DR. STUART GRASSIAN,

called as a witness by the State, being first duly sworn by the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. TIMMINS:

Q. Good morning.

A. Oh, good morning. There you are. I can't see you because of the glare.

Q. Oh, is the sun in your eyes?

A. It's okay. I don't mind.

Q. Would you please state your name and spell it for the court reporter.

A. Sure. My name is Dr. Stuart Grassian, S-t-u-a-r-t, G-r-a-s-s-i-a-n.

Q. And just pretend you're yelling at me because the courtroom volume is not very good in here, okay?

A. Of course.

Q. Dr. Grassian, what is your profession?

A. I'm a psychiatrist.

Q. Do you have a clinical practice?

A. Yes, I do.

Q. Do you see patients?

A. Yes. I've been in clinical practice ever since I finished my residency in 1977.

Q. Do you work in the area of forensics as well?

A. I do.

Q. What is forensics, just generally?

A. Generally, forensics is the application of a science to matters that are legally important. In this case, the application of psychiatry to a legally important matter.

Q. What are your strongest areas of expertise in the forensic field?

A. My strongest area that I'm pretty well known in is the psychiatric effects of solitary confinement.

I've also been pretty actively involved in evaluation of people who have been sexually abused and victims of sexual trauma.

Q. All right. Let's talk about the psychiatric effects of solitary confinement with your work.

How did you become interested in

that field?

A. I think like most things in life, pretty randomly. A friend of mine from college had become head of the Massachusetts Correctional Legal Services and was involved in a class action lawsuit at the maximum security institution in Massachusetts at Walpole.

And the class action lawsuit was against the use of solitary confinement strictly. He asked me to evaluate inmates. And I was actually pretty skeptical. And he said, don't worry. I'll pay for the day, and you see what you find. And I said, okay, under those circumstances.

Well, I evaluated inmates for one day and I was absolutely shocked. First of all, they weren't exaggerating. These guys were scared. They were so sick. They were scared of it.

And the other thing about it is, they were all sick in a similar kind of way that was different from what you see in ordinary clinical practice.

So I just--I was amazed. And what I did then is I went to the Harvard Countway Library and did some medical literature review and discovered there's this huge body of literature on this issue. It goes all the way back to the beginning of the 1800s.

MS. SCHAEFER: Objection, Your Honor. He's giving a narrative answer at this point.

THE COURT: I think he's doing his background. Well, do you have a response, first of all?

MS. TIMMINS: I'm sorry?

THE COURT: Do you have a response to the objection.

MS. TIMMINS: He's just giving his background.

THE COURT: Overruled.

A. So I discovered this huge body of literature. I mean, a description of thousands of cases of solitary confinement psychosis. And they all had, quote, unquote, a particular stamp, which is exactly the same thing I had seen.

It turned out that doing this literature review, it's amazing history. Solitary confinement was introduced to the world in modern times by the Americans, and it was by the Quakers, by Ben Franklin and the Quakers.

MS. SCHAEFER: Your Honor, I'm going to renew my objection that the response is narrative. This is going well beyond his background.

THE COURT: Sustained at this point.

Go ahead.

Q. (By Ms. Timmins) Based on your research when you first initially stepped into this subject, you found that there was a long history of solitary confinement in America?

A. There was a long history of it, but more importantly there was an extensive body of literature describing the effects. And the system was widely used in the early 1800s and was a catastrophe. People were dying. People were becoming psychotic. And it even led to the United

States Supreme Court in 1890 absolutely condemning it in a case I had mentioned to you, the case of Mr. Medley.

Q. So did this spark your interest in this area then?

A. Well, yeah. I mean, I was surprised, and clearly it was so important. You know, even the brainwashing of American prisoners of war in Korea and KGB and political prisoners. It's all solitary confinement.

So after doing the library research, I wrote a paper and--

MS. SCHAEFER: Objection, Your Honor. He has gone well beyond the scope of the question.

THE COURT: Sustained.

Q. (By Ms. Timmins) So after doing some research, you wrote a paper?

A. Yes. I wrote a paper that was published in the *American Journal of Psychiatry,* which is the leading psychiatric journal in the country, describing the syndrome that I had observed and some of the literature around

it.

Q. Once that paper was published, did you then start doing more research and being more active in this field?

A. The paper became pretty famous. As a result, I was contacted periodically by folks doing class action lawsuits regarding solitary and individual cases. So I got involved with a lot. I got involved even with terrorists who were being kept in solitary, and the effect that was having on their cooperation with the U.S. government.

I was actually just talking to an FBI agent describing the fact that, you know, I was really working--you know, the FBI and I were on the same page about this, that we were defeating our own ability to get information from people by putting them in solitary confinement rather than treating them in a way with respect and in a way that would actually encourage them to cooperate with the U.S. government.

Q. So how long have you spent working

in this field of the psychiatric effects of solitary confinement?

A. My initial day at Walpole was, I think, in 1979. The publication was in, I think, 1983, and since then I've been involved and evaluated many hundreds of people in conditions of solitary confinement, juvenile detention facilities, immigration detention facilities, a whole host of situations.

You know, I think I've mentioned to you hostages as well, hostages in Iran who were kept in Evin prison in Tehran, and terrorists who were not cooperating with the U.S. government.

Q. And you've actually--through your work in this field, you've actually not only done research or wrote papers, things like that, but you've also talked directly to individuals who have been subject to solitary confinement?

A. Yes. I've evaluated hundreds of individuals, adults and adolescents.

Q. What is your educational background?

A. I have my bachelor's degree from Harvard College, and my medical degree is from New York University Medical Center. I then did a residency in psychiatry at Harvard Medical School at the Beth Israel Hospital in Boston.

And I remained on the Harvard Medical School faculty while doing my clinical practice and other stuff for about twenty-five or thirty years. Finally, I just didn't really have the time to do that, though I still actually do lecture and give talks at Harvard Law and Harvard Medical School from time to time on this issue.

I've also done some lecturing about the effects of solitary--of sexual abuse. I did a research study on that at one point.

Q. You stated that in some of the things you've done you've consulted with law enforcement on this topic; is that right?

A. Yes. Again, especially the FBI. I really came to have a lot of respect for

what they were doing.

Q. You consult in civil or criminal cases as well?

A. Yes.

Q. What are your professional memberships?

A. I had been a member of the Massachusetts and American Psychiatric Associations. I'm no longer. I didn't have the time for it, and there was no point in spending the money for it.

So I have a lot of affiliations, but I'm not a formal member of any organization at this point.

Q. Do you teach or train others in this area?

A. Well, yes. I mean, as I said. Especially lately there has been so much of a surge of interest in reform in this area of solitary confinement that I've been asked to give talks at the American Psychological Association Annual Meeting. I've given another one at Harvard Medical School, a couple of talks there, at Harvard Law. Actually, a new one at the

Harvard Kennedy School of Government, and a lot of bar association meetings. There's a huge list.

Q. Did I ask you to provide a curriculum vitae?

A. I believe you did. I believe I provided one.

MS. TIMMINS: May I approach, Your Honor.

THE COURT: You may.

Q. (By Ms. Timmins) So we don't have to go through all of this, have you summarized your educational and professional and training experience within your curriculum vitae?

A. I trust I did.

Q. I'm handing you Exhibit 92. Is that your curriculum vitae?

A. Yes.

MR. TIMMINS: The State would offer State's Exhibit 92.

(State's Exhibit No. 92 was offered in evidence.)

THE COURT: Any objection, Ms.

Schaefer?

MS. SCHAEFER: No objection.

THE COURT: 92 is admitted for the State.

(State's Exhibit No. 92 was received in evidence.)

Q. (By Ms. Timmins) Have you ever testified as an expert in a court of law in this area?

A. Yes, I have.

Q. Where?

A. Wow, that's a tough question. I've testified in a number of different jurisdictions. I don't know if I wrote this down or not. It's probably in the range of a little over 30 states. I've testified in Canada as well in Vancouver and Toronto. I've testified in federal cases as well in various jurisdictions.

Q. You've been qualified as an expert in those cases?

A. Yes.

Q. Now, I assume that you don't testify for free?

A. Generally not.

Q. And how much do you charge?

A. At this point my fee is $500.00 an hour.

Q. And who do you normally consult with in litigation?

A. Well, in litigation it's generally people who are advocates for the plight of folks in solitary confinement or in juvenile detention, though at times I have testified or been retained--well, I was retained by the Department of Corrections of the State of Florida at one time. I was retained by a private entity that was providing detention services in New Jersey. So it's generally for advocates for inmates or juveniles in detention, but not always.

Q. In this particular case, you were asked to offer an opinion, a general opinion, about the psychiatric effects of confinement on juveniles; is that right?

A. Yes.

Q. You've been provided some general background of the case, but your testimony

here today is generally the effects of solitary confinement; correct?

A. That's my understanding.

Q. All right. Can you tell us just in a succinct manner what is solitary confinement?

A. Well, solitary confinement is the confinement of an individual generally alone in a relatively small cell. Now, typically the cell is about 80 or 90 square feet. Typically, it has a window to the outside world, which is very often a vertical window. That's most typical. Several inches wide but high. It sometimes looks out on pleasant things. It often looks out on kind of really not much of anything.

There's also a door which is usually a sliding metal door with a window in it to the tier. Inside the cell the person generally will have some sort of bedframe, which is either metal or a concrete platform on which they place a bed or mattress, and they of course have bedding.

And they have a sink and toilet combination. Very often they'll have a little shelf desk kind of thing, pretty small, but you can use it as a desk, and some kind of stool, which can be as bad as like a concrete stool. They're sometimes a little bit more pleasant than that.

Usually--and things vary--usually the individual will have at least some access to a little bit of radio or TV, or at least the audio of TV, not a lot but some. They have books. Often that also is restricted but not entirely prohibited.

They still have contact with family by phone and by visit, but it's restricted. Like, with family visits, they are usually non-contact, so you can't really hug your dad or whatever. So you're just talking through a wire mesh or actually even Plexiglas. And as I said, they have phone privileges as well, but they're restricted equally.

People are allowed out of their cells usually for an hour a day for some sort of exercise yard. In a good place

there will be both an indoor and outdoor one because, obviously, there are times when the weather is too inclement to go outdoors. Usually the exercise yard--when they're in the exercise yard, usually they're by themselves. But some of these exercise yards are like chain link, sort of dog-run looking things. So you can talk to the inmate adjacent to you pretty easily, you know, through the chain link fence.

Again, all of this can vary from place to place.

Q. What you've just described, is that typically what you see when you are looking at solitary confinement in a prison system?

A. That's what you generally see in an adult prison system. And again, I mean, there are variations in all of this. I'm giving you sort of a typical example.

Q. I think sometimes as a layperson when we hear the term solitary confinement that means that they're locked in a little dark cell and never have contact with

anyone. There are no stimuli. There's nothing else. That's not the real world of that?

A. It's not. No, that's not realistic. Usually--and again, this varies--but usually the inmates can communicate with each other. Sometimes they have to press their mouth against the gap in the sliding steel door. Sometimes they talk through the vents to each other. They also, if you've happened to see this on TV, they have this kiting where they actually can slip something out, and another guy can catch it like catching a fishing line and pull in paper or whatever.

So they have very ingenious ways to communicate with each other. That's not to say that this is ordinary levels of communication. It's still difficult. But you find--you know, people do find ways to play a game of chess with somebody they can't see, you know, but they can call out the numbers, or whatever, the place on the board.

But, you know, it's very isolated. It's not entirely isolated. And of course, in these facilities you also have somebody make rounds. You have a staff person bringing them meals three times a day. So there are those kinds of contacts as well.

And as I said, they have visits with attorneys, with families, and with counselors who generally will bring them out of their cells for some of the time.

Q. Now, is there a difference between solitary confinement and detention facility or a jail, prison, and what some people call control rooms or quiet rooms in different types of facilities?

A. Well, the term quiet room is a term that my understanding is used in psychiatric hospitals. I mean, I've used a quiet room with patients. So I'm not aware of it being used in any sort of more punitive type of setting.

But a quiet room is a place where--you know, if you have a patient who is really agitated and out of control,

sometimes you'll use actually a physical restraint to hold the person down, try to talk to them, try to calm them down.

Sometimes they need some time just to--you know, some space. So you put them in a quiet room by themselves, but there's somebody right outside trying to connect with them, trying to talk to them, trying to calm them down. And, you know, the expectation is that they'll be there for--until they can calm down, like fifteen minutes or a half hour, couple hours at the most.

You know, it's all an attempt at helping the person gain control of himself. So there's a real therapeutic feel to it. Then of course the other thing--

Q. What would be the purpose of a quiet room in a psych facility or some type of facility housing people with issues?

A. You use a quiet room when a person is really agitated. And physical restraint, literally having people hold

him down as you try to talk to him, and it doesn't seem to be working, it's getting him more upset, so you just, you know, stop putting your hands on the person, put them in the quiet room, and then you keep trying to have that conversation with him trying to quiet the person down.

So it's used for people who are acutely agitated and out of control, not in control of themselves. And as I said, there are a lot of restrictions on--you know, you have to have psychiatrists continually authorizing it every so often, every couple hours if it's going to be that long. But there's somebody right there, there has to be, one to one, making contact until the person can just be calm enough to get out.

Q. In your training and experience, are those types of rooms used as punitive measures?

A. Never.

Q. As a punishment?

A. No, no. You never use that as punishment. It's just used for people who

are not in control of themselves.

And unfortunately, you know, whether it's in juvenile detention facilities or in psychiatric hospitals, you're often dealing with people who aren't in control of themselves. You know, their emotions are running sky high and their impulses are running sky high, and there is no thinking in between the emotion and the response to it, so they're not in control.

Q. Do you yourself have personal experience in using a quiet room?

A. Yeah, sure.

Q. Can you describe that to us?

A. Yeah, sure. I mean, I've had patients who were just really out of control. I mean, I can't recall specifically why, you know, whether I would always try to use some physical restraint first, if I should hold the person. It usually takes more than one person to do this.

But, you know, if the person was in the quiet room, I usually felt it was my

obligation for myself as the psychiatrist to stay there and just to keep trying to talk to the patient.

You also have to evaluate some--you know, some of these folks, their emotions are so wild and out of control that they really do need medication, and then it's a question of trying to talk to them and get them to take something that will quiet down that over-excitement, that agitation.

Q. And when would they get out?

A. I mean, typically you get--most typically within a half hour, a couple hours at most.

Q. Are these quiet rooms within your field, within your profession, are these quiet rooms to be used for days, weeks, months?

A. Oh, no. That would never happen.

Q. Do children have particular vulnerabilities in connection with solitary confinement?

A. Yes.

Q. What is that?

A. One of the things that happens in

solitary confinement is that the person becomes less capable of processing their emotions. They're under a lot of stress, so their emotions become exaggerated, intensified, the negative emotions: fear, anger, you know, whatever, agitation. And because of the lack of adequate levels of stimulation, they're not fully alert. And you know what happens when people aren't fully alert? They're just wild and impulsive. They can't think. They're not thinking at all.

So you put a person in that condition, and if they started out being kind of out of control, they're going to get more out of control. That's pretty predictable. Adolescents are exceptionally vulnerable to this. As anyone who has been an adolescent or has had a kid who's an adolescent knows, adolescence is a time when emotions are super-intense. These kids are super-excitable, super--their emotions are over the top, and yet their ability to manage emotions, to think, to quiet, to choose

behaviors, is very limited.

The emotional intensity of the limbic system, it gets to its height maybe around early adolescence, like 13, 14, that kind of thing. And yet the frontal lobes, the ability to modulate all of that doesn't really fully develop until you're about 25, and that's under good circumstances. Imagine a kid who is all stressed out, a kid who comes from a very stressful environment, a kid who's placed in solitary confinement in a very stressful environment.

They're just not going to be able to develop those controls, that frontal lobe inhibition of the more primitive, you know, emotional centers of the brain, the limbic system, the amygdala, whatever.

Q. What you're saying, is this based on your experience? Is this based on research? Where does this come from?

A. At this point it's based on so many things. It's kind of--no one can really argue it. You can't really argue it any longer. I mean, of course it's based on

my clinical experience, whether as a clinician in a psychiatric hospital or in forensic work. But there has been a lot of brain research recently.

As many of you may be aware, there has been a lot of new technologies that have allowed people to actually look at the functioning of the brain. Not just at structures, but its actual functioning.

It has demonstrated the effects of stress. It has demonstrated how the brain actually continues developing. You know, they actually have pictures of brains as they develop over the years and shows how the frontal lobes develop late, and these deeper centers, the more primitive centers develop early. I mean, they're tremendous colored pictures. I can't tell you I could explain the technology that's used, but it's called functional MRI.

Q. Are you saying if someone is--if a juvenile, especially, is placed in solitary confinement for an extended period of time that can cause actual physical changes to their brain?

A. Well, a functional MRI shows functional changes. But there have also been studies that have demonstrated structural changes.

During this period of development, during any development of the brain, any development period, especially adolescence which is huge, the brain is plastic. I mean, neural connections form, they break off, they die, there's pruning, making things work better. And when that process goes awry, you actually can see overt structural changes in the brain, especially in a part of the brain called the hippocampus, which is involved in the processing of memory, of emotion. And the hippocampus actually shrivels, it shrinks over time, and adolescent brains are particularly vulnerable.

Q. What kind of emotional effects do you see from juveniles who are kept in solitary confinement for extended periods of time?

A. Well, what you see in juveniles you also see, though, of course to a less

dramatic extent, with adults. And maybe the best description was one that-- I've always been impressed by what somebody said about this phenomenon. The person was Elaine Ward who was the warden of an adult maximum security institution for females in New York State. And what she noticed and couldn't understand was this phenomenon she described as maxing out.

Once a person--the person might have been doing okay, but then they get into solitary for something and they never get out, because their behavior worsens over time while they're in solitary.

And I mean, you give her all the credit in the world because she was upset about it; she was worried about it. She didn't understand it. She didn't know what to do with it. But she saw it. And that's what you see in all levels. You see it with adults, and you see it tremendously in juveniles.

The incidence of mental illness, the incidence of trauma in juveniles is so high. So you have this vulnerable

population because of their histories, and then you have the vulnerable population because of their age. And you put them in these conditions that are going to make it worse. And, I mean, their tremendous fear is that you're going to impair that kid's ability to ever function normally as an adult.

Q. Now, you had brought up a lot of these juveniles in these types of facilities that do have confinement rooms or something like that have mental health histories or traumatic backgrounds. That increases the effect that solitary confinement has?

A. Oh, yes. Absolutely. I mean, that has been demonstrated over and over in research studies. Moreover, as you can well imagine, it's those kids who are the most traumatized, kids with histories of mental illness, kids also with histories of cognitive impairment, these are the kids who are least capable of controlling their behavior and are most likely to end up in solitary confinement.

So you know, you're just taking the most vulnerable of the most vulnerable, and you put them in conditions which are going to make it worse.

Q. How quickly can you see the effects occur on someone in solitary confinement?

A. Well, first of all I think the effects are--I mean, the beginning of the effect is almost immediate because there's fear. There's fear and rage, you know, when a person is placed in solitary.

One of the more dramatic ones I saw was a person who developed a florid, overt delirium and attempted suicide within hours of being in solitary. And this was an adult. So I mean, it can take you very quickly.

Q. What types of behaviors through the research and through your own experience, what types of behaviors are seen with juveniles who have been kept in solitary confinement for too long?

A. Well, there's a bunch of things that happen. First of all, the child tends to--their emotional intensity,

because of the stress, becomes greater. And their impulsivity becomes greater, in part because of the increased emotional stress, and in part because of the diminished level of alertness, as I said before.

So kids in solitary you often see them just becoming more and more out of control. Others go into a kind of stupor. You know, if you've ever experienced a period of real intense monotony, you know, after a while it's just like you can't focus at all. And then what happens then is if you--if there is a stimulus like a light or a sound, it jars you. You become hyper-responsive to external stimuli, which is one of the very characteristic symptoms associated with solitary confinement.

And actually, that is a symptom which from my experience, and there has been some research, it seems to persist maybe indefinitely after people leave solitary confinement, this hyper-responsivity to external stimuli. People

who were gregarious become loners; people who used to enjoy being outside and enjoying the world want to stay in their room. They just can't stand stimulation anymore. So you see that happening.

Another thing that happens is the person in solitary confinement when they were a kid or, you know, an adult, if they don't just go into this fog, instead they do manage to focus on something but it's almost always something unpleasant: a smell, an insult that they experienced, a little bodily sensation, you know, a bodily sensation that starts growing until, my God, it's something serious; it's a cancer; I'm going to die. And they can't stop thinking about it. It becomes an obsession. So these obsessional preoccupations become torture after a while.

So you either see that kind of, you know, lack of focus which is stupor, fog, or you see heightened--you know, the focus, and the inability to switch focus, an obsession, an obsessional thing.

Interestingly, you see that with Attention Deficit Hyperactivity Disorder. And a lot of kids who end up in solitary have Attention Deficit Hyperactivity Disorder. And in Attention Deficit Hyperactivity Disorder you see the distractable kid, but you see a kid sometimes who can pay good attention and miss everything else that's going on around him, like his homework, the fact he left something on the stove, you know, all that other kind of stuff. It's a similar phenomenon.

Q. You had brought up before the suicide attempts and things like that. Do you see through the research and your training and experience, do you see that there are higher rates of self-harming--

A. Yes.

Q. --in situations like this?

A. Yes. I mean, that has been studied both in juvenile facilities and in adult facilities. And the statistics are pretty horrendous. They're worse in juvenile facilities. I don't remember the

statistic, but I do know what it is in adults. In the adult prisons, 5 percent of population is in solitary. 50 percent of the suicides are in solitary. And self-mutilations are roughly the same percentage. And of course, you have about 5 percent in solitary, and I think it's like 50-odd percent of all self-mutilations occur among that 5 percent. So it's horrendous, and it's worse in juveniles but I don't remember the statistic on that.

Q. What is your response, then-- because there are times when a juvenile may be out of control and may need that room to not harm themselves or others; correct?

A. If a juvenile or anyone is out of control, it is critically important that the situation become safe, and that the person, the inmate, the child, feel safe.

So like when I talk about physical restraint, you know, where I'm actually holding somebody down, and not by myself of course, you know, you'll have four

people doing it. The one thing you're always careful to do is you never hurt the person. You just have enough power that you can just keep them down, and then you talk to them calmly.

It's the same thing when you put them in a quiet room. You never let that person experience it as something frightening or evil. You let them know that you care about them, that's you're trying to help them. And that's what works. I mean, it does work.

I've had patients, kids, who have been in juvenile detention in solitary confinement, and they come to my psychiatric hospital and I don't have security. I don't have any big, strong people to hold them down. All I have is respect and concern. We never have trouble, never.

You know, I've been to prisons where they say, oh, you can't see this person in the same room; they're much too dangerous; they're going kill you, or whatever. And we just say, we'll take

that risk and, literally, never have we had a problem, never. And that's hundreds of cases.

Q. Are you saying then a lot of times the--when we're talking about juveniles, the way that the adults are acting or reacting to the juvenile is also what can exacerbate the situation?

A. That is correct. In adult facilities for adults, but it's so much more correct for juveniles.

Q. What is an over-control facility?

A. Well, an over-control facility is one where-- It becomes a real problem when you really see your job as: I'm going to be in control of this situation. Because what you end up doing is you end up humiliating, enraging, and frightening the person you're doing this to. And what do you think is going to happen? The person is going to get more out of control. He's going to become more enraged, more terrified, more agitated. That's what happens.

Q. Now, doctor, you're not saying that

we should just allow children to do whatever they please?

A. Well, as I said, you know, you might be surprised that in a locked psychiatric unit for adolescents, you are seeing a lot of the same kids who might end up in juvenile detention or whatever. You're seeing the--you're really seeing the same population, but you're dealing with it very differently.

And it is really dramatic, it's really striking, to see how much better they do in the psychiatric hospital, you know. It's just that whole different attitude, an attitude that's based on trying to understand what's going on.

After all, whatever the behavior is that's troubling, there's something behind it. There are feelings. There's something leading to it. And if you care about that, and you try to figure it out with the kid, that kid is going to feel safe. He may hopefully gain some insight into what's setting him off. You know, it's not that hard once you have that

concept that it's not all: I'm going to be in control. But rather, I care about you.

Q. In a facility where environment is strictly controlled, will it increase the likelihood of disruptive behavior?

A. It does increase the likelihood of disruptive behavior, and probably even more importantly, it decreases the likelihood of a successful adjustment after the person leaves that environment. That has been demonstrated also in research.

Q. What is your response to if a child is in a control room, a quiet room, been there for an extended period of time, hasn't calmed down, yelling, screaming, those types of things, been going on for a long time, not following the rules. What is your response to someone who would say that that was, you know, a willful choice on the part of that child?

A. That child is out of control. I mean, why would--you know, if the kid was like a James Cagney, you know, a cold,

ruthless criminal, he would know when the jig is up, and it's better off to behave because you're going to get yourself in more trouble if you don't.

The kids who are like that, they're out of control. There is emotion, there's behavior, and there's nothing in between. So you know, punishing them is just going to make it worse. It's not going to make it better.

Q. Have you ever encountered situations where someone would want to be in a quiet room, a control room?

A. Well, yeah, there are situations. There are basically two kinds of situations that lead to that. One is the person has become so overwhelmed by a negative milieu. You know, they're in like--if you have like a maximum security prison, for example, or a very poorly-run juvenile detention facility, you're going to have a lot of aggression, a lot of craziness going on outside of the solitary confinement room. And kids or adults--I mean, sometimes the whole experience of

being there is like you're in battle, you're in combat twenty-four hours a day, and it's too much, it's just overwhelming. And so almost for safety, you need to get away from that, you can't tolerate it. That happens. I've seen that, unfortunately not terribly infrequently.

The other thing that happens is that if a person has been in solitary confinement for an extended period of time, I think I had mentioned--I did mention this notion of the hyper-responsivity. They reach a point where they can't tolerate any level of stimulation.

And so this is a major problem in adult prisons as well, where if you try to get the person from solitary and they've been in solitary for too long, you've got to help them transition, because otherwise they're not going to make it. They're just going to be too overwhelmed by stimulation.

I've seen tragic cases where a guy was falsely in solitary and proven to be,

and he was in solitary for a long time. He comes out and can't leave his room, even for meals with his family. He just waits until the family is done and grabs some food and puts it back in his room. He just can't tolerate any level of stimulation. So he sort of puts himself back in solitary.

Q. Do you ever feel, in your opinion, can solitary confinement be beneficial for behavioral reasons?

A. I think there's an increasing consensus that solitary confinement as punishment is destructive, that it's counterproductive, whether that's for adults and especially even more so for juveniles.

And there has been--as I mentioned to you separately--recently there have been tremendous reforms. The use of solitary in adult prisons is dramatically being reduced. The use of it in juvenile facilities has been eliminated in a lot of jurisdictions.

Q. How does the use of cognitive

behavioral therapy in connection with control rooms, quiet rooms, how do those two interplay, or do they?

A. Well, first of all, a person who says that they're using cognitive behavioral therapy with someone who is out of control in a quiet room, it doesn't--I mean, that sort of demonstrates a lack of understanding of what cognitive behavioral therapy is.

There's a difference in-- Let me just as a background just say there's a difference between cognitive behavioral therapy and another form of therapy, another form of behavioral therapy called aversive conditioning.

Cognitive behavioral therapy is based on the notion that a person is thinking, and they have a lot of negative thoughts about themselves or about their situation, and their negative thoughts are irrational, they may come from childhood or earlier experience, traumatic experience. And because they have those negative, not pertinent thoughts they act

upon them in counterproductive ways.

To give you an example, I have a patient who is an adolescent, and she avoids doing her homework. She doesn't study for her tests. She has gotten better. I mean, I've been with her for a long time. But you know, why does she engage in this negative behavior? She does because as we've come to understand, she's super-anxious, she has a lot of self-doubt. And you know, if you never try then you can't fail kind of thing, you know? So she just never tried.

And we explored some of the origins of that. I don't want to get into too much detail, but there was some family stuff that was contributing to that feeling of not being good enough. And as she was able to identify the negative thinking, it helped her to change the behavior.

But this is a girl who thinks. She spends a lot of time thinking. She's actually a wonderful--you know, I met her when she was 13, and she was a wonderful

conversationalist with adults. She was terrible with kids. But, you know, with adults because she was such a thinker, an internalized kind of person. You could really have that conversation.

Now, for her, you know, if you look at what was needed, you had cognitive behavioral therapy, understanding the negative cognitions. You had expressive therapy, which is understanding the origins. Where do these bad cognitions come from? And there's also medication to help quiet her anxiety. And the combination of the three has--I mean, it has been years, but she's doing so much better.

So that's cognitive behavioral therapy. It has no relevance to people who are acting out of control. It doesn't apply. I mean, people who are out of control, they're not thinking. They don't have a lot of negative cognitions to deal with. I mean, it's silly. It's a misrepresentation of what cognitive behavioral therapy is.

Q. So what is the aversive therapy?

A. Well, what they're really doing is something called aversive conditioning. And first of all, aversive conditioning is very controversial, and I think it's basically no longer being used whatsoever. But aversive conditioning, the paradigm is this: you take a very specific negative behavior, very specific, not like, oh, you didn't follow the rules today. No. It's got to be really very specific, and you punish it almost immediately. And the punishment should last no more than a few seconds. So the typical thing would be like a shock. You know, the kid would wear something, or an adult, and they'd get shocked, and so somebody is watching.

So you have the behavior leading to punishment like that (indicating by snapping fingers), and you have lots and lots of opportunities to change that specific behavior. So it's very specific, very short-lived punishment, very immediate.

So putting somebody in solitary

confinement has nothing to do with any of that. Even the people who are advocates for aversive conditioning would never attempt to justify using aversive--calling that aversive conditioning. It's not. And it's not going to be useful.

So a person who says, oh, I'm a strict behaviorist and, you know, I do this. They don't know what they're talking about. I don't want to be disrespectful, but they don't know what they're talking about. That's not what it's about.

Q. We had talked about-- You have a lot of prior experience working in psychiatric facilities, and I believe you were a director at one time; is that right?

A. I've been director of two inpatient psychiatric units for adults and adolescents.

Q. For the safety and best environment for persons in those facilities, was it important for you to have well-trained staff?

A. Well, of course you have to. And part of my job as director is teaching. I mean, it's one of the really enjoyable parts of it is teaching. We do case conferences where we'll go through a person's history and the staff will actually see me interview somebody, and then we'll discuss and try to understand what's going on with that individual.

So yeah, you're really--the staff, everyone, is all together on a way of conceptualizing emotion, thinking, behavior, all based on this therapeutic model of trying to rehabilitate people and make them better.

Q. And what is seen in facilities that do have locked rooms? What is seen in those types of facilities when they don't have trained staff or educated staff, or people who know how to work with others with emotional issues?

A. Well, I mean, there's a lot of sadism that occurs in those facilities. I use to falsely condemn the individuals who worked in the facilities, you know,

thinking they were sadistic. But I don't believe that anymore. I think that the environment creates this sadistic response, because you have behavior that's out of control and irrational, and if the only thing you're supposed to do is control it--but you can't, because the more you try to control it, the more out of control it gets.

You know, you as a staff member are going to feel humiliated. You're going to feel afraid, and you're going to feel rage because of the humiliation. And so your tendency is to become over-controlling and sadistic.

So I think the sadism that one sees in these situations is really a product of the system itself. And it's not that there aren't decent people who go into these places and work.

I mean, and actually I've treated officers who've worked in these types of facilities and seen the enormous pressure that they're under that leads them to sadistic responses. And, you know, it's

sad to see that.

Q. Have you ever come across a facility where it's the juveniles or the other patients or students who are assisting in policing their own peers?

A. I know you had mentioned this to me when we spoke last night. And I told you, I've never in my entire professional life ever heard of that. I just cannot imagine any justification for it.

Q. In your experience, have you seen situations where there were expectations of physical positions to be held while sitting in a control room or quiet room?

A. In all of my experience, including evaluating people who are in the notorious Tehran prison, Evin Prison, I have never seen that at all, zero, never. I mean, to me I can't think of how to describe that except as sadism.

Q. What about if there's no stimuli provided to a juvenile while they're in one of these locked rooms, no books, no school, nothing like that? What does that do?

A. Again, I mean, first of all you're describing a situation that is more onerous, harsher, more toxic than what you would typically see in a maximum security, or even a supermax facility for adults. It's just--it's beyond. I mean, there's nothing to maintain the child's alertness. There's nothing to distract him from negative thoughts. I mean, it's an enormously toxic situation, as is, by the way, keeping lights on in a cell for twenty-three hours or twenty-four hours a day. I mean, that's been condemned widely.

What you do is you have a light on during the day so that the person can read or whatever, write letters, whatever they're doing, and then there should be a separate night light, because you need to be able to look inside to make sure everything is okay, but you also need to let the person sleep. So you know, something like an orange-colored night light type thing.

Q. Would that be considered more of a

forced stimuli, to have lights on all the time, if you have speakers blaring music or some type of annoying noise, something like that?

A. Yes. That's a very good question. We used to call this thing sensory deprivation. But it's not actually sensory deprivation. It's deprivation of meaningful, anchoring perceptual stimuli. If you have white noise, if you have lights on all day long, you have noxious stimulation.

And it has been well known that if you add noxious stimulation to a situation of stimulus deprivation, things will get worse. In fact, this has been done by folks like the British in trying to break down suspected IRA terrorists. It was actually done at Guantanamo, using super-air-conditioning where it was very cold in the cells. It was done using very, very loud fans, all these things as ways of adding to the toxicity of the solitary confinement.

Q. Have you ever in your experience

seen where food is used as a punishment for being in solitary confinement, or as an incentive to get out?

A. I'm not sure what you mean by an incentive to get out.

Q. Well, do you see in your experience that special meals are served if you're in the locked room--

A. Oh, okay.

Q. --and you don't get to eat the same as the other people do?

A. No, no. People in solitary generally will get the same meal. They won't eat in a congregate setting. It will be brought to them and slid through a food tray thing. There are cases where people have for a brief period of time been given kind of a disgusting loaf diet as punishment. That seems to be disappearing. But that's only for relatively brief periods of time.

Q. Now, you understand, and I'm sure you hear sometimes, that if you make conditions miserable enough for someone, then maybe they'll just change their

behavior and not do what it was that got them in there in the first place?

A. In general, a person who is able to respond to cause and effect so well is a person who will probably never need to be in solitary in the first place.

You know, the reality is that adults and the children, the juveniles, you see in these situations are people who aren't that calm and calculating. Their behavior is not based on an anticipation of its likely consequences. It's based upon what they're feeling right here and now, which often leads to very negative consequences in a lot of different ways.

Q. And how do children on prescription medications for depression, ADHS, bipolar, those kinds of things, how is that effective if a child like that is in solitary confinement?

A. As I said--or I don't know if I actually said this--if you look at the incidence of mental illness in the population in general, and then you compare it with the incidence of mental

illness in adult prisons, it's higher in adult prisons, and it's much higher still in solitary confinement in adult prisons than it is in the adult prison general population. And this is even much more true in juvenile detention facilities where--and, again, I just don't have the statistic right in front of me. But we're talking about histories of mental illness and/or traumatic background and/or cognitive impairment--significant cognitive impairment. If I remember correctly, I think it's in the range of 65 to 70 percent of all the kids have those kind of histories. I mean, it's huge. It's huge. And, of course, the fact that they have these mental disorders will, in fact, be reflected hopefully in their being on some medication to try to quiet it down. Those individuals are the most vulnerable of all.

Q. What is the general consensus of the medical profession on the use of solitary confinement with juveniles?

A. The American Psychological

Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, even the--I forget what it's called--the Committee of Correctional Physicians, all condemn solitary confinement, and especially with juveniles.

It has been condemned by the United Nations. It has been eliminated--well, solitary confinement itself has been eliminated in many European countries but certainly with juveniles that has been eliminated. It has been condemned.

I've been involved myself in helping to eliminate the use of solitary confinement in juveniles in several jurisdictions: Wisconsin, Ohio, New Jersey. I'm working one now in the province of Ontario in Canada.

Q. And with the medical profession in particular, they have come out with these positions because, in your opinion and in the profession's opinion, it's harmful to the physical, mental, and emotional states of juveniles; correct?

A. Yes. And as I said, there has been such an influx, so much more research that has been done on these issues, especially as technologies have evolved, that at this point you really can't argue against it. I mean, there is no argument against those propositions.

MS. TIMMINS: That's all I have. Thank you.

THE COURT: Ms. Schaefer?

MS. SCHAEFER: Judge, I think--

(One of the jurors raised their hand and requested a recess.)

THE COURT: All right. Why don't we take a break for about ten to fifteen minutes. Please remember the prior admonitions.

(A recess was taken at 10:15 a.m.)

(In open court, in the presence of the jury, the Court, the Defendant, and counsel at 10:32 a.m.)

THE COURT: Please be seated. The record should reflect the jury has now been seated.

Ms. Schaefer.

CROSS-EXAMINATION

BY MS. SCHAEFER:

Q. Good morning, Dr. Grassian. I'm correct that the only information that you have regarding the charges against Mr. Trane are what Ms. Timmins has advised you of?

A. She did give me some of the declarations of some of the kids, but she asked me to really speak more generally about the issues.

Q. So you've never been to Midwest Academy?

A. Never.

Q. Any knowledge you have of Midwest Academy is what was provided to you by Ms. Timmins?

A. Correct.

Q. And you've never spoken to any of the students from Midwest Academy?

A. Exactly.

Q. Again, the only information you would have is that provided to you by Ms. Timmins?

A. Yes. And then the little bit of

written material she provided.

Q. And after hearing your direct testimony, it seems like the bulk of your research, whether it's statistical research or your anecdotal research with regard to solitary confinement, the bulk of it was for people in solitary confinement in a correctional facility of some sort; correct?

A. No. There's been a tremendous amount of research about adolescents in juvenile detention as well.

Q. But again, in a correctional-type facility versus a school setting?

A. That isn't a distinction that's really comprehended in most jurisdictions. Most jurisdictions where I've been involved in what's termed juvenile detention see themselves as having a function of having to teach, of having to rehabilitate. It's seen as something like a--it is a school as well as a place to confine individuals who are behaviorally having troubles.

Q. But you would agree that it's

different than a boarding school?

A. Well, the term boarding school--I mean it's a very loose term. When I think of boarding schools generally, I don't think of boarding schools that are like the Midwest Academy where kids are sent there because their parents think that they're having difficulty controlling them and, you know, kids are transported with the transport teams.

I have some knowledge of that type of institution. But the term boarding school usually doesn't refer to that. It usually refers to places where the kids are free. I mean, where they're not transported there against their will. I mean, like Phillips Exeter, you know, places like that are what I usually think of when I think of a boarding school.

Q. So parents don't send kids to boarding schools or military schools sometimes just to learn structure?

A. No, of course they do. I mean, Midwest Academy in that regard, it's mission was--is not unique. I mean, there

are facilities that attempt to do that, to work with kids who are having behavioral difficulties but where you really want to help the kid grow.

Q. And again, you would agree that that type of setting is far different than a correctional facility?

A. Than a juvenile detention facility?

Q. I just said a correctional facility.

A. I'm confused by what you mean. Do you mean an adult correctional facility?

Q. Someone who was placed in a facility due to the commission of a criminal offense.

A. Juvenile detention facilities are not considered correctional facilities. Corrections, that term is used for adult prisons. Juvenile detention facilities are seen as supposedly being therapeutic, rehabilitative, educational institutions. They have a different mission than the correctional facilities that are used for adults.

Q. And your definition of solitary

confinement, I believe when you described what you would ordinarily see, I just want to understand, the way you were describing them, that's a fairly self-contained cell or room?

A. I'm not sure what you mean by self-contained.

Q. Well, you described, you know, having sometimes a sink and a bathroom and a mattress and everything that presumably they would need is in there except for food.

A. Well, they all have mattresses, of course. They usually have a sink and toilet combination. They hardly ever have a shower. And, of course, they hardly ever have a self-contained exercise yard, though I've seen that. I mean, that does happen but it's extremely rare.

Q. And you indicated in your testimony that control rooms, or I believe you called them quiet rooms, can be beneficial when someone is extremely agitated?

A. I described what I understand to be a quiet room and its use in a psychiatric

hospital.

Q. Would they also be beneficial in other settings, again, if the person is extremely agitated, becoming aggressive to the point maybe of hurting themselves or others?

A. Well, if they're used in the same way, then ultimately it's for that particular period of time, it's the same setting. I mean, if you're using a quiet room where, you know, people are trying to calm the person down, trying to develop a therapeutic relationship, you know, where the expectation is they're not going to be there for very, very long at all, you know, and the doctor is going to be right involved, you know, and everyone understands that the purpose is to reach out and calm the individual, that's a good thing. I mean, it's necessary. It's not used that often, but it has to be there if it's a possibility.

Q. Is it common for school settings, which obviously are filled with adolescents, to use some sort of a quiet

room for those students who have become assaultive?

A. I'm sorry. School settings?

Q. In a school setting where a student has become assaultive to maybe another student?

A. Are you talking about public schools? What kind of school are you referring to?

Q. In a public school.

A. I'm not aware of that. I haven't heard of that.

Q. Would you be aware of the student being removed from everyone else to ensure everyone's safety?

A. Well, I mean, in a public school-- I mean, you certainly have to have the ability to restrain a student if there's an imminent danger of harm, of course, and if necessary, to bring in other agencies to help. But I mean, you have to maintain safety. There has to be some response to somebody who in danger of hurting themselves or others.

Q. And that would include someone who

is possible a danger to themselves?

A. Well, again, you're using the word possibly. There are lots of people who are possibly dangerous to themselves, but you don't restrain them. But if you believe they're in imminent danger, they're actively going to hurt themselves, well then you have to restrain them.

Q. And I believe your testimony was that when you would have to use these quiet rooms with your psychiatric patients, they were a last resort; correct?

A. Right. Well, I mean, like if you are actually physically holding down a person, you are not going to maintain that for a very long time. And as I also indicated, there are times when your attempt at doing so is simply making the person more agitated. And so, you know, it's a therapeutic decision and you give them space.

Q. So one of the things that you would recommend for a student or a juvenile who has been placed in one of these rooms

because they have presented behavior that makes one believe that they're either going to hurt themselves or possibly have already or will hurt another person, you indicated that that requires some frequent contact from staff or a psychiatrist if there is one in the hospital, but at least staff or somebody providing some contact with them?

A. Yeah. I mean, I'm just a little uncomfortable with you saying "possibly" hurting themselves because--

Q. For instance--

A. If I could just complete my response. You don't restrain somebody or put someone in a quiet room because they could possibly hurt themselves. You put them in that kind of restraint situation if they're imminently or actively attempting to hurt themselves.

So I feel very uncomfortable using that word possibly. Because there are a lot of people in psychiatric hospitals, a lot of kids in psychiatric units, who are possibly going to hurt themselves, but you

don't put them in restraints or put them in a quiet room.

Q. And when I say possibly, they're exhibiting behaviors that indicate that--

A. Imminent.

Q. --they have a plan and will act on it.

A. Imminently, yes.

Q. Or if someone, again, has been assaultive to others. But again--

A. Possibly.

Q. --your recommendation is that there be some frequent contact from someone outside of that room ensuring that they're calming down?

A. There has to be someone watching the person to make sure they're okay, but more than that, trying to make an alliance, trying to help calm the person, giving the person a sense that we care about you, we're trying to help, we're here to help, you know, we want things to get better.

Q. When it comes to changing behavior, you spoke of your patient that you've

engaged in some cognitive behavioral therapy. How long does it take to change those behaviors?

A. Boy, that's very variable.

Q. It can take years, can't it?

A. Well, in her case it certainly has taken years. Her anxiety began when she was a very young kid. And unfortunately, you know, I think there was probably a genetic predisposition towards it, but also one of her parents tended to be very harsh and critical, which added to it, and there are some other factors as well. But it took a while.

But again, cognitive behavioral therapy is used with people who are thinkers and, you know, have all these negative cognitions that are getting in their way. It's not used to deal with behavior that is--the person is angry or out of control. It's used where the person is unhappy with their behavior, but you're trying to help the person understand the rational thoughts that precede it.

Q. But again, it can take quite a bit of time to change some of those behaviors; correct?

A. It's very variable. It can. It depends.

Q. When Ms. Timmins was asking you about the forced stimuli, which you referred to as noxious stimuli?

A. Yes. I did refer to it as noxious, yes.

Q. You included keeping the lights on all the time, that that would be a noxious stimuli?

A. Yes. If you keep the lights on, except for a quiet night light, you're going to prevent the person from sleeping. You're going to make it very difficult for them to sleep.

Q. And when you say a night light, is that just an overheard light that can be dimmed down?

A. I've seen it done two different ways. I think the more successful ones have actually two different lights.

Q. But a dimmable light is something

that is used?

A. I've seen it, yes.

Q. You also indicated that you generally see those in solitary confinement getting the same meals that everyone outside of that would get; correct?

A. Yes, that's typical, correct.

Q. Would you agree that if you've got a person who is acting out, becoming aggressive, maybe attempting to engage in some self-harm, that their food or their menu may need to change so that it's foods that they can eat without the need of utensils?

A. That can happen.

Q. Because you would agree that if you have someone, especially someone who is engaging in self-harm, that even a plastic spoon could be a danger to them?

A. Yes. Again, if a person is in imminent risk of self-harm, you need to take whatever precautions are necessary to keep the person safe, and that can include eliminating the use of silverware or

things of that sort.

Q. Even if that means their menu may be a little different than everyone else's?

A. That's correct.

Q. Dr. Grassian, what is the difference between a control room and a locked cottage?

A. Those are just words. You describe what they are, and I'll tell you whether there's a difference or not. Different folks use different words to describe different things. So there is no common understood "locked cottage."

Q. And are you aware that Iowa law allows for the use of control rooms?

A. This is something I have no knowledge of.

Q. If Iowa law allowed for the isolation of a child in a control room for up to twelve hours, what would be your opinion on that?

A. I don't know. I mean, you'd have to show me the law, what it's intended to do, whether there are safeguards, in order

for me to give you an opinion about it. Up to twelve hours, obviously-- Well, who has to be involved? Who has to authorize it? Does there have to be repeated periodic authorizations every hour or two? Does there have to be somebody sitting right outside the place, you know, the room. I mean, there are so many variables. I don't have a clue. I don't know Iowa law. I haven't looked at it.

Q. If the isolation of the student involved what we sometimes called a locked cottage, where they're removed from the general population of their classmates, again, for reasons of assaultive, aggressive behavior and the like, but they're still maintaining contact with staff, they're still maintaining contact with peer mentors and counselors, is that the sort of isolation that you would regard as detrimental to their psychological well-being?

A. You're not giving me specifics. You said contact. I don't know what kind of contact you mean. You're saying you'd

keep them separate. For how long? What are the restrictions? How frequently do you have to re-evaluate? There are so many issues here. What's the nature of this place where you're putting them? What kind of amenities do they have there? Like, do they have things that will help them to distract themselves, reading material? I mean, you haven't said anything that I-- How can I respond to that?

Q. What if the child is being particularly assaultive? They have already assaulted another student, and they have a past history of assault and self-harm. Would it be appropriate to put them in a room with nothing they could use to self-harm themselves?

A. Possibly. I don't know. I don't know this student. I don't know what just happened. You can't make some generalization about it. You've got to be able to know the person, know what happened, in order to be able to make the best judgment about what you should do

right now.

Q. And you can't do that?

A. You haven't given me the specifics. You haven't told me about a particular kid. What just happened? What happened in the past? How could I possibly-- I would never try to make such a generalization, you know. Each human being is unique. You've got to get to know the person.

MS. SCHAEFER: I don't have any other questions.

THE COURT: Ms. Timmins.

MS. TIMMINS: I don't have any questions.

THE COURT: Doctor, you may step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Ms. Timmins, you may call your next witness.

MS. TIMMINS: Your Honor, at this time, the parties have agreed to take the testimony of a witness who was unavailable to be here for trial. And at this time I