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Mental Health Stigmas in Formerly Incarcerated Individuals and the Impact of Solitary Confinement on Their Attitudes Toward Seeking Treatment

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Dedicated to Los Estudiantes Sabrosos.

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Abstract

Stigmas around mental health include both an individual's stigmas, as well as public stigmas, both of which impact whether or not an individual seeks treatment for their mental health problems. These attitudes toward mental healthcare translate into prison settings as well, where individuals are often afraid to seek treatment because of the way in which they could be stigmatized by the staff and other incarcerated individuals. Between the fear around how they might be perceived if others find out they are getting treatment for their mental health and the lack of reliable and efficient healthcare resources in correctional facilities, individuals in prison have difficulty getting proper care. Given these obstacles, individuals who have spent time in solitary confinement tend to develop health complications as well as mental health problems that specifically result from prolonged isolation. In this analysis, I reviewed the literature on mental health challenges faced by those who are incarcerated or have been in the past. I then proposed an interview and survey study to examine if having been in solitary confinement affects whether or not an individual will seek treatment post-incarceration. To examine what stigmas they might have against mental health treatment, participants would complete the Self-Stigma of Seeking Help Scale (Vogel, Wade, & Haake, 2006), and the The Attitude Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). The results of these surveys, as well as the interview responses, would be analyzed to explore connections between seeking help post-incarceration and prior time in solitary confinement.

Chapter 1: Introduction

Of the 1.2 million people currently incarcerated in the United States, 43% have been diagnosed with a mental disorder, but 66% reported not receiving any mental health care during their incarceration (Prison Policy Initiative, 2023). In a recent study, Canada, Barrenger, Bohrman, Banks, & Peketi (2022) examined the mental health resources available within prisons, and the experiences that incarcerated individuals have when using these resources. Through this study, Canada et al. concluded that there is a complex and troubling relationship between mental health problems and incarceration. First, they pointed out that those suffering from mental health problems are incarcerated at a higher rate than those who are not, and – related – post-incarceration, those with mental illnesses are often at a higher risk of re-incarceration.

Canada et al. further observed that, although most prisons do provide physical health care, only some also provide mental health care. Adding to the problematic relationship between incarceration and lack of mental health care, there are also factors that deter incarcerated people from seeking out resources to improve their mental health. For example, participants in the study reported a consistently low quality of mental health (and other) care while in prison, staff interactions that both negatively impacted their health and kept them from seeking help, and concerns about being stigmatized by other incarcerated individuals and correctional officers. All these factors negatively influenced their likelihood to seek psychological help when they felt they needed it (Canada et al., 2022).

Despite these many hurdles, participants in the Canada et al. study all utilized the health services offered at the prison at least once during their incarceration. Many shared similar

experiences surrounding the urgency of their concerns, and the lack of consistent timeliness in these being addressed. The timeframe for getting a response to their mental health issues while in prison ranged from 24 hours to several months. Some of the common types of interactions that these individuals reported having included that their providers were not sufficiently trained to address their problems, or the providers would not believe the individual's reports about having a medical/health problem. Additionally, incarcerated individuals with mental health concerns reported that there was a worry about being stigmatized within the prison, by other incarcerated people as well as by the staff. Canada et al. further observed that a lack of privacy in their appointments with the mental health staff typically meant that everyone's medical information was known by the prison population, and this deterred many incarcerated people from seeking out mental health treatment.

The challenges incarcerated individuals experience with seeking and receiving good (or even adequate) health care does not end when/if they are released from prison. Previous research has found that people may have difficulty maintaining good physical and mental health post-release (Wallace & Wang, 2020). Also, as noted earlier, poor mental health both during and after incarceration are associated with higher rates of recidivism. The reasons for reincarceration are complex, but can be connected to mental health and wellbeing. It is not uncommon for formerly-incarcerated individuals to experience difficulty finding employment, reconnecting with family members and friends, and finding housing, all of which can affect their mental health.

Without ways of improving their mental health and relieving themselves of these post-incarceration stressors, parolees and formerly-incarcerated people may turn to crime as a way of coping. General strain theory posits that when there are stressors in a person's life, they

may use coping mechanisms as a way of handling these negative effects. When strain is persistent, the person may develop negative emotions like anger and frustration, leading to a tendency to reduce strain through deviant behavior (Agnew, 1992; Wallace & Wang, 2020). Imprisonment has been found to have a detrimental impact on incarcerated individuals' mental health and well-being; improving mental health post-release lowers the risk of recidivating (Cunha, Castro Rodrigues, Caridade, Rita Dias, Catarina Almeida, Rita Cruz, & Manuela Peixoto, 2023; Wallace & Wang, 2020). The stressors that individuals may face post-incarceration combined with the negative impacts that imprisonment has on mental health has negative implications for reintegration back into society.

Along with difficulty reintegrating, formerly-incarcerated individuals may continue to experience – or be worried about experiencing – certain stigmas against seeking mental health treatment, based on their experiences with the services offered within prison, as well as the fear of being stigmatized by their peers (Canada et al., 2022). Solitary confinement tends to worsen mental health problems, create tendencies toward isolation and social distrust among those who have experienced it, and thus can also increase rates of recidivism and violent behavior (Sandoval, 2023).

The purpose of the current project was three-fold: (1) The first was to review previous literature on mental health as it relates to incarceration. (2) The second goal was to understand the particular stigmas (or stigma concerns) that those who have been in prison have toward seeking mental health treatment. (3) The third was to examine how the amount of time spent in solitary confinement during incarceration may add to or exacerbate both mental health problems and the stigmas that these individuals may feel about seeking mental health treatment. Drawing on these three reviews of the literature, I will propose a study that could be done in the future to

gain more information and understanding about these populations and their lack of mental health care.

Chapter 2: Incarceration and Mental Health

PTSD and Post-Incarceration Syndrome (PICS)

Along with experiencing mental health problems while incarcerated, it is very common for formerly incarcerated people to experience symptoms of Post-Traumatic Stress Disorder (PTSD), and to develop mental health problems from having been in prison (see CIT). According to the *Diagnostic Statistical Manual (DSM-5*) of the American Psychological Association (APA, 2013), PTSD is diagnosed if when, following a traumatic event, the individual experiences certain symptoms such as a persistent negative emotional state, feelings of detachment, recurring memories about the event, and/or the inability to remember important details of the event. To receive the diagnosis, the afflicted individual must also be avoidant of certain stimuli associated with the traumatic event, and may be experiencing some sort of intrusion symptoms associated with the traumatic event, such as recurrent dreams or intrusive distressing memories associated with the trauma. A person may experience PTSD as a result of direct exposure to a traumatic event, witnessing traumatic events occurring to others, learning about a traumatic event that happened to a close relative or friend, or experiencing repeated exposure to details of a traumatic event.

PTSD, however, does not always accurately represent the complexity of the trauma that results from incarceration (Liem & Kunst, 2013). Liem and colleagues focused on the effects of incarceration on mental health and how such individuals deal with afflictions after leaving prison. Building on what is known about PTSD, they proposed Post-Incarceration Syndrome (PICS) as a potential diagnosis to fully capture all the symptoms that individuals experience specifically as a result of having been traumatized as a result of incarceration – and especially

solitary confinement – for an extended period of time. While PICS shares characteristics with PTSD, the criteria for PICS centers specifically around the experiences of formerly incarcerated individuals; PICS is assumed to only affect those who have been incarcerated and released back into society.

The research done on PICS is still limited, but it is worth considering when understanding the way in which individuals experience incarceration. According to an informational webpage on the site of the National Incarceration Association (2022), PICS is characterized by social, emotional, and psychological difficulties that can result from imprisonment, including anxiety, depression, difficulty developing and maintaining relationships, and PTSD.

The findings from Liem and Kunst's study indicate that individuals who have been released from prison after a prolonged sentence tend to report feelings of paranoia, or have difficulty trusting others and feeling vulnerable. They may also have difficulty engaging in relationships, and tend to create distance between themselves and others, isolating themselves as a response to the trauma that their time in prison caused them. Although Post-Incarceration Syndrome is not yet an officially diagnosable disorder the DSM or in the *International Classification of Diseases* (ICD), with the research that has been done on it, it is clear that time spent in prison results in a variety of mental health afflictions that are specific to formerly-incarcerated individuals.

Mental Health Challenges While in Prison

Incarcerated individuals may experience poor mental health as a result of the prison environment, but they may also be exposed to certain conditions prior to imprisonment that

affect their mental health (Armour, 2012). Whether these mental health conditions are preexisting or develop during imprisonment, incarceration tends to worsen these symptoms. Mental health symptoms within prisons include self-harm among the incarcerated population, violent or deviant behaviors, and higher rates of suicide (Doty, Smith, & Rojek 2011; Fazel, Cartwright, Norman-Nott, & Hawton, 2008; Felson, Silver, & Remster 2012).

Self-Injury

Self-injury among incarcerated individuals has been associated with stressors that occur both inside and outside of the prison, and these institutions typically respond with punitive strategies rather than implementing therapeutic interventions (Doty et al., 2011). Doty et al. describe several of the stressors that are common within prisons, which include the shame of being labeled as a criminal, feelings of powerlessness, the lack of contact between incarcerated individuals and their loved ones, and other factors typical of prison culture, like sexual assault and gang violence. The authors further point out that self-injury appears among incarcerated individuals as an initial response to these stressors, acting as a coping mechanism. Incarcerated individuals who have more trouble adapting to the prison environment may use self-injury as a way to cope, and these individuals tend to display other mental health symptoms, as well as higher rates of prison disciplinary infractions.

Doty et al. analyzed the reports of self-injurious behaviors from the South Carolina Department of Corrections between January 2004 and June 2006. The correctional staff are required to report incidents that occur within the institution, with details including the severity and nature of the situation. The South Carolina Department of Corrections reported 352 incidents of self-injury within the prison. They found that the most common stressors prompting

self-injurious behavior involved factors specific to the prison environment. In an incident report from 2007, Doty et al. describe how the incarcerated individual was showing signs of wanting to harm himself stating that he wanted to do so because he was having family problems, and he also felt as though he was being extorted for canteen items by other incarcerated individuals.

The violent nature of the prison environment, beliefs in one's wrongful imprisonment despite maintaining innocence, and in one case, excessive heat in a prison cell, were also some of the institutional factors that acted as stressors for self-injurious behavior. In a number of cases, the incarcerated individual would use self-injury as a way to be removed from the general prison population, sometimes because they felt threatened by their peers, and unsafe in their cells. The data analysis found that twenty of these incidents of self-injury involved incarcerated individuals who were experiencing an episode as a result of a mental disorder, which commonly resulted in psychoticism.

Doty et al. noted that self-injurious behaviors are prevalent among incarcerated individuals, and are often a result of stressors directly related to the prison environment. Yet, the prisons rarely provide support to address the stressors or therapeutic treatment to reduce the despair. Of over 300 reports of self-injury in a two-and-half year span from the South Carolina Department of Corrections, 75% resulted in a statement declaring that the individual would be charged for self-injuring. Rather than receiving treatment, incarcerated individuals were more likely to receive disciplinary charges for self-injurious behavior. The stressors of the prison environment resulting in self-injurious behavior among incarcerated individuals indicate the necessity of mental health interventions for incarcerated and formerly-incarcerated individuals, as incarceration itself often results in worsened mental health symptoms.

Violent Behaviors

Previous research has shown that individuals with a diagnosis of mental illness are more likely to display violent behaviors than those who do not have any mental health problems (Felson et al., 2012; Link & Stueve, 1995). Major depression and psychosis are strongly associated with a greater likelihood of offending while in prison, including violence and verbal aggression against staff, violence and verbal aggression against other incarcerated people, weapon offenses, and substance abuse violations (Felson et al., 2012). These effects were observed for various offense types, which suggests that mental illness can affect deviant behavior partly because of its impact on self-control. Felson et al. also found that paranoia is the strongest predictor of violent behavior in prison; when incarcerated individuals believe that the people around them are plotting against them, they are more likely to verbally or physically attack other people. Incarcerated individuals experiencing paranoia may also plan for violent attacks by acquiring weapons. Based on findings connecting mental health to violence within prisons, attention to mental health afflictions in incarcerated people may be beneficial for preventing these instances of violent behaviors.

Suicidality

In addition to violence against others, mental health symptoms in prisons can be associated with higher rates of self-injurious behavior, including suicide (Fazel et al., 2008). However, the existing literature on suicide in United States prisons tends to ignore the context of the prison setting and its connection to these suicides (Dye, 2010). Suicide is the second leading cause of death in prisons in the United States, after deaths from natural causes, and

suicide rates in prison and jail have been higher than suicide rates of the general United States population (Mumola, 2005).

Dye (2010) conducted a study using national survey data on state prisons in the United States to better understand the explanations for prison suicide. The study focused on two possible explanations for suicide in prison: the deprivation perspective, and the importation model. The deprivation perspective suggests that prison suicides are due to the prison environment, including the loss of freedom, isolation, and other prison conditions. The importation model indicates that suicide in prison is attributed to the social, psychological, and demographic characteristics of the incarcerated individuals. Fazel et al. found that prisons with higher rates of reported suicides were characterized by higher levels of deprivation compared to prisons with fewer reported suicide. The levels of deprivation were measured by the level of security, prison capacity, assault rate, court orders to reduce the number of incarcerated people, and whether the people that are incarcerated in the prisons were allowed to leave the facility. The existing research on suicide in prison demonstrates the direct effects that incarceration has on an individual's mental health and wellbeing (Dye, 2010).

Other Symptoms

Attention deficit hyperactivity disorder (ADHD) has also been found to be connected to higher recidivism rates (Roman-Ithier, Gonzalez, Velez-Pastrana, Gonzalez-Tejera & Albizu-Garcia, 2017). A meta-analysis of 20 empirical studies found that ADHD is an important risk factor for crime and deviant behavior (Pratt, Cullen, Blevins, Daigle, & Unnever, 2002). Although it may not be the most concerning risk factor for criminal behavior, ADHD can be linked to low self-control, which has also consistently been associated with high levels of

involvement in crime and delinquency. The connection between ADHD and deviant behavior provides insight into the relationship between mental health and incarceration, and how mental health interventions may be beneficial for incarcerated individuals.

Solitary Confinement

Within the prison system, the use of solitary confinement has been an ongoing topic of debate. There are four types of solitary confinement: administrative segregation, disciplinary segregation, protective custody, and temporary segregation, and they can be referred to as "Security Housing Units, "Restrictive Housing Units," or "Intensive Management Unites" (Labrecque, 2016). Disciplinary segregation refers to a form of punishment that is used for incarcerated individuals who violate the prison's rules. Administrative segregation is used to manage incarcerated individuals, particularly when they are demonstrating an inability to adjust to the prison environment or general population, or when officials believe that an individual is causing a disruption to the institution. The purpose of protective segregation is to separate vulnerable incarcerated individuals from the general population because of concerns for the individual's safety. Finally, temporary segregation is when an incarcerated individual is placed in restrictive housing for a range of reasons: these can include when an incarcerated individual is waiting to be transferred to another facility, or awaiting a court date. Temporary segregation is typically for shorter periods at a time, but the conditions of the isolation do not differ much despite the variety of reasons that may prompt the facility to separate the incarcerated individual from the general population.

A 2023 report by the Solitary Watch advocacy group (Casella et al., 2023) provides a comprehensive account of the use of solitary confinement in prisons and jails across the United States. The data from 2019 showed that, across the many prisons and jails in the country, more

than 122,000 people were locked in solitary confinement on a given day for at least 22 hours a day. Incarcerated individuals being held in solitary confinement have limited access to any educational, vocational, or recreational services that are available to the general prison population, and are also restricted in their visitation privileges (Labrecque, 2016). These individuals are let out of their cells for only a couple of hours a day for showering or exercising, and the recreational time that they do have takes place in a small fenced-in outdoor area, where they must remain isolated from the rest of the population. Mental health and medical services are limited as well, and when these interactions are permitted, they are generally not in a private setting. Individuals in solitary confinement are almost completely isolated and deprived of any social interaction (Labrecque, 2016). People of color, including Black people, Latinx people, and Native American people, are placed in solitary confinement at a disproportionate rate (Casella et al., 2023; US Department of Justice, 2016).

The United States prison system has significantly expanded since the 1970s, following the national prison boom: prisons built after 1970 account for about 75% of all prisons built in the United States (Sakoda & Simes, 2021). The increase in use of solitary confinement can be explained by the prison boom, and Sakoda and Simes (2021) use Kansas as an example for this growth. The use of solitary confinement in Kansas, like other states, is typical of the U.S. prison system. Prisons in Kansas, like many other prisons in the U.S., typically use two of the four types of solitary confinement noted earlier: disciplinary segregation, and administrative segregation. The time that an individual can spend in solitary confinement can greatly vary, ranging from several days to several years. Sakoda and Simes used an in depth administrative data set from the Kansas Department of Corrections (KDOC) to understand the changes in the frequency that solitary confinement is used, and the amount of time that it is imposed for.

Sakoda and Simes (2021) found that since the 1970 prison boom, the use of solitary confinement has also increased: prior to 1970, about 3% of the Kansas state prison population was held in solitary confinement, in either administrative or disciplinary segregation. The number was slightly higher, at 3.5%, for incarcerated non-Hispanic Black individuals. In 1991, the percentage of individuals in solitary confinement had almost doubled, at 5.8%, and more than 7% for non-Hispanic Black individuals. The percentage of non-Hispanic White individuals in solitary confinement increased from 2.6% to about 4.5%. Prior to prison capacity expansion, 13% of all incarcerated individuals spent time in solitary confinement at least once for longer than 30 days, which increased to 15% of all incarcerated individuals post-prison expansion. Although this study focuses specifically on the use of solitary confinement in the state of Kansas, it is valuable in understanding the changing patterns in solitary confinement use.

Racial disparities in the length of time spent in solitary confinement emerged in the period following the expansion of prisons in the United States (Sakoda & Simes, 2021). Black young adults from ages 18 to 25 had the longest average stay in solitary confinement for any demographic group; after the prison expansion, the average length of time spent in solitary confinement for this population was 60 days, which was more than triple the average length for this same population prior to the expansion. Solitary confinement is still a harsh practice in the United States, and the conditions seem to be worsening, particularly affecting incarcerated individuals of color at a higher rate than their White counterparts. The study by Sakoda and Simes demonstrates the increase in the proportion of people being held in solitary confinement, and the disparities that have more recently emerged by highlighting data about the populations most affected by solitary confinement. These findings have implications for which incarcerated individuals might be most affected by solitary confinement in terms of their mental health and

well-being, and how the conditions of solitary confinement may worsen any problems that may emerge.

Women face many physical and psychological challenges in prison, and are more likely than men to be placed in solitary confinement for minor offenses (American Civil Liberties Union, 2019; Matei, 2022). Mental illness is common among women in prison, and the rate of serious mental illnesses like schizophrenia or bipolar disorder is higher among incarcerated women than it is in men (American Civil Liberties Union, 2019). Oftentimes, women who are incarcerated end up in solitary confinement because of their mental illness, because the correctional officers are not equipped to respond to mental health problems. Women in solitary confinement are also particularly vulnerable to abuse from correctional officers, including the use of excessive force, abuses of power, and sexual abuse. It is not uncommon for incarcerated women to be placed in solitary confinement for reporting abuse in the first place. Because many of these women have experienced sexual abuse in the past, their experiences in solitary confinement can potentially retraumatize them if they are already vulnerable to these types of abuse. The American Civil Liberties Union (NYCLU, 2023) reports that women can experience severe psychological problems as a result of the conditions of solitary confinement.

A study focused on formerly-incarcerated individuals – both men and women – in North Carolina found that solitary confinement during incarceration is associated with higher mortality rates post-release (Brinkley-Rubinstein, Sivaraman, Rosen, Cloud, Junker, Proescholdbell, Shanahan, & Ranapurwala, 2019). Brinkley-Rubinstein et al found that 33.7% of the people incarcerated between January 1st 2000 and December 31st 2015 were placed in restrictive housing. A total of 14,086 deaths occurred post-release, 9.4% being opioid overdose deaths, 10.4% being homicide deaths, and 4.5% being suicide deaths. From these data, it was

found that individuals who had spent time in solitary confinement during their incarceration were more likely to die in the first year after their release of all causes, but especially from homicide and suicide. They were more likely to die of an opioid overdose in the first two weeks after they were released, and were more likely to become reincarcerated. There is also a significant connection between time spent in solitary confinement during incarceration in a state prison and mortality rate post-incarceration. These findings are indicative of the harsh conditions that an individual may face in solitary confinement, and how these conditions continue to affect them even after they have been released from prison.

The Grassian Massachusetts Study

Stuart Grassian, a psychiatrist who has focused his work on the mental health impacts of solitary confinement, has found through his research that solitary confinement can either aggravate a pre-existing mental health problem, or cause a severe mental illness (Grassian, 2006). Over 40 years ago, in a classic early study on the effects of solitary confinement, Stuart Grassian interviewed and observed 14 incarcerated individuals who had experienced extended periods of isolation in solitary confinement at the Massachusetts Correctional Institution at Walpole (Grassian, 1983). These observations took place as a result of a court order requiring the psychiatric evaluation of these individuals. Each of the individuals interviewed were plaintiffs in a class action lawsuit against the Department of Corrections for violating the Eighth Amendment and inflicting “cruel and unusual punishment” through the use of solitary confinement (Grassian, 1983).

The interviews were conducted by psychiatrists, and the participants of the study were asked questions about their experiences in solitary housing units. The results of this study

provide useful information on the ways in which isolation to this extent can cause a variety of psychological issues. Generally, these 14 individuals appeared to rely on certain defense mechanisms, including avoidance, denial, repression, and rationalization. These defense mechanisms emerged as a tool for downplaying their reactions to their time spent in isolation. Because of many of the participants' reluctance to share information, the interviewers reported that they needed to actively encourage them to do so. Several of the incarcerated individuals acknowledged that they were hesitant to openly share their experiences because they were afraid that the prison guards would be looking for any sign of weakness from the incarcerated individuals so that they could exploit the individuals and make them "crack up" (Grassian, 1983). In other instances, the individuals expressed fear that the guards would learn about their revenge fantasies. Generally, the individuals that had trouble answering questions at first were resistant because of the fear that the guards might use the information against them in some way. Some of the individuals responded to the interview questions in denial, attempting to make themselves seem unaffected or unbothered by their experiences. These individuals eventually began to describe feelings of panic, fears of suffocation, and paranoia from being in solitary confinement (Grassian, 1983). Eleven of these individuals had become more sensitive to external stimuli as a result of isolation. They became unable to eat certain foods that they had eaten during solitary confinement, or became sensitive to certain noises and smells.

Half of the individuals in this study reported experiencing distortions, hallucinations, and derealization (Grassian, 1983). Some would hear whispers or voices telling them things that were frightening, without any way of knowing if they had actually heard people talking or if they were hallucinating. Others experienced intense anxiety following solitary confinement, while some had difficulty concentrating or losses in their memory. Five of these individuals

reported a lack of impulse control and having issues with random violent acts. Three of the incarcerated individuals reported impulsive acts of self-harm. The results of this study demonstrate a range of mental health issues that can develop because of time spent in solitary confinement.

In his later work, Stuart Grassian discussed the mental health symptoms that seem to be directly connected to time spent in solitary confinement (Grassian, 2006). These symptoms – hypersensitivity to external stimuli, perceptual distortions, illusions, and hallucinations, panic attacks, difficulties with thinking, concentration, and memory, intrusive obsessional thoughts, overt paranoia, and problems with impulse control – were all very consistent among the incarcerated individuals that he observed in the Massachusetts study. Although many of these symptoms, Grassian suggests, will likely lessen after release from solitary confinement, many will likely experience permanent harm as a result of solitary confinement. The effects of solitary confinement most commonly manifests into difficulties with social interactions, which can make returning to the general prison population – and later re-integrating back into society – much more difficult for individuals experiencing solitary confinement.

Most notably for the focus of the current project, Grassian found that incarcerated individuals that had been housed in severe conditions – such as solitary confinement – were afraid of acknowledging the psychological effects that they experienced because of this confinement. The concerns that incarcerated individuals tend to have toward acknowledging the psychological impacts of solitary confinement can often be attributed to their perception that this kind of confinement is an attempt by authority to psychologically wear them down. Additionally, as Grassian points out, mental health screenings are held at the cell rather than in a more private location, and because of this, the incarcerated individuals are apprehensive about

discussing their psychological issues out of fear that other incarcerated people will hear them, causing them to be shamed and stigmatized by their peers.

Grassian is credited with identifying a specific psychiatric syndrome that develops from solitary confinement, which is made up of a combination of the aforementioned symptoms that he listed (Grassian, 2006). Grassian believed these symptoms formed a unique discrete syndrome, particularly because the symptoms experienced by individuals in solitary confinement are rare. One of the specific symptoms that he references in his research is the loss of perceptual constancy, where objects change in size or form, which is a symptom typically associated with neurological illnesses rather than psychiatric disorders. This combined with the other unique symptoms that Grassian describes make up the discrete syndrome that he believed to be specific to people experiencing this severe form of isolation. Stuart Grassian's research on incarcerated individuals in solitary confinement is valuable for understanding the specific ways that such isolation can impact a person's mental health. It becomes clear that solitary confinement as a form of punishment in correctional institutions carries significant psychiatric consequences and risks, and is unique in how it affects a person both short and long-term

Research on Time Spent in Solitary Confinement

The psychological impact of solitary confinement has been greatly debated, and continues to be a controversial topic (Labrecque, 2016; Suedfeld, Ramirez, Deaton, & Baker-Brown, 1982). Suedfeld et al (1982) produced a study in which they collected data directly from incarcerated individuals on their experiences and attitudes toward solitary confinement in five prisons in the United States and Canada. The first phase of the study consisted of interviews with 12 male incarcerated individuals, all of whom had been placed in

solitary confinement during their incarceration. The total amount of time they had spent in solitary confinement ranged from 5 days to 42 months, and the reasons for their isolation included breaking prison rules, inciting riots, aggression toward staff, possession of weapons, and fighting.

These individuals were all interviewed with a set of questions asking about their physical and psychological reactions to solitary confinement. From this first part of the study, Suedfeld at al. found that most of the complaints that incarcerated individuals had about solitary confinement were mostly about how it interfered with their normal diet, the use of physical means of control directed toward them, or humiliation by the correctional officers. The participants believed that some procedural details of solitary confinement needed improvement, but generally did not have considerable complaints relating to the social isolation or lack of stimulation of solitary confinement.

The second phase of the study examined the effects of solitary confinement on 43 incarcerated individuals using a series of survey measures. These findings demonstrated that those who had spent more time in solitary confinement tended to be more anxious, cautious, submissive to authority, and lacking in self-insight. Individuals spending longer periods of time in isolation scored higher on depression and hostility. From the interview portion of the study, Suedfeld et al. found that many of the participants discussed their time in solitary confinement with pride, indicating that having successfully dealt with their time in isolation would heighten their status among the rest of the prison population. With more time spent in solitary confinement, individuals report a feeling of detachment from the situation, which I believe could be a coping mechanism for dealing with the extreme conditions of this type of isolation.

Overall, Suedfeld et al. found that individuals who spent more time in solitary confinement were more likely to be distrustful, socially immature, and suspicious. This study is interesting because there was no significant psychological damage found among the individuals who had spent more time in solitary confinement, although this could be due to the lack of reference to the mental health measures of these individuals previous to their time in isolation. Additionally, Suedfeld et al. believe that many of these responses could be reflective of the tensions of the prison environment and its effects on incarcerated individuals more broadly.

The Washington State Study

A more recent study examining the experiences of individuals in solitary confinement in Washington State focused on a sample of 106 incarcerated people who had been in solitary confinement long-term (Strong et al., 2020). This study also highlighted the way in which Black and Latino individuals are over-represented in solitary confinement, as well as in the general prison population. The researchers distributed in-person surveys to and interviewed all 363 individuals in solitary confinement at the Washington State Department of Corrections, however, as noted above, the final sample size consisted of just over 100 participants. One-third of these individuals were interviewed again several months later, and a final interview was conducted one year later – in 2018, with the individuals from the original sample who were still incarcerated. The researchers also reviewed all medical and disciplinary files for those interviewed at the one-year mark. The participants were all assessed using the Brief Psychiatric Rating Scale (BPRS; *Psychiatric Times*, 2021), which is often used to measure various psychiatric symptoms. The final sample size had a mean stay of 14.5 months in solitary

confinement. The participants were 42% white, 12% African-American, 23% Latino, and 23% in the "other" racial category (Strong et al., 2020).

Strong et al. found that there were various barriers – all that discouraged individuals from attempting to access healthcare while in solitary confinement. For example, vitamins and pain medications are kept outside of the cells and are only available at certain times, restricting access to people in solitary confinement. Additionally, Washington State Department of Corrections (WADOC) requires that incarcerated individuals pay $4 for any non-emergency medical care, but people in solitary confinement have more restrictions on their spending, which includes spending on healthcare. Many of the participants reported negative physical health symptoms that emerged specifically as a result of being in solitary confinement, such as chronic back and knee pain. For example, one incarcerated individual described having pain and anxiety, which together interfered with his typical everyday activities: he had trouble writing letters to his family because of the anxiety that he was experiencing about re-entering society directly from solitary confinement. Incarcerated individuals are given very few resources to manage physical pain while being held in solitary confinement, which seems to result in maladaptive emotions and behaviors, including intense stress, anxiety, and rumination (Strong et al., 2020).

In the final portion of this study, the researchers collected administrative data for the entire prison population, provided to them by WADOC. The racial disparities within the prison population indicate that the ways in which solitary confinement impacts both physical and mental health are likely to be experienced at a higher rate based on racial identity (Strong et al., 2020). The data for the prison population in Washington state showed that individuals who identify as "Latino, Any Race" and "Other/Unknown" are overrepresented in solitary housing

units. In this sample, Black individuals are under-represented in the solitary housing sample, but (as is the case in most US prisons) overrepresented in the general prison population (Strong et al., 2020; United States Census Bureau, 2010 - 2017).

Because of the overrepresentation of people of color in prison as well as solitary confinement, these physical and mental health concerns often fall disproportionately on these groups.

The HALT Solitary Confinement Act

As more research is being done on the effects of solitary confinement, more evidence is available documenting the physical and mental harm that it can cause (Strong et al., 2020). In 2021, the New York legislature passed the "Humane Alternatives to Long-Term Solitary Confinement" or HALT Solitary Confinement Act, which limits who can be put into solitary confinement, and how long they can remain in solitary confinement (S2836, 2021). Whereas previously incarcerated people could spend months to years in solitary confinement, the HALT Act has limited the number of days to 15. The HALT Act went into effect in 2022, and has since been a topic of controversy throughout New York's prison system (O'Mara, 2023). There have been instances of violations of the HALT Act (Taguine, 2023), and discussion about whether or not it is helpful, as many believe that it is the cause for an increase in violence within the prisons (O'Mara, 2023).

Those in support of the HALT Act believe that solitary confinement is a form of torture, and some advocate for an end to solitary confinement altogether (Jails Action Coalition, 2021). The #HALTsolitary Campaign, a New York statewide coalition created by people who have experienced solitary confinement or known someone who has experienced it, works to advocate

against solitary confinement, and argues that removing solitary confinement as a form of punishment within prisons would save lives, reduce violence, and improve safety. The existing controversy around the topic of solitary confinement speaks to the numerous problems that arise from solitary as a form of punishment.

Craig Haney, a psychologist who – many years after his work with Philip Zimbardo on the famous (and infamous) Stanford Prison Study – has focused much of his work on the psychological effects of solitary confinement. In an interview, Haney describes the experience of being isolated in a cell for a long period of time as "isolation panic," and observes that many individuals immediately have negative reactions when they are put in solitary (Childress, 2014). Oftentimes, Haney further observes, once an individual has become more settled in solitary cells, they experience depression and hopelessness very quickly. In solitary confinement, individuals are not able to socialize or participate in any activities, which can quickly lead to them losing touch with reality. In speaking to people who had been in solitary confinement, Haney (2003) also found that some of them would lose their ability to focus, and exhibited signs of memory loss. Additionally, the intense isolation of solitary confinement can lead to people avoiding social contact even after they have been released from solitary, and back into the general prison population. This experience can make it difficult to be able to interact with others, or to even have any desire for social interaction.

Solitary confinement as punishment in prisons in the United States can be used arbitrarily, and for unspecified periods of time – a fact which the HALT Act is attempting to combat (Jails Action Coalition, 2021; Sandoval, 2023). In various carceral settings in the United States, including prisons, jails, and juvenile detention centers, individuals can be placed in solitary confinement for many years at a time. Again, these individuals are deprived of any

contact with other people, and can also be denied access to medical services or care while they are trapped in solitary confinement. Like the Strong et al. study on solitary confinement in Washington State, a recent report from the National Alliance on Mental Illness on how solitary confinement affects the incarcerated states that people of color, transgender and gender non-conforming people, young people, and people with mental health conditions are overrepresented in solitary confinement (Sandoval, 2023). Solitary confinement contributes to the pre-existing mental health problems that are common within prisons, and can also cause an increase in violent behaviors, and higher rates of recidivism.

Chapter 3: Seeking Mental Health Support

The extent to which the stigma of mental illness keeps people from seeking and making use of treatment for serious mental health issues has long been a topic of discussion. It is important to understand the stigmas surrounding mental health in incarcerated communities, as these can be particularly influential reasons for avoiding mental health treatment in and after prison.

In general, seeking professional help can be difficult for most people to do on their own because of the fear of being seen as weak, "crazy" or incapacitated by others (Vogel, Wade, & Haake, 2006). Vogel et al. define stigma as the "perception of being flawed because of a personal or physical characteristic that is regarded as socially unacceptable." If an individual believes that having mental health problems or seeking professional help for their mental health is considered to be socially unacceptable, then this belief will likely discourage them from seeking treatment.

Stigma can be defined in two ways: public stigma, or self-stigma (Corrigan, 2004). Public stigma refers to society's perception of someone who seeks psychological treatment as being socially unacceptable or undesirable. Being publicly identified as mentally ill can be harmful, because of the many places (e.g., businesses, families, communities, and schools) that may hold stigmas against people who are mentally ill. These stigmas are often associated with a person's ability to find good jobs or find decent housing, as employers and landlords may hold certain prejudices against people who are mentally ill. Additionally, stigmas surrounding mental health tend to influence the dynamic between mental illness and the criminal justice system

(Corrigan, 2004). These factors are made even more difficult for a formerly incarcerated individual who also gets stigmatized for having been incarcerated.

Oftentimes, in the US today, police are tasked with responding to mental health crises, therefore contributing to the increasing population of mentally ill individuals in prisons and jails. The general health care system is also negatively impacted by public stigmas surrounding mental health. People who are labeled as mentally ill are less likely to receive the full physical health care services that they need, compared to individuals who are not mentally ill. Individuals who are mentally ill often experience significant difficulties in public or social settings (e.g., anxious individuals may display their anxiety; people with schizophrenia may experience negative responses from others to their appearance, speech, and/or behavior), which are then made even more difficult for people who have also previously been incarcerated.

Mental health self-stigma refers to the potential decline of self-esteem and confidence in oneself as a result of the mental illness being stigmatized in society (Corrigan, 2004). Individuals may believe that seeking help would be a sign of failure or weakness, so they might refuse to seek help in an attempt to maintain a positive self-image (Vogel et al., 2006). With both self-stigma and public stigma as factors affecting an individual's self-view or self-worth, stigmas toward mental illness and seeking treatment deter people from getting the help that they need for their mental health.

It is likely that people with both a criminal history and mental health problems will experience a dual-stigma (Tremlin & Beazley, 2022). Given that formerly-incarcerated individuals with mental health problems may be particularly stigmatized by society, it is possible that this would develop into self-stigma, deterring these individuals from seeking mental health treatment. Tremlin and Beazley (2022) found in their research that the

combination of mental health and offending does increase negative stigmas that people have towards these individuals. There are also generally high levels of stigma toward people with psychiatric problems and with offending histories separately as well, which again, may promote self-stigma.

Along with the stigmas that formerly-incarcerated people may have toward mental health treatment, they may also experience other obstacles preventing them from seeking help (Nishar, Brumfield, Mandal, Vanjani, & Soske, 2023). Nishar et al. conducted interviews with 25 people who had been released from prison within the past five years. The participants in this study identified housing instability, difficulty finding employment, lack of insurance coverage, and limited options for transportation as some of the primary barriers making it difficult for them to engage with mental health care, as well as the factors impacting their mental health. Several of the participants were experiencing housing instability, which made it difficult for them to access the necessary resources for their mental health. Participants also reported not having the information that they needed in order to seek mental health services on their own; they tended to have a very minimal understanding of the services that were provided, making the process of obtaining mental health care difficult and confusing. Nishar et al. emphasize the need for "mental health literacy," or a system in which individuals are taught how to find mental health resources and obtain positive mental health habits. Formerly-incarcerated individuals tend to face a variety of obstacles when released from prison, and may have certain stigmas toward seeking mental health treatment: together these factors act as deterrents against finding the proper mental health services.

The stigmas surrounding mental health in formerly incarcerated communities cannot be properly analyzed without taking into consideration the stigmas that exist more broadly (not just

among those who are incarcerated) and within different communities. Existing research on whether mental illness is more stigmatized in different racial and ethnic minority groups is limited, and the research that does exist tends to have mixed findings on how stigmas toward mental health differ based on race or ethnicity (Wong, Collins, Cerully, Seelam, and Roth, 2017).

Wong et al. investigate how stigmas toward mental illness affect racial and ethnic minorities, using a representative data sample of adults in California experiencing psychological distress. The findings of this study indicate that experiences of discrimination and perceptions of public stigma are high among all racial and ethnic groups, but that Asian-Americans and Latinos surveyed in English are disproportionately affected by higher levels of self-stigma. Latinos surveyed in Spanish had higher levels of stigmas in certain areas, but lower in others. Latinos surveyed in Spanish and Asian-Americans were least likely to acknowledge having a mental health problem, and had very low levels of mental health service use.

Wong et al. (2017) found that the majority of their sample believed that people with mental illnesses experience a lot of discrimination and stigma. The study also took into account that people experiencing symptoms of psychological distress may not recognize these symptoms or be hesitant to acknowledge these symptoms as mental health problems as they want to avoid being labeled because of them (Corrigan, 2004; Wong et al., 2017). As noted above, Asian-Americans and Latinos surveyed in Spanish were the least likely to report having any mental health problems in the past 12 months. African-Americans were significantly more likely to report experiencing a mental health problem in the past 12 months than were White participants. Again, it may be that there is a factor of avoidance in those less likely to report having any mental health problems, as they may be worried about being stigmatized or they

may not be aware that these problems are mental health related. Wong et al. also point out that African-Americans experience higher levels of impairment when affected by mental health conditions, which may be a reason for why African-Americans were more likely to have reported mental health problems (Williams, González, Neighbors, Nesse, Abelson, Sweetman, & Jackson, 2007; Wong et al., 2017). Clearly, attitudes toward mental health treatment, stigmas about people with mental health problems, and reported and actual mental health symptoms tend to differ between racial and ethnic minority groups (Wong et al., 2017).

Another study, focusing on the attitudes that African-American people have toward mental illness found that individuals in these communities were typically less open to addressing their psychological issues and were more concerned about stigmas associated with mental health problems (Ward, Wiltshire, Detry, & Brown, 2013). Previous studies on mental health treatment seeking and the impact of stigma and race found that older African-American adults tend to view mental illness as a weakness (Conner, Copeland, Grote, Koeske, Rosen, Reynolds, & Brown, 2010). The results of this study also indicate that older African-American adults were more likely to internalize stigmas toward mental health treatment, and held less positive attitudes toward treatment-seeking than older white adults. On the other hand, Black Americans tend to have more positive attitudes toward seeking mental health care, yet were less likely to use these services than their white counterparts (Ward et al., 2013).

Ward et al. (2013) surveyed 272 participants between the ages of 25 and 72. The participants were all African-American men and women, and they were recruited regardless of their mental health history. The participants were generally unsure on their own understanding of mental illness, and unsure about whether or not they were personally affected by mental illness. Participants were somewhat open to seeking mental health care, but were very

concerned about the stigmas that are associated with mental health problems, and were not very open to acknowledging their psychological issues. The preferred coping tool was seeking religious guidance or direction. The findings on concerns about stigma are consistent with other pre existing literature on stigma around mental illness, which has been prevalent in the among African-American communities (Gary, 2005; Ward et al., 2013). These findings in particular highlight the fact that these stigmas are a concern among African-American men, providing new insight to pre-existing literature on the subject.

The study by Ward et al. – along with the study by Wong et al. – emphasize the attitudes that different communities have on mental health and treatment seeking for mental health problems. From Ward et al., it can be understood that Black people in America may have stigmas toward treatment-seeking for mental health. Black men in particular are overrepresented in prisons in the United States, and Black and Latino people are put in solitary confinement at disproportionately high rates (Pullen-Blasnik, Simes, & Western, 2021). The results of the studies designed by Ward et al. and Wong et al. have implications for an individual's willingness to seek mental health treatment after they have been released from solitary confinement, and from prison. It is conceivable that, since Black and Latino populations already tend to report the stigmas against seeking mental health treatment in general, the added factor of time spent in solitary confinement might exacerbate these sentiments, especially post-incarceration. This problem is critical to address since Black and Latino populations are the most overrepresented in both U.S. prisons and solitary confinement.

I am interested in the way in which stigmas surrounding mental health, whether coming from outside influence or from the self, affect whether or not formerly incarcerated individuals seek mental health treatment. By understanding these attitudes towards mental health and

mental health treatment, I want to more specifically examine how solitary confinement potentially shapes these stigmas. I am curious to understand if spending time in solitary confinement affects someone's willingness to seek help post-incarceration. Past work has shown the negative impact that solitary confinement has on mental health and the stigmas around mental health that can deter people from seeking help, but I want to examine whether or not having experienced solitary confinement affects the likelihood that an individual receives mental health treatment post-incarceration, and how that might differ depending on the total amount of time the individual spent in solitary confinement (Canada et al, 2022; Grassian, 1993; Strong et al., 2020).

During incarceration, people often develop mental health disorders, and their experience in prison overall can be traumatic (Liem & Kunst, 2013). The study done by Liem & Kunst in particular examined the concept of PICS as an alternative to a PTSD diagnosis, specifically for people who have spent time in prison (2013). The specific traumas caused by incarceration are still being studied and learned about, so it is not surprising that people might be unaware of some of these effects of prison. From this study, Liem and Kunst found that the most prevalent features that were reported by the interviewees were recurrent distressing dreams, sleep disturbances, emotional numbing, and persistent avoidance of stimuli. Paranoia was the most common trait that came as a result of incarceration, or having difficulty trusting other people. These, along with quite a few others, are symptoms that fall under the criteria of PICS.

The isolating effects of incarceration and the impact it has on mental health are heightened when individuals are in solitary confinement. I would theorize that many people in prison and coming out of prison and reintegrating back into society may not be aware of the ways in which their time in prison was traumatizing, and therefore might be less likely to seek

help for any mental health issues that they might be experiencing. Being in solitary confinement in particular closes individuals off, and isolates them, which may cause them to remain closed off once they have been released from solitary confinement, and prison (Grassian, 1983). Therefore, I imagine that it is more likely that people who have experienced solitary confinement will avoid getting mental health care, because of the effects that solitary confinement may have on their ability to comfortably socialize, and their willingness to open up and trust new people. However, I also anticipate that regardless of the amount of time spent in solitary confinement, most formerly-incarcerated individuals will have stigmas against seeking mental health treatment.

Chapter 4: A Proposed Research Study

Rationale & Hypotheses

As described in previous chapters, prior research has indicated that even when mental health care is available within prisons, the lack of privacy within the prison can deter incarcerated individuals from seeking out these mental health resources while they are still incarcerated (Canada et al., 2022). Moreover, the mental health care that is available tends to be of low quality, and there is a general lack of trust – and even training – among prison health care providers when addressing the incarcerated individuals' concerns. In an institution like prison, mental health problems are clearly over-represented and under-addressed. Incarcerated individuals may come to prison with mental health issues, but these most often go unaddressed. All those incarcerated in prison face stressors that exacerbate prior mental health symptoms or create new ones. Because of their prolonged isolation those who experience periods of solitary confinement likely face even worse outcomes (Grassian, 1983).

The studies and programs described in Chapter 2 highlighted how time spent in solitary confinement is a factor that can have drastic effects on physical health and associated mental health symptoms (Strong et al., 2020). When an individual is placed in solitary confinement, they may experience feelings of depression, anxiety, paranoia, and panic (Grassian, 1983). The complete isolation that is experienced in solitary confinement has implications for an individual's mental health post-incarceration, as they may continue to keep themselves isolated once they are released from solitary confinement, and even still once they are released from prison. Once released from prison, it is common for individuals to experience symptoms of PTSD, or PICS as a result of their incarceration (Liem & Kunst, 2013). However, particularly

with longer periods of time spent in solitary confinement, individuals may not be willing to seek treatment or be aware that they would benefit from mental health treatment.

The research to date on the effects of solitary confinement and mental health among incarcerated and formerly incarcerated individuals presents the following question: ***How does time spent in solitary confinement change or affect an individual's willingness to seek mental health treatment post-incarceration?*** To answer this question, I believe more research is needed. Thus, as part of this project, I am proposing a study to better understand the effects of solitary confinement on an individual's stigmas around seeking mental health treatment.

In conducting this study, it would be important to recognize that these participants may be considered to be a "vulnerable population". Institutional Review Boards (IRBs) include "children prisoners, pregnant women, or people with intellectual disabilities" as populations considered to be vulnerable (American Psychological Association, 2024). The current study would be examining the mental health symptoms and stigmas that formerly-incarcerated individuals have toward seeking treatment for their mental health which assumes that some, if not all, of the participants will have mental health symptoms, many of which would likely not have been properly addressed prior to this study. With this current project, I am not qualified to provide mental health care, and do not have access to the necessary resources to properly account for any mental health problems that might become apparent through this study. Therefore, I am proposing this as a potential study instead of carrying it out myself.

In envisioning this study, I believe it is important to explore two main hypotheses or questions:

Hypothesis 1. Many incarcerated and post-incarcerated people reintegrating into society may not be aware of – or have yet to come to terms with – the ways in which their time in prison may have affected their mental health, and therefore might not be open to seeking help for any mental health issues that they might be experiencing.

Hypothesis 2. Formerly-incarcerated individuals who have spent a longer total amount of time in solitary confinement will have even more negative stigmas toward receiving mental health care because of the effects that solitary confinement may have had on their ability to comfortably and willingly open up to and trust new people.

The Sample and Sampling Procedure

For this study, I would recommend setting a realistic yet ambitious goal of recruiting 40 formerly-incarcerated individuals. To make it manageable for the researcher – and to enable comparisons with past studies – I would recommend focusing on one state or region. Since my experience is in the Bard Prison Initiative, I would focus on recruiting individuals who have been incarcerated in state prisons in New York through various post-incarceration programs where participants would volunteer to become involved in this study.

I would focus on specifically recruiting formerly-incarcerated men, because most of my research and understanding on mental health post-incarceration has been focused on male participants. Again, I would plan to recruit participants from various post-incarceration programs, organizations, and agencies. Because lack of trust is one of the primary factors that my research has indicated as being a deterrent for mental health treatment seeking, I do expect that I would be investing time prior to recruitment to connect with these communities and build trust before collecting data. One of the first programs that I would reach out to for recruiting

participants is the Bard Prison Initiative (BPI). I have worked as a tutor for BPI, so asking to find willing participants through this program might be a good way to establish trust and recruit people for this study. The Bard Prison Initiative (bpi.bard.edu) provides a college education in seven prisons in the state of New York. Beyond their time in prison, BPI provides formerly-incarcerated Bard students with reentry support including help with long-term planning and navigating their professional lives post-release. The BPI reentry program would be one potential way for me to find participants if I were to carry out this study.

Interview Procedure & Survey Measures

The first step in the procedure of this study, participants would be fully briefed on the basic premise of the study: they would be informed that the study is about their incarceration and time spent in solitary confinement, as well as the potential short or long-term effects that isolation may have had for them – particularly in seeking mental health treatment. They would be ensured that their responses are entirely confidential, and that the only person hearing their responses directly will be the interviewer. They will also be assured that their names will not be attached to any of their interview or survey responses.

Once the participants have been properly briefed on the study, each participant would undergo a one-on-one interview process, during which they would be asked a range of questions asking about their experience in prison and with solitary confinement. The interview questions are the following:

1. How many separate times have you been incarcerated? How long (in months) in total?

2. How many separate times were you placed in solitary confinement?
3. What was the longest period of time that you spent in solitary confinement (days) at once?
4. What were the reasons for your being placed in solitary confinement (administrative, disciplinary, protective, or temporary segregation)?
5. How would you describe your mental state during the time you spent in solitary confinement? How did it affect your overall well-being?
6. Did you ever use/attempt to use any resources for your mental health (while in solitary confinement, generally while incarcerated)? How many times did you do so? How helpful did you find these resources to be?
7. Did you have any coping mechanisms for when you were in solitary confinement or isolated for a prolonged period of time?
8. Did your time in solitary confinement affect your relationships with other people, including family, friends, correctional officers, or other incarcerated individuals? How so?
9. What were some challenges you faced during solitary confinement?
10. While you were in solitary confinement did you ever attempt to/have thoughts about hurting yourself or others? Have you ever had these thoughts outside of solitary confinement? [I will also remind participants about support services available to them, when I ask this question.]
11. Did you experience any feelings of hopelessness or helplessness while you were in solitary confinement and/or incarcerated?

12. Do you believe that you could benefit from mental health resources to address issues or challenges that you face as a result of your incarceration?
13. Would you be – or have you already been – willing to reach out for help regarding your mental health?

The objective of the interview questions would be to encourage participants to answer as specifically as possible, however they may interpret the question. After they have been interviewed, participants would be given two surveys to complete on their own:

- The 10-item Self Stigma of Seeking Help (SSOSH) Scale (Vogel et al., 2006).
- The Attitude Toward Seeking Professional Psychological Help (ATSPPH) Scale (Fischer & Turner, 1970).

The 10 item Self-Stigma of Seeking Help (SSOSH) Scale was developed by Vogel et al. (2006), and is used specifically to assess the self-stigma associated with seeking psychological help. Participants would be asked to respond to each question on the SSOSH scale on a five-point Likert-type scale, from 1 being "strongly disagree," 3 being "agree and disagree equally," and 5 being "strongly agree." On this scale, items 2, 7, 9, 5, and 4 are reverse scored, and the total score ranges from 10 to 50. Higher scores on the SSOSH scale a higher level of hesitation toward seeking help from a psychologist or mental health professional, out of concern that doing so would negatively affect one's self-confidence, self-satisfaction, self-regard, and overall worth as an individual.

The Attitude Toward Seeking Professional Psychological Help (ATSPPH) Scale was developed by Fischer and Turner (1970) to measure confidence in mental health professionals, recognition of need for psychological help, stigma tolerance, and interpersonal openness. The negative items on this scale are reversed for scoring: a participant's score could range between 0 and 87, with a high score indicating a positive attitude toward getting help for mental health problems. The participants respond to each item on the list with how strongly they agree or disagree with the statement on a 4-point scale (0 to 3).

The participants in the current study would be administered both of these scales. Having data from both of these surveys would be helpful for understanding a variety of ways that stigmas toward seeking mental health treatment may affect formerly-incarcerated individuals.

Once the participants have completed both parts of the study, they will be linked to resources for mental health treatment. Because this study is based on the prediction that formerly-incarcerated individuals may have stigmas against seeking mental health treatment and therefore may not recognize the need for mental health help because of these stigmas, I would be prepared to direct participants toward programs where their mental health concerns could be properly addressed. For example, in the New York City area, Exodus is a program with five different locations that provides reentry services for formerly-incarcerated individuals, including mental health resources. The Exodus Center for Trauma Innovation (www.etcny.org), located in East Harlem, offers various forms of therapy for addressing trauma. Exodus also provides anger management classes and other forms of counseling. If possible, I would form a connection with Exodus and find the proper counseling for the individuals participating in the current study. Following the study, participants would be connected with this organization or

others like it in order to ensure that they receive help for any mental health problems that they may have.

Predicted Results/Findings

As noted above, I am predicting/expecting that people who have spent more time in solitary confinement will have more negative stigmas toward receiving mental health care because of the effects that solitary confinement may have had on their ability to comfortably and willingly open up to and trust new people.

More specifically, I am hypothesizing that many incarcerated and post-incarcerated people reintegrating into society may not be aware of, or have processed the ways in which their time in prison may have had a negative impact on their mental health and wellbeing, and therefore might be less likely to seek help for any mental health issues that they might be experiencing. I am also hypothesizing that people who have spent a higher percentage of their total incarceration in solitary confinement will have more negative stigmas toward receiving mental health care because of the effects that solitary confinement may have had on their ability to comfortably and willingly open up to and trust new people.

With the interview questions and survey measures that I am using for this study, I would expect that most participants would score high on the SSOSH scale indicating high levels of self-stigma associated with seeking help for mental health, and low on the ATSPPH scale, indicating low confidence in psychological resources, and low recognition of need for psychological help. I would expect to find that the longer incarcerated, the less likely these formerly incarcerated men would be to have sought mental health help, and the more likely they will be to have negative attitudes or stigmas toward treatment-seeking. One way to test this

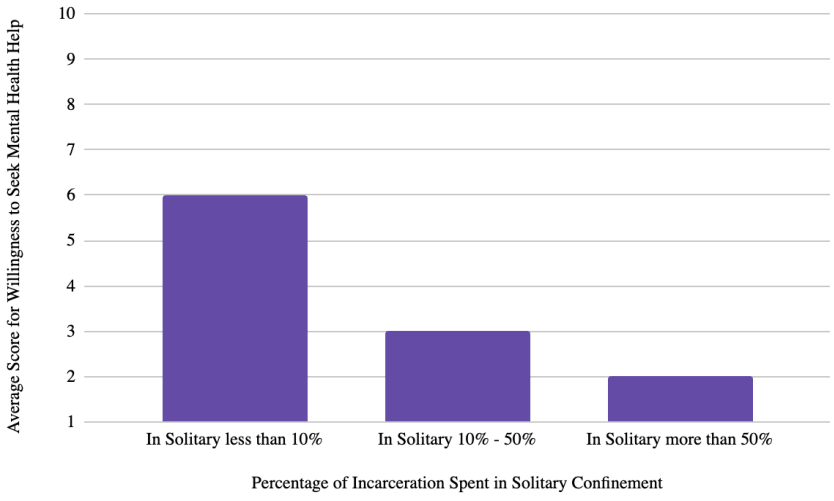
hypothesis would be to code interview responses regarding if they sought help (0, 1, 2, 3, 4 or more times) and how inclined they were to seek help (for example, responses to interview question #13). Scores will range from 0 to 10 on this coding protocol.

I will also score the SSOSH scale results and the ATSPPH scale measures and correlate these with the seeking help measure coded from the interviews, as demonstrated in Figure 1. My predicted results are shown in Figure 1, Figure 2, and Figure 3. To reiterate, these projected or anticipated graphs have been produced for the purpose of demonstrating my predicted results. There has not been any collection of data throughout this study:

The amount of time that a formerly-incarcerated individual spent in solitary confinement is represented by Figure 1.

Figure 1

Anticipated Average Level of Inclination Toward Seeking Mental Health Help



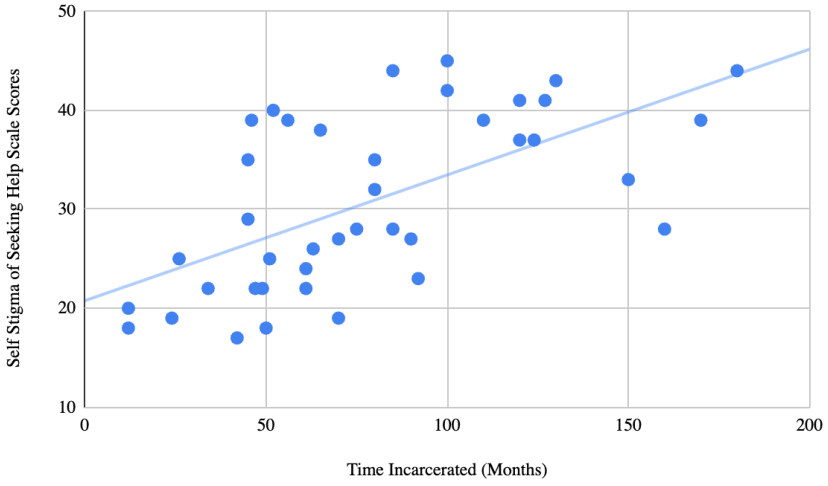
Formerly incarcerated individuals who spent a lower percentage of their incarceration in solitary confinement (less than 10%), I expect will be most likely to have either sought out

mental health treatment, or recognize that they may need mental health treatment, and be more open to seeking treatment. Individuals who spent 10 - 50% of their incarceration in solitary confinement will be less likely than the previous group to be open to seeking mental health treatment, and those in solitary confinement for more than 50% of their incarceration will be least likely to have positive attitudes or stigmas toward mental health treatment-seeking. It is important to note that although some individuals may be more willing to seek treatment than others, none of these three groups will score particularly high on willingness/positive attitudes toward seeking psychological treatment.

Figure 2 represents the predicted correlation of Self-Stigma of Seeking Help Scale scores with total time incarcerated.

Figure 2

Expected Correlation Between Months Incarcerated and Self-Stigma Re: Mental Health



These predicted results indicate that the longer an individual was incarcerated for (in months), the higher they will score for stigmas toward treatment-seeking for potential mental

health problems, and self-stigma associated with receiving mental health treatment. The potential scores range from 10 - 50, the higher scores indicating a higher level of stigma. There will likely be a positive correlation between self-stigma and amount of time incarcerated.

Figure 3 represents the expected negative correlation between the scores for the Attitude The Attitude Toward Seeking Professional Psychological Help Scale.

Figure 3

Anticipated Correlation Between Months Incarcerated and Attitudes Toward Seeking Mental Health Treatment

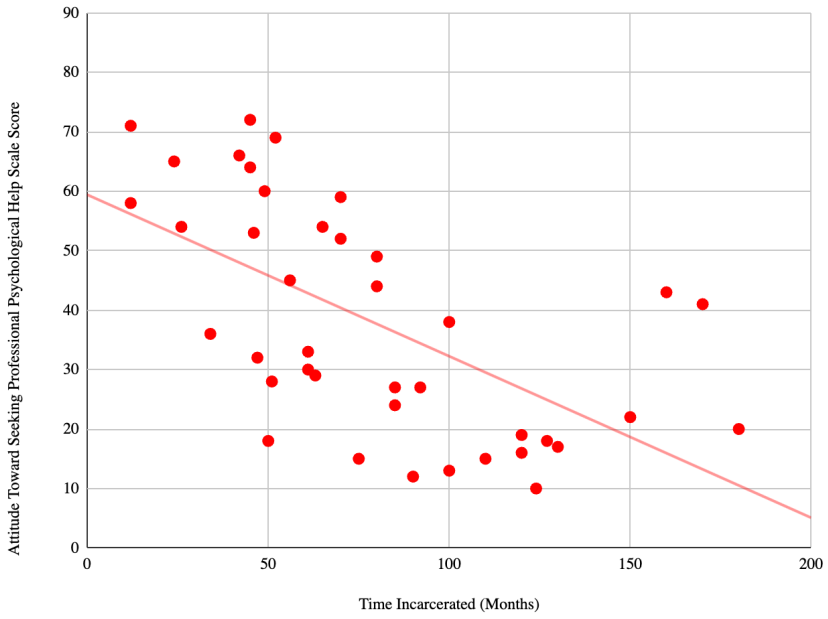


Figure 3 represents participants' predicted scores on the Toward Seeking Professional Psychological Help (ATSPPH) Scale and the total amount of time (in months) that an individual was incarcerated for. Lower scores on the ATSPPH scale indicate a low acknowledgement of need for psychological help, so therefore I am predicting that the correlation would be negative

– the longer someone was incarcerated, the more negative their attitude toward seeking mental health help.

Anticipated Challenges and Limitations

A challenge I would expect to face in this study would be building trust with the participants so that they feel comfortable answering the interview questions and completing the surveys as thoroughly and honestly as possible. My research has shown that incarcerated individuals have trouble trusting the mental health resources within prisons because of a lack of privacy and trust between them and the health care providers (Canada et al., 2022). It is possible that this distrust would still exist among formerly-incarcerated individuals, and would therefore be something to consider in carrying out this study and analyzing the results.

Another important factor to consider is that formerly-incarcerated individuals may be experiencing unresolved mental health problems and symptoms of Post-Traumatic Stress Disorder (PTSD) and PICS (Post Incarceration Syndrome, as described above), so this study must be done with mental health resources available to avoid re-traumatizing these individuals, or causing unnecessary stress on these individuals (Liem & Kunst, 2013).

Additionally, this study may be limited as it the results will likely primarily come from formerly incarcerated individuals working with reentry programs and already putting in effort to improve their mental health and well-being. The recruiting process would likely happen through reentry programs, and this may not account for formerly-incarcerated individuals experiencing more severe mental health problems as a result of incarceration. Therefore the data collected for this study may be more indicative of the attitudes of individuals that have already recognized that they may benefit from psychological treatment or other forms of mental health resources.

This is something to take into account when conducting this study, as the findings may not be generalizable to all formerly-incarcerated individuals.

Chapter 5: Reflections and General Conclusions

The analysis reported in this project attests to the fact that solitary confinement can affect an individuals mental health and wellbeing in a variety of ways. Isolation and ostracization increases levels of stress and anxiety, causes avoidance, denial, and repression, affects an individual's openness, worsens preexisting mental health problems, and enforces reclusive tendencies. The pressures of solitary confinement fall disproportionately on people of color, and Black people in particular, as they are incarcerated at a higher rate. A review of the literature supports the hypotheses directing this study: that formerly-incarcerated individuals reintegrating back into society will likely be unwilling to seek mental health treatment due to stigmas toward treatment-seeking, and the more time spent isolated in solitary confinement will exacerbate these attitudes. An interview study is proposed, as it could help to better understand these detrimental effects of solitary confinement on mental health, how these effects may lead to the development of stigmas toward seeking mental health treatment, and how different populations' mental health can be impacted.

The negative impacts of incarceration and solitary confinement point toward the need for reform in these areas. The neglect of incarcerated individuals' mental health has serious implications for violent behaviors within prisons, higher rates of recidivism, and the worsening mental health conditions that can contribute to both these issues.

Future researchers may expand on this analysis – and even the proposed study – by focusing more specifically on gender or racial differences in the stigmas that arise from prolonged periods of isolation. Incarcerated women face their own particular challenges within prisons, and these are worth focusing on in future research. Additionally, a focus on how to

provide support for racial minorities – who are so often disproportionately impacted by mental health symptoms, stigmas toward seeking treatment, and pressures within prisons – may be beneficial for improving the reentry process for these individuals and preventing recidivism. Expanding this study to different states across the United States besides just New York would also be useful for future work on this subject.

Solitary confinement is a practice that seems to do more harm than good within prisons. This severe form of isolation only worsens the wellbeing of an individual, rather than preventing deviant behavior within prisons. Recently, the New York City Council was working toward approving a bill that would ban solitary confinement in the state, a bill that has been stalled for years now. The bill would improve the conditions of solitary confinement by limiting its use, and banning it beyond the four-hour "de-escalation" period following an emergency (Fitzsimmons, 2023).

Although this bill did not pass, the support behind it provides hope for future reform policies surrounding solitary confinement as a form of punishment. Similar to New York's recent HALT act, New Jersey passed a law in 2019 limiting the length of solitary confinement to 20 consecutive days, Nebraska banned solitary confinement for minors, people with serious mental illness, and pregnant people, and other states have followed with similar regulations and limits (Fettig, 2019). These laws must be reinforced, so that prisons follow these practices without finding ways to work around them (O'Dea, 2024). There is a great deal of work on reforming solitary confinement practices that still needs to be done – changing these conditions will minimize the harsh impacts of prison that so negatively affect an individual's mental health both during and post-incarceration, and may reduce the stigmas around seeking mental health

treatment among these populations, allowing for more successful reentry for people once they are released from prison.

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Appendix A

The Attitude Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970)

Disagree, Partly Disagree, Partly Agree, Agree

0 1 2 3

Item
1. Although there are clinics for people with mental troubles, I would not have much faith in them.
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
3. I would feel uneasy going to a psychiatrist because of what some people would think.
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.
9. Emotional difficulties, like many things, tend to work out by themselves.
10. There are certain problems which should not be discussed outside of one's immediate family.
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
14. Having been a psychiatric patient is a blot on a person's life.
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
16. A person with an emotional problem is not likely to solve it alone; he *is* likely to solve it with professional help.
17. I resent a person—professionally trained or not—who wants to know about my personal difficulties.
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
20. Having been mentally ill carries with it a burden of shame.
21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know *everything* about oneself.
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.
25. At some future time I might want to have psychological counseling.

26. A person should work out his own problems; getting psychological counseling would be a last resort.
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.

Appendix B

The 10-Item Self Stigma of Seeking Help (SSOSH) Scale (Vogel et al., 2006).

'Strongly disagree' 1 2 3 4 5 'Strongly agree'

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.