says to the prisoner: "We are recommending you remain in close [custody]. You also need to take substance abuse and anger management." The inmate counters, "But I already had medium custody for two years!" An officer points out to the counselor that the inmate was probably denied last time because of a major infraction that sent him to a control unit. Looking more carefully at his record, they note that he has had no infractions for over a year. They decide to recommend medium custody.
>
> At a hearing in a different prison, an inmate describes in detail why he does not need to be kept away from one of his "separatees." When the hearing panel finally cuts him off with a promise to look into it, he breaks into a broad grin and says, "I've been working on this pitch for weeks!"
>
> A prisoner in a control unit says, "Every time I go to a hearing they use my history. I'm in here for a violent crime and since I've been down, I've been caught with a shank, had seven assaults. . . . My last hearing, as soon as I came in they says, 'Well, what do you have to say for yourself?' And I said, 'Well, I'm really trying to get out of the hole.'"

Each of these individuals is placed according to his history—including his criminal and infraction history—in a way that reflects the logic and limitations of the larger system. There is not enough flexibility, for example, to send everyone to a prison near his family.[5] Nor, of course, do those in charge of placement decisions want to be considered responsible, later, for an assault. One counselor explained, "Inmates misperceive the role of the counselor. They think he's there for them, but he is looking out for the interests of the state. We have to document what we've done to provide services. *Something.*" The something is usually programming—the courses that are the current remnant of earlier rehabilitative exercises. In apparent recognition of this state sponsorship, prisoners use the word "program" even for unwanted or aversive placements (as in "I am doing this control unit program right now").

Classification hearings are routine for every inmate. Disciplinary hearings, on the other hand, occur in response to specific situations. A prisoner in trouble, most often for fighting, is brought before a disciplinary hearing in which he may be placed into segregation or a control unit—and his record amended to preserve the incident for future consideration. As with the second prisoner above, the specifics of such events may dog his placement for years or, in a few cases, decades.

One day in a control unit a series of disciplinary hearings follow on the arrival of several inmates admitted after a fight between rival groups at another institution. The first prisoner has a nasty black eye. He is escorted into the glass-walled room by two officers who, once he is seated and cuffed up, stand impassively on either side of him. The psychologist, unit manager, and classification counselor sit at the round table across from the prisoner. The unit manager introduces himself, his co-workers and me, and then asks the prisoner what happened. The man readily admits that he fought out of loyalty to his friends. The unit manager gives a short pep talk about the consequences of the path he is on: "You'll get a felony! You'll be in prison longer!" He asks rhetorically, including everyone in the room, "How many times have I given this lecture?" He questions the prisoner about whether he has any friends or enemies at another facility. When the answer is no, he agrees to send the inmate there, and the officers escort the man from the room. He will be returned to his cell to wait—for an unpredictable length of time—until the transport arrangements are actually made.

Classification separates and homogenizes inmates while at the same time attending to individual characteristics that allow them to be clumped into workable groups. Seen in terms of the management of large populations, it produces an orderly grid that can align the prisoners, in all their diver-

sity, with the limited physical enclosures of the prison system.[6] But classification also opens up a space of unequal but not completely closed negotiation. For example, prisoners and staff in disciplinary hearings are adept at acknowledging the social situation behind an incident while evading the specifics. They speak, for instance, of how fighting is both necessary and punished.[7] Dan Garrity, a prisoner whose tattoos marked him as a member of a "security threat group" to prison intelligence officers, said of the fight for which he was segregated, "If you don't help your partner it is considered weak. You got to live on the main line . . . So I ain't no tender guy." An administrator acknowledged:

> You know it's a Catch 22 for inmates. You've got to fight at times. You've [either] got to have a huge reputation built on the fact that you fought before or you've got to fight now. And when they fight, of course, if we catch them, then they might end up [in the control unit]. And we tell them, "Don't do it again." But they've got to do it.

An African American convicted of a drug offense, Garrity went on to explain the complexity of his relationship to classification.

> [Staff] keep bringing up, You was affiliated with a gang, so you dangerous to the main line. [But other] people in here kill for cold-blooded murder! I am not holding it against them, but they are more dangerous than me . . . That is what I don't understand. Some [unit staff] is fair . . . They said, why would you get in this trouble [on main line]? And I said 'cause they was harassing me over there, treating me like bad, bad, and fabricating infractions on me . . . I write the superintendent, I tell him, look at my record . . . Back here [in the control unit] these [staff] people treat you with respect . . . They are changing me. I took the program. I am moving forward now. But if you keep on giving me this theory, telling me that I am dangerous, making me think that I am nobody . . .

Garrity vigorously takes up, argues, uses, and contests the issues and forces bearing down on him, protesting against the assumption that he is a gang member, comparing himself to "worse" inmates, describing how his own behavior has differed depending on context, making careful distinctions among correctional workers, and writing a letter of protest to the superintendent. He responds to the fact that classification is both a set of rules that governs the sorting of inmates *and* a space of negotiation in which a variety of assumptions about behavior and learning are in play. A custody worker noted that what happens to inmates depends on "the way that they carry themselves . . . their history, too. [We] err on the side of caution." Issues of self-defense, rules about gang affiliation, efforts to avoid damaging jackets, and punishment are all on the table. On the table also is psychiatry, for whatever its diagnostic categories may mean outside prison, inside they provide an additional way to make sense of how the prisoner "carries himself."

CLEAR AND DISCRETE DISORDERS

> The current *DSM* process gives the image of precision and exactness. In fact, many have come to believe that we are dealing with clear and discrete disorders rather than arbitrary symptom clusters.
>
> GARY TUCKER, "Putting *DSM*-IV in Perspective," p. 159

> Prison is a botanical garden of the *DSM*.
>
> MENTAL HEALTH WORKER

> Schizophrenic, schizoid . . .
>
> PRISONER, DESCRIBING HIMSELF

Control, rehabilitation, and psychiatry have been deeply enmeshed—in changing proportions—since the nineteenth century.[8] Sociologist John Irwin describes the effects of shifting political tides just since the 1950s when he was imprisoned at Soledad. At that time many prison departments took up an optimistic medical model of criminality and changed their names to "corrections." By the early 1960s "the treatment era was welcomed with general enthusiasm . . . Convicts . . . were led to believe that they would be able to raise their educational level . . . learn a trade . . . and receive help [to solve] their psychological problems." In the 1970s, however, prisoners began to suspect "a grand hypocrisy in which custodial concerns, administrative exigencies and punishment are all disguised as treatment."[9] The 1980s saw a renewed emphasis on incapacitation and punishment as the most rational responses to crime. Describing, in 1997, a control unit cell extraction, Irwin and James Austin note sadly, "Rehabilitation, the guiding principle of penology, has fallen into disrepute."[10]

The current reduction of treatment from a global project of corrections to its current identification with "mental health" is one consequence of this history.[11] Treatment in this narrower sense requires that mental health workers police entry to their limited beds, relying primarily on the standard psychiatric taxonomy. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (*DSM*-IV) can be found on the desks of psychiatrists and mental health workers everywhere. Viewed in light of the overwhelming numbers involved in contemporary incarceration, the key virtue of this bible of psychiatry is that it separates the mad from the bad in a seemingly definitive way. In their conference during the escape attempt, for example, the mental health workers were refining their knowledge of a category recognized by the *DSM* and the prison system as "serious mental illness." To diagnose schizophrenia, a mental health worker can use the decision tree in the manual to check whether certain sets of defining symptoms are present: "Schizophrenia . . . lasts for at least six months and includes . . . [two or more] of the following: delusions, hallucinations, disorganized speech."[12]

One day I followed an inmate, Eddie Mullen, as he was admitted into a mental health unit.[13] Recently sent to prison for a drunken attack on family members, he was a small, disheveled man with several tattoos and scars. The admitting mental health worker questioned him carefully about his crime and his symptoms. Mullen described himself as "hurting inside" and suffering from paranoia and anxiety. "Sometimes I hear things that aren't there, but I can't make them out . . . I black out from anxiety—anxiety attacks, that's what they're classified as. Last year I planned to blow my head off, but I lost my nerve and chicken-shitted out." He expressed remorse, crying and wondering if "I'm gonna be able to forgive myself for what I did."

The mental health worker listened attentively. He gently suggested that Mullen exercise in the yard, shower regularly, and begin programs to address his anger and substance abuse. The critical thing, he said, is "to get yourself under control." Mullen agreed, "That's why I came here, to get the fundamentals." After Mullen was taken out of handcuffs and escorted to his cell by an officer, the mental health worker turned to me:

> My guess is personality disorder. The tattoos suggest an antisocial, maybe we will find a fair amount of anger. Also we need to rule out borderline, which is suggested by his hitting walls . . . There's a borderline feel to it. Sometimes he hears voices, but he's not schizophrenic. There's lots of emotion, maybe he has an anxiety disorder, but I'm guessing it's secondary. What does his remorse [really] mean?

This comment—and the whole conversation with Mullen—reflected the everyday use of the categories of the *DSM* and the assumptions that lie behind them. Mullen was interested in presenting himself as seriously mentally ill because he did not want to be sent to a more threatening environment.[14] He described himself as paranoid, anxious, delusional, and remorseful. The mental health worker expressed suspicions centered on different diagnostic categories: antisocial or borderline personality disorder. He looked for clues above and beyond what Mullen said about himself, such as his anger, tattoos, and scars. He did not trust Mullen's remorse.

The diagnostic definitions of the *DSM* do not refer to individual persons, their histories, or even their personalities in any specific sense; instead they provide a language for describing sets of features that should be clear to any trained observer.[15] Disorders are divided along axes, broad taxonomic categories that differentiate between diseases (or "states") and character (or "traits"). Axis I is for clinical syndromes and includes the major mental illnesses of schizophrenia, depression, and bipolar disorder. In the idiom common in psychiatry, this axis is for the "mad" whose symptoms are recognizable and often florid, but for whom, in general, some (almost always pharmacological) treatment exists. Axis II refers to personality disorders (and some developmental disorders). It encompasses the "anxious," "eccentric," and "erratic"—those whose traits emerge from and result in "conflict between the individual and society."[16]

Mullen's suggestions for diagnoses fall onto Axis I. A diagnosis of paranoid schizophrenia or anxiety disorder would allow his behavior to be viewed as symptomatic and would suggest medication. He would *have* a condition.[17] But if he is to be diagnosed, as the mental health worker suggests, on Axis II, the implication is "characterological." His antisocial behavior would be seen as a trait ingrained in his personality and not susceptible to change through medication or any kind of treatment. He would *be* "behavioral."

Psychiatric diagnosis is a primary mechanism through which mental health workers negotiate the acceptance or rejection of those referred to

them. In their view the diagnosis of a major mental disorder indicates that the prisoner can be helped by what they have to offer, particularly medication. The control unit prisoner in the last chapter who said that mental health workers "wish [medication] on you" was close to the mark in one sense: the wish of treatment is that there should be a treatment. In the circular logic of biological psychiatry, when antipsychotics or antidepressants work it is because the prisoner is psychotic or depressed. Encirclement then makes sense because what the patient says about himself is taken to point either directly, or through various clues, to his condition. In clinical case notes, Axis I diagnoses include speculation about the effects of past trauma, consideration of delusions and paranoid ideas, and accounts of suicide attempts and self-care problems. One mental health worker said, "Our power is approaching the person with the assumption that you *can* change him." In other words, what he has is a state.

How is the difference between state and trait determined? Diagnostic features—such as the coherence of Mullen's speech and whether he expresses remorse—enter strongly into the equation. But when the mental health worker said, "There's a borderline feel to it," he also treated his own emotional reaction as a clue to diagnosis. Describing the training of young psychiatrists, Luhrmann writes of the Axis I/II distinction: "It is the general idea of the personality disorder, with shades of awkwardness and annoyance, rather than a specific diagnostic category, that is invoked [with the phrase] Axis II flavor." For many psychiatrists outside prisons, "Personality disorder patients are the patients you don't like, don't trust, don't want . . . One of the reasons you dislike them is an inexpungable sense that they are morally at fault because they could choose to be different."[18] The issue inside prisons is not whether psychiatrists themselves "believe in" the Axis I/II distinction—many have a highly nuanced view of its uses and limitations—but how the seeming clarity of the taxonomic system is used by mental health and other prison staff who carry out the everyday work of classifying and interacting with prisoners.

The interview with Mullen suggests how the diagnostic taxonomy can come to matter in the prison context. The *DSM*'s shorthand method for separating "illness" from "behavior" is in the background of the conversation for the mental health worker, and even for Mullen, in the sense that he too uses the vocabulary of psychiatry. They are sparring over the discovery and definition of the "truth" about him, a truth in which each has

something at stake. The mental health worker does not want to miss the diagnosis of antisocial personality disorder, which is the most common Axis II diagnosis in prison and largely synonymous with male criminality. He fears that if he does, Mullen will harm the more vulnerable inmates in his care or, perhaps, his staff. From Mullen's perspective, if he is diagnosed antisocial he loses his best chance to be treated as someone who is damaged rather than bad. If he were a plant, he would hold still as he is sorted for entry into the botanical garden of the *DSM* that, in the eyes of the mental health worker quoted at the beginning of this section, makes the prison a fascinating place. As a human speaker, however, Mullen himself attempts to participate in his placement in the diagnostic taxonomy. But his words, by the very fact that they may not be the truth about him, may tell the further truth that he is manipulating. In that case, also, he has a place: it is not in the enclosure of treatment but out on the main line where the antisocial character belongs.

HE TEETERS ON THE STUPID SIDE

> Sometimes I get sick of them being so stupid. I yelled at [an inmate] the other day, it just came out.
>
> OFFICER ON A MENTAL HEALTH UNIT

> To be rational means not questioning irrational conditions, but to make the best of them from the viewpoint of one's private interests.
>
> THEODOR ADORNO, *The Stars down to Earth*, p. 43

> You make your own nest. If you want to live in feathers and down, it's nice. If you put in river rock, it's going to be a little lumpy . . . And that goes for . . . whether you're staff or inmate.
>
> OFFICER

Classification and the *DSM* are brought to bear in situations that require explicit decisions about placement. But what of the average prisoner who gets into trouble? A vernacular logic that deals with everyday misbehavior forms the background of the relationship between custody and treatment. It privileges custodial forms of expertise that do not require a decision about what the inmate *is* (his diagnosis) but rather focus on what he does.

To "get stupid" means to behave badly or irrationally but in a way that does not require consignment to a category. The "stupid" inmate is considered capable of rational choice, but not up to exercising this capacity. The notion is pervasive in prison, and does not mean what it does in everyday talk outside. I first realized this in a conversation with a teenager in a mental health unit. Sweet-faced, light hair curling in a nimbus around his head, he had been brutally attacked in a four-man general population cell. "Being in prison is rough at my age," he said, "a lot people in here prey on the young. [Some of the] guards try to get you mad and get you in trouble. There are a lot of people to stay away from. But in here it's pretty safe." He described how the inmates he left behind in general population were trying to get him to carry out a hit job on another inmate in his present unit. Some of them, he said, "have no morals." An officer on the unit came into the office where we were talking and heard this last comment. To me she said, "He teeters on the stupid side." The boy enthusiastically agreed. "I get stupid sometimes. What helps me is [this officer, who takes a friendly interest in him], the guards who yell at me, and my friends [in here]. People tell me when I'm out of line. There are so many ways to get in trouble."

In a context of multiple pressures and temptations, this conversation speaks to ordinary difficulties of self-determination and the possibility of immediate, local intervention. Later, after I had heard about getting stupid in other contexts, I asked an officer to clarify.

OFFICER: Getting stupid means that they basically did something that they would not have done [normally]. They were being escorted and turned on an officer for no reason, just got stupid and got thrown down for it.

LAR: So, when the officers say that he got stupid, they mean going off for no reason?

OFFICER: Going off for no reason . . . [An inmate] tries to go across the table after the hearings officer. Or, he is being escorted and tries turning on an officer, stuff like that.

LAR: So, it is not stupid in the sense of . . .

OFFICER: It is not stupid in the sense of being dumb. No, not at all.

LAR: It means doing something without . . .

OFFICER: Without real justification.

LAR: If somebody did something like that, and then later he said, "Well, I did it because so and so disrespected me," would it still be stupid?

OFFICER: Depending on what it was. If he did it because an officer did something to him, but it wasn't the same officer, it is still pretty much [stupid]. But, if he did it because that officer did something to him while he was escorting him, it varies. The officer will still consider it getting stupid. For the inmate, it has justification.

This is a thoroughly social concept—not a description of a prisoner alone in his cell, but an account of seemingly senseless or poorly thought-out social behavior.[19] The inmate fights something he cannot win and does not think of the consequences. Further, whether any particular act is stupid depends on whether justification can be found for it, and that justification may depend on the person doing the describing.

Getting stupid can be applied to oneself or others, and to inmates or staff. One prisoner, Sam Delano, said contemptuously of his former cellmate,

> He killed a guy for some dope. Eleven dollars worth of poison. That was stupid. If the guy rips you off or disrespects you, sure, kick his head in. Teach him a lesson. Don't kill him, or don't get caught at least anyways, you know. If you get caught, then the law says you will be here. Boo hoo, you know.

An officer in a control unit described feeling some frustration with young officers who seemed to have little awareness of the consequences of their behavior with inmates.

> For every action there's a consequence. When I get stupid at the big yard gate, shakin' inmates down, or I get stupid in the chow hall and I put the guy on front street, he has to defend his honor among his peers. I have no business as another staff member dragging you in with me when I dig that hole. Don't create a situation that doesn't need to be created.

To create a situation that doesn't need to be created is the essence of getting stupid. Delano is enthusiastic about the use of violence, but considers murder—or at least getting caught—to be stupid. The officer's admonition to his younger peer points to the context of respect and performance within which such unnecessary actions produce their consequences. A pris-

oner said, "I knew they were going to take my radio so I smashed it up and threatened [officers]. I just acted stupid for a while."

Some staff and inmates place stupid behavior in a larger social context of alienation and lack of opportunity. One staff member said of the young inmates on his unit:

> Ordinary life is unattainable to most of these kids. [When they get out of prison] they get off the bus and they're lost. They can't read the street signs, a relative or parent doesn't arrive. They think they have the penitentiary stink. They're treated just like any other welfare inmate. [It's] just like a kid with his nose up against the toy store.[20]

Wondering about larger contexts of constraint, I asked whether he thought this was about class. "Yeah," he said. "But it's almost invisible [to them and to us]. They're *used* to being shoved to the back of the line. The only way they got attention was being destructive." One prisoner, less than twenty years old, provided much the same analysis of his own loss of hope in the future:

> I am pretty rebellious and antisocial, pretty violent . . . I am not very susceptible to rules . . . I will probably be coming back to prison . . . I talk a good game [but] I am not doing good. I get out [of prison] soon but I ain't got nowhere to go . . . I don't got a lot going for me . . . I am a convict, and nobody will give me a job. It is terrible, but I am a drug addict, an alcoholic. I like doing what I want to do. And I really don't have very good self-control. I had a rough life, and that could be my excuse to be a drunk loser, a punk the rest of my life. I want to change but what is the full benefit of it? Squares that got a job, they are struggling, they are bored . . . Is that the way I want to be? I don't have anybody that loves me, so what's the point?

Speaking of young prisoners like this one, and in further response to my question, the staff member added,

> [It's about] pleasure and pain . . . These guys don't make the connection between consequences. The word stupid has been used against them all the time. They never had anything, everything could be taken away at any moment. [You and I] know cause and effect. We look forward to our grandchildren. They see about six months ahead.

Like Bentham in the late eighteenth century, this man sees the problem with what he regards as the criminal classes to be their inability to reason, not because they can't, but because their environment has never made it clear why they should. The "stupid" prisoner—as the young man who considers himself one is quick to point out—is capable in the abstract, but too young and too warped by his environment to manifest the capacities he has. It became clear in the context of a long conversation with this prisoner that he did see the effects of his actions: addiction, an irresistible desire for power over others, and lack of incentive to do anything else are leading him inexorably to another prison term. He considers himself—just as the prison worker considers those like him—irreparably damaged. Later in our conversation he described his difficulty sleeping and the dissociative experiences that haunt him in isolation.

> I see myself slipping into somewhere I don't want to go . . . It is like my mind is trying to go somewhere else. Something real bad happened to me [as a kid] and I used to try to do things else when it was happening, block it off and go to a different place. [That is happening in here too].

The developmental orientation of mental health workers who might pick up on this admission seemed remote to the context of this conversation, conducted in the visiting booth of a control unit. But a rough and ready form of intervention does sometimes interrupt the mix of toughness and fragility conveyed by this prisoner. The practice associated with getting stupid was touched on by the prisoner who talked of how the guards helped him by "yelling at him." Both officers and inmates believe that exhortation—a kind of no-nonsense coaching—can pull the stupid prisoner back from the brink.[21] Talking to prisoners about just where their actions will lead—as many prison workers explain they would with their own children—does not require some sort of special expertise. They need only be willing to step in and directly apply the assumptions about rational choice that are central to the infraction system. Sam Delano, who criticized his cellmate in the quote above, was eventually released from the control unit into a transition program in which he was expected to learn to live in general population. Within a week, according to a worker from the control unit who took an interest in his success, he "did bad." He altered his name tag so that he could get into the weight lifting room, thus earning an in-

fraction for "forgery." This is a good example of the "stupid" act performed by a rational individual who ignores obvious consequences in order to attain a short-term objective. The control unit worker went to see him and "chewed him out real good." Delano "got the message and ever since then he's done well." Eventually he was recommended, with the support of this prison worker, for a less restrictive unit.

A control unit supervisor gave an example of this approach with an inmate whose intractably strange and self-destructive behavior—and the assumption by staff that it was volitional—was the reason he was being kept in a strip cell.

> We don't personalize it. We say, hey, here's your choice. I talked to him. I says, listen, let's work together. Do you think we want this? Do you think we want to have you in this demeaning [situation] with only a blanket? I mean, come on. Get real. We don't want this to happen to you. You need to cooperate with us and let's go forward. It's as simple as that.

A mental health worker described a similar conversation, what he called a "father-son talk" in which he told a disturbed, tearful inmate who was being moved back and forth between a mental health unit and a control unit: "This is stupid. This [behavior] isn't getting you anywhere, this has got to stop. You can get through [your long control unit sentence] if you can just keep your chin up."

These efforts on behalf of inmates who have "gotten stupid" are the custodial version of the parenting and encircling gestures of mental health. To be stupid is to be neither mad nor bad, but "teetering." Through exhortation, prison workers attempt to call forth the prisoner's underutilized reason before he receives a lowered classification or is transferred to a control or mental health unit. This locally informed, seat-of-the-pants effort to change behavior assumes that the prisoner's susceptibility to reason is so obvious a human quality that the intervention of experts is not required. And because it is human susceptibility, not character, that is implied by stupidity, prisoners also rely on its explanatory power. Recognizing and addressing stupid behavior is thus the backdrop—for both staff and inmates—to the more formal knowledge systems of classification and psychiatric diagnosis.

ALL TIED IN WITH HIS ANTISOCIAL STUFF

> I said, You treat mental patients like this? I have a psychiatric disorder. Why am I being treated like a subhuman? You put me in restraints and it's not necessary. You come in with pepper spray. This is not how you deal with an individual who has psychological disorders. And the psychiatrists and the psychologist said, "Well, our hands are tied, you know. You violated the rules and regulations of this facility and they dealt with you accordingly." And so, it was a war.
>
> CHRIS HALLOWAY, ON HIS EXPERIENCE IN A MENTAL HEALTH UNIT

> A guy had been hiding in his cell in the control unit, refusing to cooperate with any treatment. He was perched like a bird on his sink. Stark naked all the time, perched, wouldn't talk or get his food. The psychologist said, "This is behavior, he's not psychotic." I said, "We have a responsibility. That's not normal, that *ain't* normal!" The psychologist said, "You can't tell me what's normal. If he has no prior diagnosis and he doesn't want help, we can't test him." That means that he's only a mental patient when he [already] has that diagnosis. It makes no sense! I grabbed a mental health worker who had recently started at the prison [and insisted he visit the inmate]. He said, there's something wrong with this guy. He took him to the [treatment unit]. The guy deteriorated so badly there, he wiped feces all over himself. He was kicking the door and acting out . . . The mental health worker tried to get him to stop. Finally he said, I will help you. He got a towel and took the guy's hand—it was covered with feces and there was a couple of day's worth of smell. He took his hand, and he said, I will come with you, we'll talk. He led him to the shower and talked to him and got him cleaned up and in a clean cell . . . He walked him through it one step at a time. The guy's hurting, is what he said.
>
> A CONTROL UNIT ADMINISTRATOR DESCRIBING HIS ADMIRATION FOR A MENTAL HEALTH WORKER

On the cusp of mental health, these two prisoners are caught in a confusion of categories, intentions, and missions. Halloway is relying on diagnostic norms to make the case for his psychological condition. He has been

disciplined for what was undoubtedly described as his "behavior," and in the course of it realizes that staff adherence to custodial rules is stronger than the psychiatric discourse into which he wants to insert himself. He insists that his war against the system started because the system was at war with itself. The story of the second prisoner expresses the inscrutability of psychiatric classification. The psychologist is represented playing the card of his expertise—"Trust me, I have a degree," as one person sarcastically described it. He defined the normal and insisted that no matter how bizarre the behavior, it did not qualify as mental illness. The second mental health worker is described reaching beyond himself to contact and transcend the abject body of the prisoner. He reframed psychiatric categories as suffering and, like the psychiatrist who took Kramer's hands, made himself available to the prisoner at the most concrete and—to the administrator telling the story—human level.

I have so far drawn a picture of mental health units as enclosures where there is substantial agreement on treatment. While this is a necessary starting place, it does not do justice to situations like these, in which complex alignments and disagreements occur between custody and mental health workers over specific issues of interpretation. At one hearing I attended, custody, mental health, and administrative staff were deciding whether a prisoner's claim of mental illness entitled him to transfer out of general population. As they gathered around a table with the inmate's records, one person explained, "We don't know if he's a legitimate mental health guy. He *wants* to be mental health, and he's trying to convince [his unit supervisor] that he's crazy." A custody supervisor from the inmate's general population unit said, "He's acting like a true mental health guy, he holes up in his room and acts loopy when you talk to him. But he has grabbed staff through his cuffport, he's throwing, threatening. It's hard to tell if he's mentally ill or faking it. Sometimes he *says* he's making up false symptoms." Various speakers questioned the validity of past diagnoses and speculated that the prisoner wanted out of general population. A treatment unit supervisor said, "I think he's just a manipulator. Does he have mental health concerns or is it all tied in with his antisocial stuff?" They studied his file: he was not on medication and had symptoms such as hearing voices, paranoia, and—less convincing to the group—seeing "blue lights switched to red." The supervisor read out loud, "He does not have a thought disorder but is more characterological." Someone else said uncertainly, "Well, he sounds convincing. There's lots of mental information here, *and* he's a manipulative thug with an antisocial personality."

The prisoner, a short, serious man named Andrew Gomez, was called in and sat at one end of the table, nervously swinging one leg as he talked. He had spent four years in a control unit.

GOMEZ: I need to see a psychiatrist. I see voices; at times they are introverted and sometimes they are out. I've been thinking it's telepathic, from the officers.

SUPERVISOR: They said you're just faking.

GOMEZ: They gave me just a little pill.

SUPERVISOR: Are you afraid to go out in general population, is that the bottom line? Because I'm not buying this.

GOMEZ: I thought I was being attacked psychically.

MENTAL HEALTH UNIT CUSTODY WORKER: I don't buy what you are saying. You can't come to a mental health unit and play games [when] your problem is behavior . . .

SUPERVISOR: You've got lots of staff assaults. It bothers me, especially when you're antisocial.

GOMEZ: I done a lot of bad things. I got hit on the head and voices are getting in.

SUPERVISOR: We won't put up with it. The first behavioral problem [you have] you're out, you're antisocial. There are mental health counselors over there and you are going to have to deal with them. You want out of general population.

GOMEZ: (*letting out a sudden sigh*) I was *told* I was gonna get shanked over there.

The staff reluctantly agreed among themselves to send Gomez to mental health, but not before warning him that by seeking the "mental health jacket" he was creating a new set of problems for himself.

The most immediate issue here is placement: where does this inmate belong? The staff of the unit to which he wants to go express their primary concern: Is he violent? What about his staff assaults? Gomez is also,

at the very least, trying to solve a placement problem of his own. The Axis I/II distinction is implied in the effort to sort out whether he is mentally ill or antisocial. Though one staff member suggests that he is likely both, they must settle on one side or the other. Thus the terms of a minimal psychiatry—antisocial personality and, as Gomez clearly knows, hearing voices, hallucinating—are the terms in which this decision must be framed. Contained within them is the same issue suggested in the conversation with Mullen: are the inmate's words "truly" reflecting "real" mental illness or are they a manipulation intended to perform a version of mental illness that will get him where he wants to go?[22]

Aligning on Common Ground. The decision about Gomez shows custody and treatment staff aligning in their use of the psychiatric vocabulary, which here supports their desire to keep separate the functions of treatment and general population units. The group as a whole considers the available categories, trying to make sense of how they have been applied in the past and strategizing to get them to work in the present. With only two options, they make a placement decision that goes against their preference for the Axis II interpretation. Andrew Gomez gets what he wants, but only after the terms on which he is trying to get it, as well as his truthfulness, are subjected to their shared, and suspicious, gaze.

In mental health units, control units, and hearings, the practices of the security staff and the mental health staff are acutely visible to one another. The glass-walled offices of counselors are only one sign of a myriad of situations that create this transparency; thus, for instance, at Gomez's hearing a supervisor insists that the inmate "deal with mental health." In terms of how custody and treatment staff come to see their interactions, no one result flows inevitably from this. One possibility is that they move closer to one another, acknowledging their mutual dependence and intertwined, often similar, skills. On one mental health unit a treatment worker and an officer were at pains to make clear to me the complementarity of their roles. The mental health worker explained that he was not such an "inmate-lover" that advantage could be taken of him. "The inmate knows I'm gonna dump [punish or infract] him just as quick as an officer." The officer said, appreciatively, "He'll talk 'em down with me." Each saw the other as providing a kind of backup and capable of performing the role usually attributed to the other. The mental health worker added quickly,

"But I'll advocate for the inmate, write letters for him, go to store." These are things the officer cannot do, but she nodded in understanding. Then she turned to me and said, "Now listen to this guy, this is reality. Sometimes I get frustrated by the little communication between us and psychiatry [the psychiatrists who work on a contract basis for the prison]. But we don't have one mental health worker that walks down the tier [that is, responds] when an inmate cries. They know a game."[23]

Officers and mental health workers are brought together in part by these shared experiences of their "reality"—situations that place them on the inside of a world comprehensible only to them. A mental health worker said:

> In here you have close relationships with people who've done things so outcasted. A hard-line custody guy was joking with an inmate who killed twelve people. You get letters from child-molesters. That relationship can only be inside here—it's a bond.

On special units where custody and treatment staff have close daily contact with inmates, they may develop substantial agreement. A nurse described how all the staff in her unit became invested in a charismatic and difficult prisoner:

> [The officers] got along with him. They talked to him through his door for a long time. A few swing shift officers would talk and talk. His counselor also saw something good in him and wanted to help him. People were pulling for him.

Similar agreement can develop about the effects of medication, which are often the most visible and dramatic evidence of the value treatment can have to custody—and also the one least subject to interpretation in terms of manipulation.[24] Custody staff often advocate for a "trip to mental health for a tune-up." An officer said approvingly about one inmate, "For a while he was on meds that seemed to just make him human." Whatever medication does or does not do for a prisoner's experience of his mental life, it may help him fit into the situation of group living.

In these examples, what the mental health workers know—diagnosis, medication, ways of classifying inmates, interpersonal skills—is seen as supporting custodial control. One mental health worker remarked that this

relationship is at its best when it is informal—when the mental health workers refrain from "reminding custody that 'we have the degrees,'" and when a "common language" allows everyone to say both "whacko" and "decompensated." In these moments of alliance, respite from difficult inmates—regardless of diagnosis—is accepted by mental health workers as a reason to admit them to mental health units and by custody workers as a reason for a stay in a control unit. One disadvantage to prisoners of this kind of harmony was noted by this mental health worker when he said that mutual understanding can develop—"none of it said"—that sends an inmate into a control unit regardless of his mental state. An advantage is that custodial workers who trust "mental health" may provide some space in which treatment workers can approach and offer help to a disturbed, violent prisoner.

Conflict at the Divide. Cooperation between custody and treatment is commonplace, but fragile. Custodial staff complain that mental health workers do not appreciate that they are working in a prison. An officer on a mental health unit made these bitter reflections on the increasing number and influence of mental health workers during his tenure there:

> Mental health thinks we're just brainless blue shirts beating them up. Anybody that comes here to work should be on line as an officer before they step up into their high and mighty job. Custody works with the inmates constantly; everything they want comes from us. Mental health talks for an hour and writes for three hours. You're dealing with all one hundred of them. You can't pick one out but mental health can show some favoritism.
>
> They talked one guy down, did their school stuff and made a deal with him.[25] It's like one parent saying no, the other yes. The inmates play us off against each other. If [mental health workers] cross the line of security that's been battered into our heads . . . they lower blue shirt opinion of ourselves, and we start putting up a wall against them. It's like getting beaten down one pebble at a time.

This passage well represents the variety of issues that custody workers have with their position. On the most basic level are some practical and safety matters on which they feel that mental health workers "cross the line of security." Granting exceptions to rules is a problem that reveals fundamental disagreement about what kind of person the exemption is being given to. Custody workers tell cautionary tales of mental health workers who are too eager to see inmates in their offices and—glass wall or not—end up being attacked and injured, or who grant some privilege only to find later that they have been lied to. The custodial point is that prisoners—no matter what their symptoms—are more willful and their intentions more malignant than mental health workers want to believe.[26]

In this conflict, treatment can become equivalent to "care," which is then conflated with the amelioration of deserved suffering. At its sharpest, the custodial critique suggests that criminals simply do not deserve the privileges that are the province of mental health workers to dispense. This is a comment by an administrator:

> There's a contradiction in rehabilitation. Our first mission [as custody] is to protect citizens and staff but mental health professionals want to cure everybody. Inmates have to *want* to rehabilitate. It makes more sense to dispose of [execute] mentally ill killers.

An officer in a control unit said bluntly, "I am not a treatment person. I really don't care about the inmates. You did the crime and I don't care if you suffer." Referring to the either/or quality of this argument, officers say of one another, "He's a black and white sort of guy." One explained to me, "I have a hard time with gray. I like black and white."[27]

In order to keep this perspective in place, the inmate has to be seen as rational, and knowledge of his rationality—which is a form of knowledge that custody workers feel they have—given priority over diagnosis. A custody supervisor gave his opinion of a conflict on his unit about an inmate who had repeatedly cut himself.

> SUPERVISOR: He knows what he's doing. He's manipulating, he's playing us. Now mental health has a different view. But I think that within his limited scope, [he's still able to make choices]. If [we set things up] so that there is no choice [that is, so that there is no escape into mental health] then we can show alternatives and show that they have consequences. My experience with this guy is that he has been trained that good things happen to him when he acts as he does [he is sent to the infirmary, gets attention]. How do we change that? We make sure bad things happen and steer him toward the results we want. How? We

stop letting good things happen and start making him suffer consequences.

LAR: Do you see him as rational?

SUPERVISOR: I've been around him for years and he's very rational. His *reaction* is irrational but *he's* a rational person.

If the inmate is rational "himself" or "in himself"—as many people believe is the case for a misbehaving child—then it is the responsibility of those in charge of discipline to make sure that he experiences consequences that will speak to this aspect of himself. When this prisoner later "got stupid" and spat at an officer who was escorting him, one officer went to him afterward. "Is this how you want to live your life? Don't your parents care [what happens to you]?" The prisoner's only reply was "Fuck you!" "He's just so angry," she said to me later. She speculated that he might have been abused, but at some point—as a teenager, at least—"he has to take responsibility for his actions." Some officers feel that psychiatric medication interferes with this potential for responsibility; one objected that if prisoners are medicated "you can't get into any of the causes of their behavior. I mean they can't think, they're drooling." In this view inmates need to experience the pain that will connect them to their capacity for reason.

Mental health workers describe frustration with this perspective. A counselor for the inmate who cut himself sees him as depressed and suicidal. He finds it difficult to see inmates infracted for behavior that he feels is not volitional and suggests a more complex approach to motive; "You can get into the inmate's head and avoid these things." Another explained,

> It's a dichotomy of mission. The counseling mission isn't well defined. When the officers are faced with an inmate who is brain damaged and unable to learn, they insist that he's just playing, just manipulating us. We'll say, he's *unable* to conceptualize. Officers talk the same way about children, that the "threat of punishment" will change behavior. They say, "They *know* what they're supposed to be doing." Yet we see borderlines, schizophrenics, fetal alcohol syndrome, all from broken homes.

Discouraged mental health workers complain about specific ways in which custodial routines and regulations interfere with their efforts to provide treatment. "I give them something for sleep, and then the nurse wakes them up at 4 A.M. for meds!" Others simply protest, "No one gives a shit about the inmates."

In these conversations the divide between treatment and custody marks a string of oppositions: a division of labor, a disagreement about volition and responsibility, friction between security and care. Prison workers cross back and forth as they argue with or strategically enter into both the custodial and psychiatric perspectives. Some individuals, like the "boom-boom" mental health worker who spoke at the beginning of this chapter, stand firmly on one position—his, of course, being the opposite of what one might expect. Others mix and match interpretations, making strategic use of the alternatives available and fitting them, as best they can, into the difficult situations at hand.

SIGMUND FREUD COULDN'T DO ANYTHING ABOUT IT

> Custody people say he's got to be crazy, but we know he knows exactly what he's doing. He's an antisocial guy who demonstrates he can give out more crap than we can handle. Sigmund Freud couldn't do anything about it.
>
> MENTAL HEALTH WORKER

> They stopped my medications and then they said, there's nothing wrong with you, you're just a behavioral problem. That's what people use to abuse you—oh, he's just a behavioral problem, look at his record. It's easy for people to say that, because they can just justify everything.
>
> CONTROL UNIT PRISONER

Classification and diagnosis work to connect the behavior of an inmate to a stable identity—to "clinch" him into place as mentally ill or not. This work is at its most problematic—and the seams of the system most apparent—when it comes to what is simply called "behavior." Two mental health workers told me—only half joking—that the "evolution of a behavioral diagnosis" goes like this: "1) he's schizophrenic—crazy, really ill, 2) he does that on purpose, 3) have you noticed that every time he wants x he does y? 4) he's manipulating us, 5) I really wonder if those guys knew what they were doing with that diagnosis—and finally, 6) this guy's behavioral." The point is that the inmate who appears to connect his "y"

with the "x" that he wants can't be crazy because to be crazy is, by definition, to be wholly unconscious of such cause-and-effect relationships. We have seen this calculus of inclusion and exclusion threading through conversations in which prisoners are confronted with evidence of their intentionality and staff argue among themselves about whether, in any given case, a prisoner "knew what he was doing." Room for interpretation is greatest when a prisoner's behavior is clearly aberrant yet seemingly useful to him.

The rejection by mental health units of inmates diagnosed on Axis II—particularly those whose aberrant behavior, like throwing, is extreme—makes no sense to custody workers. "There's behavior beyond the scope of custody," said one custody worker. "If you crap on the floor and play with it—it's nuts! What does it *take* to classify it as a mental health problem?" Mental health workers counter that they should not be expected to do the work of custodial containment. One said wryly, "Maybe they'll find a drug for antisocial personality. You can't make somebody do something they don't want to."

Yet of course the project of the prison as a whole is to make people do what they do not want to do. Custody and treatment offer ways to frame this project that differ just enough to provide alternative interpretations of misbehavior, yet not enough to allow either side to escape the other's terms. A control unit administrator explained why prisoners, whether mentally ill nor not, end up in control units:

> Their behavior is a disruptive element in our system . . . so you have the punitive measures because of the behavior. Same thing with the mentally ill. Maybe they weren't thinking right . . . but you still have to punish the behavior. So we're in a real quandary [if prisoners are simply given treatment] . . . where's their consequences? It's not a real pretty picture.

This comment acknowledges irrational thinking but not in a way that affects what happens to the inmate, which is nevertheless framed in terms of punishment. A mental health worker takes up the same logic but resists it as she argues for the impairment of one of her charges:

> Maybe he knew what he was doing with that assault. But I don't see him as that calculating. One day he refused to cuff up, and I said, "I know you don't want them [custody] to come and hurt you." He was sitting on the toilet wringing his hands. I don't think he could calculate like that.

In other words, can this prisoner "think right" enough to get himself out of trouble? Should he be punished whether he can or not?

Classification and diagnosis are brought to bear on these recurring questions, but they do not simply fit down over the prisoners like a grid. Instead they have to be thrashed out, as we have seen, in the practices through which custody and treatment not only control and manage prisoners but constitute themselves as reasonable. The prisoners who are the object of these practices experience effects ranging from irreparable harm to compassionate attention—effects, as we have seen in this chapter, that are not the simple product of one side or the other of the "divide." Paradoxically, in fact, prisoners sometimes gain some space for maneuver from the moments of fragility and indecision that accompany the process of negotiation.

In some cases, however, there is a further possibility. A mental health worker argued for it when speaking of a proposed transfer to his unit. "You're not going to do anything with [that inmate]. He's a *control unit* inmate! Lots of them have life sentences, they are institutionalized. Why pour resources into them?" We have seen in this chapter that in the case of the prisoner who is considered "stupid" or "behavioral" the question of intention has a little space in it, some room for argument. The next chapter turns to what happens when the elements of custody/treatment alliance coalesce around the long-term control unit prisoner.