
Mental Health Issues in Long-Term Solitary and “Supermax” Confinement

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This article discusses the recent increase in the use of solitary-like confinement, especially the rise of so-called supermax prisons and the special mental health issues and challenges they pose. After briefly discussing the nature of these specialized and increasingly widespread units and the forces that have given rise to them, the article reviews some of the unique mental-health-related issues they present, including the large literature that exists on the negative psychological effects of isolation and the unusually high percentage of mentally ill prisoners who are confined there. It ends with a brief discussion of recent caselaw that addresses some of these mental health issues and suggests that the courts, though in some ways appropriately solicitous of the plight of mentally ill supermax prisoners, have overlooked some of the broader psychological problems these units create.

Keywords: supermax; solitary confinement; effects of imprisonment

The field of corrections is arguably impervious to much truly significant change. Of all of the institutions in our society, prisons retain the greatest similarity to their early 19th century form. Indeed, until relatively recently, more than a few prisoners were housed in facilities that had been constructed a half century or more ago. Although there have been advances in the methods by which correctional regimes approach the task of changing or rehabilitating prisoners, and a number of improvements made in overall conditions of confinement compared to the 19th century (often brought about by litigation compelling prison systems to modernize and improve), many of the basic facts of prison life have remained relatively constant. Notwithstanding increased sophistication in the technology of incarcerative social control, and the waxing and waning in popularity of one or another kind of prison treatment program, the argument that there has been nothing fundamentally new on the correctional landscape for many years would be difficult to refute.

However, in this article, I suggest that the last decade of the 20th century did see the rise of a new penal form—the so-called supermax prison. Increasing numbers of prisoners now are being housed in a new form of

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solitary or isolated confinement that, although it resembles the kind of punitive segregation that has been in use since the inception of the prison, has a number of unique features.¹ At the start of the 1990s, Human Rights Watch (1991) identified the rise of supermax prisons as “perhaps the most troubling” human rights trend in U.S. corrections and estimated that some 36 states either had completed or were in the process of creating some kind of “super maximum” prison facility. By the end of the decade, the same organization estimated that there were approximately 20,000 prisoners confined to supermax-type units in the United States (Human Rights Watch, 2000) and expressed even more pointed concerns about their human rights implications. Because most experts agree that the use of such units has increased significantly since then, it is likely that the number of persons currently housed in supermax prisons is considerably higher.

There are few if any forms of imprisonment that appear to produce so much psychological trauma and in which so many symptoms of psychopathology are manifested. Thus, the mental health implications of these units are potentially very significant. Despite the slight (and sometimes not so slight) variations in the ways different state prison systems approach this most restrictive form of confinement, supermax prisons have enough in common to permit some generalizations about what they are, why they have come about, what special mental health issues they raise, and how they might be regulated and reformed to minimize some of the special risks they pose. I will try to address each of these issues in turn in the pages that follow.

SUPERMAX CONDITIONS OF CONFINEMENT

Supermax confinement represents a significant variation in the longstanding practice of placing prisoners in what is known as solitary confinement or punitive segregation. For practical as well as humanitarian reasons, prisoners have rarely been confined in literal or complete solitary confinement.² But prisoners in solitary or isolation have always been physically segregated from the rest of the prison population and typically excluded from much of the normal programming, routines, opportunities, and collective activities available in the mainline institution. By the late 19th century, most jurisdictions in the United States had, for the most part, restricted solitary confinement to relatively brief periods of punishment that were imposed in response to specified infractions of prison rules.³

In contrast to this traditional form of isolation, supermax differs in several important ways—primarily the totality of the isolation, the intended duration of the confinement, the reasons for which it is imposed, and the technological

sophistication with which it is achieved. In particular, supermax prisons house prisoners in virtual isolation and subject them to almost complete idleness for extremely long periods of time. Supermax prisoners rarely leave their cells. In most such units, an hour a day of out-of-cell time is the norm. They eat all of their meals alone in the cells, and typically no group or social activity of any kind is permitted.⁴

When prisoners in these units are escorted outside their cells or beyond their housing units, they typically are first placed in restraints—chained while still inside their cells (through a food port or tray slot on the cell door)—and sometimes tethered to a leash that is held by an escort officer. They are rarely if ever in the presence of another person (including physicians and psychotherapists) without being in multiple forms of physical restraints (e.g., ankle chains, belly or waist chains, handcuffs). Supermax prisoners often incur severe restrictions on the nature and amounts of personal property they may possess and on their access to the prison library, legal materials, and canteen. Their brief periods of outdoor exercise or so-called yard time typically take place in caged-in or cement-walled areas that are so constraining they are often referred to as “dog runs.” In some units, prisoners get no more than a glimpse of overhead sky or whatever terrain can be seen through the tight security screens that surround their exercise pens.

Supermax prisoners are often monitored by camera and converse through intercoms rather than through direct contact with correctional officers. In newer facilities, computerized locking and tracking systems allow their movement to be regulated with a minimum of human interaction (or none at all). Some supermax units conduct visits through videoconferencing equipment rather than in person; there is no immediate face-to-face interaction (let alone physical contact), even with loved ones who may have traveled great distances to see them. In addition to “video visits,” some facilities employ “tele-medicine” and “tele-psychiatry” procedures in which prisoners’ medical and psychological needs are addressed by staff members who “examine” them and “interact” with them over television screens from locations many miles away.

Supermax prisons routinely keep prisoners in this near-total isolation and restraint for periods of time that, until recently, were unprecedented in modern corrections. Unlike more traditional forms of solitary confinement in which prisoners typically are isolated for relatively brief periods of time as punishment for specific disciplinary infractions, supermax prisoners may be kept under these conditions for years on end. Indeed, many correctional systems impose supermax confinement as part of a long-term strategy of correctional management and control rather than as an immediate sanction for discrete rule violations.

In fact, many prisoners are placed in supermax not specifically for what they have done but rather on the basis of who someone in authority has judged them to be (e.g., "dangerous," "a threat," or a member of a "disruptive" group). In many states, the majority of supermax prisoners have been given so-called indeterminate terms, usually on the basis of having been officially labeled by prison officials as gang members. An indeterminate supermax term often means that these prisoners will serve their entire prison term in isolation (unless they debrief by providing incriminating information about other alleged gang members).⁵ Prisoners in these units may complete their prison sentence while still confined in supermax and be released directly back into the community. If and when they are returned to prison on a parole violation or subsequent conviction, they are likely to be sent immediately back to supermax because of their previous status as a supermax prisoner.

To summarize: prisoners in these units live almost entirely within the confines of a 60- to 80-square-foot cell, can exist for many years separated from the natural world around them and removed from the natural rhythms of social life, are denied access to vocational or educational training programs or other meaningful activities in which to engage, get out of their cells no more than a few hours a week, are under virtually constant surveillance and monitoring, are rarely if ever in the presence of another person without being heavily chained and restrained, have no opportunities for normal conversation or social interaction, and are denied the opportunity to ever touch another human being with affection or caring or to receive such affection or caring themselves. Because supermax units typically meld sophisticated modern technology with the age-old practice of solitary confinement, prisoners experience levels of isolation and behavioral control that are more total and complete and literally dehumanized than has been possible in the past. The combination of these factors is what makes this extraordinary and extreme form of imprisonment unique in the modern history of corrections. Its emergence in a society that prides itself on abiding "evolving standards of decency" (*Trop v. Dulles*, 1958) to regulate its systems of punishment requires some explanation.

THE ORIGINS OF THE MODERN SUPERMAX

Two important trends in modern American corrections help to account for the creation of this new penal form. The first is the unprecedented growth in the prison population that started in the mid-1970s and continued into the early years of the 21st century. The rate of incarceration in the United States (adjusting for any increases in overall population) remained stable over the

50-year period from 1925 to 1975. Remarkably, it then quintupled over the next 25-year period. Most state prison systems doubled in size and then doubled again during this period, with no commensurate increase in the resources devoted to corrections in general or to programming and mental health services in particular (Haney & Zimbardo, 1998).

This dramatic influx of prisoners—and the overcrowding crisis it produced—occurred at approximately the same time that another important change was underway. In the mid-1970s, the United States formally abandoned its commitment to the rehabilitative ideals that had guided its prison policy for decades. Often at the insistence of the politicians who funded their prison systems, correctional administrators embraced a new philosophy built on the notion that incarceration was intended to inflict punishment and little else. The mandate to provide educational, vocational, and therapeutic programming in the name of rehabilitation ended at an especially inopportune time (Haney, 1997). Prisons throughout the country were filled to capacity and beyond, and the prisoners who were crowded inside had few opportunities to engage in productive activities or to receive help for preexisting psychological or other problems.

Under these conditions of unprecedented overcrowding and unheard of levels of idleness, prison administrators lacked positive incentives to manage the inevitable tensions and conflicts that festered behind the walls. In systems whose *raison d'être* was punishment, it was not surprising that correctional officials turned to punitive mechanisms in the hope of buttressing increasingly tenuous institutional controls. Of course, disciplinary infractions often were met with increasing levels of punishment in the modern American prison, even before these trends were set in motion. But the magnitude of the problem faced by correctional administrators in the 1980s pushed their response to an unprecedented level. Supermax prisons emerged in this context—seized on as a technologically enhanced tightening screw on the pressure cooker-like atmosphere that had been created inside many prison systems in the United States. As the pressure from overcrowding and idleness increased, the screw was turned ever tighter.

Historically, correctional polices often harden in times of prison crisis. But once the problem causing the increased tension or turmoil has been identified and resolved, the punitive response typically de-escalates, sometimes leading to even more hospitable conditions and treatment. Unfortunately, the prison overcrowding problem did not subside during the 1980s and 1990s, and the continued punitive atmosphere that marked this period meant that corrections officials were in no position look “soft” in the face of the crisis.

The politics of the era deprived prison administrators of alternative approaches and guaranteed a one-way ratcheting up of punishment in the face of these tensions. They became increasingly committed to more forcibly subduing prisoners whose behavior was problematic ("a threat to the safety and security of the institution"), taking fewer chances with others whom they suspected might be a problem, and set about intimidating everyone else who might be thinking about causing disruption. Supermax simultaneously provided politicians with another stark symbol to confirm their commitment to tough-on-crime policies (Riveland, 1999) and gave prison officials a way of making essentially the same statement behind the walls.

I belabor this recent correctional history to debunk several myths that surround the rise of the supermax prison form. This new kind of prison did not originate as a necessary or inevitable response or backlash to some sort of "permissive" correctional atmosphere that allegedly prevailed in the 1960s, as some who defend the recent punitive trends in imprisonment have suggested (cf. O'Brien & Jones, 1999). It was not a badly needed corrective to liberal prison policies or to previous capitulations to the prisoners' rights movement. Quite the opposite. Supermaxes began in response to the overcrowded and punitive 1980s and came into fruition in the even more overcrowded and more punitive 1990s. They are in many ways the logical extension of a system founded on the narrow premise that the only appropriate response to misbehavior is increased punishment.

In addition, there is no evidence that the rise of supermax prisons was driven by the threat of some new breed of criminal or prisoner. The natural human tendency to individualize, dispositionalize, and sometimes even to demonize problematic behavior, and to ignore the contextual forces that help create it, is intensified in prison systems as perhaps nowhere else. Thus, when correctional officials faced unprecedented pressures from dramatically increased levels of overcrowding and idleness, they naturally ignored the contextual origins of the problem (over which they had little or no control) and blamed the prisoners (over which they did).

But, even if supermax prisons now contain only "the worst of the worst"⁶—a phrase that is often used to justify the use of these newly designed units but whose accuracy is hotly disputed by their critics—there is no evidence that these allegedly "worst" prisoners are any worse than those who had been adequately managed by less drastic measures in the past. In assessing the benefits and burdens of supermax confinement, it is important to keep in mind that correctional officials have not been given a mandate to engage in such extraordinarily punitive and unprecedented measures because they now

confront not only an extraordinarily dangerous but new strain of prisoner that has never before existed. There is no such new breed and no such mandate.

*THE PSYCHOLOGICAL PAINS
OF SUPERMAX CONFINEMENT*

In assessing the mental health concerns raised by supermax prisons, it is important to acknowledge an extensive empirical literature that clearly establishes their potential to inflict psychological pain and emotional damage. Empirical research on solitary and supermax-like confinement has consistently and unequivocally documented the harmful consequences of living in these kinds of environments. Despite some methodological limitations that apply to some of the individual studies, the findings are robust. Evidence of these negative psychological effects comes from personal accounts, descriptive studies, and systematic research on solitary and supermax-type confinement, conducted over a period of four decades, by researchers from several different continents who had diverse backgrounds and a wide range of professional expertise. Even if one sets aside the corroborating data that come from studies of psychologically analogous settings—research on the harmful effects of acute sensory deprivation (e.g., Hocking, 1970; Leiderman, 1962), the psychological distress and other problems that are created by the loss of social contact such as studies of the pains of isolated, restricted living in the free world (e.g., Chappell & Badger, 1989; Cooke & Goldstein, 1989; Harrison, Clearwater, & McKay, 1989; Rathbone-McCuan & Hashimi, 1982), or the well-documented psychiatric risks of seclusion for mental patients (e.g., Fisher, 1994; Mason, 1993)—the harmful psychological consequences of solitary and supermax-type confinement are extremely well documented.

Specifically, in case studies and personal accounts provided by mental health and correctional staff who worked in supermax units, a range of similar adverse symptoms have been observed to occur in prisoners, including appetite and sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations, and self-mutilations (e.g., Jackson, 1983; Porporino, 1986; Rundle, 1973; Scott, 1969; Slater, 1986). Moreover, direct studies of prison isolation have documented an extremely broad range of harmful psychological reactions. These effects include increases in the following potentially damaging symptoms and problematic behaviors: negative attitudes and affect (e.g., Bauer, Priebe, Haring, & Adamczak, 1993; Hilliard, 1976; Koch, 1986; Korn, 1988a, 1988b; Miller & Young, 1997; Suedfeld, Ramirez, Deaton, & Baker-Brown, 1982), insomnia (e.g., Bauer et al., 1993; Brodsky &

Scogin, 1988; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b), anxiety (e.g., Andersen et al., 2000; Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Hilliard, 1976; Koch, 1986; Korn, 1988a, 1988b; Toch, 1975; Volkart, Dittrich, Rothenfluh, & Werner, 1983; Walters, Callagan, & Newman, 1963), panic (e.g., Toch, 1975), withdrawal (e.g., Cormier & Williams, 1966; Haney, 1993; Miller & Young, 1997; Scott & Gendreau, 1969; Toch, 1975; Waligora, 1974), hypersensitivity (e.g., Grassian, 1983; Haney, 1993; Volkart, Dittrich, et al., 1983), ruminations (e.g., Brodsky & Scogin, 1988; Haney, 1993; Korn, 1988a, 1988b; Miller & Young, 1997), cognitive dysfunction (e.g., Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b; Miller & Young, 1997; Suedfeld & Roy, 1975; Volkart, Dittrich, et al., 1983), hallucinations (e.g., Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b; Suedfeld & Roy, 1975), loss of control (e.g., Grassian, 1983; Haney, 1993; Suedfeld & Roy, 1975; Toch, 1975), irritability, aggression, and rage (e.g., Bauer et al., 1993; Brodsky & Scogin, 1988; Cormier & Williams, 1966; Grassian, 1983; Haney, 1993; Hilliard, 1976; Koch, 1986; Miller & Young, 1997; Suedfeld et al., 1982; Toch, 1975), paranoia (e.g., Cormier & Williams, 1969; Grassian, 1983; Volkart, Dittrich, et al., 1983), hopelessness (e.g., Haney, 1993; Hilliard, 1976), lethargy (e.g., Brodsky & Scogin, 1988; Haney, 1993; Koch, 1986; Scott & Gendreau, 1969; Suedfeld and Roy, 1975), depression (e.g., Andersen et al., 2000; Brodsky & Scogin, 1988; Haney, 1993; Hilliard, 1976; Korn, 1988a, 1988b), a sense of impending emotional breakdown (e.g., Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b; Toch, 1975), self-mutilation (e.g., Benjamin & Lux, 1975; Grassian, 1983; Toch, 1975), and suicidal ideation and behavior (e.g., Benjamin & Lux, 1975; Cormier & Williams, 1966; Grassian, 1983; Haney, 1993).

In addition, among the correlational studies of the relationship between housing type and various incident reports, again, self-mutilation and suicide are more prevalent in isolated housing (e.g., Hayes, 1989; Johnson, 1973; A. Jones, 1986; Porporino, 1986), as are deteriorating mental and physical health (beyond self-injury), other-directed violence, such as stabbings, attacks on staff, and property destruction, and collective violence (e.g., Bidna, 1975; Edwards, 1988; Kratcoski, 1988; Porporino, 1986; Sestoft, Andersen, Lilleback, & Gabrielsen, 1998; Steinke, 1991; Volkart, Rothenfluh, Kobelt, Dittrich, & Ernst, 1983). The use of extreme forms of solitary confinement in so-called brainwashing and torture also underscores its painful, damaging potential (e.g., Deaton, Burge, Richlin, & Latrownik, 1977; Foster, 1987; Hinkle & Wolff, 1956; Riekert, 1985; Shallice, 1974; Vrca, Bozikov, Brzovic, Fuchs, & Malinar, 1996; West, 1985). In fact, many

of the negative effects of solitary confinement are analogous to the acute reactions suffered by torture and trauma victims, including post-traumatic stress disorder or PTSD (e.g., Herman, 1992, 1995; Horowitz, 1990; Hougen, 1988; Siegel, 1984) and the kind of psychiatric sequelae that plague victims of what are called "deprivation and constraint" torture techniques (e.g., Somnier & Genefke, 1986).

To summarize, there is not a single published study of solitary or supermax-like confinement in which nonvoluntary confinement lasting for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects. The damaging effects ranged in severity and included such clinically significant symptoms as hypertension, uncontrollable anger, hallucinations, emotional breakdowns, chronic depression, and suicidal thoughts and behavior. Of course, it is important to emphasize that not all supermax prisons are created equal, and not all of them have the same capacity to produce the same number and degree of negative psychological effects. Research on the effects of social contexts and situations in general and institutional settings in particular underscores the way in which specific conditions of confinement do matter. Thus, there is every reason to expect that better-run and relatively more benign supermax prisons will produce comparatively fewer of the preceding negative psychological effects, and the worse run facilities will produce comparatively more.

THE PREVALENCE OF PAIN AND SUFFERING IN SUPERMAX

In addition to the serious nature and wide range of adverse symptoms that have been repeatedly reported in a large number of empirical studies, it is important to estimate their prevalence rates—that is, the extent to which prisoners who are confined in supermax-type conditions suffer its adverse effects. My own research at California's Pelican Bay "security housing unit" (or SHU)—a prototypical supermax prison at the time these data were collected—provides one such estimate. In this section, I describe this research in some detail and situate its findings by comparing them to prevalence rates among several other relevant groups.

In the Pelican Bay study, each prisoner was individually assessed in face-to-face interviews. Because the sample of 100 SHU prisoners was randomly selected, the data are representative of and, within appropriate margins of error, generalizable to the entire group of prisoners at this supermax facility.⁷ The following two important areas were explored in each interview. In the

TABLE 1: Symptoms of Psychological and Emotional Trauma

<i>Symptom</i>	<i>% Presence Among Pelican Bay SHU Prisoners</i>
Anxiety, nervousness	91
Headaches	88
Lethargy, chronic tiredness	84
Trouble sleeping	84
Impending nervous breakdown	70
Perspiring hands	68
Heart palpitations	68
Loss of appetite	63
Dizziness	56
Nightmares	55
Hands trembling	51
Tingling sensation ^a	19
Fainting	17

NOTE: SHU = security housing unit.

a. Not necessarily a symptom of psychological trauma. It is included as a control question to provide a baseline against which to measure the significance of the trauma-related responses.

first, one series of questions focused on whether the prisoner experienced any of 12 specific indices of psychological trauma or distress. A list of those symptoms regarded as reliable indicators of general psychological distress was employed. They were essentially the same indices of distress that Jones (1976) and others have used to assess mainline prison populations. In the second, a different series of questions was designed to determine whether the prisoner suffered any of 13 specific psychopathological effects of isolation. Based on previous research conducted by Grassian (1983) and others (e.g., Brodsky & Scogin, 1988; Korn, 1988a, 1988b), a list of isolation-related symptoms was developed and used to assess each prisoner in this regard.

The results of this prevalence study are depicted in Tables 1 and 2. As Table 1 indicates, every symptom of psychological distress but one (fainting spells) was suffered by more than half of the representative sample of supermax prisoners. Two thirds or more of the prisoners reported being bothered by many of these symptoms in the SHU, and some were suffered by nearly everyone. For example, virtually all of the isolated prisoners were plagued by nervousness and anxiety, by chronic lethargy, and a very high percentage (70%) felt themselves on the verge of an emotional breakdown. In addition, a very high number suffered from headaches and troubled sleep, and more than half were bothered by nightmares. Well over half of the supermax prisoners reported a constellation of symptoms—headaches, trembling, sweaty palms, and heart palpitations—that is commonly associated with hypertension.

