

An Ethical Analysis of Solitary Confinement in U.S. Prisons

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INTRODUCTION

Solitary confinement, also known as segregation, is used in the American prison system as the harshest sentence an inmate can receive short of capital punishment. According to Beck (2015), the practice is fairly common, with nearly 20% of all inmates having been placed in restrictive housing or solitary confinement within a year of placement. Confinement generally takes place for extended periods of time, as Beck states that nearly half of these inmates had spent no fewer than 30 days in their sentenced restrictive housing or solitary confinement. Apart from the ethics of solitary confinement from a humanitarian standpoint, as the American Civil Liberties Union has deemed the practice a violation of human rights, the psychological effects of confinement also call into question its widespread use in the prison system, both nationally and globally. Grassian (1983) reported that, by 1830, medical evidence began to show an increase of “insanity” among prisoners exposed to “especially rigid forms of solitary confinement.” Since then, numerous studies have been conducted internationally linking segregation and the onset of mental illness, ranging in severity from anxiety and depression

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to schizophrenia and psychosis. Solitary confinement's ability to induce hallucinations and cause the onset of psychosis poses the question of whether the practice is ethical and should be continued. Due to the wide scope of international prison systems, this investigation will specifically focus on the American prison system; however, the practice of solitary confinement is used globally. Three main ethical perspectives and frameworks (medical, legal, and prison) will be used to assess the ethics of this practice.

BACKGROUND

There are multiple ways that a prisoner may be placed in solitary confinement, the first of which is a court-ordered sentence. In these cases, the justification for confinement is not only for punishment purposes, but also for the protection of other inmates from physical harm. However, prisoners who are not sentenced to solitary confinement can still be placed in it as a punishment for unruly behavior, referred to as disciplinary confinement. Despite the severity of solitary confinement, Shames (2015) found that, in Illinois, 85% of prisoners who were released from disciplinary solitary confinement were placed there for relatively minor infractions, such as not following orders and using vulgar language. The same report discussed an inmate in South Carolina who was placed in segregation for 37 years for posting to Facebook on 38 different days. Prisoners who are part of minority groups, such as people of color and members of the LGBT community, can also be placed in segregation, commonly known as protective custody, as a form of protection from other inmates.

The physical conditions of confinement vary greatly by prison, including the size and features of cells, as well as time allotted to spend outside of the cell or socializing. In one study, Metzner (2010) reports the conditions of a supermax prison,

describing “tens of thousands of prisoners spend[ing] years locked up 23 to 24 hours a day in small cells.” He outlines their daily routines as having little to no social interaction, environmental stimuli, or “purposeful” activities. At the Maine State Prison, Benjamin (1975) highlights that inmates have absolutely no human contact for the first 15 days of their sentence, then have restricted visitation at the warden’s discretion. Apart from these visits, the Maine inmates were “deprived of all human contact.” The cells themselves are barren, according to Grassian (1983), with little lighting and plain steel furniture in a cell about 50 square feet large. While some prisons do have programs in place to increase the mental stimulation and socialization of inmates held in segregation, these programs are uncommon in the American prison system.

The lack of stimulation that arises from these physical conditions has a detrimental effect upon the mental health of inmates. Sensory deprivation has a direct link to derealization, perceptual distortions, and hallucinations, as reported by Burnett (1994), eventually causing the onset of illnesses such as schizophrenia and Ganser syndrome (Andersen 2001). This is attributable to a similar phenomenon as the origin of Charles Bonnet Syndrome, in which individuals with vision or hearing impairments begin to experience hallucinations through their impaired senses. As the brain requires constant stimulation to form perception, the absence of new input, which prisoners in solitary confinement experience, can cause the brain to fill in gaps with auditory, visual, and bodily hallucinations. According to Illingworth (2014), prisoners are already at a “substantially higher risk” for depression and psychotic illnesses than the general population, reporting an average 12.3 percent prevalence for depression and a 3.8 percent prevalence for psychotic illness. Placing these at-risk individuals under the harsh conditions of isolation, which Metzner (2010) claims is

“as clinically distressing as physical torture,” essentially guarantees the individual’s likelihood to develop such an illness.

Prisoners who are placed in solitary confinement for only a short period of time can still experience severe psychological effects from the lack of social engagement and sensory deprivation, such as “anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis” (Metzner 2010). Grassian (1983) notes that the speed of onset varies by patient, which is partially attributed to the conditions of the cell, such as light exposure and soundproofing. A study by Mason (2009) found that “an anechoic chamber produced a high incidence of auditory and visual hallucinations even within an hour.” Illingworth (2014) found that, after three months in prison, inmates held in solitary confinement experienced visual hallucinations, changed perception, derealization, and depersonalization, while non-solitary confinement inmates displayed none of these symptoms.

As prisoners are kept in segregation for a long period of time, these short-term effects can manifest into full-blown psychosis. According to Andersen (2000), the incidence of psychiatric disorders among inmates kept in solitary confinement (28%) was nearly double that of non-solitary confinement inmates. The differences in psychosis prevalence rates based on the confinement status of an inmate are clearly linked to the conditions of segregation. A study by Grassian (1983) highlighted that, in a 55-year period, 37 articles were published in German journals analyzing hundreds of cases of psychosis that were reactive to prison conditions. Over half of the articles in this group specifically reported solitary confinement as responsible for causing the psychosis, noting that prisoners showed quick improvement once removed from

solitude. The mental illnesses that inmates develop from segregation are then further worsened by its conditions, as stated by Metzner (2010), with continued sensory deprivation causing severe psychotic symptoms and significant functional impairments. Thus, not only does solitary confinement have definitive links with sparking the onset of hallucinations and psychotic disorders, but the nature of the practice also worsens the symptoms of these conditions.

CASE STUDIES

Several existing studies about the psychiatric effects of solitary confinement include case studies and anecdotes to provide examples of how isolation has varied detriments. Benjamin (1975) includes quotes from inmates at the Maine State Prison who describe difficulty with maintaining a sustained train of thought and frequent daydreaming. These symptoms, clinically referred to as thought disorder and delusions, are common positive symptoms of schizophrenia. He also discusses several inmates reporting vivid hallucinations, with one insisting ““that a tiny spaceship had got into the chamber and was buzzing around shooting pellets at him.”” The following two case studies provide an in-depth illustration of the spectrum of symptoms that inmates can experience, such as bodily hallucinations and delusions.

PATIENT FROM BURNETT ET AL. 1994

In his 1994 study, Burnett discusses the case of a patient imprisoned at age 14 for the murder of his mother’s boyfriend, who was noted to have abusive tendencies towards both the patient and his mother. By age 21, the patient was moved to an adult prison and placed in solitary confinement at age 24. He was kept in his segregation unit for at least 23 hours a day for

over a year. During this time, the patient began to experience bodily hallucinations associated with masturbation, believing that his body would physically deteriorate with each instance of him masturbating. His concerns about his physical state led to prison doctors performing multiple medical tests upon him, each of which indicated no physical ailment or change in the patient's physical wellbeing. He was prescribed antipsychotic medications, but refused to comply with treatment because he was convinced that his condition was purely physical. The patient was eventually admitted to the hospital, but still would not comply with any treatment plans involving medication. The end of Burnett's report states that the patient continued to suffer from his delusions and bodily hallucinations, despite his placement in therapy.

FRANK DEPALMA

In a 2019 interview published by *The Marshall Project*, former Ely Maximum Security Prison inmate, Frank DePalma, discusses his experiences with solitary confinement. He was initially placed in a segregation unit as a form of protective custody to be separated from imprisoned gang members, but was later kept there because of a violent outburst. DePalma was kept in solitary confinement for over 22 years, during which his human contact was limited to only interactions with the guards stationed outside his cell. He soon developed agoraphobia, a fear of crowded or enclosed public spaces, and was physically unable to leave his unit without having a mental break. DePalma recounted bodily hallucinations with feelings of being "between two pillars of concrete that were moving and crushing [him]." The severity of DePalma's agoraphobia caused him to refuse to set foot outside his cell for the last five years of his sentence.

DePalma also experienced strong delusions and fantasies while he was kept in solitary confinement, a coping mechanism to detach himself from the reality of long-term segregation. He recounted:

Little by little I started divorcing myself from everyone I had known in my life before solitary. I would live in fantasies. I would create relationships with imaginary people, and I'd fall in love with them, sometimes for months... Even that got to be so painful because there's nothing so miserable as unrequited love.

DePalma considers these delusions to be a natural neurological response to the conditions of isolation, writing that, "Being in a cell like that with nothing, all you got is your mind, and it's already warped from years of fighting to stay alive, it's not right. It's not human, it's not normal."

After more than twenty years in confinement, DePalma was sent to a psychiatric hospital with extremely limited speech capabilities and an unwillingness to be outside of his cell. He was in the ward for ten months before being reintegrated into the general population of the prison. Four years later, DePalma was released altogether, after a total of 42 years served in prison, but still suffers from frequent mental breaks due to his agoraphobia.

ETHICAL DISCUSSION

An analysis of the ethics of solitary confinement cannot be conducted without a clearly established ethical framework to compare the practice and its effects. There are three critical perspectives, each of which has their own ethical frameworks, to consider: medical, legal, and prison perspectives. While these perspectives may conflict with one another, they are important to consider in conjunction because of the intersectionality of the issue.

MEDICAL PERSPECTIVE

The medical perspective provides the most direct answer to the ethics of confinement. Placing individuals, especially those deemed high risk for developing psychiatric illnesses, in an environment which is clinically associated with the onset of serious psychotic conditions essentially guarantees them the contraction of later mental illness. A medical endorsement of solitary confinement in the American prison system would be an approval of the intentional allowance of patients to become ill, a violation of the core goals of the medical community to heal. While offering mental health resources to inmates in solitary confinement is preferable to providing none, the most medically ethical path would be to discontinue the practice altogether, especially for prisoners who are diagnosed with an existing major mental disorder or those considered high risk due to family history.

LEGAL PERSPECTIVE

The most important clause to consider in the legal perspective is the 8th Constitutional Amendment, which prohibits “cruel and unusual punishment.” A number of American court cases have taken place over the matter of solitary confinement, most of which do not deem confinement a cruel and unusual punishment in itself. However, according to Benjamin (1975), the effects of isolation do potentially qualify as unconstitutional. An article on a prisoner’s constitutional rights published by the University of Washington’s Law Review states that, in 1910, the phrase “cruel and unusual punishment” was deemed as a fluid definition and not solely applicable to torture and violence. The article highlights that, in the case *Sostre v. McGinnis*, solitary confinement itself is not

unconstitutional unless the conditions threaten the health of the inmates or the sentence is disproportionate to the crime.

As solitary confinement has been proven to have detrimental mental health effects, this interpretation is consistent with the medical perspective, as both concur that it is unethical to place inmates in conditions which actively compromise their health. Similarly, the ruling from *Wright v. McMann* argues that the conditions of solitary confinement are intolerable and threaten the sanity of inmates. Thus, while the physical act of solitary confinement may seem ethical from a legal standpoint, the psychological effects of isolation are what make the practice unconstitutional.

Additionally, the ruling from *Sostre v. McGinnis* states that a sentence to segregation is unconstitutional if it is “disproportionate” to the crime, calling the use of disciplinary isolation and protective custody into question. As Shames (2015) reports, a majority of inmates released from disciplinary solitary confinement were originally placed there for minor infractions. In an interview with *Slate*, Terrence Slater recalled being sent to a segregation unit for refusing to level scoops of food because he deemed them too small of food portions for the inmates. Benjamin (1975) attributes the tendency of guards to readily sentence inmates to solitary confinement to the power complex of prisons. Furthermore, those placed in segregation for protective custody did not commit any infractions to justify their punishment, especially considering that these inmates are subject to the same conditions as all others held in solitary confinement (Shames 2015). Thus, according to this perspective, confinement is not a legally ethical or constitutional practice for inmates who commit minor infractions while in prison or those in protective custody.

PRISON PERSPECTIVE

The ethics of solitary confinement from a prison perspective rest largely upon the question of whether the justice system exists to punish law-breakers or rehabilitate them. DeLuca (1991) lists the four objectives of the criminal justice system: deterrence, punishment, incapacitation, and rehabilitation. The court case *Lollis v. New York* ruled that “isolation as a ‘treatment’ is punitive, destructive, defeats the purpose of any kind of rehabilitation efforts and harkens back to medieval times” (Benjamin 1975). With its harsh psychological effects upon inmates, segregation is exclusively a punishment to inmates, offering little opportunity to prisoners for rehabilitation if there is no supplemental programming. Shames (2015) states that tens of thousands of inmates are released annually directly from solitary confinement into the community without any restorative or rehabilitative programming. Regardless, when inmates are released from confinement, they may still suffer from mental illnesses from their time in segregation, a result that would continue to punish them mentally and prevent them from being fully rehabilitated.

Another ethical grey area within this perspective is when confinement is used as a protective measure for inmates who may experience violence when integrated in the prison’s entire population, known as protective custody. While solitary confinement is too harsh of a punishment for inmates who are only placed in it for protective reasons, it would also not be ethical to knowingly place prisoners in an environment where they may be physically harmed or even killed by other inmates. Therefore, it is ethical to separate minorities who require protective custody, but not to subject them to the harsh punishment of solitary confinement with no provocation.

ALTERNATIVE PRACTICES

Bearing these various perspectives in mind, solitary confinement is a largely unethical practice, especially when it is disproportionate to the crime that an inmate committed or the cause of serious psychological damage. Therefore, it is vital to consider alternative practices to create a more ethical justice system within all of these frameworks.

One of the largest areas for reform is in implementing a pre-screening process to assess inmates for their risk of psychosis. According to Beck (2015), 29% of inmates with symptoms of “serious psychological distress” spent time in confinement within the past 12 months. Staying in isolation with a serious psychiatric illness only worsens the severity of the symptoms; thus, preventing at-risk individuals from ever entering confinement would be the most ethical choice for American prisons. Pre-screenings could be designed to analyze the inmate’s family history and schizotypal behaviors. Not only would these pre-screenings be used to prohibit certain inmates from being placed in solitary confinement, but they would also highlight which prisoners need additional support from mental health resources during their sentence.

For inmates who are sentenced to solitary confinement, an important reform measure would be to reduce the sensory deprivation they are subjected to. This could include simple measures such as increasing time spent outside cells, implementing regular social interaction with other inmates, or providing menial tasks for inmates to complete. A more advanced version of this concept is the Bard Prison Initiative, one of two dozen selective programs in which prisoners are permitted to take college-level classes during their sentence and earn a degree upon release. This privately-funded program appeals to the perspective that prisons exist to rehabilitate inmates alongside their punishment rather than exclusively punish them for their crimes.

Although Metzner (2010) states that many elected officials are hesitant to provide more restorative practices due to “scant public support for investments in the treatment (as opposed to punishment) of prisoners,” the positive outcomes of a rehabilitatory approach emphasize the importance of implementing such programs. Hardiman (2019) highlights that the reincarceration rate among participants in the Bard Prison Initiative is four percent, compared to national averages between 40 and 60 percent. She also mentions the disproportionate incarceration of African Americans and low-income Americans, many of whom are raised in communities with a poor education system, which creates a cyclical effect of these groups not having proper access to education, thus resorting to crime. Gerard Robinson, scholar at the American Enterprise Institute, commented that, “The right thing to do is not only give them a second chance, but to also admit the fact that many of them didn't receive a first chance.”

Not only should the quality of solitary confinement be improved to make the practice more ethical for those sentenced to isolation, but the total number of people kept in isolation can also be reduced for inmates under disciplinary confinement and protective custody. The standards for what constitutes segregation must be increased beyond an inmate using vulgar language or disobeying vague commands to make the punishment proportional to the infraction. Standardizing the qualifications for disciplinary segregation on a state or federal level would reduce abuses of this practice at the jurisdiction of prison guards. Additionally, a more ethical approach to protective custody would be to create specialized housing units for minority groups who qualify for protections to live in together, rather than subjecting those inmates to the same conditions as those sentenced to solitary confinement.

These alternative programs are not only more ethical sentences than solitary confinement, but also have clear economic benefits for American prisons. Shames (2015) states that the average cost per prisoner in segregation is two to three times that of a prisoner kept integrated among the general population. Additionally, Noguchi (2017) notes that the costs of educational restorative programs are far less than those of housing inmates because of the increased likelihood of inmates finding employment post-incarceration and decrease in reincarceration rates. Thus, while the initial costs of implementing these programs are higher than those of continuing current practices, they are an investment in society that have significant returns in the mental health of inmates and the effectiveness of the American prison system.

CONCLUSION

The practice of solitary confinement in the American prison system, whether punitive, disciplinary, or protective, has severe ramifications for the mental health of inmates, with links to hallucinations and psychosis from the sensory deprivation that inmates experience. These effects lead the practice to be deemed entirely unethical from a medical and legal perspective, as well as partially unethical when considering the need for prisons to have rehabilitative programming. Alternative practices, such as implementing mental health pre-screenings, educational programs, and reducing the number of non-sentenced inmates held in solitary confinement would serve to reduce the use of this practice and create a more ethical prison system. Possible areas for further research include analyzing the long-term effects of solitary confinement after release, evaluating screening methods for inmates at risk of psychotic illness, and examining the impact of restorative programming upon inmates' mental health.

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