Restraint
Reduction
Network

# Solitary confinement

## What is it and what should we do about it?

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# What is solitary confinement?

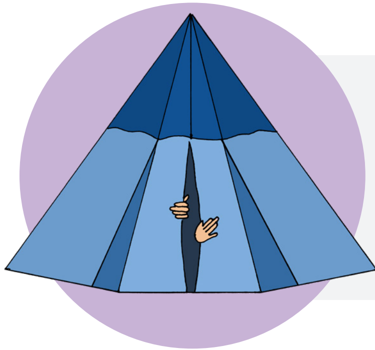
**Solitary confinement can be defined as enforced isolation from meaningful human contact.**

- Meaningful human contact is when people are able to communicate face-to-face with those they love (e.g., a loved one, friend or significant other) and receive empathy, warmth, and nurturance.
- Meaningful human contact does not include being with staff in institutions and/or talking to people through medical necessity.

# What practices does solitary confinement include?

Solitary confinement includes all practices that deny people meaningful human contact.

For example:



when a child is put in a time-out tepee in school;

when a person is put in a calming room, their bedroom, a sensory room, or locked in the garden;

when a person is locked in a seclusion room in an inpatient hospital, or housed in a segregation suite or purpose-built flat.

All of these practices result in disconnection from people and society. This is because, regardless of the size or functionality of the space, they all deprive people of meaning in their lives and the warmth gained through loving relationships.

# Is solitary confinement psychologically therapeutic?

Human beings are wired to connect (Leiberman, 2013; Mearns and Cooper, 2018). Scientific research across various disciplines shows that there is nothing psychologically therapeutic about confining people (Haney, 2019). Since 1960 it has been known that solitary confinement, even for a short time, can result in *deep emotional disturbances* (Cormier and Williams, 1966; Toch, 1975).

Recent studies confirm that people can suffer anxiety, panic, a sense of emotional impending doom, hypersensitivity, irritability, aggression, rage, ruminations, paranoia, hallucinations, cognitive dysfunction, loss of emotional control, mood swings, hopelessness, depression, social withdrawal, self-harm and suicidal thoughts and behaviour when they are confined to sensory and socially deprived spaces (Cloyes et al., 2006; Frottier, 2007; Guenther, 2013; Grassian, 2006; Haney, 2003; Haney, 2018; Haney, 2019; Haney and Lynch, 1997; Smith, 2006).

# If a person is in solitary confinement for a short time (e.g., seclusion), does it still result in harm?

It doesn't matter whether a person is confined for a long or a short time – they are still likely to be harmed by the experience. Many people say they have immediate aversive reactions (Haney, 2019).

**Isolation panic**, for instance, is suffered at the time of confinement or shortly after being isolated (Toch, 1975). Isolation panic includes experiences of rage, loss of control, breakdowns in wellbeing, psychological regression and increases in self-harm.

Suicide and self-harm are more likely to occur in confinement and in the immediate period after confinement (Frottier, 2007).

# The longer the isolation, the greater the harm

The harms people experience from solitary confinement are dose dependant (Haney2019). This means that the more people experience solitary confinement, whether in frequency or length of isolation, the greater the harm.

The more people are exposed to solitary confinement, the more they will be forced to adapt and adjust to the poverty-ridden social and sensory space. Because all people are different, there will be variations in how people respond to each dose of confinement; not every person will suffer every adverse side effect.

That said, the practice is stressful and painful. When people come to expect disconnection and feel chronically alone, future social interactions become more difficult (Guenther, 2013; Haney, 2019).

An inability to build and maintain meaningful relationships impairs all areas of people's lives, e.g., home, family, work, social etc.

**Solitary confinement can create and sustain risks of harm and are reflected in the difficulty of moving people out of confinement.**

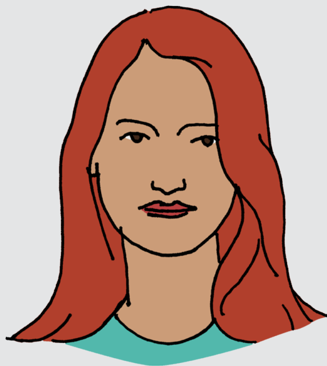
# What are the long-term psychological impacts of being denied meaningful human contact?

People eventually *adjust* to confinement (Haney, 2019).

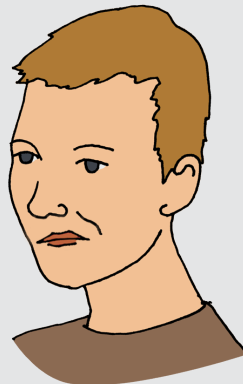
Adjusting to confinement does not mean the experience is less painful. People have told us they feel *"empty"*, *"unable to get close to others"* and believe *"they will not feel close to another person again."*

People might also *adjust* to the sensory deprivation and find normal rooms, people and interactions unpredictable and difficult to cope with. People have told us:

*"I got overwhelmed if there was someone in the room or if there was a noise."*



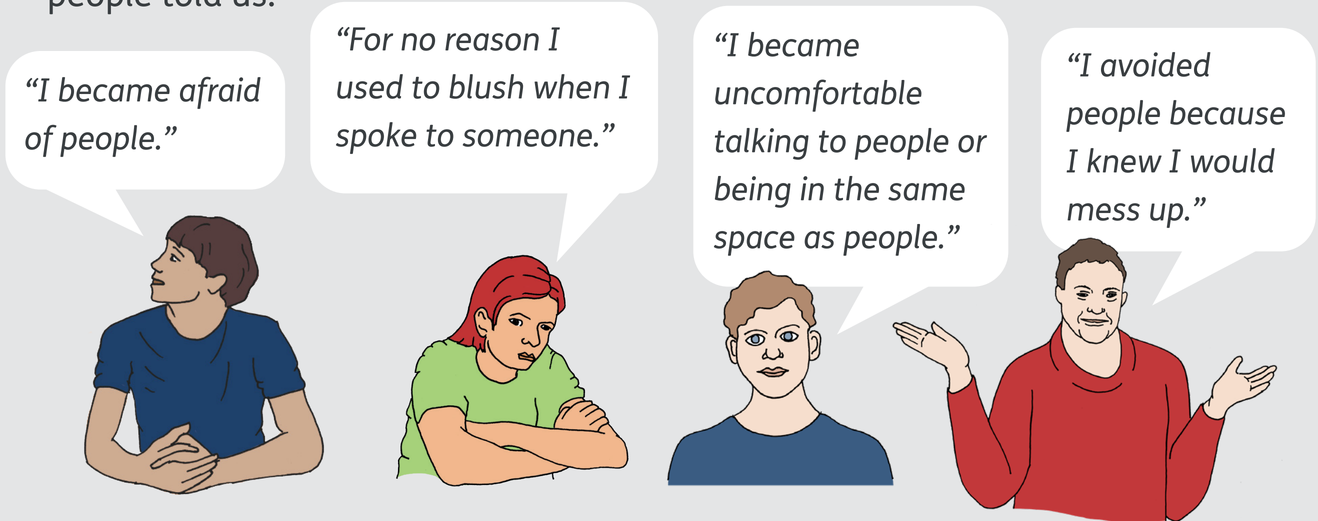
*"I was scared of conversations because I didn't know what to do."*



*"I wasn't used to it* [being with people] *anymore and would kick off because I could only cope with silence."*

## People develop chronic strategies of disconnection (Stern, 2003; Mearns and Cooper, 2018).

This means that to cope with the painful, asocial nature of confinement, people might push others away to protect themselves from being hurt in relationships. For example, they might convince themselves they do not need people. Some people told us:




Adaptations to sensory and socially deprived spaces are particularly problematic for autistic people whose adaptive behaviour is then seen as a symptom of their disorder!

## People's psychological adaptations interfere with their ability to lead a fulfilling (social) life and can result in social death.

Alexis Quinn, from the UK, describes an inability to feel deep positive emotion for people after being confined for both short and longer periods of time. In her book, *Unbroken*, she describes no longer having the capacity to connect deeply with people.

Alexis says, *"I lost my identity, my family and everything I cared about. I am lost without any anchor point – I don't know who I am anymore. It's very confusing. Now, I long for closeness and having relationships. I am fearful of people and think I have lost the ability to love and trust again."*

Alexis's experience is consistent with that described by Guenther (2013) as **social death**.

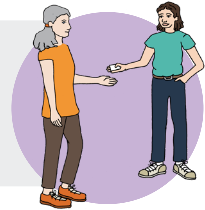
# What we need to do

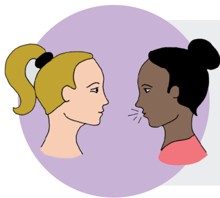
We must accept that denying people meaningful contact exposes them to psychologically painful and harmful experiences. The longer confinement continues, the greater the harm (Haney, 2019). Social death can and does result from disconnection and this has deep, devastating, long lasting effects.

Where solitary confinement is practiced, staff must realise and be honest about the damage the practice is inflicting. **Staff should:**

Recognise confinement is not therapeutic and can be devastating.

Remove the need for hypervigilance and pervasive distrust so that people can establish authentic selves, increase their agency and gain opportunities to develop cooperative trust.



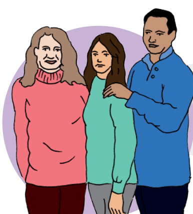


Work proactively to ensure that people have good, meaningful relationships with staff. Even if this is restricted to one or two staff in a team, that is valid – no one can like everyone.

Work relationally to provide people with outlets to discuss, share and have their pain and distress acknowledged.

Make every effort to ensure people maintain daily connections with family, friends and the home environment.

Ensure people have access to activities they find meaningful both within and out of the confinement space.



Ensure confinement is for the shortest time possible.

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