SOLITARY WATCH .ORG

The Psychological Effects of Solitary Confinement

FACT SHEET #3

Solitary confinement—also known as segregation or restrictive housing—refers to the isolation of incarcerated individuals for up to 24 hours a day with no meaningful human contact.[1] Within prisons and jails in the United States, solitary is used to punish disciplinary infractions, to separate people classified as "dangerous" from the general population, and to allegedly protect vulnerable individuals.

At least 75,000 incarcerated individuals are held in solitary confinement on any given day in state and federal prisons alone.[2] It is estimated that anywhere from one-third to half of these individuals have some kind of mental illness.[3] This is in part due to the fact that prisons and jails have become de facto mental health facilities, despite being unqualified to provide adequate care: A 2014 Treatment Advocacy Center report found that more than 350,000 individuals with severe mental illnesses were being held in U.S. prisons and jails in 2012, while only 35,000 were patients in state psychiatric hospitals.[4] Many of these individuals end up being put in solitary for exhibiting symptoms of untreated mental illness.[5]

A growing body of research has found that solitary confinement not only further exacerbates the symptoms of mental illness in individuals already diagnosed with psychiatric conditions, but also creates new mental health issues in people with no previous history of mental illness.

Symptoms of Psychological Distress Among People in Solitary Confinement

"Seg has took a toll on me mentally, emotionally, physically… I even hear voices at night it frightens me to the point I sometimes just want to take my life. It's hard time in seg."

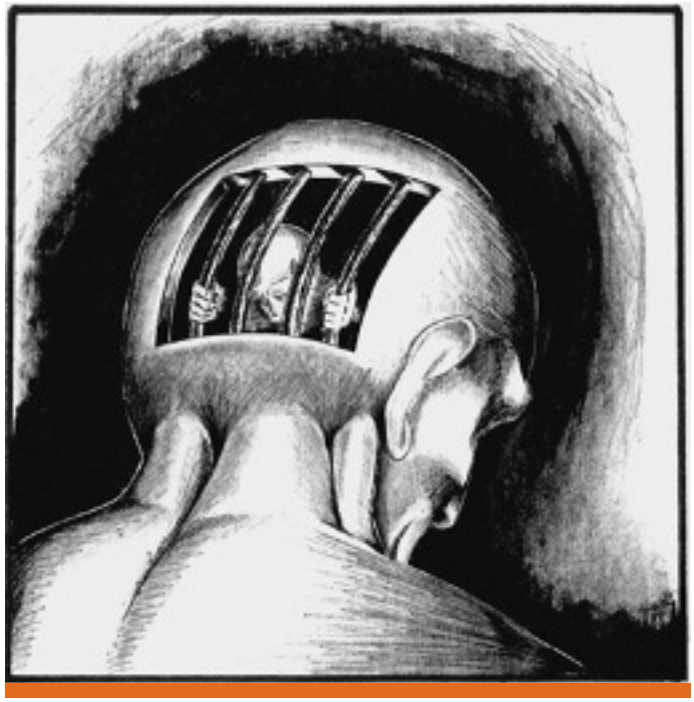
—Leon, held in solitary confinement in a Louisiana prison[6]

Since the mid-twentieth century, many psychologists and behavioral analysts have conducted empirical studies into the effect of solitary confinement on individuals' psychological health. Using both quantitative (standardized psychological assessments) and qualitative (personal accounts) methodologies, researchers have painted a detailed picture of the intense psychological trauma caused by solitary confinement.[7]

Affective Disturbances: Affective disturbances, such as anxiety and depression, are among the most common symptoms of psychological distress caused by solitary confinement. Both figured prominently in a study conducted in the Washington State prison system. In 2017, people in a solitary confinement unit called the Intensive Management Unit (IMU) reported high rates of psychological distress. A year later, in 2018, those who had moved out of solitary saw improved results, while those who were still in the IMU had worsened.[8]

Psychosis: From October to December 2017, researchers from the University of Maryland School of Medicine and the Mental Illness Research, Education, and Clinical Center surveyed 176 formerly incarcerated adults in Baltimore and New York on their prison experiences and mental health histories. An analysis of the data, published in August 2020, determined that there was a 59% probability that individuals who were diagnosed with schizophrenia or psychotic symptoms had been held in solitary confinement.[9]

Self-Harm: A study of the New York City Jail System found that individuals placed in solitary confinement were 6.9 times more likely to commit acts of self-harm and 6.3 times more likely to commit acts of potentially fatal self-harm than people in general population.[10] Additionally, a 2017 study that surveyed people in the Washington State Department of Corrections Intensive Management Unit found that "22% had a documented suicide attempt, and 18% had documentation of other self-harm, all at some point during their incarceration."[11]



Drawing by Todd Hyung-Rae Tarselli (Instagram @toddhyungraetarselli)

Suicide: A report published in 2020 by the #HALTsolitary Campaign (a group pushing for solitary reform in New York state) analyzed suicides in New York City's Jails from 2015 to 2020 and found that individuals in solitary were 12 times more likely to die by suicide than prisoners held in general population.[12] In 2019, the Journal of the American Medical Association published a study that linked time spent in solitary with an increased likelihood of suicide post release. The study showed that, of the 229,274 participants, "individuals who spent any time in restrictive housing were 24% more likely to die in the first year after release, especially from suicide (78% more likely)," than those who did not spend time in restrictive housing.[13]

SHU Syndrome

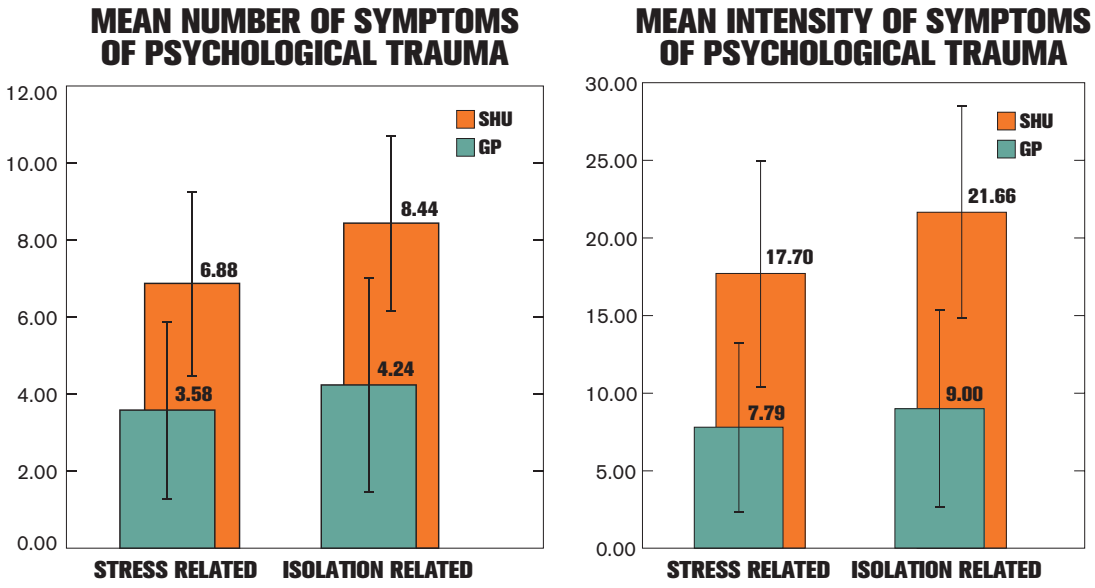
"Before I came to [solitary confinement] I was whole and well grounded. Now I feel as if I kind of forgotten how the 'old me' use to work. I be depressed/stressing more than anything being back here. I have started forgetting who certain people are and what are certain things. It's like being in a cell this long has started making me lose hope and being back here has started feeling like the cell walls are closing in on me."

—Trevon, held in solitary confinement in a Louisiana prison[14]

The symptoms of solitary confinement are so widespread and consistent, they have been grouped by some medical professionals into "SHU Syndrome," referring to Special Housing Unit or Security Housing Unit, common euphemisms for solitary confinement. SHU Syndrome is described as "a "major, clinically distinguishable psychiatric syndrome."[15] In 1983, psychiatrist Dr. Stuart Grassian first outlined this syndrome in an article in the *American Journal of Psychiatry*, analyzing the clinical observations resulting from the interviews of 15 people held in long-term solitary confinement in Massachusetts. Grassian found that 14 of the interviewees exhibited a set of significant symptoms of psychological distress, including hypersensitivity to external stimuli; affective disturbances (depression and anxiety); difficulties with thinking, concentration, and memory; disturbances of thought control, and problems with impulse control. It was also found that once individuals left solitary confinement, the prevalence of these symptoms decreased significantly.

Building on the foundations laid by Grassian, social psychologist Dr. Craig Haney conducted research at California's Pelican Bay security housing unit (SHU) on the psychological effects of supermax confinement conditions. In 2003, he published the article, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," which solidified the connection between solitary confinement and psychological distress. Haney found that among the 100 incarcerated people interviewed, "virtually all… were plagued by nervousness and anxiety, by chronic lethargy, and a very high percentage (70%) felt themselves on the verge of an emotional breakdown."[16] Haney found that the intensity of solitary confinement mattered: Those placed in the security housing unit had a symptom prevalence 14.5% greater when compared to prisoners in other segregation units (such as protective custody) at non-supermax facilities.[17]

Despite the numerous studies demonstrating the harmful, and sometimes lethal, psychological effects solitary confinement, supporters of the practice typically point to one Colorado study to try and argue the opposite. In the widely debunked study, researchers purported "to show that psychological effects of solitary confinement range from harmless to beneficial."[18] In a 2018 article, Craig Haney said of the study: "The problems proved insurmountable: comparison groups were not comparable, and the integrity of the 'treatments' each group received was quickly corrupted."[19]



Number and intensity of stress- and isolation-related trauma symptoms reported by solitary confinement (SHU) versus general population (GP) prisoners in a 2017 study at Pelican Bay State Prison in California. (Error bars show standard deviation of each group's scores.)[20]

Inadequate Mental Health Treatment

"A lot of times [officers and psychologists] won't send us to [the mental health unit], but strip us naked, take all our clothes, blankets, mattresses, and leave us in our cells cold and naked and sleeping on steel bunks. They do this as punishment for acting, in their words, like an asshole."

—Tashon, held in solitary confinement in a Pennsylvania prison[21]

In 2012, a lawsuit was filed on behalf of men held in

solitary at the federal supermax ADX Florence. One of them was John Powers, who, despite being diagnosed with PTSD and prescribed medication, was consistently denied mental health treatment. At that time, no one at the facility "was to be given psychotropic medicine no matter how badly they needed it."[22] As a result, Powers repeatedly self-mutilated, even severing his Achilles tendon and biting off his pinky fingers, in desperation to receive care.

While both the federal Bureau of Prisons' (BOP) policies and interpretations of the Eighth Amendment prohibit staff from denying individuals needed mental health treatment, Powers's case was not an anomaly. Data collected by the Marshall Project in 2018 showed that while 23% of people incarcerated in the federal system had been diagnosed with a mental illness, the BOP "classified just 3 percent of inmates as having a mental illness serious enough to require regular treatment."[23]

Less data is available for most state prisons and local jails, but numerous lawsuits[24] and reports,[25] as well as high suicide rates behind bars,[26] indicate that inadequate mental health care for individuals both in and out of solitary is a serious problem in carceral facilities across the country.

Racism plays a role, and research has shown that incarcerated people of color are even less more likely to be punished for exhibiting symptoms of psychiatric illness, and less likely to receive proper treatment.[27]

A "Vicious Cycle" of Mental Illness and Solitary

"Solitary confinement causes mental illness and anger, which can result in a 'vicious cycle'—the prisoner becoming more angry and incapable of controlling his temper and the resulting disciplinary tickets leading to more time in the isolation setting that induces the angry behaviors. Prisoners in solitary confinement who exhibit signs of mental illness such as refusing an order, self-mutilation or cutting, or expressing anger at officers likewise receive disciplinary sanctions rather than treatment. Even suicidal behavior is sometimes treated as a behavioral rather than psychological problem."

—Shira E. Gordon, "Solitary Confinement, Public Safety, and Recidivism"[28]

While incarcerated, people with mental illnesses rarely have adequate access to proper psychiatric health care, often resulting in the worsening of their symptoms. This results in many incarcerated individuals with mental illnesses being placed in solitary confinement not specifically for what they have done, but rather because prison authorities have deemed their behavior to be "disruptive" or "dangerous."

Once in solitary confinement, individuals' already limited access to mental health care is even further restricted. Psychiatric health care in solitary confinement is often limited to the administration of psychotropic medication and brief and infrequent interaction with clinicians through the food slot in the cell door.[29] This can create a revolving door, where people's clinical conditions lead them to solitary, where their mental health further deteriorates, leading to more time in solitary.

Group therapy cages for individuals incarcerated at Mule Creek State Prison near Sacramento. Photo via U.S. District Court, Eastern District of California.

Alternatives to Solitary for People with Psychiatric Disabilities

The first and most effective way to prevent people with mental illness from being placed in solitary confinement is to divert them from the criminal justice system entirely. By implementing systems of community support and improving access to comprehensive mental health care, it is possible to divert most, if not all, individuals with serious mental illness from entering the carceral system in the first place.

In Denver, for example, the Support Team Assistance Response (STAR) program dispatches mental health workers rather than police in response to certain crisis calls. In the program's first six months, starting in June 2020, clinicians responded to 748 incidents, resulting in a reduction of nearly 1,400 reported criminal offenses.[30]

For those who are already in prison or jail, alternatives to solitary—while imperfect—do exist. In 2008, the New York State Legislature passed the SHU Exclusion Law, which attempts to prevent incarcerated people with serious mental illnesses from being placed in solitary confinement.[31] Several other states have passed similar laws, although implementation has been problematic.

On New York City's Rikers Island, alternative units known as Clinical Alternative to Segregation Program (CAPS) units and Program for Accelerated Clinical Effectiveness (PACE) units were established in 2013 and have been held up as models, although they have the capacity to house just a small fraction of the individuals with mental health diagnoses held in the city's jails.

Resources

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Solitary Watch is a watchdog organization that investigates, reports on, and disseminates information about solitary confinement in U.S. prisons and jails to promote awareness, create accountability, and shift public narratives.

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