

Detention Centers: Walls... But Essentially Men and Women. A Poem of Psychopathology in Jail

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Abstract

This article wish to illustrate the most important suffering in situation of suicide attempt.

Prevention of suicide appear like a most important attitude for couple mother-children and particularly in prison.

Keywords: *Suicide Attempt; Prevention; Prison*

LN has been in jail for three years in the women block of Fleury Mérogis Detention Center and I have visited her on a regular basis since the beginning of her imprisonment.

She has always believed that she was a wanted child. She enjoyed playing with kids of her age, but her father objected to it. She also liked to play with her sister though her father would beat them both whenever they played together after he had started drinking. Her mother quickly gave up interfering as her husband would lose his mind too often and there was no reasoning him.

Both parents worked in a factory. Life changed when her father started drinking for a reason she could never figure out. Alcohol makes him totally forgetful.

She is no longer interested in school and she feels annoyed by her schoolmates, often quarrels with them and even with her teachers over the years. The family lived in a peaceful region and LN started loathing the place very early in her youth. She is 12 when her father left her mother to go living periodically with another woman who shared his interest in liquor. Whenever he came back his violent manners broke forth continuously and mood at home was no longer the same. LN's taste for life faded away, that's what she says to me during our first interviews. Boys and girls are of no interest whatsoever to her, and at school she can only keep looking out the window, unable to focus and pay attention. Her educational orientation had to be modified when she reached 7th grade: she kept getting bad marks and had no idea about what she should be doing professionally in the future.

By chance, she met a lady in a shopping place to whom she expressed her feelings. The lady's overwhelming kindness and motherly affection, free of any designated object, so much impressed on her, that they had to meet again many times. They came to discuss LN's lack of professional plans for the future. The huge amount of attention and affection helped LN draw plans to try and anchor herself into a hateful reality: to study and get a hair style diploma. She commenced the training syllabus without any conviction though.

Against all odds, the hair styling training proved to be fruitful: she established friendly connections with other girls who happened to have found themselves in a similar situation and relationships with her sister and her father and mother seemingly gained some sort of stability. She would go on living with her parents until training was over and visit her friend Ms. P on weekends.

She began considering working in the film industry as a studio technician assistant so she might meet with people of interest (could it be she was thinking about the easy going artists' bohemian lifestyle?).

After she had succeeded in getting her diploma, she became fully aware of her craving to leave the region where she had been living and that she considered so dull. During the last year of her training syllabus she was unfortunate enough to come across a party of young people in the habit of using “soft” drugs. She liked hanging around with them and she adopted their behaviors accordingly.

A few months later, in order to use drugs, she went to buy some hashish from a young man who, as it is, will become her first boyfriend. A most romantic story despite the way they first met. They are in love with each other, consider life differently though, they have even been thinking about marriage, but none of them seriously believe in making a living by working in any way. Mr. G has never worked. He is 23 and living in a squat. He asks LN to live with him. Then, noticing an amenorrhea, she must face the reality of a pregnancy. She will definitely not have an abortion but Mr. G says he does not feel fit for parenthood just now. Disappointed, LN starts staying away from him until she makes up her mind to break up.

She frequently goes to “bristrots” (drinking establishments typical in France), although she never gets fully intoxicated, to think over her bitter situation. One day, a man treats her to a drink. He is 20 years older than she is, a calm and measured man. He is Mr. B, “first important man in my life” with whom she will peacefully spend the two last months of her pregnancy.

Thus, she gives birth to a baby boy, whose name will be Kevin and whom she starts to love and cherish. Since they have met, she has been living at Mr. B’s place. She gets government benefits for her child and use the money to share in the household expenditures. Mr. B. disapproves on her financial help since, as a former drug dealer, he seems to have comfortable revenues.

They plan to leave their geographical area and move into Paris, something LN has been dreaming of for a long time. As it is, she was hoping to get a job there, still interested in the film industry.

Kevin brings some harmony to the new household and the relationships he’s developed with B appear well adapted.

Drugs addiction level for B and LN remains steady, and arguments break out now and then due to thymic variations accordingly.

They stay together during three years nevertheless. At this time Kevin was commencing kindergarten and this is precisely when she met with the “man of her life”, while they were both taking their respective sons to the same school. The love story begins and they both share a far more romantic and overwhelming experience than what she had ever felt before in terms of love. She asks B to break up their relationships on mutual consent and then she moves into a hotel.

The third man never uses drugs, leads a near-normal life, but indulges himself regularly with beer and hard liquors while meeting his friends. She does not protect herself on the psychological and symbolic levels or within the reality of such an intense love, and as a result, she becomes, pragmatically, pregnant again. The father of her child remains as a part of her past couple, and the new relationship, even if regular, cannot be satisfactory enough for LN. She gives birth to a baby girl (whom she decided to keep in spite of her loneliness) and will go on living in the same hotel for years within a cheap area of Paris. One year later, Mr. B contacted her, still in love with her, even though she had left him, and offered to help out and to take care of her.

Despite her solitude, she managed to organize a little family life with her children while maintaining some sporadic relationships with Mr. B. She keeps using such drugs as hashish and cocaine. She has few friends, talks to some neighbors and people she meets in shopping places, some of them total strangers... On a morning, she awakes overwhelmed by a profound desire to die. She picks up all the money from government benefits she got the day before and makes for B’s place to buy herself her daily dose of drug. She’ll never get there though, stopping many times on the way to buy liquors, stepping inside several drugstores to get benzodiazepine. Then she comes home where her children have been waiting for her and starts consuming what products she bought. At this time, her daughter is 2 years old and frequently plays near the window that overlooks a public garden. LN can no longer remember how the saddest thoughts took her over

and how she revived the violent edginess which used to mark the days when she lived with G. She can see herself standing in front of the window, her head spinning, tears in her eyes, the field of consciousness overwhelmed with childhood memories, pale clouds in the sky and then the fall... she did take hold of her children's hands before she threw herself out the window with them. There was much blood and many people and screams and an excruciating pain in her.

LN could see firemen standing and kneeling beside Kevin whose dead body seemed torn to pieces to her. Later on, in the hospital, when she learned she still had one crippled child left alive, she collapsed in a massive depression. She would no longer eat and open her eyes and speak. The neurosurgery she underwent allowed her to find shelter in a lengthy silence for in this particular unit she had been sent for recovery, patients are seriously ill and there's hardly room left for speech. People come to weep over their relatives. B and LN's sister alone paid her visits. The rest of the family had been terrified by what she had done and wouldn't see her.

In the meantime, the police started investigating. As soon as her clinical condition improved, she was transferred into the neurosurgery intensive care unit at La Pitié Salpêtrière hospital, then for a short time into the special unit for detainees ("CUSCO room") in Hôtel Dieu Hospital and in Fresne Prison Hospital whence she was eventually moved onto Fleury Mérogis Detention Center to be incarcerated in the women block. Interview sessions were organized very quickly even though she had no desire to speak to anyone there.

The first interviews began and she seemed to be quite able to talk about the facts which caused her to be imprisoned although words came along with a lot of crying. She keeps questioning herself very much about the family breakup and the tight connection with her daughter accordingly. She frequently imagines that what has been happening must be some punishment for the sufferings that were inflicted by her father to her sister and mother. She talks about her own desire to have children, past desire, about "the wrong way" and the drifting away of her emotional life caused by men and her way to cope with things by suffering. She speaks about her dead child like he was still alive, and she keeps making plans for him as part of some delusional mental associations.

She often talks about her father and things left unsaid between them and about her own relationship with drinking alcohol. She mentions her own sexual behaviors and the need to hurt herself like it was just another way to punish herself. With a most vivid orality, she remembered how she used to indulge her children by cooking a great deal of good meals. She says this is true happiness for her, to cook for her kids and to know they are at home while she is out shopping.

During a large part of the interviews she will be denying the cruel reality as she will keep speaking about her children constantly.

Why does she never talk about her mother? To what symbolic mother is she related? For she is bound to the symbolic mother and to the affectivity which organizes the structure of her own psyche. Despite our great many attempts to identify the dimensions which compose the basis of her personality's mode of operation, the answer involved dimensions of "sensations seeking mode".

When I asked her how old she was when she became mother, she did not answer. Likewise, she would leave gaps on the matter of how she paid for drugs when she lived alone and I asked myself if she ever used her own body to make profits. She does not criticize her sexual behaviors and there is not much elaboration when she speaks about the men in her life even if they were of importance.

Regarding her studies, she regrets very much her lack of investment at that time, she believes that an exciting professional life could have been most satisfactory.

She enjoyed solitude a lot, seldom joined in the daily walk around the prison yard in the beginning of her detention. She uses that time of isolation to think a great deal about the facts. She thinks constantly about her children and we talk about them during the interviews, causing a huge rise in emotion that makes her cry.

One day I ask the question "what could have prevented the things that happened?" A long pause followed, not even the faintest sound of breathing could be heard and I could only see the saddest look in her eyes. She answered "love... and my father". Only now did she start

to mention to me the inappropriate behavior of her father in her childhood, during two years exactly, which did not cease until she turned 7, when, from then on, her father chose her sister for love object as she looked more mature than LN in his eyes.

These memories were way too painful for her and could not be evoked in one single interview. As it is, it took several months for her to talk to me about that subject matter and at a very slow pace.

Since the very beginning she had been asking for a medication to “relieve her”. To relieve her from what? Her father’s lack of affection, or else the lack of knowledge in how to live with and look after children? She claims to have used Methadone® and Subutex® illegally, blended with the usual benzodiazepine combination, in the underground drug addicts circles she used to frequent. Self-consciousness and consciousness of the other, her identity originates from the unfolding of identification processes. Language, memory, attention modulation, emotive or affective, will play a major part to preserve the permanency of her body, her corporeal self. She keeps aggressing her body, she frequently uses all sorts of drugs and falls asleep anywhere, during the daily walk in the prison yard or in her own cell and while she is chatting with other detainees. She has to be admitted in Fresne Hospital many times and this is how sequels from the fall were detected.

Thus, the diagnosis of sequels guides her naturally along the path of self-consciousness. To quote Voltaire: “Locke is the first to point out the true nature of identity and what it means to be to the same person, the very same self”. We could discuss it by quoting Saint Augustin and Descartes, but LN always elaborates her own comments before and after her acting-outs without much influence from philosophical readings. She stores away painful memories and recent neurological disorders; she can barely walk and has developed a permanent claudication. The present malfunction interferes with her identification to the mother she used to be...

Apart from her request for psychotherapeutic support, she is committed to the Subutex® treatment I have prescribed at a low dosage, and to another psychotherapy she keeps from succeeding by mixing molecules during the daily walks. One day, she asks for antidepressants, another day she will not have them and demands another product and the next day she needs nothing at all because she says she feels all right. She is also committed to use hypnotic molecules for reality comes back at her in the night through bad dreams and keeps troubling her. In her dreams, the image of herself and the consciousness of her corporeal self remain unchanged, she displays no neurological disorders and both her children are always tagging along.

It is frequently assumed that memory is traditionally the keeper of identity. But what memory? At first sight, LN’s long term memory, in its autobiographical modality, eludes some extremely resistant habits to forgetfulness. Could it be a form of identity amnesia?

Besides memory disorders, LN also displays vigilance deficiencies. Relentless use of all sorts of drugs and behavioral disorders cause LN to become frequently aggressive towards guards and detainees as well when they are close by. When becoming unfriendly, she can hardly speak during our interviews, she doesn’t want to speak actually and she can only say that she is being unwell and that she wants to die. Plato said that thought and speech are similar things. If he is true, even partially, what is going to become of her if she is denied speech? For it is so hard to comprehend the relationships between language and identity that discretion about such a subject matter in classical literature is quite understandable. I ask her the question as such and her reply makes excellent sense, she reflects thoroughly, criticizes her actions, but unfortunately she will act out again in a similar way a few days later.

During our interviews, she will frequently comment on some sort of emotional anesthesia: she will hardly ever cry when she speaks about her children. This pain asymbolia made me think about somatognosic disorder for she can no longer link up pain to her body. The loss of emotional reactions to fear and anxiety made me diagnose depression. Her ability to dream about her own body without any somatic troubles made me consider a projection of some non-recognition type delusion, namely non-recognition of her claudication and furthermore of her moral sufferings connected to the loss of her children. Having survived, her little girl has almost become blind since

the fall and been living at her aunt's place (a sister of LN's), and it is quite unlikely that the juvenile judge will ever permit LN to get her back after her detention is over. This behavioral inhibition pattern may be considered a risky temperament prone to induce anxiety or depression-related disorders. Her temperament can be included in the dysthymic and cyclothymic characteristics.

Wouldn't she have had a depressive episode in her childhood? Indeed, as not all childhood's disorders will be turning into a depressive episode during adolescence, many depressive episodes in adolescence did often result from a first episode that happened during childhood. Thus, medical histories, depressive symptoms set apart, related to depressive episodes in adolescence frequently show anxiety disorders in childhood and, according to the clinical condition displayed by LN, these very same disorders must definitely have existed. Depressive disorders in adolescence far outnumber those in childhood, and deserve to be seriously analyzed, as LN's case will demonstrate, particularly as we know that 52.9% of French teenagers who went through a major depressive episode had relapsed four years later, 35.7% of them showing symptoms of dysthymia and 11.8% showing symptoms of chronic depression. These epidemiological observations are most relevant in LN's case because our patient was under 20 when she jumped from the window and because when she was a child she would invest in her parents as caregivers and providers of desire. Of course, as long as LN-child remained a child, as long as her body's sexual immaturity kept concealing the ambiguity of the relationships between object of care and object of desire, the underlying attention in between those two relational accommodations remained unnoticed.

Sexual immaturity protected her and made possible the oedipal investment in her father despite the weakness of his own response to it. Thus, the child was sufficiently protected against depressive pain by the specific position that "parental objects" investment would occupy. But she grew up and became an adult and to be an adult means, among a host of other things, to recognize that the subject adhere to a relative dependence to her environment. As it is, the men she has known, the position of movie studio technician she briefly occupied, and, mostly, the detention center. LN as an individual, acknowledges that investments in objects and desire are necessary although they may constitute obstacles and imputations against her own narcissistic investments. Unlike so-called neurotic or normal personalities, in LN's case, love of others weakens and impoverishes love of oneself. The narcissistic base having been damaged in childhood, LN's abilities to face life's challenges are limited.

To conclude on the definition of the depressive episode experienced by our patient, symptoms may have assumed the shape of:

- Boredom, complex combination of monotony, lack of interest, fatigue, feeling of time running slow, almost always accompanied by affectivity and intellectual inhibition, "vague expectation of something and inability to tolerate that very expectation".
- Morosity, "refusal to invest in the realm of objects and beings" and "impression that everything is useless and the world is empty", not falling within the definition of thymic disorder.
- Depressive mood defined as a demeaning consideration of oneself which adds colors to unhappiness, representations and activities and affectivity, designed as a fuse box meant to contain a depressive surge.

Thus defined, depressive mood should be nothing more than a fleeting moment meant to warn the subject of a danger of narcissistic deprivation against which a defensive system will develop to prevent the constitution of a real depression.

Since all behaviors may be regarded as major depressions, we need to ponder the meanings of depressive threat, suicide, abandonment depression, altruistic suicide and filicide suicide.

In abandonment depression, violent acts against others or oneself prevail over all other symptoms. Those actions take place to avoid having to face depressive affect and when they are prevented by an external or internal cause, a more typical depression-related symptomatology develops, characterized by a feeling of emptiness and abandonment.

The goal of an acting out is precisely to fill that very emptiness.

On this topic, Braconnier's hypothesis about the end of adolescence points out that this type of depression would represent the revival of feelings of abandonment developed in the first stage of separation-individuation which occurs between the age of 1 ½ and 3. An overly close or absent mother would have inhibited the psychological individuation of her child during the early stage of children development. Because of a lack in maternal support, the child's attempts to gain autonomy would have failed. The child would then have experienced a distressful feeling of abandonment, the intensity of which would have stalled the intrapsychic autonomy process.

In adolescence, regarded as the second part of the separation-individuation process, abandonment feelings would be reactivated and the subject, whose fragile narcissistic position make it difficult to cope with depressive affects, would counter attack in acting out. If we add addictive traits to the personality development, then the course is set for our patient.

All these theoretical considerations have been evoked only to support the diagnosis of major depression, in psychopathological terms. LN's depressive mood was frequently substituted by mild irritability or by pseudo temperament characteristics.

Likewise, we could say that severe depression may be an element of unipolar or bipolar disorders for, according to Braconnier's studies on the subject matter, 20 to 40 % of young adults who have been experiencing a severe case of depression will be developing type I bipolar disorders within five years after the beginnings of the troubles. Our patient history will remind us of such a nosographic entity. Clinical characteristics associated with an increase of type I bipolarity chances in adolescence and adulthood are an early emergence of disorders, psychomotor retardation or psychotic elements, family history with bipolarity cases or a severe mood disorders heredity.

In young adults, evolution towards type II bipolar disorders is connected to early emergence of depression, displaying such characteristics as atypical pattern, seasonality, long-term duration, mood lability, massive use of drugs, high rate of psychosocial issues.

In LN's case, depression does not mean boredom or morosity or even depressive mood as those affects can only be transitory and will be included in the necessary psychological reflection in adolescence to gain access to adulthood.

Studies on attachment process seem to be quite promising in terms of early detection of patients at risk and psychopathological understanding of clinical forms of depression in young adults. As far as our patient is concerned, we have noticed mood disorders and even astasia-abasia type troubles whenever she must face situations which need an increased use of her affects and emotions. Only one single fit of akatisia has been reported so far which could not be ameliorated despite the use of such correctors as Akineton® or Lepticur®. In my opinion, benzodiazepines alternative did not appear suitable in that particular case: use of glutamate blockers which strongly operate on memory, and hallucinogenic LSD, were used before by LN. To hope for psychosocial rehabilitation in these circumstances would be vain.

Some of LN's character and behavioral traits, which seem to demonstrate the existence of a severe alteration in her functionalities and her interpersonal relationships, lead us to classify her within the drug users category. However, it is my opinion that we should emphasize the lack of existence of such a thing as a drug addict personality, despite the belief of many. Indeed, no empirical research has ever validated the concept of an addictive personality that would comprise severe and multiple addictions. As a matter of fact, the true nature of the connections between LN's own personality traits and her use of drugs remains unknown: predisposing personality or consequences of drug consumption?

Identification of LN's personality disorders is nevertheless of the utmost importance for it must be considered when it comes to establish a prognosis and organize complex drug and psychological therapies. I want to make it clear that I have always prescribed the minimum effective dose in terms of psychotropic treatment and insisted on their being administered orally, as relationships between caregivers and the patient have improved.

LN has remained detained in Fleury-Mérogis jail to this day and I hope that the upcoming transfer into the new detention center where she must remain incarcerated until the end of her prison sentence will bring her the peacefulness she has been longing for in a long time.

In conclusion, disorders of personality, along with repeated neurotic and psychotic decompensations, stand as the definite diagnosis in LN's case.

This clinical situation supports the hypothesis of a possible suicide prevention form within the complex core of the interface between life as a free individual and life as a prisoner in jail, and the interface related to family life after it has been broken by traumatic and traumatogenic events. The question about therapeutic alliance remains definitely fundamental.

In this specific clinical case, we will notice an exact relationship, in terms of statistics, between the theoretical characteristics of psychopathic personality (border-line) and the personality traits of our patient.

General criteria for a personality disorder

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
 - a. Alteration of cognition (i.e. ways of perceiving and interpreting self, other people and events).
 - b. Alteration of affectivity (i.e. range, intensity, lability and appropriateness of emotional response).
 - c. Trouble of Interpersonal functioning.
 - d. Trouble of Impulse control.
2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
3. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.
4. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
5. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
6. The enduring pattern is not due to the direct physiological effects of a substance (e.g. a drug abuse, a medication) or a general medical condition (e.g. head trauma) [1-18].

Conclusion

Prevalence of personality disorders in overall population would amount to 10 to 13% and that of antisocial personality disorders to 1% of women and up to 3 % of men. In jail, these figures will be 7 times higher.

Medical publications show at least one case of personality disorder was observed in 60 to 70 % of cocaine-addicted patients and in 35 to 66 % of heroin-addicted patients.

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