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CRIMINOLOGY

DOCILE BODIES? CHEMICAL RESTRAINTS AND THE FEMALE INMATE

KATHLEEN AUERHAHN* AND
ELIZABETH DERMODY LEONARD**

We can influence others in two radically different ways—with the sword or the pen, the stick or the carrot. Coercion is the threat or use of force to compel another's submission. If it is legally authorized, we call it "law enforcement"; if it is not, we call it 'crime.' Shunning coercion, we can employ verbal, sexual, financial and other enticements to secure the other's cooperation. We call these modes of influence by a variety of names, such as advertising, persuasion, psychotherapy, treatment, brain-washing, seduction, payment for services, and so forth.

—Thomas Szasz¹

I. INTRODUCTION

This paper addresses a little-discussed but apparently common phenomenon—the administration of psychotropic drugs

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¹ THOMAS SZASZ, *CRUEL COMPASSION: PSYCHIATRIC CONTROL OF SOCIETY'S UNWANTED* at ix (1994).

to jail and prison inmates for primarily nonmedical reasons.² Psychotropic drugs, which include antidepressants and antipsychotic agents, are used in the treatment of psychiatric disorders such as schizophrenia, severe depression, panic disorder, and bipolar disorder (manic depression). The use of these drugs in prisons has raised suspicion as to the motives of those administering the drugs for nearly three decades; criticisms of these motives have appeared in the form of autobiographical writings of prison inmates³ as well as in scholarly writings.⁴ In this paper, we examine the historical antecedents of the use of chemical restraints on female inmates in the context of other responses to women's deviance, and examine the consequences of this prac-

² We must confess that, strictly speaking, we do not have certain knowledge of what goes on in the hearts and minds of prison staff members administering the drugs. However, at the very least, whatever the *intent* of psychotropic drug administration, these drugs are overprescribed relative to their use in the general population, and there is much evidence that medical supervision and personnel with the qualifications for diagnosing the disorders for which these medications are appropriately prescribed are lacking in prison and jail facilities. Connie Fortin, *Jail Provides Mental Health and Substance Abuse Services*, CORRECTIONS TODAY, Oct. 1993, at 106. See also generally LAURA BRESLER & DONALD LEONARD, WOMEN'S JAIL: PRETRIAL AND POST CONVICTION ALTERNATIVES: A REPORT ON WOMEN ARRESTED IN SAN FRANCISCO (1978).

³ See, e.g., JACK HENRY ABBOTT, IN THE BELLY OF THE BEAST: LETTERS FROM PRISON 40-41 (1981); VICTOR HASSINE, (INMATE AM4737), LIFE WITHOUT PAROLE: LIVING IN PRISON TODAY (1996).

⁴ KARLENE FAITH, UNRULY WOMEN: THE POLITICS OF CONFINEMENT AND RESISTANCE (1993); ROBERT R. ROSS & ELIZABETH A. FABIANO, FEMALE OFFENDER: CORRECTIONAL AFTERTHOUGHTS (1986); JOE SIM, MEDICAL POWER IN PRISONS: THE PRISON MEDICAL SERVICE IN ENGLAND 1774-1989, at 109-14, 172 (1991); Deborah Baskin et al., *Role Incongruence and Gender Variation in the Provision of Prison Mental Health Services*, 30 J. HEALTH & SOCIAL BEHAV. 305, 305-14 (1989); Elaine Genders & Elaine Player, *Women in Prison: The Treatment, the Control, and the Experience*, in GENDER, CRIME, AND JUSTICE 161, 165 (Pat Carlen & Anne Worrall eds., 1987); Jill McCorkle, *Justice, Gender and Incarceration: An Analysis of the Leniency and Severity Debate*, in EXAMINING THE JUSTICE PROCESS: A READER 157 (James A. Inciardi ed., 1996); Merry Morash et al., *A Comparison of Programming for Women and Men in U.S. Prisons in the 1980s*, 40 J. RES. CRIME & DELINQ. 197, 200, 208-12 (1994); Nancy Shaw, *Female Patients and the Medical Profession in Jails and Prisons: A Case of Quintuple Jeopardy*, in JUDGE, LAWYER, VICTIM, THIEF: WOMEN, GENDER ROLES, AND CRIMINAL JUSTICE 261, 264-65 (N.H. Rafter & E.A. Stanko eds., 1982); Richard Spiegelman, *Prison Drugs, Psychiatry, and the State*, in CORRECTIONS AND PUNISHMENT: 8 SAGE CRIMINAL JUSTICE ANNUALS 149-67 (David S. Greenberg ed., 1977).

tice through the use of in-depth, semi-structured interviews with forty-two female inmates of a California prison.⁵

The use of psychotropic medications as a means of controlling inmate populations is not a new phenomenon. Spiegelman's 1976 study of medical and psychiatric care in prison documented the common practice of "chemical pacification" with Thorazine in a California prison; additionally, inmate-author Jack Henry Abbott writes of the practice from personal experience:

I've myself been crucified a hundred times and more by those institutional drugs that are for some sinister reason called "tranquilizers."⁶ They are phenothiazone drugs, and include Mellaril, Thorazine, Stelazine, Haldol.

Prolixin is the worst I've ever experienced. One injection lasts for two weeks. Every two weeks, you receive an injection. These drugs, in this family, do not calm or sedate the nerves. They attack. They attack from so deep inside you, you cannot locate the source of the pain. The drugs turn your nerves upon yourself. Against your will, your resistance, your resolve are directed at your own tissues, your own muscles, reflexes, etc. These drugs are designed to render you so totally involved with yourself physically that all you can do is concentrate your entire being on holding yourself together. (Tying your shoes, for example). You cannot cease trembling.

In *Life Without Parole: Living in Prison Today*, an insightful memoir, author Victor Hassine devotes a chapter to the practice of drugging inmates in both prisons and jails. Hassine asserts that the number of inmates "doing the brake-fluid shuffle" has risen in response to facility overcrowding:

⁵ The interview data used in this paper were originally collected for another study, which focused on the imprisonment of women for participating in or causing the death of abusive intimate partners. Elizabeth Dermody Leonard, *Convicted Survivors: The Imprisonment of Battered Women Who Kill*, 1997, available in PROQUEST DIGITAL DISSERTATIONS, Publication No. AAT 9816668 (search of <<http://wwwlib.umi.com/dissertations/main>>). The issue of chemical restraints was not part of the author's original study; the information that emerged on the practice was one of the many "perks" that come from doing this type of qualitative research.

⁶ In the past, antipsychotic drugs were commonly referred to as "major tranquilizers." This term is no longer used, as these drugs are *not* tranquilizers, but actually more potent drugs with a different mechanism of action than those that are properly called "tranquilizers," such as benzodiazepine drugs like Valium and Xanax. JACK GORMAN, *THE ESSENTIAL GUIDE TO PSYCHOTROPIC DRUGS* 213 (1997).

⁷ ABBOTT, *supra* note 3, at 35.

This new system of mind-altering and mood-altering psychotropic drugs was rapidly becoming the prison administration's "quick, cheap, and effective" solution to warehousing masses of inmates into smaller spaces, while using fewer support services. The reasoning seemed to be that every dose of medication taken by an inmate equaled one less fraction of a guard needed to watch that inmate, and one less inmate who may pose a threat to anyone other than himself. Hence, *overcrowding had brought about a merging of the psychiatric and corrections communities.*

While it may have taken overcrowding to facilitate the "merging of the psychiatric and corrections communities" for the male inmate, these two communities have happily coexisted for centuries with respect to the *female* criminal. In this paper, we will show that female crime—as well as other forms of misbehavior—has a long history of being attributed to medical or physio-psychological causes, and that the medication of female prisoners is a logical consequence of the "treatment" metaphor that pervades the response to the female criminal.

The issue of chemical restraints in prisons and jails is a problem that has received some judicial attention in recent years. In *Harper v. State*,⁹ the Washington Supreme Court held that prison inmates had the right, under the protections of the United States Constitution, to refuse to take antipsychotic drugs prescribed by prison authorities, and that this right could be overridden only when the state: proves (1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of drugs is both necessary and effective for furthering that interest.¹⁰

Incredibly, the United States Supreme Court reversed the ruling of the lower court in *Washington v. Harper*.¹¹ The *Washington* Court upheld the right of inmates to refuse medication, but found that the burden of proof placed upon the state by the Washington Supreme Court was excessive, and that inmates can be medicated against their will if the state can show that medicating the inmate is "reasonably related to legitimate penological interests," which, according to the Court, included the

⁸ HASSINE, *supra* note 3, at 79 (emphasis added).

⁹ 759 P.2d 358 (Wash. 1988).

¹⁰ *Id.* at 3.

¹¹ 494 U.S. 210, 236 (1996).

"maintenance of order in the prison environment."¹² The Court further opined that "the fact that the medication must first be prescribed by a psychiatrist, ensures that the treatment in question will be ordered only if it is in the prisoner's medical interests, *given the legitimate needs of his institutional confinement*."¹³

Three Justices offered a dissenting opinion, which highlighted the self-referential and insular character of the determination of "legitimate penological interests."¹⁴ Since the review that determines whether the administration of the drug is "appropriate" is conducted *within* the institution, by representatives or agents of the institution, the Justices argued that such a review process is necessarily biased toward the protection of the interests of the institution, rather than those of the inmate.¹⁵

*Riggins v. Nevada*¹⁶ dealt with the issue of drugging pretrial detainees against their will. The Court, in *Riggins*, held that the administration of antipsychotic drugs to jail detainees violates the right to due process guaranteed by the Sixth Amendment by introducing the "strong possibility" of prejudice into the trial process since "the effects of antipsychotic drugs may have impacted Riggins' outward appearance, his testimony, and his ability to follow the proceedings and communicate with his attorney."¹⁷

The *Riggins* Court further held that a departure from the standard set down in *Washington v. State* was warranted given the differences in the legal status and constitutional protections afforded pretrial detainees relative to *convicted* prison inmates.¹⁸

These court decisions, however, do not address the common practice of chemically restraining *healthy* inmates that is revealed in our interviews with incarcerated women. The crucial difference between this practice and the cases heard by the Court is that both Harper and Riggins were diagnosed with

¹² *Id.* at 223.

¹³ *Id.* at 222 (emphasis added).

¹⁴ *Id.* at 246-50 (Stevens, J., concurring in part, and dissenting in part).

¹⁵ *Id.* at 255 (Stevens, J., concurring in part, and dissenting in part).

¹⁶ 504 U.S. 127 (1992).

¹⁷ *Id.* at 137. The drug in question in *Riggins* was Mellaril, a drug commonly mentioned by female inmates in our study. *Id.* at 129.

¹⁸ *Id.* at 135.

mental illness—the fact of their mental illness was not in dispute. There is court precedent for the rights of mental patients to refuse drugs (*Rogers v. Okin*¹⁹), which may have influenced the movement of these cases up to the high court. However, as the narratives we present (as well as numerous other sources) demonstrate, jail and prison inmates in the United States are frequently medicated *without* diagnosis or proper psychiatric and physical assessments.²⁰ This is what we mean when we speak of “chemical restraints”—the forcible or indiscriminate use of powerful psychotropic drugs in the absence of appropriate medical justification.

The highest court in our nation has yet to address this type of psychiatric abuse²¹ in prisons and jails. One of the first cases to receive significant public attention was that of *Liles v. Ward*.²² In 1976, several women in a New York state prison were transported (after being strip-searched and shackled) to a state mental hospital because it was determined by the correctional staff that they were “disciplinary problems.”²³ Immediately upon arrival at the state hospital, the women were medicated with Elavil (an antidepressant); a few days later the medication was changed to Thorazine (an antipsychotic).²⁴ Other drugs were added to the regimen over the course of the women’s confinement in the hospital.²⁵ These included the antipsychotic agents Haldol, Sparine, Loxitane, and Prolixin; antidepressants Elavil and Sinequan; sedative-hypnotics Sodium Amytol and Chloral Hydrate; and tranquilizers, such as Valium and Vistaril.²⁶ Although the staff psychiatrists conducted brief interviews and

¹⁹ 738 F.2d 1 (1st Cir. 1984).

²⁰ The use of psychotropic medications in the absence of appropriate medical justification in nursing homes has been the subject of a congressional investigation, see SENATE SPECIAL COMMITTEE ON AGING 143 (1994), but no such inquiry has been focused on the practice in prisons.

²¹ We borrow this term from PETER BREGGIN, *TOXIC PSYCHIATRY* (1991).

²² 424 F. Supp. 675 (S.D.N.Y. 1976); Charles H. Jones & Stephen Latimer, *Liles v. Ward: A Case Study in the Abuse of Psychotropic Drugs in Prison*, 8 NEW ENG. J. ON PRISON LAW 1 (1982).

²³ Jones & Latimer, *supra* note 22 at 4.

²⁴ *Id.* at 6.

²⁵ *Id.* at 8.

²⁶ *Id.*

physical examinations of each of the women (totaling about ten or fifteen minutes each), no clinical diagnosis of mental disability was made in any of the cases.²⁷

Later, when the women brought action in the courts, the staff psychiatrists admitted that the drugs were not administered for treatment but rather "to maintain peace and tranquillity on the ward."²⁸ The hospital staff also acknowledged that, because of this, it was not deemed necessary to make diagnoses in these cases, since they were prison inmates, not mental patients.²⁹ Staff members admitted that the drugs were sometimes forcibly administered via intramuscular injections; one hospital staff member confessed that "the women did not like taking Thorazine and Sparine because of the effects."³⁰

Liles v. Ward was settled out of court (resulting in the hospital paying damages of \$4,857.14 to each prisoner),³¹ and the question of the use of psychotropic drugs was never litigated. As a result, the apparently common practice of forcibly and/or indiscriminately medicating prisoners who are *not* diagnosed with mental illness has yet to be resolved by the courts. Another case, that of Jane "Daisy" Benson, is currently pending on appeal in the California Supreme Court. Convicted of second-degree murder in 1988,³² Benson is petitioning for a new trial on the grounds that she was unable to participate in her own defense due to the multiplicity of drugs administered to her in jail without her knowledge or consent, and that these drugs altered her behavior in such a way that prejudiced the jury, including: "jerking limbs, making inappropriate outbursts, sprawling inappropriately in her chair, her legs spread apart in

²⁷ *Id.*

²⁸ *Id.* at 11.

²⁹ *Id.* at 7.

³⁰ *Id.* at 13.

³¹ Jones & Latimer, *supra* note 22, at 14 n.56.

³² Benson contends that the shooting death of Elaine Wright was accidental. Suzanne Solis, *Lake County Prisoner Voluntarily Took Sedatives*, S.F. CHRONICLE, Nov. 15, 1997, at A24.

a vulgar and suggestive manner, entirely inappropriate for a female defendant in front of a jury."³³

The list of pharmaceuticals administered by jail staff is not in dispute in Benson's case—a combination of Valium, Vistaril, Robaxin (a muscle relaxant), Elavil, Benadryl, Phenergan (a sedative), and Tylenol with codeine, dispensed four times daily. What is disputed is whether or not Benson took the drugs voluntarily. Benson had requested something to relieve her chronic back pain; she was told by jail staff that she had to take *all* the medications offered—without knowing what they were—or receive no relief for her pain. At her first appeal in California Superior Court, members of the jail staff testified that Benson was threatened with being stripped naked and placed in a "rubber room" if she refused the medication—and that this threat was actually carried out on one occasion.³⁴

The issue of chemical restraints has received only limited attention in the criminological research literature. Offhand mentions of the practice abound, but with few—relatively obscure—exceptions,³⁵ the apparently widespread practice of drugging inmates in the absence of adequate medical justification has not received serious analytical attention. This paper is an attempt to begin to remedy that situation.

While there are many references in both scholarly and autobiographical works to the drugging of both male and female prisoners, there is some evidence that female inmates are subjected to medication in custody with much greater frequency than male inmates. The tendency of medical professionals to overprescribe mood-altering, psychotropic drugs for women is not exclusive to correctional institutions. Throughout the country, significantly more women than men receive prescriptions for antidepressants, tranquilizers, and sedatives.³⁶ Genders and Player provide evidence that in Great Britain, female in-

³³ Petitioner's Supplemental Hearing Brief at 8, *Benson v. California* (Cal. Ct. App. (1997) (No. CR-4450) (on file with author).

³⁴ Petitioner's Supplemental Hearing Brief at 6, *Benson* (No. CR-4450).

³⁵ See, e.g., Spiegelman, *supra* note 4, at 149.

³⁶ BREGGIN, *supra* note 21, at 242. See also BARBARA EHRENREICH & DEIRDRE ENGLISH, *FOR HER OWN GOOD* 255 (1978); BERNICE LOTT, *WOMAN'S LIVES: THEMES AND VARIATIONS IN GENDER LEARNING* 302 (1994).

mates receive antidepressants, sedatives, and tranquilizers at five times the rate of male inmates.³⁷ Similarly, Shaw has asserted that female inmates are medicated at two to ten times the rate of their male counterparts, depending on the institution.³⁸ Indeed, one California inmate, Daisy Benson (her case is discussed above) has formed a support/advocacy group called Women Prisoners Convicted by Drugging.

This paper thus focuses on the medication of female inmates, both as convicted prisoners and pretrial detainees. Our theoretical analysis focuses on the ways in which this practice is consistent with historical developments and ideologies surrounding the response to the female criminal. We argue that the use of chemical restraints on women is ideologically justified within the criminal justice system by a rubric of *treatment*. While the use of psychotropic medications on male inmates is often justified with reference to "problems of institutional control," we assert that female inmates are drugged in the name of "treatment"—and that, sadly, this particular form of "treatment" differs little from other kinds of "treatment" to which women have been subjected for centuries.

II. WOMEN'S NATURE AND WOMEN'S CRIME: DIFFERENCE, SICKNESS, AND THE "FEMININE IDEAL"

On the one hand, based on maternity, females had an innate moral superiority, which explained why so few women committed crime; on the other hand, female crime . . . was evidence of women's natural, physiological inferiority and sexualized propensities for evil and chaos.

—Karlene Faith³⁹

In Western society, there is a long tradition of "medicalizing" the deviant behavior of women. This propensity to attribute women's criminal or otherwise deviant behavior to

³⁷ Genders & Player, *supra* note 4, at 165.

³⁸ SIM, *supra* note 4, at 172; Morash et al., *supra* note 4, at 208-12; Shaw, *supra* note 4, at 265. See also FEMALE CRIMINALITY: THE STATE OF THE ART (Concetta C. Culliver ed., 1993); McCorkle, *supra* note 4, at 171.

³⁹ FAITH, *supra* note 4, at 12.

physiological causes resulted from the mythologies that developed to define "woman's nature." Women were, on the one hand, the "mothers of civilization," entrusted with the literal and symbolic reproduction of society by virtue of their idealized femininity; on the other hand, the very biology that enabled them to reproduce rendered them unstable and devious. This paradox led to the development of an elaborate mythology of "women's nature" that served to explain and account for these contradictions. Women's bodies figured centrally in accounts of "women's nature."⁴⁰

The very idea of "women's nature" derives from the nineteenth-century fascination with the *differences* between men and women. Ehrenreich and English identify the industrial revolution as the point of the emergence of difference-based gender ideologies.⁴¹ The increasing distinction of the public and private realm that accompanied the burgeoning factory system, coupled with the rise of science—particularly medicine in the form of gynecology—combined to conquer the prevailing view of women as "men, only less so," into a view of women as something inherently *different* than men.

Paradoxically, the notion of women as somehow *different* from men was also accompanied by the idea that all women, in being a different sort of creature, were alike. Lombroso's seminal work on the female offender highlights the importance of this sameness:

The common character of a genus are also more evident in the forms of the female. Most naturalists are agreed that for the type of a species also one must look to the female rather than the male and this remark may be applied with equal justice to the moral sphere.⁴²

With these beliefs, it is not surprising that nineteenth-century thinkers looked for physical causes to explain women's deviance. By the same token, the "sameness" attributed the fe-

⁴⁰ See generally EHRENREICH & ENGLISH, *supra* note 36, at 91-126.

⁴¹ *Id.* at 9.

⁴² CAESAR LOMBROSO & WILLIAM FERRERO, *THE FEMALE OFFENDER* 130 (1895).

male sex made deviations from the normalized "stereotype of femininity" such an alien, threatening prospect.⁴³

The coincidence of the "discovery" of physiological difference and the emergence of gendered social roles in the public and private realm led many nineteenth-century thinkers to link these in a causal fashion. Men were suited for practical pursuits; women, due to their biology, were destined to bear children and engage in simple, homebound, non-intellectual pursuits. Genevieve Lloyd highlights the embeddedness of this body-mind/reason-madness dichotomy in Western thought; in addition to invoking "Francis Bacon's metaphors of nature as a chaste bride to be wooed by male science,"⁴⁴ she explicates the importance of *symbolic gender*⁴⁵ in the very construction of the concept of "reason":

The philosophical tradition has constructed reason as male in opposition to female emotion, sense, imagination, and so on. But it has also constructed the soul, of which it is the attribute, as sexless, as transcending bodily difference The metaphors of male and female come into the conceptualization of reason in two ways. On the one hand, male reason is opposed to female, nonrational traits; on the other, sexless reason is opposed to all that pertains to body, including sexual difference. Here sexual difference is itself equated with the female. The supposed sexual neutrality of reason demands a male viewpoint—it coincides with the male position, which can take the female as its opposite.⁴⁶

The notion of bodily difference as somehow connected to the faculty of reason facilitated the development of a discourse that focused on the *bodily* nature of women as deterministic of their behavior.

The social consequences of the view of woman as "different" were many and varied. The rise of gynecological medicine facilitated a focus on the female reproductive process as the prin-

⁴³ RUSSELL P. DOBASH ET AL., *THE IMPRISONMENT OF WOMEN* (1986); see also Barbara Welter, *The Cult of True Womanhood: 1820-1860*, 18 AM. Q. 2:1, 151-74 (1966).

⁴⁴ Genevieve Lloyd, *Maleness, Metaphor, and the "Crisis" of Reason*, in *FEMINIST SOCIAL THOUGHT: A READER* 287, 299 (Diana Tietjens Meyers ed. 1997).

⁴⁵ SANDRA HARDING, *THE SCIENCE QUESTION IN FEMINISM* (1986).

⁴⁶ Lloyd, *supra* note 44, at 295; see also Joy Damousi, *Beyond the "Origins Debate": Theorizing Sexuality & Gender Disorder*, in *CONVICT WOMEN'S HISTORY*, 27 AUSTRALIAN HISTORICAL STUDIES 06, 59-71 (1996).

cial source of this difference. The nineteenth century saw the emergence of the pathologization of femininity; the female reproductive cycle was seen as inherently pathological, in part due to the pain and bloodshed associated with menstruation. As Shapiro puts it, "pathology becomes, then, the condition where biological functions are visible."⁴⁷ Indeed, the menstrual cycle captured the imagination of more than one nineteenth-century physician, resulting in the prevailing view among members of the medical profession that the uterus was the central determining factor of woman's nature: The uterus was constructed by physicians as "a mythical physiological system that revealed the alleged truth of the female body."⁴⁸ The centrality of women's reproductive function has been a remarkably persistent theme in the formulation of explanatory theories of women's crime. As late as 1950, Otto Pollak proclaimed that woman's deceitful nature arose from the habit of concealing menstruation each month, concluding that "[o]ur sex mores force women to conceal every four weeks the period of menstruation . . . they thus make concealment and misrepresentation in the eyes of women socially required and must condition them to a different attitude toward veracity than men."⁴⁹

Gynecologists were not the only group of physicians to hone in on women's reproductive capacity as the source of disease. Tellingly, early psychiatrists—whose patients, not coincidentally, tended to be women—were known as *alienists*. This, in and of itself, tells us a great deal about the importance of difference in medical discourse. These alienists devoted a great deal of attention to the pathologies of womanhood and the menstrual cycle. Menstruation was seen as the cause of madness in women, and it was common for medical texts to speak authoritatively of "the pathogenic effects of the uterus on the brain."⁵⁰ It is important

⁴⁷ ANN-LOUISE SHAPIRO, *BREAKING THE CODES: FEMALE CRIMINALITY IN FIN-DE-SIECLE PARIS* 102 (1996).

⁴⁸ *Id.* at 109; see also EHRENREICH & ENGLISH, *supra* note 36; DAVID B. MORRIS, *THE CULTURE OF PAIN* (1991); Dorie Klein, *The Etiology of Female Crime: A Review of the Literature*, 8 *ISSUES CRIMINOLOGY* 3-30 (1974).

⁴⁹ JOCELYN M. POLLOCK, *SEX AND SUPERVISION: GUARDING MALE AND FEMALE INMATES* 11 (1986).

⁵⁰ SHAPIRO, *supra* note 47, at 102.

to note the subtleties of this view: It was not so much that menstruation *caused* mental disease in women—rather, the physiological and hormonal changes that accompanied the menstrual cycle merely facilitated the emergence of *latent* pathology.⁵¹ Woman's physicality left her always in the throes of "a cycle that left her in a permanent state of physical, mental, and spiritual disequilibrium in which she fluctuated between reason and unreason."⁵²

In the nineteenth century, sickness came to be explicitly incorporated into notions of the "feminine ideal." As the industrial revolution took hold, household functions that were traditionally part of the woman's domain were increasingly taken over by the external wage economy. As a consequence, women who did not participate in the wage economy found themselves forced into a state of idleness and purposelessness; consequently many upper-class women became what we would now call "depressed," and thus began an epidemic of "female invalidism."⁵³ Soon, a sickly wife came to be a symbol of status, reflecting the fact that only a successful and wealthy man could afford to support such a wife. Sickness thus became an essential part of woman's nature. In addition, "a morbid aesthetic developed, in which sickness was seen as a source of female beauty."⁵⁴ It was a short step from the idea of sickness being a part of women's nature to comprising the totality of it. Ehrenreich and English argue that the practitioners in the burgeoning field of gynecology made enormous gains in legitimacy through the normalization of women's sickness.⁵⁵ The fact that the cause of female invalidism was commonly diagnosed as *hysteria* illustrates the connection with female sexuality and her innate tendency toward illness, "hysteria" deriving from the Greek *hyster*, mean-

⁵¹ *Id.* at 118; see also MORRIS, *supra* note 48.

⁵² SHAPIRO, *supra* note 47, at 101; see also EHRENRICH & ENGLISH, *supra* note 36.

⁵³ EHRENRICH & ENGLISH, *supra* note 36, at 97. It should be noted that women were, in some ways, active agents in perpetuating this medical discourse. In so doing, women could reduce their own cognitive dissonance about their new idleness. In a society dominated by the Protestant work ethic, sickness legitimated idleness.

⁵⁴ See *id.* at 98. It is interesting to note the lingering effects of this legacy today, as seen in anorexic models and the "heroin chic" high-fashion style.

⁵⁵ *Id.* at 85-88, 91-126.

ing uterus.⁵⁶ The hysteria diagnosis is also indicative of the ambivalence and distrust men had about women's sickness; hysteria became the common term to describe feminine frailty at the same time that popular accounts shifted their name of the condition from "female invalidism" to "female parasitism."⁵⁷ This shift cemented the link between the moral weakness of the female mind and her sexual and reproductive function. Indeed, according to Morris, "the hysteric in effect became the victim of a double affliction. She suffered not only from multiple pains but also from the suspicion of male doctors that her pain was merely the gossamer product of an overheated, labile, sexually deranged, morally corrupt female imagination."⁵⁸

Caesar Lombroso explicitly linked women's criminality with hysteria.⁵⁹ According to Lombroso, hysteria was a chronic condition of women, and hysterical women were most prone to crime at the time of menstruation.⁶⁰ The criminal hysteric was simultaneously unreasonable and cunning: she was delusional, yet she was also manipulative.⁶¹ Lombroso also explicitly sexualized the criminal woman, writing that in his view "all the criminality of the hysterical subject has reference to sexual function."⁶²

Hilary Allen has offered a compelling explanation of *why* female crime has been, and continues to be, medicalized. In her study of court reports for use in trial proceedings in England, Allen finds that reports on female offenders are twice as likely as those prepared for males to contain references to the offender's psychological condition; additionally, approximately 20% of the text of the reports concerning female offenders consists of psychological information.⁶³ Allen asserts that focusing explanatory attention on psycho-sexual-physiological explana-

⁵⁶ MORRIS, *supra* note 48, at 107.

⁵⁷ EHRENREICH & ENGLISH, *supra* note 36, at 120-26.

⁵⁸ See MORRIS, *supra* note 37, at 112.

⁵⁹ LOMBROSO & FERRERO, *supra* note 42, at 218.

⁶⁰ *Id.* at 219-23.

⁶¹ *Id.* at 218-43.

⁶² *Id.* at 224.

⁶³ Hillary Allen, *Rendering Them Harmless: The Professional Portrayal of Women Charged With Serious Violent Crimes*, in GENDER, CRIME, AND JUSTICE, *supra* note 4, at 83.

tions of women's crime "systematically neutralizes the assertion of the woman's guilt, responsibility, and dangerousness."⁶⁴ In this way, the threat that a deviant woman presents is somehow rendered less threatening. Faith has noted a similar phenomenon in the current discourse surrounding Premenstrual Syndrome and women's crime. Faith says that "she may be fearsome but she is also pathetic."⁶⁵ Allen concludes that the contradictions inherent in the representation of female offenders as *both* sick *and* normal is somehow less disturbing than the idea of a woman willfully committing crimes. He concludes that "[in the court reports] there is a simple denial of the woman's mental engagement with her behavior, as if such an unreasonable and unreasonable condition were a quite natural state of womankind."⁶⁶

III. THE FEMININE IDEAL: THE DOUBLE STANDARD WITHIN THE DOUBLE STANDARD

The feminine ideal has, historically, been applied at different levels of expectation for different kinds of women. As well as the powerful *informal* controls placed on the behavior of different types of women, these distinctions have also been reflected in written law. For example, England's Infanticide Act of 1624 subjected married women committing this offense to charges of murder, while unmarried women could not be so charged; unmarried women, under the act, would be prosecuted for "concealment of pregnancy or birth."⁶⁷ This distinction constituted unmarried women as somehow less culpable than married women for the same act; the logical underpinning of this provision in the law was that married women "had no excuse" for such behavior, given their status as "mothers of the race."⁶⁸ By implication, the unmarried woman was somehow less in possession of the virtues of womanhood, and therefore held to a lesser standard.

⁶⁴ *Id.* at 82.

⁶⁵ FAITH, *supra* note 4, at 49.

⁶⁶ Allen, *supra* note 63, at 84.

⁶⁷ FAITH, *supra* note 4, at 33.

⁶⁸ *Id.*

Not surprisingly, race and class have been salient in establishing these expectations. Eugenics and "racialist" ideologies supported the "scientific" differentiation of the white, well-to-do woman from her working-class, non-white counterparts.⁶⁹ As one physician observed in 1874: "The African negress, who toils beside her husband in the fields of the south, and Bridget, who washes and scrubs and toils in our homes in the north, enjoy for the most part good health, with comparative immunity from uterine disease."⁷⁰

This pattern seems to inhere in Leonard's study of California women incarcerated for causing the death of their abusive partners. Although all women in the study were similarly situated in terms of their criminal offense, a distinct bias is present in terms of their sentences they receive; overwhelmingly, white women receive harsher average sentences than their African-American and Hispanic counterparts.⁷¹ These data would appear to demonstrate that white women are held to a higher standard than women of color—and when they violate that standard, they are harshly punished.⁷²

IV. TREATMENT: THE DARK SIDE OF CHIVALRY

The question of the extent to which the feminine ideal serves to place women at a comparative advantage or disadvantage in the criminal justice system has been addressed at some length in the literature on women and crime. Some authors argue that the "chivalry factor" in the criminal justice system serves to result in women receiving more lenient treatment than men.⁷³ However, others have noted that this "chivalry" also

⁶⁹ NICOLE H. RAFTER, *CREATING BORN CRIMINALS* 35-50 (1997).

⁷⁰ *Reproduced in* EHRENREICH & ENGLISH, *supra* note 36, at 103.

⁷¹ Leonard, *supra* note 5, at 71.

⁷² Carolyn R. Block & Antigone Christakos, *Intimate Partner Homicides In Chicago Over 29 Years*, 41 *CRIME & DELINQUENCY* 496-506 (1995); Karen D. Stout, *Women Who Kill: Offenders or Defendants* 10 *AFFILIA* 194-204 (1991) (noting that it is not just in the criminal justice system that women's transgressions against the feminine ideal are punished; for example, women in abusive relationships are much more likely to be killed by their abusive partners when they try to leave the relationship).

⁷³ See, e.g., Elizabeth F. Moulds, *Chivalry and Paternalism: Disparities of Treatment in the Criminal Justice System*, in *WOMEN, CRIME, AND JUSTICE* 277-99 (Susan K. Datesman & Frank R. Scarpetti eds., 1980); Nicolette Parisi, *Are Females Treated Differently? A Review*

serves to disadvantage women insofar as differential treatment based on assumptions about "women's nature" results in disparity of punishment for offenders who are similarly situated in all respects except gender.⁷⁴

The biological basis of the conception of "women's nature" and the prevailing view of the female criminal as "sick" has resulted in a criminal justice system response oriented toward *treatment*.⁷⁵ These attempts to remedy the deficiencies of the female offender have taken a variety of forms; as the discussion below will show, the medication of female prisoners with psychotropic drugs is merely one in a long line of strategies designed to "cure" the female offender and restore her to her "true nature."

The medical model of the response to female criminality has its origins in the general "pathologization of femininity" that occurred in the nineteenth century. Since the cause for *all* of women's behavior was sought and found in women's reproductive capacity, it should come as no surprise that women's *criminal* behavior provoked similar explanations. The conception of the essential nature of woman as "sickly," coupled with the rise of a medical profession—a rise that was directly supported by nineteenth-century figurations of women—resulted in a variety of curative strategies. Since the female reproductive organs were believed to constitute the source of female sickness, many of these "cures" directly involved manipulations of these organs in one way or another:

of the Theories and Evidence on Sentencing and Parole Decisions, in JUDGE, LAWYER, VICTIM, THIEF: WOMEN GENDER ROLES, AND CRIMINAL JUSTICE, *supra* note 4, at 210-15.

⁷⁴ See, e.g., HELEN BORITCH, *FALLEN WOMEN: FEMALE CRIME AND CRIMINAL JUSTICE IN CANADA* (1997); BARBARA BRENZEL, *DAUGHTERS OF THE STATE: A SOCIAL PORTRAIT OF THE FIRST REFORM SCHOOL FOR GIRLS IN NORTH AMERICA, 1856-1905*, at 160-67 (1983); Susan K. Datesman & Frank R. Scarpitti, *Unequal Protection for Males and Females in Juvenile Court*, in *WOMEN, CRIME, AND JUSTICE*, *supra* note 73, at 257-63; Marilyn G. Haft, *Women in Prison: Discriminatory Practices and Some Legal Solutions*, in *WOMEN, CRIME, AND JUSTICE*, *supra* note 73, at 320; McCorkle, *supra* note 4; Carolyn E. Temin, *Discriminatory Sentencing of Women Offenders: The Argument for ERA in a Nutshell*, in *WOMEN, CRIME, AND JUSTICE*, *supra* note 73, at 257-63.

⁷⁵ See generally BRENZEL, *supra* note 74; DOBASH ET AL., *supra* note 43, at 124-58; FAITH, *supra* note 4, at 122-24; ROSS & FABIANO, *supra* note 4, at 13-24; Baskin, *supra* note 4, at 305-14; Genders & Player, *supra* note 4, at 162-65; Morash et al., *supra* note 4, at 200.

This treatment had four stages, although not every case went through all four: a manual investigation, "leeching", "injections" and "cauterization." Dewees [an American medical professor] and Bennet, a famous English gynecologist read widely in America, both advocated placing the leeches right on the vulva or the neck of the uterus. . . . The final step, performed at this time, one must remember, with no anesthetic but a little opium or alcohol, was cauterization, either through the application of nitrate of silver, or in cases of more severe infection, through the use of much stronger hydrate of potassa, or even the "actual cautery." a "white-hot iron" instrument.⁷⁶

Echoing this practice, one observer reports that "in California during the 1970s, hysterectomies (literally the surgical removal of the source of female hysteria) were indiscriminately performed on women [in prison] by general practitioners in retirement from military careers who had virtually no experience in gynecology."⁷⁷

Other medically intrusive treatments documented by Faith include:

In 1971, 300 women in the California prison (then half the prison population) underwent procedures to remove tattoos and moles, having been convinced that this would make them appear more attractive and feminine. The men wielding the knife were students from the medical school of the nearby University of California Los Angeles, who were learning fundamental techniques of cosmetic surgery. . . . [A]t this same prison in 1970, fifty-four women . . . were given "nose jobs" by the UCLA medical students. They, too, were persuaded by the authorities that it would make them more attractive, in keeping with the hegemonic "feminine" appearance imperative. Unfortunately . . . the medical students must have been operating from a single pattern. That is, all fifty-four women came out with pretty much the same nose . . . it was a running joke among women at the institution that you could always recognize "the CIW nose."⁷⁸

A nineteenth-century medical intervention that purportedly had enormous success in curing hysterical women patients was the so-called "rest cure." Popularized by its inventor, Dr. Silas Weir Mitchell, the "rest cure" is eerily reminiscent of the prac-

⁷⁶ EHRENREICH & ENGLISH, *supra* note 36, at 111; see also MORRIS, *supra* note 48, at 108.

⁷⁷ FAITH, *supra* note 4, at 239.

⁷⁸ *Id.*

tice of "treating" today's female inmate with the overprescription of psychotropic drugs:

The notion of the female body as the battleground of the uterus and the brain led to two possible therapeutic approaches: one was to intervene in the reproductive area . . . [and] the other approach was to go straight for the brain and attempt to force its surrender directly The rest cure depended on the now-familiar techniques of twentieth-century brainwashing—total isolation and sensory deprivation. For approximately six weeks the patient was to lie on her back in a dimly lit room. She was not permitted to read. If her case was particularly severe, she was not even permitted to rise to urinate. She was to have no visitors and to see no one but a nurse and the doctor. Meanwhile, while the unwary brain presumably drifted off into a twilight state, the body would be fortified with feedings and massages.⁷⁹

While the medical model applied, in a sense, to all aspects of women's lives (given that their very nature constituted pathology), the emphasis on treatment and disease was particularly prominent in the social response to criminal women. The reformatory movement in particular reflected this curative emphasis. Many reformatories for women were established in the United States between 1870 and 1930.⁸⁰ Elizabeth Fry, a prominent nineteenth-century advocate for separate facilities for women prisoners, stressed rehabilitation and socialization to the feminine ideal; female criminals were seen by Fry as "a grotesque perversion of the ideal of feminine chastity, honour, wifely obedience, and motherly love."⁸¹ Women were to be sent to these reformatories and "re-educated" into their proper feminine roles; however, the reformatory system focused on

⁷⁹ EHRENREICH & ENGLISH, *supra* note 36, at 118.

⁸⁰ See generally ESTELLE FREEDMAN, *THEIR SISTERS' KEEPERS: WOMEN'S PRISON REFORM IN AMERICA 1830-1930* (1981); Nicole H. Rafter, *Hard Times: Custodial Prisons and the Example of the New York State Prison for Women in Auburn, 1893-1933*, in JUDGE, LAWYER, VICTIM, THIEF: WOMEN GENDER ROLES, AND CRIMINAL JUSTICE, *supra* note 4, at 210-15; NICOLE H. RAFTER, *PARTIAL JUSTICE: WOMEN IN STATE PRISONS 1800-1935*, 83-99 (1985) (commenting on the persistence of women's prisons with a primarily *custodial* emphasis throughout this period; it was to these prisons that the "dangerous and unreformable" women were sent; reflecting the multiple levels at which the "feminine ideal" applied to different types of women); but see Rafter, *supra*, at 237-60.

⁸¹ Reproduced in FAITH, *supra* note 4, at 130; see also BORITCH, *supra* note 74 (also acknowledging the role of "first-wave" feminists in designing the reformatory system and emphasizing rehabilitation and "remedial socialization" as the best way to "cure" the female offender).

physical as well as mental deficiencies of female offenders, in that "vaginal examinations constituted not only the main form of [the] reformatory's admission tests but also, apparently, a regular part of the institutional program."⁸²

One result of the establishment of reformatory prisons for women was the application of proportionately harsher sentences for women, who were often sentenced to longer indeterminate terms than were male offenders, often for much less serious offenses. Rafter notes that during World War I, "women's reformatories from Connecticut to Arkansas began receiving women whose only offense was venereal disease."⁸³ These long, indeterminate terms had a rehabilitative justification, while preserving the possibility of lengthy detention for those who were not "cured."

Although the reformatory model for women's prisons fell out of fashion in the 1930s, the influences that effected its creation persist in the treatment of incarcerated women today. The practice of sentencing women and girls to longer terms of incarceration than men (often for much less serious offenses) has been documented extensively.⁸⁴ While incarcerated, women are subjected to much stricter supervision and more disciplinary action than men, despite the fact that their conduct consists of much less serious (i.e., non-violent) institutional infractions than that of their male counterparts.⁸⁵ Additionally, vocational training programs in prisons in the United States and Canada

⁸² RAFTER, *supra* note 80, at 67.

⁸³ *Id.* at 54; *see also* BORITCH, *supra* note 74.

⁸⁴ *See generally* BORITCH, *supra* note 74; MEDA CHESNEY-LIND & RANDALL G. SHELDEN, *GIRLS AND DE-INSTITUTIONALIZATION: IS SEXISM AND JUVENILE JUSTICE A DEAD ISSUE?* 3-6 (1985); MEDA CHESNEY-LIND & RANDALL G. SHELDEN, *GIRLS, DELINQUENCY, AND JUVENILE JUSTICE* 101-64 (1992); Datesman & Scarpitti, *supra* note 74, at 306-09; Haft, *supra* note 74, at 321-24; McCorkel, *supra* note 4; Temin, *supra* note 74, at 257-63; Leonard, *supra* note 5.

⁸⁵ POLLOCK, *supra* note 49, at 48-49. *See also* Dorothy S. McClellan, *Disparity in the Discipline of Male and Female Inmates in Texas Prisons*, 5 *WOMEN & CRIM. JUST.* 75-90 (1994). This particular aspect of "treatment" may have serious detrimental consequences for female inmates; some research has shown that a record of institutional infractions has a negative influence on parole board hearings. *See* Leo Carroll & Margaret C. Mondrick, *Racial Bias in the Decision to Grant Parole*, 11 *LAW & SOC'Y* 93, 101 (1976); Joseph E. Scott, *The Use of Discretion in Determining Severity of Punishment for Incarcerated Offenders*, 65 *J. CRIM. L. & CRIMINOLOGY* 214, 219 (1974).

continue to reflect the nineteenth-century upper- and middle-class "feminine ideal," concentrating heavily on "domestic" and "feminine" skills—such as cooking, sewing, and cosmetology—which, as many have pointed out, do not help women very much in securing employment upon their release.⁸⁶

The disproportionate medication of female inmates is a manifestation of this legacy. Nancy Stoller Shaw, in citing the fact that female inmates are substantially more likely to be medicated than their male counterparts, notes that: "Staff explanations of the difference focus on greater frequency of drug addiction and prison-induced emotional problems for women, and the assertion that overprescribing for women is a general social phenomenon that should draw no special attention."⁸⁷

Ironically, this attitude is reinforced by Shaw's treatment of the issue of psychotropic medications in women's prisons, although she is certainly not alone in her neglect of this phenomenon. While the practice is often mentioned in discussions of women's confinement, it is rarely the central issue at hand,⁸⁸ thus reinforcing the conclusion that this practice not only should, but indeed does "draw no special attention."⁸⁹

Little empirical data are available to address the prevalence of this practice at the national level. We were able, however, to explore the phenomenon at the aggregate level using a national sample (N=13,792) of state prison inmates measured in 1991. The Survey of Inmates of State Correctional Facilities, part of an ongoing Bureau of Justice Statistics research initiative, is an exhaustive survey covering virtually all facets of inmate characteristics, criminal history, characteristics of conviction offenses, and

⁸⁶ See generally FAITH, *supra* note 4, at 156; ROSS & FABIANO, *supra* note 4, at 16-33; RITA SIMON & JEAN LANDIS, THE CRIMES WOMEN COMMIT, THE PUNISHMENTS THEY RECEIVE, 89-91 (1991); Genders & Player, *supra* note 4, at 162-65; Morash, *supra* note 4, at 198; Imogene L. Moyer, *Women's Prisons: Issue's and Controversies*, in *It's A CRIME: WOMEN AND JUSTICE* 191-97 (Roslyn Muraskin & Ted Allerman eds., 1993); Roslyn Muraskin, *Disparate Treatment in Correctional Facilities*, in *It's A CRIME: WOMEN AND JUSTICE*, *supra*, at 191-97.

⁸⁷ Shaw, *supra* note 4, at 265.

⁸⁸ See, e.g., BRESLER & LEONARD, *supra* note 2; FAITH, *supra* note 4, 238; ROSS & FABIANO, *supra* note 4, at 97; Genders & Player, *supra* note 4, at 165; McCorkle, *supra* note 4.

⁸⁹ Shaw, *supra* note 4, at 265.

the incarceration experience. The interview schedule contains a question concerning whether the inmate has been medicated for a mental or emotional problem during his or her incarceration (although not information on particular medications). After first ascertaining that women in our sample were indeed significantly more likely to receive medication for mental or emotional problems ($F = 66.9$, $p < .001$), we conducted logistic regression analysis in order to determine the unique effects of several variables—mental health history, whether or not the conviction offense was a violent crime, history of serious institutional infractions, and race⁹⁰—on the likelihood that inmates will be so medicated. Separate analyses were performed on male and female inmates. These results are offered in Table 1. A single-equation main model with sex-specific interaction terms was estimated for the sample as a whole, the results of which led to the same conclusions as those reported here.⁹¹ The separate analyses are reported here for their relatively greater ease of interpretation for the less methodologically sophisticated reader.

⁹⁰ Race is included in the analysis largely as a control variable, although our finding that whites of both sexes are more likely to receive psychotropic medications does have some interesting implications (although this finding is only significant for male inmates).

⁹¹ The single-equation model was estimated for the dependent variable ("inmate given medication"), with the independent variables sex (female=1, male=0), race, infraction history, violent conviction offense, mental health history, both with and without interaction variables representing the unique effect of each of the independent variables combined with being female. All regression coefficients in the model estimated without interaction terms were in the expected direction and significant at the .05 level. All regression coefficients in the model including interaction terms were significant and in the expected direction at the .05 level, with the exception of sex alone. This seemingly paradoxical finding actually provides strong support for the thesis presented in this paper—namely, that it is not solely the condition of being female that triggers the "treatment" response—but rather that it is the unique effect of being female and exhibiting behavior that is inconsistent with the normative requirements of the feminine ideal. The effect of sex is significant in the first-order main effects model because in the absence of interaction terms, this variable acts a crude proxy for the sex-specific interaction effects. Full results of these analyses are available from the authors upon request.

TABLE 1.
EFFECTS OF INDEPENDENT VARIABLES ON THE ODDS THAT AN
INMATE WILL BE GIVEN MEDICATION FOR AN EMOTIONAL OR MENTAL
PROBLEM (LOGISTIC REGRESSION)

	Male (N=11,013)	Female (N=2,779)
Mental Health History ^A	7.97 ^{***}	4.76 ^{***}
Violent Conviction Offense	1.63 ^{***}	2.11 ^{***}
Race ^B	.75 ^{***}	1.05
Serious Institutional Infraction ^C	1.33 ^{***}	1.81 ^{***}

^{***} p < .001

^A The question reads: Before your admission to prison, had you ever been admitted to or sent by the courts to a mental hospital or mental health treatment program where you stayed overnight?

^B Race is coded such that white=1, African American=2, and others are coded as missing.

^C Serious institutional infractions are here defined as being found guilty of any of the following: escape or attempted escape, assaulting an inmate, assaulting a staff member, possession of a weapon, or "other major violations."

The coefficients represent the multiplicative impact on the odds of being medicated, while controlling for all other variables in the equation. The difference between the strength of the influences between the male and female samples is striking. For example, while having had prior mental health problems is significantly related to the likelihood of being medicated in prison for both male and female inmates, the magnitude of this effect is nearly twice as large for males as it is for females. Similarly, even controlling for prior mental health history, the effects of conviction for a violent offense are much more important for women than for men—indeed, a violent conviction offense, controlling for the record of institutional infractions *and* prior psychiatric history, serves to double a woman's chance of being medicated. This finding is particularly paradoxical given the evidence that women convicted of violent offenses do not tend to be institutional problems.⁹² These findings are consistent with the conclusion of a group of re-

⁹² See FAITH, *supra* note 4, at 97; see also BONNY WALFORD, *LIFERS: THE STORIES OF ELEVEN WOMEN SERVING LIFE SENTENCES FOR MURDER* 96-98 (1987).

searchers that role-incongruent behavior exhibited by women in prison is likely to be "psychiatrized."⁹³ While these results must necessarily be interpreted with some caution (as is often the case with secondary analyses), by and large they do seem to support our contention that women in custody are "treated" with medication in an attempt to correct their deviant behavior in a psycho-physiological manner.

V. CHEMICAL RESTRAINTS: EXPERIENCES IN CUSTODY

In order to demonstrate some of the consequences to women prisoners of the widespread practice of drugging, we analyzed interview data gathered for an earlier study.⁹⁴ Our sample consisted of forty-two women, all incarcerated in a California prison for participating in or causing the death of a battering male partner. While we do not claim that this sample is representative of the female inmate population in general, and we freely admit to using this data due to its depth and availability more than any other reason, these cases are in many ways extremely appropriate for illustrating the theory we develop in this paper. We assert that women's deviance is responded to in ways that resemble or approximate medical treatments; and that this "treatment" response is related to violations of what we have called "the feminine ideal." Here, we are dealing with what might be called "extreme cases" with respect to violation of the feminine ideal: all forty-two of these women were not only convicted of crimes of violence, but, indeed, the murders of their husbands or boyfriends. It is hard to imagine a more egregious violation perpetrated upon the feminine ideal. For this reason, it is not surprising that the majority of women in our sample report being medicated by jail authorities while in custody.⁹⁵

This study draws from interviews with forty-two women serving prison terms for the death of their abusive partners. The

⁹³ Deborah R. Baskin et al., *Role of Incongruence and Gender Variation in the Provision of Prison Mental Health Services*, 30 JOURNAL HEALTH & SOCIAL BEHAVIOR 305-14 (1989).

⁹⁴ Leonard, *supra* note 5.

⁹⁵ *Id.* In addition to the in-depth interviews, follow-up questionnaires were received from a subsample of interview subjects (N=27). Of these, *two-thirds* report being given psychotropic medications in jail, a figure that is consistent with other research on female prisoners.

majority (64%) of the women in the sample are forty-five years of age or older, the median age being forty-seven years. The sample is predominantly white (67%), with African-Americans comprising 17% and Latinas 7% of the group. Seventy-six percent of the women report training or education beyond high school, either technical school or some college or more. Just more than half were employed, full or part-time, prior to their arrest. Compared to the general population of female prisoners, the women in this study are older, more educated, and less likely to be women of color.

For the overwhelming majority of the battered women defendants in this study, the homicide arrest was their first experience with interrogation, arraignment, or commitment to a county jail facility. Frightened, confused, and often traumatized from a recent beating and their own lethal actions, many women report that confinement in county jail was more trying than subsequent confinement in state prison. One recurrent criticism that arises from their jail time is the use of prescription drugs—antidepressants and antipsychotics⁹⁶—as ordered by jail staff.

VI. NARRATIVES

One woman's comments reveal the promise of psychological escape through drug treatment. She also exposes the trial advantage that comes to those who receive bail:

When I was first arrested, they put me on drugs. They said I needed them—the doctor that was there. At that time, you want anything that will make you sleep. You don't want to think about what's happening. And everyone sleeps all day and all night. They do it by getting on to the drugs. When they say, I want to give you whatever, whether it's Mellaril, I don't remember what it was. I continued to stay on that drug and sleep. Luckily enough, I was bailed out so I fought my case on the street and I wasn't on drugs. I knew I had to testify. I knew I had to tell them the story.

⁹⁶ Frequently mentioned antidepressants and antipsychotics include: Mellaril, Elavil, Desyrel, Triavil, Vivactil, Vistaril, Haldol, Lithium, Stelazine, Sinequan, and Thorazine. See Appendix A for a discussion of the properties and side effects of some of these drugs.

In contrast, a woman who serves a seventeen-year to life sentence observes,

[A]fter eleven months of being on 250 milligrams of Sinequan—no, anywhere from 150 to 300—during the trial, I took 100⁹⁷ milligrams of Mellaril four times a day. I fell asleep seven times during the trial.

A former high school English teacher describes her self-presentation in the courtroom and the impact of drug treatment on her ability to testify. She is serving a sentence of twenty-five years to life.

The jail psychologist or psychiatrist put me on drugs in jail. I was too distraught to make a rational decision about medication. During the trial I was on both a tranquilizer and an antidepressant. I was not able to testify well—I was a zombie. They said I was cold and remorseless, not showing any emotion. I'm articulate—a college graduate with a graduate degree—the meds made me inarticulate. The D.A. made Marcia Clark look like a Girl Scout. She destroyed me on the stand. My lawyer didn't prepare me for what was going to happen during cross-examination.

Another woman, having so far served twenty-one years of a sentence of seven years to life, describes the impact of the homicide and its aftermath in combination with “psych meds:”

In jail, the psych doctor decided to put me on drugs. I don't know what it was. I was in total shock. I did not even have a period for eight months. My whole body shut down—my mind, too. This was during the trial too.

Unable to recall the composition of the jury, one woman offers an explanation for the memory gap:

I don't really remember the jury. . . . They put me on psych meds about three months before the trial.

The women's stories of their medication experiences in custody also reveal the inadequacy of the psychiatric staff who are prescribing these drugs. As a twenty-year-old with an addiction

⁹⁷ The women in our sample frequently report being given an antidepressant and an antipsychotic simultaneously—in this case, Sinequan (an antidepressant) and Mellaril (an antipsychotic). Both of these drugs have sedating properties, but when combined, the effect is synergistic (in the same way that, for example, the effect of combining barbiturates and alcohol is greater than simply the sum of the two effects). See Appendix A for a fuller discussion of side effects of psychotropic medications.

to illegal drugs at the time of the homicide, a woman exhibits concern over the combination of medications prescribed for her in jail:

I don't know who decided I had to be on medications in jail. They gave me antidepressants and other drugs. I was on like four different types that should not have been mixed together. I didn't even know why I was getting it and I didn't want it.

Other interviews revealed that drugs were frequently ordered by nurses, psychologists, and even correctional officers—persons who are neither legally permitted to prescribe medications nor qualified to diagnose the psychiatric conditions for which these medications are appropriate treatment. Despite this, several interviewees expressed ambivalence toward the prescription of mood-altering medications. One said:

Deputies and a nurse ordered Vistaril and Phenergan. I was depressed and "out of it" so I did and didn't want it. I was taking shots in jail . . . and medications—Vistaril, and Phenergan was one of the shots—antidepressants—I know they gave me 50 milligrams of it. That was ordered by somebody but there's no record of it.

Another said:

The counselor or the jail nurse put me on Vistaril and Elavil. I was told to take them and I did. I wanted to and I didn't want to. They kept me on them during the trial. It lasted two months. I stopped the day I came to prison.

Others were unequivocal in their objection to medications given during their jail confinement:

In jail they gave me Prozac prescribed by a psychiatrist. I didn't want it because I'm fearful of "psych" drugs.



The doctor in jail prescribed Sinequan for me. I didn't want the drug. I only wanted something to get rid of the migraines and allow me to sleep at night. They gave it to me during the trial.



The jail nurse gave me Elavil that I did not want.



The jail doctor gave me Sinequan and kept me on it during the trial. I didn't want it.



In jail, the psychologist gave me Sinequan. I didn't want it.



The jail staff . . . decided I had to be on Mellaril, Lithium, Elavil, Sinequan, Vistaril, I didn't want to take it. I was on all of it during the trial.



The doctors and attorneys decided I needed medications when I was in jail. They gave me psychotropic drugs that I didn't want. Even during the three months of the trial I was on Thorazine, Stelazine, Triavil, Desyrel, and others.

One respondent's daughter alerted her to the observable effects of the drug treatment. The woman defends her right to feel the emotions "normal" for her situation and she manages to exercise some control over her dosage:

At Sybil Brand [Los Angeles County Jail for women] they put you on, well, they put me on Sinequan. When I was first arrested, they put me in an orange outfit and put me in a mental observation ward. They were giving me medication—a handful of pills. And I was taking the medication because a doctor was giving it to me so I must need it. Days went by and my daughter came to visit me and she was like, "Mom! What's wrong with you? What are they doing to you?" I knew I was sleepy all the time and I had trouble sorting things out. I asked the doctor, "What is this for and what is this for?" You know, I wanted to know what those pills were for. I started sneaking and not taking them all. But, I asked him what they were for and they told me that they were antidepressants. I was furious because, to not be depressed in my situation would not be normal. I'm supposed to be depressed. And that's what I explained to the doctors—that it's, like, when someone dies you go through the grieving. I just didn't just kill somebody. I killed somebody that I loved very much. I had the right to be depressed and I refused to take the medication. They didn't take me completely off the medication though, but they put me under a level that I could go out into population [with other inmates] on a trial basis.

A Native American woman repeatedly refused to take a psychotropic drug. She reports that jail staff attempted to coerce her into accepting the medication in exchange for releasing her mail. She took her complaint to a higher authority. Her account indicates her perceptiveness regarding the reasons the jail authorities wanted to medicate her:

When I was in Sybil Brand, every day they were calling me to go upstairs to take—what was it they wanted to put me on? Thorazine. And I'd go up the ramp and come right back down. I didn't want to be on that medication. I'd seen girls on that medication. And I wouldn't. I wouldn't. . . . One time I went up to court and I told the judge that they were holding my mail. They wouldn't give me my mail. They were trying to put me on these meds. I had two court orders where

I was not allowed to go up there and be on meds—a court order—and for them to release my mail. Because they were telling me they were going to lock me up if I didn't take them. I said, "I'm not taking them." But it wasn't the judge ordering them, it was just Sybil Brand. I think it made a difference that I was a woman. I think being a woman, and going through the system, and what I was charged with, it was like, women don't do them things.

The women interviewed also indicated an awareness of the prevalence of drugging inmates with powerful psychotropics:

I was on medications when I was in jail. They started me on Atavan, and then they put me on Xanax. They'd give me stuff to sleep, but it never—it just didn't do it. I wasn't on anything like Sinequan or anything like that. I was careful.



I didn't want to be on that medication [Thorazine]. I'd seen girls on that medication.



I was out on bail during my trial. I wasn't on any meds but I could have been.

Another inmate indicates this awareness in the context of the paucity of programs for lifers, and the coercive nature of this type of "drug treatment":

Most lifers are lucky to be in a group for over two years. . . . Unless you have a psychological problem—they're trying to do away with groups for lifers, and that's a board recommendation, and the only way you can have it is if you've got a mental problem [or] on psych drugs.

The interviews also revealed that the quality of medical and psychiatric care was often questionable, despite the liberal dispensation of powerful medications:

I was hyperventilating, because they'd bring me—they called me the brown bag girl—they'd bring me little paper bags to breathe into while I was in jail. I begged to see a counselor and the same one that had seen me and my husband, [the man] who had told on me, told [my husband] what I had said to him in confidence, came to see me one time.



The doctor gave me Sinequan. I didn't want it. I only wanted something to get rid of the migraines and allow me to sleep at night.



The night they came back with my life without [parole] sentence, I had told them I needed something to sleep with. Two weeks later when they finally got me up to the infirmary, I said, "I don't need anything now. It's too late."

VII. CONCLUSION

The drugging of prison and jail inmates with psychotropic agents is by no means a new phenomenon. Evidence exists that this practice has been taking place in U.S. prisons and jails since at least the 1970s. In light of some evidence that female inmates are more likely to receive psychiatric drugs in correctional or detention facilities, we analyzed both quantitative data from a national sample of prison inmates and qualitative data consisting of interviews with forty-two incarcerated women concerning their experiences in pretrial detention.

Based on our findings, we conclude that women's medication in prisons and jails is best understood in the context of a historical tradition of "treatment" responses to the behavior of deviant women. Like other treatment-oriented strategies directed at the female offender, the drugging of female inmates can result in disproportionately harsh outcomes for these offenders. For example, the drugging of jail detainees before and during trial can raise some serious problems with respect to the ability to participate in one's own defense and to receive due process of the law. Although the use of chemical restraints throughout the criminal justice system is a problem that greatly deserves further study, the medication of women, in particular, raises some unique theoretical and practical issues that should be examined in greater depth by criminological researchers.

APPENDIX A: A NOTE ON THE MEDICATIONS

In Elizabeth Dermody Leonard's study of incarcerated women convicted for causing the death of abusive partners,⁹⁸ the drugs most frequently mentioned by the inmates include the antidepressant drugs Sinequan, Elavil, Desyrel, Vivactil, and Vistaril, and the antipsychotics Thorazine, Haldol, Mellaril, and Stelazine. Many of these drugs have serious side effects; in addition, many of them require a great deal of medical supervision and preliminary medical testing. Another feature of psychotropic medications is the potential for synergistic effects when combined. Of particular interest here is the common practice reported by the women in our sample of simultaneous administration of a cyclic antidepressant and an antipsychotic. The sedative effects of cyclic antidepressants interact with the sedative effects of antipsychotics to enhance the magnitude of this effect such that the sedating effect of the drugs in combination is greater than that of the summed effect of the individual drugs.⁹⁹ Since antidepressants and antipsychotic agents constitute the majority of psychotropic medications given to women prisoners, a brief discussion of each of these drug types with reference to some of the specific medications mentioned by inmates follows.

A. ANTIDEPRESSANTS

The antidepressant drugs Sinequan, Elavil, Desyrel, Vicartil, and Vistaril are frequently mentioned by respondents in the data analyzed in this paper. With one exception (Desyrel¹⁰⁰), the antidepressants most frequently administered to jail and prison inmates in our sample are *cyclic* antidepressants. Common side effects of these drugs include extreme sedation,

⁹⁸ Leonard, *supra* note 5.

⁹⁹ Thomas R.E. Barnes & J. Guy Edwards, *The Side Effects of Antipsychotic Drugs I & II: CNS and Neuromuscular Defects*, in *ANTI-PSYCHOTIC DRUGS AND THEIR SIDE-EFFECTS* 213 (Thomas R.E. Barnes ed., 1993).

¹⁰⁰ GORMAN, *supra* note 6, at 150. Although not a cyclic antidepressant, Desyrel is included in the class of "Sedative Antidepressants" (along with Elavil and Sinequan) and entails the common side effects of sleepiness, dizziness, and nausea and vomiting.

blurred vision, dizziness, and weight gain.¹⁰¹ Additionally, many of these drugs can aggravate pre-existing medical conditions, such as glaucoma and certain heart conditions; as such, extensive medical tests are required before prescribing these drugs, something which is not reported by prisoners in talking about their drugging experience.¹⁰² An additional problem with these drugs is that ceasing them abruptly may induce serious physiological withdrawal symptoms,¹⁰³ something that is likely to happen if inmates are transferred to another prison, transferred from jail to prison, or released.

The use of antidepressants in the United States has greatly increased in the past decade.¹⁰⁴ The introduction of the class of antidepressant drugs known as SSRIs (Selective Serotonin Reuptake Inhibitors), which includes Prozac, Zoloft, and Paxil has, in the words of one physician, "revolutionized the treatment of depression."¹⁰⁵ This same author also notes that SSRI antidepressants are safer. "The tricyclics all have important effects on the heart and blood pressure, which, for some, can be dangerous. None of the newer antidepressants have dangerous side effects . . . for the most part, the only reason tricyclics are still used is because they are cheaper than newer antidepressants."¹⁰⁶

Indeed, this appears to be the case in the prescription of cyclic antidepressants to female inmates; Table A1 offers a per-dose cost comparison between some of the drugs used, and SSRI drugs, which are, in the words of a respected physician, the "first-line treatment for depression."¹⁰⁷

¹⁰¹ *Id.* at 59-80; Shaw, *supra* note 4, at 263. Weight gain may not seem to be in the same class as the other side effects mentioned here; however, weight gain can result in many serious health problems (e.g., diabetes, hypertension). This may be particularly problematic in light of the fact that many women experience a significant weight gain in prison due to other factors associated with the prison experience.

¹⁰² Interviews by Elizabeth Dermody Leonard with Jane Ellyn (Daisy) Benson, at California Institution for Women, Cal. (1998); Leonard, *supra* note 5, at 100-08.

¹⁰³ BREGGIN, *supra* note 20, at 153-55.

¹⁰⁴ See generally DAVID HEALY, *THE ANTIDEPRESSANT ERA* (1997); BREGGIN, *supra* note 21 (on the recent increase in antidepressant use in the United States).

¹⁰⁵ GORMAN, *supra* note 6, at 92.

¹⁰⁶ *Id.* at 90-92.

¹⁰⁷ *Id.* at 90.

TABLE A1: COST COMPARISONS OF ANTIDEPRESSANT DRUGS

Drug	Cost per dose*
<i>Drugs Commonly Given to Inmates</i>	
Elavil	11 cents (generic)
Sinequan	19 cents (generic)
Desyrel	26 cents (generic)
Vivactil	46 cents (generic not available)
<i>SSRIs</i>	
Prozac	\$2.28 (generic not available)
Zoloft	\$2.00 (generic not available)
Paxil	\$1.93 (generic not available)

*Usual recommended dose.

Source: GORMAN, *supra* note 6.

B. ANTIPSYCHOTICS

The other drugs with which female inmates in our sample frequently report being medicated are a variety of antipsychotic agents. Antipsychotic drugs are used in the medical community for the treatment of schizophrenia.¹⁰⁸ Nearly all of these drugs result in heavy sedation of the patient taking them, but a physician warns:

Antipsychotic drugs are not powerful tranquilizers, they are medications designed to treat specific sets of psychotic symptoms found in patients with specific diagnoses They are not to be used for treating anxiety in nonpsychotic patients for two very good reasons: first, they don't work very well in that situation, second, it is not correct to expose a

¹⁰⁸ See generally *id.*

patient to the risk of severe side effects when drugs with fewer side effects are available.¹⁰⁹

Among the antipsychotic drugs frequently mentioned by inmates are Mellaril, Haldol, Thorazine, and Stelazine. All of these drugs have the capacity to produce a constellation of short-term side effects that includes drooling, painful muscle spasms, hand tremors, restlessness or agitation, convulsive seizures, weight gain, changes in endocrine functioning, and *neuroleptic malignant syndrome*, a condition in which paralysis is accompanied by accelerated heart rate, difficulty breathing, and high fever.¹¹⁰ Another serious side effect that can appear "within days" of drug administration is *parkinsonism*, a group of symptoms so named due to their resemblance to Parkinson's disease. These symptoms include drooling, muscle rigidity, and tremors.¹¹¹

In addition to these, a serious long-term side effect of antipsychotic drugs, *tardive dyskinesia* (TD), occurs in varying degrees of severity in 20 to 70% of patients. The physical manifestations of TD include:

involuntary and purposeless movements of the head, neck, trunk, and extremities. TD often begins with wormlike movements of the tongue, grimacing, chewing, or lip smacking. There may also be a variety of sudden or writhing movements of the hands, arms, and legs. The patient cannot control the movements although they may be made worse by stress.¹¹²

TD can appear after taking the medication for just one year (although it usually appears after several years of medication), and can be permanent, even when the medication is stopped. Of particular interest for this research, Barnes and Edwards report evidence that the prevalence of TD is significantly greater for women than men.¹¹³ Gorman notes that this is an effect

¹⁰⁹ *Id.* at 213.

¹¹⁰ *Id.* at 219; BREGGIN, *supra* note 21, at 72. See also Barnes & Edwards, *supra* note 99, at 217, 250-52.

¹¹¹ Barnes & Edwards, *supra* note 99, at 218; GORMAN, *supra* note 6, at 215.

¹¹² GORMAN, *supra* note 6, at 217-18; BREGGIN, *supra* note 21, at 69, 74-76.

¹¹³ Barnes & Edwards, *supra* note 99, at 232.

more commonly produced by "older" antipsychotic drugs.¹¹⁴ As is the case with antidepressants commonly dispensed to women in jail and prison, the drugs mentioned by women in our sample are all "older" drugs. These "older" drugs are no longer considered the "first choice" in treating patients with true psychotic symptoms, due to the harmful side effects associated with them, and the existence of alternatives.¹¹⁵ A cost comparison between the "older" and "newer" (also called "atypical" antipsychotics) drugs is provided in Table A2.

TABLE A2: COST COMPARISONS OF ANTIPSYCHOTIC DRUGS

Drug	Cost per dose*
<i>Drugs Commonly Given to Inmates</i>	
Thorazine	33 cents (generic)
Mellaril	25 cents (generic)
Haldol	90 cents (generic)
Stelazine	\$2.55 (generic)
<i>"Atypical" Antipsychotics</i>	
Clozaril	\$5,000 year (includes cost of weekly blood monitoring; generic not available)
Risperdal	\$11.40 (generic not available)
Zyprexa	\$7.74 (generic not available)
*Usual recommended dose. Source: GORMAN, <i>supra</i> note 6.	

¹¹⁴ GORMAN, *supra* note 6, at 208.

¹¹⁵ *Id.* at 219-22.

Other potential long-term consequences of antipsychotic drug use include brain damage, which can result in "serious mental dysfunction, including dementia."¹¹⁶ Women treated with these drugs are also exposed to the risk of infertility and changes in the menstrual cycle; some studies also indicate an association between antipsychotics and increased risk for breast cancer.¹¹⁷ Additionally, like many antidepressants, antipsychotics should be tapered, as abrupt cessation can result in withdrawal symptoms,¹¹⁸ a likely occurrence if inmates are transferred or released.

¹¹⁶ BREGGIN, *supra* note 21, at 81.

¹¹⁷ *Id.* at 87; F. Leuschner et al., *Toxicology of Antipsychotic Agents*, in *PSYCHOTROPIC AGENTS, PART I: ANTIPSYCHOTICS AND ANTIDEPRESSANTS* 225, 242-44 (F. Hoffmeir & G. Stills eds., 1980).

¹¹⁸ BREGGIN, *supra* note 21, at 88-89; Barnes & Edwards, *supra* note 99, at 241.