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Isolated Insanity: The Damaging Effects of Solitary Confinement

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Abstract

Solitary confinement is a popular form of punishment in prisons. However, it often results in the deterioration of the inmate's mental health, especially when it is prolonged. It may lead to severe mental illness or self-harm, including suicide. In addition to the mental health effects, solitary confinement inhibits the rehabilitation process as it limits or eliminates exercise, visitation hours, medical treatment, and group recreation. Without these, many inmates lose their sense of identity and their hold on reality, thereby reducing the odds of successful reentry into society. To improve solitary confinement conditions, prison administrators should provide accessible psychiatrist treatment and limit the duration of time inmates spend in isolation.

Keywords: isolation, mental health, solitary confinement

Isolated Insanity: The Damaging Effects of Solitary Confinement

In October 2015, the Brigham Young University women's soccer coach received a package from the Utah State Prison in Gunnison, UT. In the package there was a large crocheted blanket and a handwritten letter that ended with the following: "I will never get to see a game in person. So please [accept] this blanket as a token of my appreciation, it is for the entire team" (J. Rockwood, personal communication, October 2015). A prisoner serving a lifetime sentence, a man who would never experience another day of freedom, was the giver. Nearly six months later, the coach received a letter from another prisoner in Gunnison. Prior to the second letter, the soccer coach had related the earlier event during a televised speech, and the second inmate (the cellmate of the first) was watching and shared the news with his cellmate. The second inmate sent a letter to inform the coach that his cellmate was overjoyed to see that his blanket and letter were accepted and appreciated. The coach recounted that the most genuine acts of kindness she had ever received were not from fans, players, or staff members, but from criminals—that is, from dangerous men (J. Rockwood, personal communication, October 2015).

While the above prisoners appear to have made progress toward the goal of rehabilitation, many inmates are dehumanized, tortured, and isolated in the name of rehabilitation (Applebaum, 2015; Arrigo & Bullock, 2008; Grassian, 1983; Haney, 2003; Mears & Reisig, 2006; Metzner & Fellner, 2010; Pizarro & Stenius, 2004). Further, they are likely to develop and be diagnosed with mental disorders in the process (Haney, Weill, Bakhshay, & Lockett, 2016). In solitary confinement, an inmate is isolated in order to eliminate any human contact (Shalev, 2011). Solitary confinement is a standard feature of "supermax prisons," where inmates are housed in isolated cells and are not eligible for educational, religious, or rehabilitation programs (Pizarro & Stenius, 2004). In supermax prisons, inmates spend their entire sentence in solitary confinement, isolated for 23 hours every day.

According to Haney (2003), current prison systems in the US still operate in much the same way they did in the 19th century, including the use of solitary confinement. According to the Mental Health Director at Rikers Island, a prison complex in New York City, officials are "severely addicted to solitary confinement" as a way to manage

crowded jails rather than utilizing it for disciplinary purposes (Haney et al., 2016, p. 127).

Because mentally ill prisoners often fail to adjust to incarceration, often exhibiting nonconformity and extreme anxiety, they are at greater risk of being placed in solitary confinement (Haney, 2003). This inhibits their opportunities for successful rehabilitation and their return to normal life, including the increased probability of being rearrested (Haney et al., 2016). Although solitary confinement may be successful in separating dangerous prisoners, its negative impact on mental health rehabilitation is reason for reevaluating its use.

Solitary Confinement and Mental Health

The risk of developing mental illness or the risk of intensifying already-existing mental illness increases when inmates are isolated and alone. It is not unusual for them to be forced to occupy a 60-to-80-square-foot cell for many years (Haney, 2003; Shalev, 2011). The cells typically have a small window with limited sunlight, little fresh air, and a slotted door to allow food and medications to be dispensed (Shalev, 2011). Researchers have shown that isolation is a psychological stressor that can become as distressing as physical torture (Metzner & Fellner, 2010), and may be especially damaging in mentally ill prisoners.

Symptoms of Deteriorating Mental Health

Psychological stressors may result in the following: anxiety, depression, obsessive compulsive disorder, paranoia, anger, perceptual distortions, psychosis, panic, insomnia, hallucinations, self-mutilation, suicidal behavior, violence, emotional breakdowns, and withdrawal (Andersen, Sestoft, Lillebaek, Gabrielsen, & Hemmingsen, 2003; Grassian, 1983; Haney, 2003; Haney et al., 2016; Metzner & Fellner, 2010; Pizarro & Stenius, 2004; Shalev, 2011). Anderson and colleagues (2003) reported that a higher risk for mental disorders exists in solitary confinement inmates than in those not exposed to solitary confinement. In studies of the psychological consequences of solitary confinement, Haney (2003) utilized both case studies and personal accounts of mental health workers in supermax prisons. He concluded that there is not a single study wherein inmates placed in solitary confinement for more than 10 days did not present negative psychological symptoms (see also, Applebaum, 2015).

Grassian (1983) identified a psychopathological condition termed Security Housing Unit (SHU) syndrome. It is characterized by generalized hyper-responsiveness to external stimuli, perceptual distortions, difficulty concentrating and remembering, problems of impulse control, and the emergence of ego-dystonic fantasies—fantasizing about revenge, torture, and the mutilation of prison guards (Grassian, 1983). As disturbing as these symptoms are, the author found that all of them remitted within hours following the inmate's release from isolation, and the severity of their effects varied directly with the degree of isolation.

Mentally Ill Inmates in Confinement

Although mentally healthy inmates are susceptible to the negative consequences of solitary confinement, inmates with preexisting mental disorders have a higher probability of being sent to solitary confinement, where it may have substantial adverse effects, including refusing to leave their cells, setting fire to themselves or their cell, destroying property, smearing urine and feces on themselves and walls, and harming themselves otherwise (Applebaum, 2015; Arrigo & Bullock, 2008; Haney, 2003; Haney et al., 2016; Metzner & Fellner, 2010). Also, the longer inmates are forced to stay in solitary confinement, the greater their risk of permanent mental disorders (paranoia, withdrawal, panic psychosis, etc.). The majority of mentally ill inmates require psychiatric hospitalization in order to reduce their symptoms, but treatment is often unavailable while an inmate is in isolation (Arrigo & Bullock, 2008; Haney, 2003; Metzner & Fellner, 2010).

Improvements in mental health services, such as allowing inmates with mental illnesses to meet with psychiatrists, are occurring in prisons as the American Psychiatric Association and the National Commission on Correctional Health Care (NCCHAC) develop guidelines for such. However, the majority of visits, when they occur are not face-to-face (Metzner & Fellner, 2010). Although the NCCHC and human rights experts have formally stated that mentally ill prisoners need to be excluded from solitary confinement, their statement is generally viewed as a recommendation (Metzner & Fellner, 2010). Furthermore, federal judges have ruled against the segregation of mentally ill inmates, but only a small fraction of prisons are governed by the decisions and elected officials have been reluctant

to pass laws that would accommodate the decisions (Metzner & Fellner, 2010

Increasing Numbers of Mentally Ill Inmates Are Placed in Solitary Confinement

As the proportion of inmates with mental illnesses continues to grow, the number placed in solitary confinement also grows (Applebaum, 2015). Even though it is estimated that two-thirds of mentally ill prisoners are undiagnosed, researchers have shown that, on average, 15% or more of the inmates in each prison have a diagnosed mental illness (Haney et al., 2016; Metzner & Fellner, 2010), and over 50% of the inmates in solitary confinement have diagnosed mental disorders (Haney et al., 2016; Metzner & Fellner, 2010). Moreover, the U.S. Justice Department's own investigation in 2013 showed that on any given day, 15% to 25% of juveniles in incarceration were in solitary confinement and, of these, 71% had been diagnosed with mental disorders (Haney et al., 2016).

Suicide and Self-Harm in Solitary Confinement

Due to the mental deterioration associated with solitary confinement, inmates engage in suicidal behavior and self-harm (Arrigo & Bullock, 2008; Haney, 2003). Self-harm is the leading cause of death among inmates and was described by Kaba et al. (2016) as an act that an individual perpetrates on him or herself that may result in physical injury, disability, or death. The absence of freedom, the presence of a rigidly enforced schedule, and the absence of opportunities for human interaction that define solitary confinement are obvious severe psychological stressors and may readily conduce suicide.

Marcus and Alcabes (1993; as cited by Haney et al., 2016) examined the New York City jail system and found that 42% of suicides occurred within the first 30 days of solitary confinement, and that 52% of inmates who committed suicide suffered from mental illness and were serving their sentence in isolation. A more recent study of the New York City jail system by Kaba et al. (2014) included the analysis of data from prison intake and documented acts of self-harm between January of 2010 and December of 2012. They analyzed 1,303 inmates' records and found that 2,182 acts of self-harm had occurred during the two-year period, including laceration (34%), ligature (28%),

swallowing a foreign body (15%), and overdose (14%). Moreover, 7.3% of the inmates had spent time in solitary confinement, and 4% of these inmates had been diagnosed with a severe mental disorder while in solitary confinement. The authors also reported that 53.3% of the acts of self-harm and 45% of the acts of potentially fatal self-harm occurred within this group of inmates (Kaba et al., 2014)

Solitary Confinement Inhibits Rehabilitation

Solitary confinement also inhibits inmates' rehabilitation. They are denied access to recreation, regular visitation hours, and proper psychiatric treatment (Haney, 2003; Haney et al., 2016; Pizzaro & Stenius, 2004; Shalev, 2011). Without these vital programs that enhance their living state, inmates will often struggle to adapt to regular society upon their release from prison (Haney et al., 2016). Solitary confinement is harming society: it takes away vital programs from the prisoners and eliminates their human contact, which lessens their ability to adapt to life outside the prison system and increases the likelihood that they will commit additional crimes and re-enter the jail system.

Prison administrations throughout the US are required to provide activities for inmates as well as visitation hours and contact with the outside world—they still retain rights as members of society. However, Pizarro and Stenius (2004) found that when inmates were sentenced to solitary confinement, within a supermax prison or elsewhere, these rights were limited extensively. Inmates were typically limited to three to seven hours of exercise per week in a small, isolated space that was often indoors (Pizarro & Stenius, 2004; Shalev, 2011). An inmate in Rikers compared it to being in a cage at a zoo: "No weights, no basketball, no sports, no nothing" (Haney et al., 2016, p. 139). Only about 1 in 10 inmates in isolation exercises each day, and they report feeling degraded when they are searched and shackled in the course of moving into the isolated area for recreation (Haney et al., 2016).

In addition to exercise, other limitations apply to education, work, group recreation, therapy sessions, medical treatment, and visitation hours. One inmate recounted that, in order to receive medical treatment for his toothache, he had to slice his wrists so that the

attending officer would respond and take him to the doctor (Haney et al., 2016).

Pizarro and Stenius (2004) reported that the visitation hours varied across prisons, some allowing only one hour per month and other allowing a few hours per month. The inmates often were not allowed to have direct contact with the visitors but spoke to them instead through video or an intercom (Pizarro & Stenius, 2004).

Many inmates who endure isolation and the restriction of activity exhibit increased social withdrawal, which likely inhibits their rehabilitation (Pizarro & Stenius, 2004). Haney (2003) divided the transformation that an inmate typically experiences in solitary confinement into five segments: (a) dependency on the prison system; (b) inmate loss of focus; (c) loss of their sense of reality; (d) fear of social interaction and subsequent withdrawal; and (e) extreme frustration.

The transformations were illustrated in the case of Kalief, a 16-year-old sent to Rikers Island for allegedly stealing a backpack (Haney et al., 2016). He struggled to adjust to the prison environment and was placed in isolation, where he became increasingly depressed and attempted suicide. After doing so, he spent time in the prison hospital but, upon recovery, was immediately returned to solitary confinement. After three years in prison, the last 17 months in isolation, Kalief was unexpectedly released when a judge decreed that he was innocent. After his release, his friends and family noticed that he was different. He paced around his room and preferred to be alone. He attempted suicide multiple times, and as he continued to struggle with depression and paranoia, he explained, "I'm not all right. I'm messed up. There are certain things that changed about me and they might not go back" (p. 128). He later hanged himself.

Arguments in Support of Isolation

Deterrence is a prominent component of arguments in support of solitary confinement, that is, inmates behave better because of the fear of returning to isolation (Mears & Reisig, 2006; Pizarro & Stenius, 2004). Placing inmates in solitary confinement also serves as a threat to the other inmates (Mears & Reisig, 2006). The existing research on deterrence has not demonstrated that the use of isolation decreases prison violence (Mears & Reisig, 2006).

Concern for safety—their own and others'—is another common

reason for placing inmates in solitary confinement. Applebaum (2015) acknowledged that high security is required for dangerous inmates who are a threat to other inmates and officers. However, Applebaum asserted that most inmates placed in isolation are not dangerous. Instead, they are disruptive. Applebaum also found that vulnerable inmates are placed in isolated security for their own protection. Inmates who are transgender, mentally ill, or have developmental disabilities are frequently in this category. If an inmate is in isolation for her or his protection, it seems reasonable that she or he should not have the same restrictions that apply to others in isolation.

Despite the absence of clinching evidence that inmates in solitary confinement are more likely to have been diagnosed with mental disorders and to experience intensification of the symptoms (Glancy & Murray, 2006), when they are transferred from solitary confinement to the general prison population, their symptoms typically subside (Anderson et al., 2003). Ironically, there is widespread agreement about the damaging psychological effects of war, including those of prisoners of war or hostages who are kept in isolation. In contrast, prison inmates, whose institutional isolation may be equally as extreme are viewed differently (Haney, 2003).

Conclusion

Adjustments need to be made to solitary confinement policies and procedures in order to improve isolated inmates' mental health and rehabilitation. Two adjustments that are promising: improving the conditions of solitary confinement, including limiting the duration of time spent in isolated cells and increasing opportunities for recreation and visitation; and increasing the availability of psychiatric treatment for those who are confined and whose existing mental illness likely was a major factor in their assignment to isolation.

The current psychiatric treatment in prisons consists of "walk-bys" (the psychiatrist walking by each cell and asking how the inmate is feeling) and occasional personal meetings (Haney, 2003; Haney et al., 2016). Prison administrators should hire additional psychologists, psychiatrists, and mental health workers in order to allow inmates more frequent treatment. Indeed, the enhanced provision of mental

health care may be the most beneficial approach to reducing prison population.

Even though solitary confinement may be successful in separating particularly dangerous inmates from each other and the rest of the prison population, the majority of inmates in isolation are not dangerous and have been placed there as a means of social control (Haney et al., 2016). Researchers generally agree that solitary confinement is counterproductive and has damaging and possibly lasting effects on the mental health of those confined to isolation, to say nothing of impairing their odds of successful rehabilitation.

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