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An Ex-Patient's Response to Soliday

Stanley M. Soliday's article expresses the view that patients need to be better educated about seclusion in order to bettter accept the use of this treatment modality. Speaking as a former patient and as an activist in the psychiatric inmates' ("mental patients'") liberation movement, I find Soliday's views extremely odd. It seems natural that patients have negative views toward seclusion; who wouldn't dislike being forcibly confined in a barren room, especially at a time of extreme emotional pain? It would seem to be a sign of health to reject seclusion, and a sign of pathology to accept it docilely.

Patients and former patients commonly view seclusion as a form of torture. This is true not only of activists in the ex-inmates' movement; most patients, when they have a chance to speak in a supportive and nonpunitive atmosphere, will speak negatively of their experience of seclusion (as well as of other forced treaments, and of psychiatric incarceration itself).[1]

The very word "seclusion" is a gentle euphemism for an extremely degrading practice which, in prisons, is referred to far more accurately as "solitary confinement" (the term that will be used for the balance of this discussion). Solitary confinement, when used in prisons, prisoner-of-war camps, and similar settings, is widely recognized as torture, or, at the very least, as a highly unpleasant form of punishment. In fact, long-term solitary confinement, in these settings, is recognized as a way to "break" or brainwash a prisoner. How, then, did solitary confinement become an acceptable method of "treatment" for psychiatric patients?

For the answer, we must look at the history of psychiatric institutions, which were not originally medical settings at all. The historic roots of mental hospitals go back to the poorhouses and workhouses of the 17th and 18th centuries. These settings were clearly punitive in nature; people who were indigent were seen (according to the prevailing religious philosophy of the time) as unworthy and in need of firm control (3). All sorts of people ended up in the poorhouses and workhouses; all were poor, of course, but they included widows and orphans, alcoholics, vagabonds and drifters, as well as those who, in modern terminology, would be referred to as mentally retarded and mentally ill. It was only early in the 19th century that these categories began to be sorted out according to currently used terms, and a medical overlay was given to institutions of incarceration for those labeled mentally ill (2). Various kinds of mechanical restraints had already been in widespread use; once the institutions were called hospitals, and their inmates called patients, physical restraints became identified as forms of medical treatment.

Staff in psychiatric institutions use solitary confinement as a method of imposing control. The common justification is that the patient is "out of control" or "acting out"; the therapeutic rationale is that the "reduced stimulation" provided by solitary confinement will help the patient to regain control. This justification ignores several important factors. First, the behavior the patient is displaying may be legitimate anger at the situation in which he/she has been placed. Involuntary commitment, forced drugging, denial of visits or phone calls, or any one of a number of real circumstances may leave the patient feeling justifiably frustrated and angry; his/her attempts to express these emotions may then be labeled as a loss of control requiring the imposition of solitary confinement, leading to further anger and further therapeutic justifications. If patients had the opportunity to express this anger to someone (such as a legal advocate or ombudsperson) who would respond not to the supposed pathology of the anger, but to actual grievances the patient might have, many instances in which staff perceives the "need" for solitary confinement might be averted.

Second, whether the patient does or does not have legitimate reasons for his/her anger, the question remains whether "treatment" by solitary confinement is really helpful. Most people will acknowledge that in times of extreme stress and emotional pain, they yearn for human contact. For many patients, the worst aspect of solitary confinement is the forcible denial of such contact. In fact, staff in psychiatric institutions seldom touch patients except punitively. Putting a patient into solitary confinement or administering an unwanted injection of psychiatric drugs involves punitive touching; seldom does a staff member hold a patient's hand, offer a shoulder to cry on, or attempt similar caring kinds of touching. Patients are usually forbidden to offer this kind of supportive touching to one another. Alternative, nonmedical crisis facilities use friendly touching, including massage, as a way of calming an agitated person without the use of drugs or restraints (1). The efficacy of such methods is deserving of further investigation.

Third, it is widely acknowledged that sensory deprivation can cause hallucinations and other forms of bizarre behavior. Mental health professionals do not

[1] Patients or ex-patients have these opportunities at meetings or conferences from which staff and mental health professionals are excluded. The author has participated in many such meetings, including those held inside institutions with current patients. Examples in the text of experiences and opinions of patients and ex-patients are from the author's experiences during such meetings.

seem to have looked at this phenomenon in relation to the use of seclusion on psychiatric patients. Yet it is not uncommon for a patient placed into solitary confinement to become more agitated the longer he or she remains isolated (leading, of course, to justification for further isolation). It is possible that the "treatment" itself is producing more "symptoms," more pathology.

Finally, patients' own efforts to gain/regain control over their own behavior are thwarted by many staff practices, including exclusive control over the seclusion room. Numerous patients have related that when they asked voluntarily to use the seclusion room as a retreat, either because of chaotic conditions on the ward or because of their own feelings of imminent loss of control, they were not allowed to do so. Often such situations result in the patient later being forcibly put into solitary confinement. Staff has retained the position of authority and control, but at what cost?

It is argued that solitary confinement is valuable as a psychiatric technique because it "works"; indeed, most (but not all) patients emerge (eventually) from isolation subdued and "in control." There are many possible explanations. Soliday (and most mental health professionals) conclude that seclusion is an efficacious "treatment" for extreme agitation. Certainly, solitary confinement is negative reinforcement—it is so uncomfortable and unpleasant that many patients will learn to stop doing the things that cause staff to impose it. In this sense, solitary confinement can be said to "work"; this argument could equally be used to justify beatings.

Most patients are smart; they quickly learn that certain behaviors elicit desirable (or undesirable) reactions from staff. Patients are most likely to be thought "well" when the express the ideology of staff, and "sick" when they deny it. Therefore, many patients after an episode of solitary confinement (or forced drugging) will learn that the best way to avoid another one is to acknowledge therapeutic benefit, even if this is not how they really feel. When I was a patient, I remember thanking the staff for putting me into solitary confinement, and stating that it had helped me to regain control, being quite conscious at the time that I was deliberately lying (and being quite surprised that no one recognized it as such). I have heard innumerable similar accounts from other patients and former patients. In fact, in the ex-patients' movement, such tactics are known as "learning to play the game," and playing the game is widely recognized as the way to secure one's freedom.

Therefore, it is impossible to know how many patients who answered Soliday's questionnaire were expressing their opinions, and how many were, once again, playing the game. Patients who indicated on the questionnaire that seclusion "shows staff care" or that patients should be secluded were mirroring staff ideology, and quite possibly attempting to impress the researcher with their "wellness."

Soliday speculates on reasons why patients who had never themselves been secluded had similar feelings about the "treatment" to patients who had experienced it, and concludes that patients verbally and nonverbally communicate their needlessly negative opinions. He then advocates patient education as to its benefits, and proposes that such education might make solitary confinement less traumatic and more efficient, and reduce its undesirable effects. In other words, Soliday wants patients who have been isolated to feel only calm and in control as a result of the experience; they should not feel anger or humiliation. In fact, it may be an accurate perception by a patient that he/she has been put into solitary confinement as punishment—surely Soliday would agree that this happens (although he would hope that staff could be taught to use seclusion only "therapeutically"). In at least these cases (and we have no way of knowing how often they occur), anger and outrage are the "healthy" reactions. It is the position of the ex-patients' movement that, given the existence of involuntary commitment and the gross disparity in power between patients and staff, all interactions between them are tainted.[2] True helping cannot take place when the "helper" has so much real power over the person in need. This is the essence of the fundamental difference between mental health professionals and members of the ex-psychiatric inmates' movement. Our anger and outrage are real, no matter how often they are dismissed as just a further manifestation of our "pathology" or "paranoia."

We have experienced solitary confinement, forced drugging, and involuntary commitment itself as painful and humiliating. It is essential that mental health professionals stop denying our perceptions, and start listening to them.

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3. Rothman, D. J. *The Discovery of the Asylum*. Little, Brown & Co., Boston, 1971.

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[2] For information about the ex-patients' movement and its developing positions, see *Madness Network News*, P.O. Box 684, San Franciso, California 94101.

[3] Mental Patients' Liberation Front, P.O. Box 514, Cambridge, Massachusetts 02238.