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Repetitive Self- Harm in Solitary Confinement

Terry A. Kupers, M.D., M.S.P.

A big part of the psychological harm of solitary confinement[1] in prison and jail is the extraordinarily high risk of suicide and self-harm. Averaging the various states for which we have figures for prison suicide rates, 50% of prison suicides—actions leading to death, as distinct from attempts—occur among the 3% to 6% or 8% of the prison population consigned to some form of solitary confinement.[2]

It is important to examine the link between solitary confinement on the one hand, and prison suicide and self-harm on the other. A large amount of research provides evidence that solitary confinement for longer than 15 days causes emotional distress, damage and disability.[3] After considering the risk of psychiatric damage in solitary confinement, American courts (the *Madrid v. Gomez* & *Jones 'El v. Berge* class action lawsuits)[4], state legislatures (New York, New Jersey and others), the National Commission on Correctional Heath Care (NCCHC), the American Psychiatric Association (APA), and the United Nations (Mandela Rules) provide standards and laws that greatly limit the time a prisoner can be consigned to solitary confinement, especially a prisoner suffering from mental illness.

Despair, Depression, and Self-harm

Solitary confinement induces despair, and despair leads to suicide. As if

[1] According to the United Nations' *Standard Minimum Rules for the Treatment of Prisoners,* the "Mandela Rules": "For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact." But it is not social isolation alone that causes lasting damage; there is also the lack of meaningful activity. (United Nations' *Standard Minimum Rules for the Treatment of Prisoners,* the "Mandela Rules, U.N. Office on Drugs and Crime, December, 2015.

[2] Mears, D.P. & Watson, J. (2006). "Towards a fair and balanced assessment of supermax prisons," Justice Quarterly, 23,2, 232-270.; Way, B., Miraglia, R., Sawyer, D., Beer, R., & Eddy, J. (2005). "Factors related to suicide in New York state prisons," International Journal of Law and Psychiatry, 28,3, 207-221.; and Patterson, R.F. & Hughes, K. (2008). "Review of completed suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004," Psychiatric Services, 59, 6, 676–682.

[3] Grassian, S. 2006. "Psychiatric Effects of Solitary Confinement." Washington University Journal of Law and Policy 22:325–53.; Haney, Craig. 2003a. "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement." Crime and Delinquency 49 (1): 124–56.; Kupers, T. 2013. "Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?" In The Routledge Handbook of International Crime and Justice Studies, edited by Bruce Arrigo and Heather Bersot, 213–32. Oxford: Routledge.; and Scharff Smith, Peter. 2006. "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature." Crime and Justice 34:441–528.

[4] Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal., 1995); Jones 'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001).

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New Medicaid Eligibility Rules: What They Mean for Jails and Prisons

By Daniel Mistak, MA, MS, JD and Rebecca Sax, MPH

Health providers in carceral settings have a significant impact on community health and safety. Healthcare providers in jails and prisons are often tasked with caring for people who have much greater physical and behavioral health needs than those on the outside. People who are incarcerated have much higher rates of chronic and infectious diseases as well as unmet mental health and substance use disorder needs. Without sufficiently funded safety net services and diversion programs, jail staff are faced with the overwhelming task of maintaining the health and safety of an ever-increasing number of systems-involved people. This combination of factors causes major challenges for correctional staff and exacerbates a mental health crisis on both sides of the bars.

Much of the challenges with connecting these discrete systems comes from the fact that public health and public safety have historically been separate, siloed systems. Both systems increasingly recognize that cross-sector collaboration is necessary to improve individual and community health and well-being. Policymakers across the country are also taking action

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explaining the connection, a man who had been in solitary confinement for 12 years told me, "I'm going to die in here."

"Why do you say that," I asked, "you've only been sentenced to six months in solitary."

"Yeah," he retorts, "but being in here gets me so wired and so depressed at the same time, I know that during the next six months I'll get agitated and have some kind of confrontation with a guard, then they'll write me up (a "ticket" or Rule Violation Report) and I'll get another six months seg, and then another after that. I'm gonna' die in this cell." This man's hopelessness puts him at risk of self-destruction.

I also discover an immense amount of depression in solitary confinement units, and depression involves a lack of motivation to do anything, often a preference for lying around and doing nothing. When mental health clinicians treat depression, we try to encourage people to exercise robustly and develop meaningful pursuits. Having an active exercise program and productive activities tends to ward off or diminish depression, whereas lying around doing nothing tends to bring on or worsen depression. The depressed patient on a psychiatric ward wants to stay in his room, not participate in ward events, treatment groups, or informal congregate activities such as a checkers game or a group watching television and talking. In a psychiatric hospital, nursing staff go to depressed patients' rooms and encourage them to come out into the dayroom and take part in activities. In a solitary confinement cell, there are no activities, and there is nobody to come by and encourage a person to take part in social programs. There are no social activities in solitary confinement. In all too many cases, despair and depression breed thoughts of suicide, and all too many suicide attempts.

Anxiety

Individuals consigned to solitary confinement for months or years report severe anxiety. There is something about being alone in a cell with no productive pursuits or rehabilitation programs that causes an immense amount of anxiety or panic, along with insomnia and quite a few other disturbing symptoms. Social connection and meaningful activity are essential elements of being human.

Quite a few cases of self-harm or suicide can be shown clearly to emanate from severe anxiety, as if the self-harming individual is attempting to lessen the anxiety. Almost all individuals I have examined in the course of my forensic work profess feeling very anxious in solitary confinement, but only a small sub-group, for reasons they cannot always explain, feel compelled to cut or harm themselves. I ask one man how he felt after cutting himself, and he tells me with a smile, "I feel relief!—the anxiety lifted, I guess seeing the blood (others say feeling the pain) reminded me that I am alive."

Solitary confinement is a first order cause of self-harm and suicide in prison.

I ask another man why he harms himself repeatedly in solitary and he responds, "My nerves were going bonkers, I was so nervous I couldn't stand it. I wasn't sleeping, I was up pacing all night, I was getting paranoid, and I just felt I had to do something." I ask how he feels after self-harming, and he responds, "Just seeing the blood reminds me that I'm alive, not just an animal in a cage, but a bloody human being." He claims feeling great relief after self-harming, and tells me he feels less anxiety. That is not how a depressed person feels after waking from a suicide attempt—she is more likely to castigate herself, "You're useless, you can't even succeed at committing suicide." In other words, individuals self-harm in solitary confinement in order to attain relief from unbearable anxiety and other unendurable inner states. Sadly, it is a dysfunctional and possibly fatal activity.

Self-Harm in Solitary Confinement

Sometimes self-harm is propelled by a strong wish to die; other times there are different motives for serious self-harm. Cummings & Thompson caution against a false dichotomy between truly suicidal self-harm and self-harm where the motive is not entirely clear.[5] When self-harm is clearly suicidal in intent, there are well known protocols for identifying risk factors, ensuring safety with close monitoring, and providing crisis intervention.[6]

But an explicit suicidal motive is not always clear. Non-Suicidal Self-Injury is a category of mental disorder in *DSM-5*. It appears in the section on "Disorders for Further Study," so it may become an official diagnosis when *DSM-6* is published.[7] Non-Suicidal Self-Injury (I am calling it self-harm) is much more prevalent among adolescent girls then it is among adult males, the exception being adult males in solitary confinement.[8] It is interesting that the description of Non-Suicidal Self-Injury in *DSM-5* focuses on superficial cutting, not on the kind of severe cutting and mutilation of the body that all too often occurs in solitary confinement units. And the description does not mention prison solitary confinement as the site of a disproportionate number of incidents of self-harm in adult males.

We never know for certain that a serious act of self-harm is "non-suicidal." The suicidal component of self-harm can be unconscious. There is the tragic scenario, "suicide by cop," where a person

[5] Cummings D. L., Thompson M. N. (2009). Suicidal or manipulative? The role of mental health counselors in overcoming a false dichotomy in identifying and treating self-harming inmates. *Journal of Mental Health Counseling*, 31(3), 201–212. https://doi.org/10.17744/mehc.31.3.f3332r77x526477k

[6] Hayes, L. (1995). Prison Suicide: An Overview and a Guide to Prevention. *The Prison Journal*, 75, 4, available at <https://journals.sagepub.com/doi/10.1177/0032855595075004003>; World Health Organization. (2007). Preventing Suicide in Jails and Prisons. Available at https://apps.who.int/iris/bitstream/10665/43678/1/9789241595506_eng.pdf.

[7] American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, DSM-5*. Wash, D.C.: APA, pp. 803–806.

[8] Cipriano, A., S. Cella & P. Cotrufo. (2017). Non-suicidal Self-injury: A Systematic Review. *Frontiers in Psychology*, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5682335/>; Hollander, M. (2023). What is Teen Cutting and Self-Injury?. Mass General Brigham McLean Hospital. Available at <https://www.mcleanhospital.org/essential/teen-cutting-and-self-injury>

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forces an armed confrontation with police and gets himself shot to death. The person who commits "suicide by cop" is not conscious of a wish to die. Similarly, we usually know little about the psychological experience of people who die of suicide or self-harm in jail or prison. Were they consciously planning to kill themselves? Unconsciously? Were they trying to hide their wish to die behind a ludicrous act of self-harm that would appear anything but lethal? Or was their death accidental, their plan being merely to cut themself to relief the anxiety? We don't know, because in most cases we do not have much information about the individual who self-harmed in solitary. I believe there is always some degree of suicidal intent involved when a person in solitary confinement harms himself. And there are complicated motives for self-harm that are not clearly suicidal. In any case, even if a person committing repeated acts of self-harm in solitary confinement explicitly denies being suicidal, that person remains a high risk of suicide.

The Complex Motives Involved in Self-Harm

There are many paths to self-harm. The wish to die leads to many suicide attempts in solitary confinement, and too many deaths. Again, the despair caused by solitary confinement is a major factor in the many suicides that occur in prison solitary confinement units. Serious Mental Illness is also a strong risk factor for self-harm and suicide. Solitary is well-known to exacerbate serious mental illness.[9] Sometimes it's a matter of the mental illness leading to strong thoughts of suicide, as in severe depression. Sometimes a person suffering from Schizophrenia hears a voice (auditory hallucination) commanding him to cut himself or kill himself.

There is still another kind of self-harm, driven largely by anxiety. Quite a few adolescents who have attempted to kill themselves in recent years suffer more from anxiety than from any stated despair or depression. Many report feeling so anxious and agitated that they knew they had to do something extreme to win relief, and cutting themselves seemed like it might accomplish that. It is like that in solitary confinement. There are simply many, many instances in solitary confinement where a grown man suffers massive anxiety and cuts or mutilates himself badly.

Trauma is an important part of the story. Overwhelmingly, individuals I have encountered who repeatedly cut themselves or mutilate their bodies when consigned to solitary confinement have a lot of serious trauma in their backgrounds prior to incarceration, including physical and/or sexual abuse as a child, domestic violence as an adult, and traumas that occur in prison such as witnessing up close a knife fight leading to death on the prison yard. Individuals who commit repeated acts of self-harm have many traumas in their personal backgrounds.

One man who repeatedly cuts himself and mutilates his body whenever he is consigned to solitary confinement, and never commits acts of self-harm outside of a solitary confinement setting, explained to me that the physical pain caused by his severe self-harming is actually desirable, "It takes my mind off the psychological pain." He avers severe anxiety when confined to a cell nearly 24 hours per day, he experiences the walls closing in on him, he becomes agitated and paces frenetically, he feels overwhelmed by intolerable emotions, and he feels he has to do something to get his mind off the psychological pain. He cuts himself in very sensitive areas of his body, the more physical pain the better, and he believes the temporary relief from exclusive focus on the psychological pain "makes the physical pain worth it."

Individuals who repeatedly commit acts of self-harm in jail and prison typically acknowledge a pattern of increasing severity of their self-harm over a long period. One man reports that when he was first consigned to solitary as a much-younger man he began to experience unbearable anxiety, he felt his heart pounding in his chest and he felt like the walls were closing in on him. He witnessed an individual in a neighboring cell cut himself, and saw the blood spurt out. He decided to try cutting himself to see if that might offer some relief. At first he made superficial cuts on his arm with a broken spoon he had in his cell. As time went on, he discovered that even after cutting himself and spending a few days in suicide observation he would be sent back to a solitary confinement cell where the anxiety would mount anew. He incrementally made deeper cuts and eventually began inserting pieces of metal into the gaping wounds, requiring that he be transferred to a hospital for surgical repair. The process became habitual, whenever he was returned to a solitary confinement cell he would experience severe anxiety and cut and mutilate himself again. He exclaimed, "Cutting became automatic, a habit."

Self-harm is epidemic in solitary confinement units. While the explicit purpose of the self-harm may not be to die (usually there is a combination of suicidal intent combined with some anxiety-driven compulsion to self-harm that is not fully explained by a conscious wish to die), it is a pathological reaction to intense emotional pain—in this case severe anxiety and agitation that predictably mount in solitary confinement. An incident of self-harm constitutes a psychiatric emergency.

The act of self-harm is not, typically, entirely willful. Prisoners who commit self-harm tell me that they feel like they simply have to cut themselves, they have no choice in the matter. They tend to use the word "driven" to describe the experience. As a psychiatrist, I find it more on-point to use the word "compelled." Self-harm, in most cases, is to a great extent not really a "choice" on the part of the self-harming prisoner, rather the self-harm is compelled by intolerable levels of anxiety and paranoia, and to a certain extent self-harm becomes a habit. Even if there is no conscious wish to die, death can result by accident.

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[9] Haney C. (2003). Mental health issues in long-term solitary and "supermax" confinement. *Crime & Delinquency*, 49(1), 124–156. https://doi.org/10.1177/0011128702239239; Hudgins, S. & Cote, G. (1991). 'The Mental health of penitentiary inmates in isolation,' *Canadian Journal of Criminology*, 177–182; Metzner J. L., Fellner J. (2010). Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics. *Journal of the American Academy of Psychiatry and The Law Online*, 38(1), 104–108.

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Is Self-harm Simply "Manipulative" or "Malingered"?

Very often, when I encounter an individual in solitary confinement who commits repetitive acts of self-harm, mental health progress notes in his chart reflect that the individual does not suffer from serious mental illness and is not actually suicidal, rather his repeated acts of self-harm are merely attempts to manipulate his way out of solitary confinement. This double allegation—no mental illness and self-harm as manipulation—is quite foolhardy and leads to a great amount of suffering on the part of the maligned individuals, as well as too many deaths by suicide.

When a note is entered in a prisoner's mental health chart declaring the individual's acts of self-harm to be "merely manipulative," or "malingering," or, what amounts to the same thing, the only psychiatric diagnosis is "Antisocial Personality Disorder" (ASPD), the individual is essentially deemed to be more "Bad" than "Mad," and the problem is left to custody staff as a discipline matter. Indeed, in just about all the cases of repetitive self-harm I have investigated, the prisoner received a rule-violation report or "ticket" for the act. In one case, the ticket was for the act of self-harm itself. In the others it was for possession of contraband (the razor or piece of metal used for self-harm), possession of a weapon (again, the instrument of self-harm), or destruction of state property. In two cases, the individual was strapped into a restraint chair to prevent a reoccurrence.

Under-diagnosing is the process whereby an individual who is actually suffering from serious mental illness is incorrectly diagnosed only with a personality disorder, usually ASPD. And under-diagnosing tends to support an attribution of "manipulating" or "malingering." It is as if mental health staff believe, "If there is no serious mental illness, then the self-harm must be fake." And once one clinician writes a note in the chart that the individual is cutting or mutilating himself simply as a manipulation, the impression is brought forward in subsequent progress notes that echo the original determination of manipulativeness without any further rigorous assessment. The danger is that the mental health staff will stop at determining manipulation and look no further for the presence of mental illness and the high risk of severe bodily damage or death.[10]

The possibility of malingering is often raised. Is this self-harming individual "feigning or exaggerating clinical symptoms for the purpose of secondary gain?" Malingering is an important consideration in forensic psychiatry. An assessment for malingering or deception is a standard component of forensic psychiatric evaluations and expert reports. I have published my approach to assessment for malingering.[11] I very rarely find convincing evidence of malingering in cases of repetitive self-harm in solitary confinement.

An individual who is actually suffering from serious mental illness is often incorrectly diagnosed only with a personality disorder, usually ASPD—and under-diagnosing tends to support an attribution of "manipulating" or "malingering."

False Bravado

It is true that some prisoners who repetitively self-harm while denying suicidal intent say things to staff while in Suicide Observation that lead staff to conclude they were "merely manipulating" to win release from solitary confinement. They might say, "I only did it to get out of solitary," or "Fooled you, I'm not really suicidal." Too often mental health staff assume this kind of silly banter entirely explains their self-harming ways, and miss the opportunity to diagnose more serious underlying mental illness and very dangerous inclinations toward serious self-harm and suicide. I am reminded of prisoners I have encountered in solitary confinement settings who are confronted at cell-front by custody staff and told that if they do not return their food tray or do not put their wrists through the food slot so they can be handcuffed, the officers will enter their cell in force (a "cell extraction") and subdue them. These prisoners "put up their dukes" in mock combat stance and say, "Come on in if you're man enough." This bizarre stance on the part of a prisoner who knows he will not prevail in a fight with multiple officers in riot gear reflects the extremity of existence in solitary confinement. Solitary confinement fosters extreme and bizarre behaviors. A rational prisoner, one who is not suffering from mental illness, who has just cut himself or mutilated his body intent on manipulating to win release from solitary confinement, would not tell staff that he just did it to get out of solitary—that would be entirely self-defeating, and a mentally stable person would not choose this kind of self-defeating and self-destructive behavior.

Social scientists Angela Hattery and Earl Smith provide a snapshot of the extremity of human experience in solitary confinement: "Have you ever seen a movie or a YouTube video in which a wild animal chews off a paw to escape a trap? A quick Google search will yield dozens of these heartbreaking videos. The notion that human beings can be locked in cages for twenty-three hours a day, given only an hour out, if they are lucky, to shower and "exercise" is in and of itself a construction rooted in dehumanization. After being locked in solitary confinement for even a few days, many human beings will begin to respond like the wild animal whose paw is caught in a trap. The more we treat human beings like animals, the more they engage in behaviors none of us think we ever would. They will cut themselves, they will bang their heads against the wall until they bleed, they will spread feces on their walls, they will attempt suicide, they will do anything to get out of the cage."[12]

[10] *Op. cit.,* Cummings D. L., Thompson M. N. (2009).

[11] Kupers, "Malingering in Correctional Settings," *Correctional Mental Health Report*, 5,6, March/April, 2004.

[12] Angela Hattery & Earl Smith. (2023). *Way Down in the Hole: Race, Intimacy, and the Reproduction of Racial Ideologies in Solitary Confinement*. New Brunswick: Rutgers University Press, p. 101.

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Self-harm can involve very serious injuries. I have seen deep cuts made in the arms, pieces of metal such as battery parts inserted into the gaping bloody wound, metal objects inserted into the abdomen through a deep cut in the abdominal wall, and prisoners swallowing a battery or part of a metal knife. Or the denizen of solitary confinement cuts off a part of his body, an ear, a finger, his testicle, his penis. Self-inflicted injuries can be quite ghastly, surgery is often needed to repair the damage, and too many deaths have resulted.[13]

The Cycle: Solitary-Cell-to-Suicide-Observation-and-Back-to-Solitary

I have thoroughly investigated the cases of quite a few individuals who repeatedly harm themselves while in solitary confinement—including cutting their arm, mutilating their body, swallowing harmful objects, and even cutting off bodily parts—who all reported to me the same pattern: Each time they cut themselves or cut off a body part, they are treated medically and sent to a Suicide Observation cell, where they are monitored and counseled for a few days, then they are sent back to their solitary confinement cell with little or no follow-up by mental health staff. Some report "recycling," i.e., going from solitary cell to Observation and back to solitary where they harm themself again, and back to Observation, and onward. I have investigated over three dozen successful suicides in solitary confinement settings and, in just about every case, the clinical chart reflects a cyclic process wherein the prisoner repetitively attempted suicide or engaged in self-injurious behavior while in solitary, was transiently transferred to the infirmary or a crisis stabilization unit, and then was sent back to solitary confinement where he eventually killed himself.

In every lawsuit launched on behalf of the prisoner who repeatedly harms himself in solitary confinement and then recycles between Observation and solitary cell multiple times, where I serve as psychiatric expert witness, I find clinical notes in the medical record reflecting the individual is not suffering from any mental illness other than ASPD, and is merely manipulating, or malingering, or is simply deceptive. In almost all such cases, I conclude this is an incorrect diagnosis, and returning the individual to a solitary confinement cell is a very foolhardy treatment plan (actually, I usually find there is no treatment plan on the chart covering the period subsequent to Suicide Observation).

Individuals who have repeatedly attempted suicide or harmed themselves in a solitary confinement cell must not be sent back to solitary after a brief period in Observation. Rather, a mental health treatment plan must be developed with them, including incrementally diminished monitoring as they evidence lower risk, and they must be housed in a treatment setting, perhaps a stepdown unit. In several cases, federal judges have ordered that the individual under consideration be transferred out of solitary confinement, where he was during the court proceedings, and into a treatment program.

Why do I claim that many repeatedly self-harming individuals in solitary confinement are under-diagnosed? I cannot answer about all cases of repetitive self-harm, but in all the ones I have looked into I have discovered that the individual was actually suffering from serious mental illness even though no diagnosis other than ASPD appeared on his chart. Very often there was severe trauma in the individual's background, and a diagnosis of Posttraumatic Stress Disorder (PTSD) or Borderline Character Disorder[14] was warranted. In several cases, the individual claimed he did not want to die, but I felt there was at least an unconscious wish to die, or perhaps an ambivalently held wish to die. In any case, I have arrived at the conclusion that most individuals who practice repetitive self-harm in solitary confinement do suffer from a serious mental illness, and should not be returned to solitary confinement after a stint in Suicide Observation because solitary confinement is what brought on the anxiety, agitation, despair—and the plan to self-harm.

Needed: An End to Recycling

Returning individuals intent on self-harm from a Suicide Observation cell to a solitary confinement cell is both cruel and foolhardy. We know that the prevalence of successful suicide in solitary confinement is sky high. We know that a previous suicide attempt is among the strongest risk factors for suicide. And we know that individuals who repetitively commit acts of self-harm mostly do so only in solitary confinement, and not while they are in general population or in the community.

What sense does it make to transfer a self-harming or suicidal individual back into solitary confinement?

The *Madrid v. Gomez* court made a very wise ruling in this regard.[15] Federal Judge Thelton Henderson ordered that the California Department of Corrections "be permanently enjoined from confining in the Pelican Bay State Prison Security Housing Unit those 'at risk' inmates who meet one or more of the following definitions:" In addition to Schizophrenia, Bipolar Disorder, Major Depressive Disorder and so forth, the list of "definitions" includes "Inmates diagnosed with a mental disorder that includes being actively suicidal; (and) Inmates diagnosed with a serious mental illness that is frequently characterized by breaks with reality, or perceptions of reality that lead the individual to significant functional impairment." These two groups would capture individuals who repeatedly commit self-harm in solitary confinement even when they are not

[13] Louis Favril. (2019). "Non-suicidal self-injury and Co-occurring Suicide Attempt in Male Prisoners." *Psychiatric Research*, available at <https://pubmed.ncbi.nlm.nih.gov/31102884/>

[14] Judith Herman points out that individuals diagnosed Borderline Character Disorder very often have multiple severe traumas in their background. J. Herman, Trauma and Recovery, Basic Books, 1992.

[15] Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal., 1995).

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diagnosed with Schizophrenia or Bipolar Disorder.

The strongest root "cause" of prison suicide is solitary confinement itself. In that light, self-harm in solitary is iatrogenic. The self-harm and the suicide are iatrogenic in the sense the prisoner known to be at very high risk of suicide or self-harm is sent to the place we know is correlated very strongly with self-harming and suicidal behavior. And typically, mental health staff perform a pre-segregation evaluation and approve the individual's return to solitary confinement.

We need to properly diagnose the mental disorder expressed in suicidal and self-harming behaviors. We need to assess the role of prior traumas and current anxieties. We need to halt the stigmatization of individuals who, under unendurable stress in a solitary cell, resort to cutting and other acts of self-harm "to control the anxiety" or to "feel better when the physical pain takes my mind off the psychological pain." And we need to halt the practice of returning a prisoner to a solitary confinement cell immediately after he or she is discharged from Suicide Observation. There is too high a risk of repeat acts of self-harm. Too many deaths and irreversible damage occur, even by accident. The alternative to returning the self-harming prisoner to solitary confinement is transfer to a mental health setting, perhaps a "stepdown" residential mental health treatment unit within the prisons. A basic principle of the Hippocratic Oath sworn by physicians is "first, do no harm." We know that certain prisoners are going to cut or mutilate themselves in solitary confinement, and we know that they never harm themselves when they are out of solitary confinement. Solitary confinement is a first order cause of self-harm and suicide in prison. What sense does it make to transfer a self-harming or suicidal individual back into solitary confinement soon after he self-harms and spends a short time in Suicide Observation? ■