Department of Applied Psychology

Applied Psychology OPUS

Effects of Solitary Confinement on the Well Being of Prison Inmates

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In the United States, approximately 80,000 inmates are placed in solitary confinement each year (Dingfelder, 201 2). Sensory stimulation and social contact are extremely limited in solitary confinement. Typically, confined inmates are alone in their cells for twenty-three hours a day (O'Keefe, 2008; Bonta & Gendreau, 1990; Smith, 2006). While these conditions vary depending on the prison, the average period of time in solitary confinement is thirty-seven days (Smith, 2006). Solitary confinement is often used to prevent particularly risky inmates from escaping, to keep an inmate from harming other inmates and staff, or to punish an inmate for misconduct occurring within the prison (O'Keefe, 2008; Weir, 2012; Smith, 2006).

Despite the frequent use of solitary confinement in prisons, there has been a continuous debate over the effectiveness of this experience on rehabilitating prisoners' behavior (Briggs, Sundt, & Castellano, 2003). While some research defends solitary confinement as a humane practice, the majority of research suggests a wide range of psychological and physiological effects associated with solitary confinement (Haney, 2003; Shalev, 2008; Smith, 2006). Given that approximately twenty-two percent of prisoners are already experiencing psychological symptoms upon incarceration, it is imperative to identify the effects of solitary confinement on inmates (Smith, 2006). Understanding the psychological and physical effects of solitary confinement can help policymakers determine whether solitary confinement should continue to be used in prisons (Smith, 2006). Therefore, this review of the existing literature will examine the psychological and physiological effects of solitary confinement on the well being of prison inmates.

Physiological Effects of Solitary Confinement

Confined inmates often experience various physiological symptoms, even after a short amount of time in confinement. Isolated inmates often report symptoms similar to those of hypertension, such as chronic headaches, trembling, sweaty palms, extreme dizziness and heart palpitations. (Smith, 2006; Haney, 2003; Shalev, 2008). Inmates also experience trouble with their eating and digestion, especially within the first three months of solitary confinement (Smith, 2006). A lack of appetite and drastic weight loss is often accompanied with irregular digestion, particularly diarrhea. Inmates in isolation may also have difficulty sleeping, and some may experience insomnia (Smith, 2006; Haney, 2003). Consequently,, inmates report feelings of chronic lethargy (Shalev, 2008).

While some of these effects may be physical manifestations of psychological stress related to the isolation, other physiological effects may be directly caused by the inmates' physical state of confinement. For example, inmates complain of abdominal pains, as well as muscle pains in the neck and back, which may be caused by the long periods of inactivity (Smith, 2006; Shalev, 2008). Further, many researchers conclude that some adverse consequences of solitary confinement are a direct result of sensory deprivation (Smith, 2006; Shalev, 2008). Confined inmates may experience an increased oversensitivity to normal stimuli, such as the sound of closing doors, something that may contribute to sleeping difficulties (Smith, 2006). The increased likelihood that inmates will overreact to stimuli makes their return into the general prison population much more difficult (Smith, 2006). These physical symptoms may worsen with repeated visits to solitary confinement and aggravate already existing psychological symptoms, as well as lead to the development of new psychological effects (Shalev, 2008).

Psychological Effects of Solitary Confinement

Confined inmates experience a multitude of psychological effects, including emotional, cognitive, and psychosis-related symptoms (Smith, 2006; Shalev, 2008). Solitary confinement is considered harmful to the mental health of inmates because it restricts meaningful social contact, a psychological stimulus that humans need in order to remain healthy and functioning (Smith, 2006). Longer stays in solitary confinement are associated with greater mental health symptoms that have serious emotional and behavioral consequences. (Smith, 2006; Shalev, 2008).

Emotional and behavioral effects of solitary confinement. The majority of those held in solitary confinement experience adverse emotional effects that can range from acute to chronic, depending on the individual and the length of stay in isolation (Shalev, 2008). Confined prisoners also report feelings of panic and rage, including irritability, hostility, and poor impulse control. Additionally, they frequently exhibit symptoms of anxiety that vary from low levels of stress to severe panic attacks. Isolated inmates also experience symptoms of depression, such as hopelessness, mood swings, and withdrawal. These depressive symptoms may even escalate to thoughts of self-harm and suicide. As compared to the general prison population, rates of suicide and self-harm, such as cutting and banging one's head against the cell wall, are particularly high in prisoners assigned to solitary confinement (Haney, 2003; Shalev, 2008; Greist, 2012).

Many of the issues that confined prisoners have during isolation are also prevalent post-isolation. Those who are isolated also exhibit maladjustment disorders and problems with aggression, both during confinement and afterwards (Briggs et al., 2003). Furthermore, inmates often have difficulty adjusting to social contact post-isolation, and may engage in increased prison misconduct and express hostility towards correctional officers. (Weir, 2012; Dingfelder, 2012; Constanzo, Martinez, Klebe, Torrence & Livengood, 2012). While cases in which inmates have exhibited positive behavioral change after isolation have been documented, such a result is rare (Smith, 2006).

Cognitive effects of solitary confinement. In addition to having disruptions in their emotional processes, inmates' cognitive processes tend to deteriorate while they are in isolation. Some confined inmates report memory loss, and a significant portion of isolated inmates report impaired concentration (Smith, 2006; Shalev, 2008). Many are unable to read or watch television since these activities are their few sources of entertainment. Confined inmates also report feeling extremely confused and disoriented in time and space (Haney, 2003; Shalev, 2008).

Psychosis-related effects of solitary confinement. Another confinement related psychological symptom that inmates may experience is disrupted thinking, defined as an inability to maintain a coherent flow of thoughts. This disrupted thinking can result in symptoms of psychosis (Haney, 2003; Shalev, 2008). Inmates who exhibit these symptoms of psychosis often report experiencing hallucinations, illusions, and intense paranoia, such as a persistent belief that they are being persecuted (Shalev, 2008). In extreme cases, inmates have become paranoid to the point that they exhibit full-blown psychosis that requires hospitalization (Smith, 2006).

The aforementioned mental health difficulties are not anomalies. Confined inmates often describe feelings of extreme mental duress after only a couple of days in solitary confinement (Haney, 2003; Smith, 2006). Some researchers have even compared confined inmates to victims of torture or trauma because many of the acute effects produced by solitary confinement mimic the symptoms associated with post-traumatic stress disorder. It is unclear how long these symptoms persist after release from solitary, but they are at least prevalent during and immediately after solitary confinement for most inmates (Haney, 2003).

Conclusion

The existing literature demonstrates that solitary confinement has both significant physiological effects, such as gastrointestinal upset and hypertension, and psychological effects, including psychosis and depression (Shalev, 2008). These findings suggest that the physiological and psychological consequences of solitary confinement are extremely dangerous to the well being of inmates. However, research regarding psychological effects is limited by the fact that many inmates are mentally ill prior to incarceration, making it difficult to distinguish whether psychological symptoms are directly produced by solitary confinement. Additionally, research is limited by the settings in which the studies must be conducted. Naturalistic studies conducted in actual prisons do not have control groups (Constanzo et al., 2012; Smith, 2006), while studies using contrived settings are also limited because they cannot fully mimic the harsh conditions of prisons due to the researchers' ethical obligations. For example, the volunteers in studies using contrived settings are confined for much shorter periods of time compared to actual inmates (Bonta & Gendreau, 1990). Thus, these findings cannot be accurately compared to the real-life experiences of prisoners (Smith, 2006).

While these limitations must be considered, this research has serious implications for policy(Griest, 2012). Future evaluations of solitary confinement must be conducted to determine whether solitary confinement can be safely used in prisons or if it should be limited or eliminated (Griest, 2012). In addition, there is definite need to find alternative incarceration methods to effectively manage the behaviors of inmates without causing harm to their physical and mental health. Developing new incarceration methods is particularly important to ensure the well-being of confined inmates who are mentally ill prior to incarceration (Bonta & Gendreau, 1990).

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