



Volume 20
Issue 1
2026

Will It Ever Be Enough?

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We had asked each of the men in our group therapy session to list the person they most admired and I was, admittedly, surprised when Tolkien was the first answer proffered. This seemingly banal ice breaker, within the typical question and answer construct of a group therapy session, was designed to give each individual the opportunity to open up. Its purpose was to invite them into the embrace of vulnerability in the safe confines of a conversation, a chance to begin the healing process that starts with a nominal confession of their proverbial sins.

I was sitting in my loafers and button-down shirt (no tie, per the warden's rules), holding a clipboard with my white coat draped across me. The speaker, whom I'll call John (for Tolkien's sake), was garbed in standard issue fatigues with cloth sneakers, but his answer was so close to my own that I was forced to examine our similarities without lingering upon our differences. He was enviably well read, just as I strove to be, and appeared to be about my age and about my build. Tolkien, he said, had been one of his favorites in the time before, though now his circumstances were drastically different. John had once been a seemingly carefree youth with a future ahead of him; now he was a downtrodden inmate with a

serial number identifying him as a member of the psychiatric ward of our state's correctional facility. John's transgressions appeared to be many, and after establishing this common ground of our literary bona fides, he introduced me to a depth of despair that I had not considered possible. The crime for which he'd been convicted was now the deepest regret of his waking hours. He went on repeating, "I keep seeing her, seeing what I've done."

What he had done—a heinous, unspeakable act—was committed in a moment of psychotic dissociation, yet now was remembered daily with a visceral clarity that is difficult to fathom. It kept him awake at night and often led him to the brink of suicide. Our hope, our job, was to keep it from taking him further.

John was one of the many inmates—patients they'd be called in a different setting—who I met while working with a group of forensic psychiatrists within our state's criminal justice system. I remember feeling overwhelmed and intimidated by the knowledge I still needed to gain, for in addition to understanding the spectrum of diseases in the DSM-5, I also had to possess a passing familiarity with a wide range of prison jargon. This was both to ensure that I correctly understood my patients (i.e., to "catch a case" meant disciplinary action that affected an inmate's level of freedom) and that I did not lose my credibility by misspeaking (i.e., correctional officers were never labeled as "guards"). I also learned that the psychiatric ward was the only air-conditioned unit in this particular

correctional system. There had been an issue with lithium toxicity due to excessive heat in the past; inmates could contrive to get themselves admitted to the unit for a nice break, though most had severe or intractable mental illnesses that necessitated a multi-pronged and extensive treatment approach.

My work at this unit was divided into two phases. The first was heavily focused upon severe cases of psychiatric illness, in which we could only see patients through the shatter-proof glass of their cells, and the second involved caring for a more subdued population with which we could interact in recreation rooms. Every day we would gather the list of patients that we were to see, review their medical charts, and then depart for a brief sojourn in whichever cell blocks our schedule dictated. We conducted our patient interviews, discussed each inmate with the correctional officers and social workers responsible for their care, and made adjustments to our treatment plans as necessary.

This all seemed very simple and straightforward, assuming that the patient was in a stable frame of mind and willing to cooperate, but this seemed to be the exception rather than the rule, as I was soon to be reminded. The wards were filled with patients who suffered from diseases across the spectrum of mental illness, though delusions and depression seemed to be their most common manifestations. Many delusions were of government surveillance or persecution, though some were of a more personal nature. I was finishing up a patient interview with a gentleman I'll call Tom,

when he broke from our conversation to yell that he knew all about me and my activities as a spy. Though I felt Tom and I had established a decent rapport upon our first meeting, he adamantly believed that I was spying on him for a family I'd never met from a town I'd never heard of. The mistrustful part of me thought that it might be an act, that Tom must have some ulterior motive that would eventually make itself clear. The empathetic part of me, however, argued otherwise and fortunately prevailed. The emotion that I recall feeling most deeply was either pity, sorrow, or a melancholy mixture of the two; it would return each time I went back to Tom's cell block, as he continued to respond to me in the same manner. From that point forward, I found myself attempting to escape his notice, though I can't honestly say whether that was for his sake or my own.

I had great difficulty connecting with my patients in this section of the facility and felt that it was impossible to make any difference in the conditions from which they suffered. There is already a considerable barrier between physicians and their patients, but it becomes immeasurably wider when the physicians are seen as employees of the state and the patients are seen as inmates. This gap becomes almost insurmountable when there is a literal steel divider between the two sides of a conversation, especially when one of the two speakers is yelling through a plexiglass window and banging on the steel cage that is his cell in an effort to get his points across.

As the days passed and I transitioned to caring for individuals with lower security requirements, I

left each day feeling more fulfilled though I ultimately struggled to move past the dismal outlooks that most of these patients carried with them. I found myself taking longer and longer to diminish the sadness that was growing inside of me, eventually deciding that I must allow it to reside in its proper place within my psyche. I would classify this time as similar to a classic inpatient psychiatric medical practice, but one that contained an encyclopedia of caveats. We could prescribe an adequate range of psychiatric medications, but occasionally found ourselves hampered by the constraints of a state-approved formulary. We were allowed to speak with patients across a table, rather than through the crack in their cell door, but only in the protective presence of correctional officers. We were able to gauge for ourselves the efficacy of our psychiatric interventions but often had to do so amidst the tingling remainders of aerated pepper spray.

It was during this latter portion of time that I was given the privilege of conversing with patients, including John and his cell mates, during group therapy sessions. These were truly the bright spots of my interactions there. I found myself extremely invested in their care, sharing in their hopes and aspirations, and saddened by the conditions that brought them into the correctional system. We did everything we could to help, but so many were raised in broken homes or cast-off as products of neglect and abuse and had simply continued living out the examples that were given them. We talked of inspirational figures, of plans for the future, of coping strategies for aggression,

and the roles of meditation and prayer in personal well-being. I learned to see beyond my privilege and ignorance about lack of education and the absence of heritable promise.

As part of my preparations for reporting to this prison, I'd read *Crazy* by Pete Earley, in which he details the state of the mental health system through the lens of his own son's struggle with schizophrenia. After reflecting on his experience, in which I heard echoes of John, Tom, and others among my patients, I was led to explore other books pertaining to mental illness. I found many truths in the fictional accounts of Ken Kesey's satirical *One Flew Over the Cuckoo's Nest* and in Sylvia Plath's semi-autobiographical *The Bell Jar*, but perhaps was most struck by Susannah Cahalan's *Brain on Fire: My Month of Madness* about her harrowing experience while suffering from an anti-NMDA receptor encephalitis. In each of these writings, I discovered more about the collective humanity of this group of patients. Particularly when combined with the circumstances of their imprisonment, it created a striking mixture, one that continues to unseat a myriad of baseless assumptions hidden deep inside of me, spurring me on towards greater empathy and a broader understanding of the patients under my care.

Though my stint in the correctional health system is over, my thoughts often return to John and I continue to hear his refrain, "I keep seeing her, seeing what I've done." I wonder how he will continue to cope with his internal demons, but also consider what his future holds beyond the confines of the penal system. Upon their release from

incarceration, patients like him will receive thirty days of their psychiatric medication and instructions to establish care within the community for additional treatment. This being the case, it is no wonder that so many of our former inmates will end up homeless, wards of the state, or convicted again for similar and seemingly intentional crimes. My fear is that John will end up like Brooks Hatlen, from Stephen King's *Rita Hayworth and Shawshank Redemption*, yielding to suicide after not being able to cope with his life outside of prison. John's crime was unpardonable, but I hope that after rehabilitation and much needed psychiatric care, he can keep himself in check and move past the damage that mental illness has wrought upon him. I keep seeing him, seeing what we've done to help him, and wondering, "Will it ever be enough?"

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