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6 Seclusive Space: Crisis Confinement and Behavior Modification in Canadian Forensic Psychiatric Settings

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This essay offers a theoretical reflection emerging from the authors' qualitative empirical studies examining ethical practice and mental health care in Canadian forensic psychiatric settings. Forensic psychiatry is a specialized area of psychiatry uniting the fields of mental health, law, and criminology. Forensic psychiatry implies the use of (para)medical psychiatric knowledge or 'opinion' concerning patients who have legal issues. According to the American Academy of Psychiatry and the Law, forensic psychiatry involves 'civil, criminal, correctional, regulatory or legislative matters, and...specialized clinical consultations in areas such as risk assessment or employment' (AAPL 2005). While the AAPL's ethics guidelines acknowledge the 'special hazards' and 'potential for unintended bias' in the practice of forensic psychiatry—particularly in the courtroom—the Academy urges its members to 'minimize such hazards' and to 'strive' to reach an 'objective opinion' (AAPL 2005). Our research focuses on the clinical use of forensic psychiatry within correctional facilities, where it is applied to a captive population of inmates who have been diagnosed with a mental disorder linked, in some respects, to their incarceration.

This research milieu is of particular interest because it represents a hybrid space where psychiatry and corrections are entangled: correctional settings serve both as psychiatric hospitals and, foremost, as prisons where patient-inmates are serving out a criminal sentence. They are

both, and yet neither in any straightforward sense. As such, the milieu affords particular insights into the ways that corrections has been psychiatrized, and, conversely, how psychiatry has been informed by correctional or penal techniques, such as behavior modification programs (BMPs). As these settings are both psychiatric and correctional, the ethical collisions of these respective practices and discourses begin to come to light. Thus, our analysis may be germane to a critique of seclusion—especially segregation used as part of a BMP strategy—in both psychiatric hospitals and correctional facilities. Considered independently, the forensic psychiatric settings under study offer a privileged perspective on the manner in which psychiatric and correctional practices and discourses are mutually (albeit selectively) informative. This raises explicit questions about the nature of punishment in these settings: whether it is carried out in the name of corrections, in the name of psychiatric treatment, or at the extremities of each, in an equivocal space that secretes elements of both. It also raises questions about the authority of psychiatric and correctional interventions and the claims to ‘knowledge’ or ‘opinion’ upon which they rely.

Our argument focuses on the use of seclusion as an integral dimension of institutional behavior modification programs and part of a patient-inmate’s mental health treatment regimen. Because there is little empirical data, it is very difficult to trace the history of the use of the seclusion room as a BMP strategy in the Canadian context; however, it is worth noting that forensic psychiatric hospitals (special hospitals) and psychiatric units in the federal correctional system represent two settings where the use of seclusion was (and still is) linked directly, in many instances, to BMPs. Although the history of such a practice is difficult to establish, these two settings are sites where the practice began in a very systematic manner in the 1970s (Rothman 1975). BMPs were then ‘exported’ to (regular) psychiatric institutions when patients ‘controlled’ through these plans were transferred from corrections/special hospitals to regular psychiatric settings. If the former settings held the expertise to develop and implement BMPs, these plans were simply deployed in regular psychiatric settings following a training session with a liaison-nurse, usually offered when a ‘difficult’ patient is transferred from a highly secure environment to a less secure one. The penetration of these ‘special’ plans into regular psychiatric settings has had a salient impact on their use. Indeed, regular psychiatric settings have linked the use of seclusion to BMPs, and in many instances this practice has prompted public inquiries from professional colleges. Repeatedly, professional colleges have reaffirmed irrevocably that the use of

seclusion for BMP purposes constitutes a breach of professional ethics (e.g., OIIQ-CMQ 2011).

This chapter advances an ethical perspective, arguing that seclusion and the use of BMPs cannot be understood without a nuanced, critical examination of the place of the lived-body and how that body assumes a place, and takes place, as a necessary dimension of human subjectivity and personhood—for it is on this dimension of human subjectivity, we argue, that seclusion and BMPs are brought to bear. This constitutes the extreme nature of such ‘treatment’, as it occurs in ways that are not necessarily visible or quantifiable as punishment per se. If the lived-body is neither visible nor quantifiable as such, the challenge is to render the invisible visible, much as Pittendrigh (this volume) seeks to do in her analysis of inmates’ words, gestures, and symptoms, an agency which only makes sense within the context of the lived-body. We adopt a critical phenomenological perspective (Guenther 2013; Merleau-Ponty 1962; Murray & Holmes 2013, 2014) that understands the experience and the place of the lived-body as crucial to ethical inquiry. Our analysis unfolds in three parts, the first two elaborating a critical theoretical frame for the analysis of forensic psychiatric settings that follows in part three. In the first part, we begin with a discussion of medical ‘crisis’ (Foucault 2008a) in historical and contemporary contexts. We contend that the rhetoric of crisis offers us some useful terms by which we might better understand the effects of seclusion on lived-bodies. While the original meaning of ‘crisis’ was abandoned by medicine in the early 19th century, we explore its use in the history of psychiatric discourse. Through a discussion of seclusion, we argue for the value of crisis as a way to grasp the phenomenology of the lived-body and as a way to counter the neoliberal understanding of seclusion, which involves ubiquitous management paradigms and economic ‘efficiencies’ increasingly in place across forensic psychiatric institutions, including correctional facilities.

In the second part, we draw on Guenther’s (2013) chronology of seclusion or solitary confinement in the US prison system—from its early redemptive impetus, to reformative strategies, and then most recently its neoliberal guises. While Guenther does not discuss forensic psychiatric facilities, we argue that her historical periodization of seclusion is relevant here. She claims that the history of seclusion must be understood within the structural context of race and racism, both socially and institutionally. We take up the question of race in the Canadian setting, discussing the ways the secluded lived-body is stigmatized both by mental illness and the legacy of race and racism. Our purpose is to suggest that critical methodological approaches to race and racialization, such

as Guenther's, are of value to a critical phenomenological study of forensic psychiatry, BMPs, and the place of seclusion within this nexus.

Finally, in the third part, we use this theoretical frame to return to the place of seclusion and the use of BMPs in the forensic psychiatric setting. We argue that seclusion represents an extreme foreclosure of place, and yet place is nevertheless the necessary condition within which the lived-body takes place, where its subjectivity is made meaningful and personhood and ethics are properly conceived. In the foreclosure of place, then, personhood and ethics become inconceivable. In effect, persons have been disappeared, reduced to objective bodies for the application of liberal law, penalty, and psychiatry. We call for a different understanding of the seclusive spaces in which these powers are exercised—spaces that correctional and psychiatric powers constitute 'objectively' as grids of intelligibility, securitization, and management. We argue that, for those who experience them, these spaces are neither neutral nor objective sites of medical knowledge or correction; they are, rather, intersubjective *places* that are lived, inhabited, and embodied subjectively, by a lived-body.

The phenomenological crisis of the secluded body

While administrative segregation is seen as an essential tool for crisis management, the Committee learned that CSC [Correctional Services Canada] uses it too often to deal with offenders with mental health issues (Standing Committee on Public Safety and National Security 2010, p. 53).

The rhetorical use of the term 'crisis' gives us a way to think about what it means for a lived-body to occupy space, objectively, and to take up a meaningful place, intersubjectively, in relation to his or her lived environment. 'Crisis' is an ancient term, dating back to the Hippocratic corpus, and yet today it is married, as it is above, with a neoliberal 'management' paradigm, alongside 'seclusion' or 'administrative segregation', which is conceived as an 'essential tool' for 'dealing with' a captive population with mental health 'issues' (note the elision of 'illness' in this report). For more than two millennia, crisis was a pivotal concept for medicine, before the advent of modern pathological anatomy in the early 19th century. Crisis represented the truth of a disease, the turning point in its development, announced in, on, and through the lived-body itself. As Foucault (2008a) writes of this early definition, 'the crisis is quite precisely the moment of combat, the moment of the battle, or

even the point at which the battle is decided. The battle between Nature and Evil, the body's struggle against the morbidic substance, or, as doctors in the eighteenth century will say, the battle between solids and humors' (p. 242).

The early understanding and use of crisis gradually disappears from medicine beginning in the late 18th century with the birth of statistical medicine, anatomopathology, and physiopathology. However, while medicine abandoned the crisis paradigm, in the 19th century early psychiatry came paradoxically to rely increasingly on medical crisis, provoking and producing crises as a rhetorical justification for psychiatry's own claims to science and truth, for its own institutionalization and self-authorization. Psychiatry needed bodily crisis, Foucault argues, because 'neither the disciplinary regime...nor pathological anatomy, enabled psychiatric knowledge to be founded as truth' (2008a, p. 250). In other words, with no anatomical etiology for most mental illness, psychiatry invented one. With this critique, Foucault seeks to discredit psychiatry as baseless, unscientific, the domain of simulation and mere opinion. No surprise, then, to find early psychiatry allying itself with crime and penalty: crime was cast as a form of madness, and the mad as potential criminals. The prison, with its captive population, was the ideal laboratory. This allegiance was a way, Foucault writes, 'of founding psychiatric power, not in terms of truth, since precisely it is not a question of truth, but in terms of danger' (2008a, p. 250). The crises of mental illness ostensibly posed a danger to civil society, and society had to be protected from mad crimes (here early psychiatry anticipates the rise of neoliberalism and its calls for the efficient management of 'dangerous' offenders). In this manner, psychiatry comes to justify itself on the basis of pseudo-medical and criminological knowledge, observation, and demonstration. Foucault concludes: 'the psychiatric hospital literally invented a new medical crisis. This was no longer that old crisis of truth played out between the forces of the disease and the forces of nature...but a crisis that I will call a crisis of reality, which is played out between the mad person and the power that confines him, the doctor's power-knowledge' (2008a, p. 252). Consequently, the seclusion room becomes a privileged locus for the dramaturgical 'realization' of madness, the space in which madness is made 'real' through a crisis that is induced, in a circular logic, by seclusion itself.

In Foucault's understanding, as we are reading it, crisis is the *effect* of psychiatric seclusion rather than its cause (also see Reiter & Blair this volume). Psychiatry produced crises and then explained them as physiological in origin. But the effect of seclusion is not simply physiological;

it is a 'crisis of reality' for lived-bodies, which are not simply objects distributed spatially among other objects, *partes extra partes*. They are relational subjects confronting the powers that confine them and the power-knowledge and 'objective opinions' of the medical establishment. In other words, the secluded person is subject; he or she inhabits a place, takes place, and lives in and through that place. While the term 'space' might be construed as geometric, Cartesian, and easily mapped in reality, by contrast we propose the term 'place' as experiential, lived, and embodied. Thus, crisis is produced and provoked when the phenomenological *places* of the lived-body are dis-placed by the *spaces* of seclusion. Merleau-Ponty (1962) argues that the lived-body is essentially intersubjective, a subject that exceeds its physical location or biophysiology. And as Guenther (2013) discusses in the context of prisoners subject to solitary confinement, 'the intersubjective basis for their concrete personhood, and for their experience of the world as real and objective, as irreducible to their own personal impressions, is structurally undermined by the prolonged deprivation of a concrete, everyday experience of other people' (p. 35). Seclusive space dismantles the referential and interpersonal place of the lived-body, structurally undermining the conditions for a meaningful experience of the subject's personhood and humanity. Together, lived-body, place, and the intersubjective presence of others permit a mode of subjectivity without which therapeutic relationships and mental health are reduced to lifeless abstractions and (punitive) injunctions. Along with Malpas (2003), our understanding of place concerns 'the making of persons through place and, more particularly, the way in which human persons are determined in their character as persons, or, indeed, as non-persons, through the institutional places in which they are located' (p. 234).

To be clear, we are not arguing for a return to pre-pathological nosology based on the early Hippocratic crisis; nevertheless, we would like to suggest that crisis is a fruitful metaphor to understand the lived-body phenomenologically (Murray 2012). And it may give us a way to describe the place of the lived-body in terms that continue to resonate for those who experience seclusion. The battle between nature and evil, or against a morbidic substance, as Foucault (2008a) describes it, is perhaps not so alien to the experience of secluded patient-inmates, particularly those who suffer from a mental illness. This way of speaking might be more appropriate if we hope to understand intersubjective relationships, which necessarily involve embodied fear, vulnerability, trust, interdependence, and uncertainty—elements that have no clear anatomical or biophysiological origins. We are arguing for a sense of crisis

that is necessary and intrinsic to relationality, sociality, and embodied history—a bodily exposure and precariousness (Butler 2004) without which there can be no true therapeutic relation, no mental health, and no ethical treatment program.

This existential sense of crisis is undermined by seclusion: seclusive space is no-place, it is what Foucault would call a heterotopia. Heterotopias, he writes, 'are something like counter-sites...outside of all places, even though it may be possible to indicate their location in reality' (Foucault 1984 [1967]). Foucault's brief history of heterotopias sheds light on the crisis of the secluded body: from bodies entering sacred or forbidden places to social bodies 'in a state of crisis: adolescents, menstruating women, pregnant women, the elderly, etc.' (n.p.). He contends that these sites of bodily crisis are disappearing in our society: 'heterotopias of crisis are disappearing today and are being replaced, I believe, by what we might call heterotopias of deviation: those in which individuals whose behavior is deviant in relation to the required mean or norm are placed' (n.p.). Existential and bodily crises (in the ancient sense) have given way to crises of deviance and abnormality—crises that are socially and institutionally manufactured, by psychiatry and by the prison (and Foucault names them both). In other words, we move from the crisis of a body in transition to a crisis of permanent and endemic deviance and abnormality.

The shifting notion of 'crisis' comes to correspond to particular places, and these places, increasingly, are not just sites where bodily crisis is localized, but they produce crisis, and become essential tools or technologies for crisis management, through the social and institutional ascription and then containment of deviance and abnormality. Foucault (1984) characterizes heterotopias through the metaphor of the mirror, a placeless place. 'In the mirror I see myself there where I am not, in an unreal, virtual space that opens up behind the surface; I am over there, there where I am not, a sort of shadow that gives my own visibility to myself, that enables me to see myself there where I am absent' (n.p.). This is a (non)place, then, of self-relation, in which the subject seeks in vain for self-reflection. As Foucault remarks, the mirror is both real and unreal: 'The mirror...makes this place that I occupy at the moment when I look at myself in the glass at once absolutely real, connected with all the space that surrounds it, and absolutely unreal, since in order to be perceived it has to pass through this virtual point which is over there' (n.p.). That unreal virtual point is social, intersubjective, and embodied. I am given back to myself through others, in a relational exchange that cannot wholly be subjected to neoliberal, statistical, or predictive

rationalities, to management or efficiency paradigms. To offer a critical articulation of these de-realizing forces, we turn now to a history of seclusion in the prison setting before taking up the specific question of seclusion and BMPs in forensic psychiatry.

Confinement in historical context

Replacing chains with total institutions was merely a first step in a seemingly endless process of enslavements, culminating in the self-enslavement of today's so-called 'service users', 'voice hearers' and miscellaneous mental patients on the dole demanding free 'professional services' from the very professionals they identify as their victimizers (Szasz 2014, p. 28).

In her recent book on solitary confinement in US prisons, Guenther (2013) offers a history of what she identifies as three waves of solitary confinement since the 19th century (based on Shalev 2009). Guenther's overview of what we are calling the crisis of the secluded body helps to situate our own analysis of seclusion in the forensic psychiatric setting. She characterizes the first wave as a moral and religious reform movement in the 1850s, which 'gave rise to the penitentiary system as a site of redemption through prolonged solitude' (Guenther 2013, p. xvi). While the first wave was organized around the redemption of the prisoner's soul, the second wave in the 1960s and 1970s adapted Cold War studies in counterintelligence interrogation and sensory deprivation to emphasize rehabilitation through BMPs that included seclusion as part of the correctional paradigm. Finally, the third wave began with the rise of neoliberalism in the 1980s 'and was led by prison administrators who sought less to redeem or rehabilitate criminal subjects than to isolate and control prison populations in ways that best suited the needs of wardens, prison staff, legislators, planners, and other stakeholders in the political economy of crime and incarceration' (p. xvii). The US supermax prison is the quintessential embodiment of this third wave of solitary confinement, where seclusion is used to control a 'dangerous' population and to manage risk with the greatest possible efficiency.

Guenther's text is more than an institutional history; she looks toward social, cultural, and political forces at play in the practice of seclusion. And she argues that the long history of solitary confinement in the US prison system cannot be understood apart from the legacy of slavery and the mass incarceration and hyperincarceration of people of color: 'a complex history of slavery, abolition, reconstruction, Jim Crow, and

the convict lease system, in which African Americans were both freed from slavery and hypercriminalized in ways that replicated and even intensified the dynamics of slavery' (p. 139). Institutionalized racism thus complicates the historical periodization of solitary confinement, suggesting an ongoing history of discrimination where the politics of 19th-century moral reform and redemption continue to operate implicitly across behavior modification, discourses of rehabilitation, and the efficient 'management' of predominately racialized populations (including purported gang members) deemed to pose some risk to a fantasized neutral, law-abiding population that is white, middle-class, and cast as essentially if not enduringly vulnerable. Solitary confinement in the prison is presented as one available tool to securitize law-abiding citizens and to stave off their moral panic—while discursively reproducing and invoking that panic, perpetually, through the reification of endemic dangerousness. The logic is circular. Within the neoliberal context, the use of statistics, models, and forecasts, involving costing, type of crime (violent, etc.), crime rates and rates of recidivism (by gender, age, race, socioeconomic status, region), and so on, are presented as self-evident 'facts' supporting this pursuit, while they nevertheless veil a social and structural classism and racism that operates as a violent norm and that perpetuates the systemic violence of the prison system itself. We might even say that these 'facts' reify or produce an understanding of race (or class) as real, or even biological, and thus serve to justify racism (or classism) as the consequence, rather than contributing cause, of incarceration. Much in the way that early psychiatry provoked and produced crisis as ostensibly physiological in origin, these sites simultaneously produce and punish what is constituted as intrinsic deviance, abnormality, located in and as the offending body itself.

To be clear, this is not an essay on the vagaries of race and racism in corrections or mental health, whether in the American or Canadian systems. Nor was this the object of our empirical studies. And yet, we would be remiss to ignore how race and racism operate as social and structural fantasies and forces in these contexts, how race and racism operate on the lived-body in ways that are often difficult to see or quantify—one manner, in Pittendrigh's terms (this volume), to make visible the invisible conditions of human suffering and harm. What is most significant for our argument here is the centrality of the lived-body and place—racialized, in one register, psychiatrized in another, and oftentimes both at once. Race and mental illness are the structural effects of social, institutional, and political *processes* that are too often tactically eclipsed by the ostensible neutrality of statistics and 'facts' (also see Metz 2010).

While the Canadian context differs in many ways from the American one, Canada's prisons are also sites of racialization and hyperincarceration of people of color, notably for Black and Aboriginal populations (Office of the Correctional Investigator 2014). Public Safety Canada (2014) reports in particular that the number of incarcerated Aboriginal (*self-identified* Inuit, Innu, Métis, and North American Indian) persons is disproportionately high: 33.0 percent of incarcerated women, 22.6 percent of men, while Aboriginal adults represent barely 3.0 percent of the Canadian population—an over-representation that far exceeds the per capita over-representation of African Americans in the US prison system. In Canada, Aboriginal persons also serve a higher proportion of their sentences before being released on parole. According to the Office of the Correctional Investigator (2013), 31 percent of offenders in segregation units self-identify as Aboriginal. However, these statistics only represent federal institutions, not provincial ones, and thus they do not include the many institutions that run segregation facilities known euphemistically and variously as 'alternative housing arrangements, secure living environments, special needs units, mental health units, intensive support units or gang ranges'. The government report flippantly refers to these as 'Segregation "Lite"' (government reports are not known for their irony, and in this spirit we are inclined to satirize these policies as 'Racism Lite'). As the report attests, these provincial units operate outside of administrative segregation law, and, therefore, according to the Correctional Investigator (2013), 'do not have [the] appropriate level of procedural safeguards/oversight'.

Thus, race and mental illness variably define the bodies and experiences of those who find themselves incarcerated and in segregation units, for these are lived-bodies that find themselves no-place in society, beyond the vanishing point of the mirror. As Szasz (2014) suggests, race and mental illness are historically interrelated: 'Replacing chains with total institutions was merely a first step in a seemingly endless process of enslavements, culminating in the self-enslavement of today's so-called "service users," "voice hearers" and miscellaneous mental patients on the dole demanding free "professional services" from the very professionals they identify as their victimizers' (p. 28). Szasz's position (for some, controversial) is that neither race nor mental illness are natural categories but are the effects of normalized social, historical, and political institutions. Racialized and pathologized suffering is no less real, of course, but it would be mistaken to see this suffering as emanating from 'race' or 'pathology' as such. He observes the historical continuity from slave plantations, to prisons, to psychiatric total institutions,

and finally, to our 'advanced psychiatric society' (Castel, Castel & Lovell 1982), where psychiatric power is normalized, widespread, and informs the ready uptake of neoliberal 'self-help' regimes, whether they are peddled by 'Dr. Phil' or are elaborated and underwritten by statistical 'science'. The statistics tell one kind of story, certainly, but they belie the lived experience, the phenomenology of those bodies that they seek to encompass; nor do statistics permit a real understanding or critique of the social and ideological forces that are propagated and implemented by institutions, turned into technologies and spaces that seize upon the lived-body and reify its place and its experience. In neoliberal terms, we are meant to believe that the patient-inmate confines him- or herself, through the rational, free, and autonomous choices he or she willfully makes, or through the imminent 'nature' of his or her race or pathology.

But it is much more than this if we begin to consider the ways that one's particular embodiment is intersectional and lived across and through the meaningful ways of appearing and being-in-the-world, much as Fanon (1963, 1967) does so eloquently in the context of race, racism, and subjectivity. Borrowing from Merleau-Ponty (1962), Fanon (1967) describes the lived-body in terms of 'bodily schema', which captures the ways our bodies are referential and intersubjective: 'In the white world the man of color encounters difficulties in the development of his bodily schema' (p. 110). 'Then', he continues, 'assailed at various points, the corporeal schema crumble[s], its place taken by a racial epidermal schema' (p. 112). The Black man finds himself no-place, and yet he is fixed in his place, his subjectivity foreclosed, with a meaning that is 'negative', a 'third-person consciousness' that defines the relation between his lived-body and the world as objective, 'epidermal'. The place of the racialized body, as Fanon describes it, helps us to grasp how bodies are displaced in and by particular settings or spaces, diagnoses, or 'opinions'. While the legacy of slavery in the US informs Black subjectivity and the carceral archipelago, in Canada, we must come to terms with the grim legacy of Aboriginal residential schools, the expropriation and exploitation of Native lands, high rates of poverty, HIV infection, suicide, and substance abuse, among many other social realities, the historical and institutional causes of which are multiplex. If Aboriginal youth are more likely to be incarcerated than to finish high school, this statistic must be understood together with the historic crimes committed in and by the residential school system, the crimes of the Church, the history of institutional barriers to resources, systemic racism, a medical system that condoned human experimentation on Aboriginal populations, and the intergenerational trauma of these experiences (see Coulthard 2014).

Admitting the significance of such a legacy, it is clear that the three historical periods of seclusion, as Guenther (2013) describes them—to redeem, to reform, and to implement a neoliberal management paradigm—overlap in subtle and often less subtle ways. Indeed, such a neat periodization (one could hardly call it ‘progress’) becomes somewhat implausible in the context of forensic psychiatric treatment and its use of seclusion. In our neoliberal present, the ‘rhetoric of rehabilitation or spiritual redemption’ is not ‘gone’, as Guenther (2013) at one point suggests of the US prison system; in forensic psychiatry it discreetly continues to inform stigmatizing perceptions of mental illness and treatment. We see, for example, a discourse on moral redemption operating when seclusion, used for behavior modification purposes, is presented as a therapeutic, rather than punitive, intervention, or as part of a behavior ‘contract’ or so-called ‘administrative’ segregation, the phenomenological effects of which are neither truly contractarian nor administrative. While moral redemption might strike us as an outmoded concept, it is nevertheless obliquely produced and demanded by neoliberal discourses that are hyper-individualizing and disciplinary, where the will and the interior desires of the subject must be reified and normalized through an entrepreneurial project of self-help and self-management. The normative force of neoliberalism is experienced as a *moral* imperative. It is driven by an onto-logic that turns the subject back toward what is presumed to be an interior reality, the identitarian ‘truth’ of who he or she is. In the supplicant, solitary interiority of seclusion, the subject is enjoined to find some causal link to an identity, as if his or her behavior emerged from some interior reality.

Meanwhile, what is violently effaced are the subject’s history, socio-cultural environment, race, embodiment, and relationships—in short, the subject’s world, his or her lived-body. Seclusion becomes the perfect metaphor for the neoliberal subject, turned back on the self, in itself, to take stock of his or her own resources, as if the world flowed from the self, and as if the failure to recognize this could justify cruel punishment or ‘correction’. In Foucault’s (2008b) terms, the neoliberal subject is an ‘entrepreneur of himself, being for himself his own capital, being for himself his own producer, being for himself the source of his earning’ (p. 226). This subject is ‘manageable’ and ‘governable’; this subject is rational, statistically informed, and ‘accepts reality’. ‘Rational conduct is any which is sensitive to modifications in the variables of the environment and which responds to this in a non-random way, in a systematic way, and economics can therefore be defined as the science of the systematic nature of responses to environmental variables’ (p. 271). Under

such a regime, achieving mental health would require the economic analysis of the subject’s own resources and rewards—enabling him or her to accept the reality of new ‘environmental variables’, and to work within them in order to maximize profits and minimize loss.

While Guenther and others (e.g., Davis 2002; Oshinsky 1996) have argued that the legacy of racism complicates the history of solitary confinement in the US prison system, we suggest that the study of mental illness and seclusion in forensic psychiatric settings could benefit from their social critique and how such a critique is modeled and deployed methodologically. While race and mental illness are dissimilar social phenomena, would it be farfetched to suggest that racism and psychiatry are mobilized by similar biopolitical and neoliberal strategies? The point, most emphatically, is not to reduce one to the other, but to complicate both fields of power-knowledge, to locate their intersections, and to attend to the embodied dimensions of these experiences (e.g., see Metz 2010). If the ‘truth’ of race is (re)produced through the prison system, and evidenced in part through the history of solitary confinement, to what extent might we say that the ‘truth’ of mental illness is (re)produced through forensic psychiatry and its use of seclusion? And what might this suggest for a study that turns to a critical account of the place of the secluded body?

Seclusion in/as behavior modification

[W]e must insist on distinguishing between such diverse and mutually antagonistic goals as custody and rehabilitation. We cannot permit administrators to slip so conveniently from one rationale to another (Rothman 1975, p. 23).

Most behavior modification programs (BMPs) are presented as ‘incentivizing’, comprising rewards and punishment programs, where ‘token economies’ are used and subjects are fashioned as the entrepreneurs of their own success or failure. Under such a regime, behavioral infractions can cause patient-inmates to lose ‘points’ that can be used to ‘purchase’ various rewards (snacks, or ‘life rewards’ such as television, social time, or later bedtimes). It matters little whether this is construed as a ‘loss’ of a potential reward or as a ‘punishment’, properly speaking. The results are experienced as equivalent. In one setting under study, these behavior modification techniques are administered by nursing staff, which, as we have argued (Holmes & Murray 2011), conflates and confuses the purposes of care and corrections, with potentially devastating effects

on the therapeutic relationship between a psychiatric nurse and his or her patient. We have critiqued such practices as neoliberal biopolitical paradigms that extend far beyond particular institutional constraints that might be deemed simply 'repressive' or 'extreme'. But BMPs do not solely consist of rewards-based 'token' economies; compliant behavior is also enforced through the threat of *losing* rewards and privileges, often involving seclusion as a negative reinforcement, a consequence of behavioral deviation in need of 'correction'.

Although the use of seclusion and BMPs in nursing is ethically controversial and has been criticized when employed as part of a patient's treatment plan (Holmes, Kennedy & Perron 2004; Holmes & Murray 2013; Muir-Cochrane 1995; Muir-Cochrane & Holmes 2001; Taxis 2002), the hybridity of the forensic psychiatric space allows these practices to continue unabated, in a gray zone—just one instance where correctional paradigms take priority over, transform, and often undermine, ethical therapeutic practice. At one of the facilities under study, the *Policies and Procedures Manual* (1997/2010) states: 'the [name of institution] is first and foremost a correctional institution. The operation needs of correctional services and the administration of justice in the provincial criminal justice system *will have priority* in the manner in which MCSCS [Ministry of Community Safety and Correctional Services] approaches its relation with [the hospital]' (emphasis added). Notwithstanding Rothman's (1975) early historical overview of behavior modification that warns against the 'convenient' administrative slippage between 'such diverse and mutually antagonistic goals as custody and rehabilitation', the very design of this setting facilitates and institutionalizes such slippage and antagonism.

In some respects, then, the institution becomes the metaphor (Douglas 1986)—from its behavior modification/treatment programs to its architecture—through which the individual comes to relate to him- or herself in neoliberal terms. And these neoliberal modes of (self-)relation are presented as the institutional means by which subjects will achieve their own redemption or salvation, by which they will be (re)habilitated to our new socioeconomic 'reality'. Once again, the use of seclusion to 'transform' behaviors is an apt metaphor for the self-reliant, entrepreneurial subject who is enjoined to claim responsibility for his or her own being, in isolation from—or 'ideally', as an individual in competition with—others. When used in conjunction, seclusion and BMPs seek to (re)habilitate and modify an individual's behavior to conform to a neoliberal socioeconomic system that is not in the least 'social' in any edifying sense. It champions an individualism that is ultimately sociopathic.

Here, a crisis of reality cannot be meaningful because we lose the sense in which the body is intrinsically and irreducibly relational, social, and historical. For mental health can only mean that the individual is not only or solely responsible for him- or herself, but to the commons, for a world that is shared, and for those wider conditions that will ensure that his or her place in that world is valued, meaningful, real.

The counter-therapeutic effects of seclusion are well documented. Grassian (2006) reports specific psychiatric symptoms linked with solitary confinement: (a) hyperresponsivity to external stimuli, (b) perceptual distortions, illusions, and hallucinations, (c) panic attacks, (d) difficulties with thinking, concentration, and memory, (e) intrusive obsessional thoughts, (f) overt paranoia, and (g) problems with impulse control (pp. 335–6). Meehan, Vermeer, and Windsor (2000) observe that patients who had experienced seclusion perceived the practice as punitive rather than therapeutic. Nevertheless, in one facility under study, BMPs constituted a regimen that included seclusion, managing patient-inmates' access to other parts of the unit, controlling how patient-inmates will spend their time, and dispensing or withholding 'rewards' and 'privileges'.

When used in conjunction with BMPs, seclusion is intended to modify or to correct deviant behavior—behavior that breaches what is figured as the 'social contract' in force at the institution. In one institution under study, upon release from 'administrative' segregation, patient-inmates are asked to sign a 'behavior contract' before being reintegrated into the unit. The contract states: 'In exchange for the privilege of spending time in his room out of locked seclusion, _____ will agree to...', which is followed by a bullet point list that includes the following: 'take olanzapine [which treats psychosis and bipolar disorder]...if either he or nursing staff feel he requires it to calm down, or de-escalate'; 'agree to re-enter the special observation room if either he or nursing staff feel he is escalation [*sic*] or losing control'; and 'no unsupervised contact with other [inmates] for 72 hours'. At the end it states: 'If any of the above criteria are not met, you _____ will be transferred to the [number] unit, and into a locked cell'. The contract is to be signed by the patient-inmate and two 'witnesses'. In one respect, these behavior contracts do operate loosely as social contracts intended to maintain order on the unit and to give the subject a sense of agency with respect to his or her actions, with the awareness that there are consequences for behaviors deemed unacceptable.

But this is not a contract in the proper sense of the term. Consent is illusory because the patient-inmate does not enter into this contract

freely or as an equal subject under the law; this person has had no hand in designing the contract's terms or penalties, and they remain in some instances vague. He or she accepts from the position of a secluded subject, not a social one; the subject accepts as one whose social privileges have been revoked, who no longer holds the moral authority to enter a binding contract; social reintegration is promised, and purchased, with compliance. The illusion of freedom and agency is the manner by which the subject comes to conform to a set of norms, to modify his or her behavior. Yet, if the nursing relationship involves embodied fear, vulnerability, trust, dependence, and uncertainty, then the therapeutic relation is arguably undermined when intersubjectivity becomes contractarian, when its terms are abstract, and when nursing staff are required to police and punish breaches of contract. This power exceeds, if it does not pervert, the therapeutic relation; the contract figures this power as purposefully arbitrary, based on what the individual nurse 'feels' is best. Finally, we might even say that BMPs and their related discourses seize a subject who is not really there, a phantom subject—in the name of a future subject, a subject, who, ideally, one day, through (re)habilitation and compliance, will become empowered to consent, but who cannot do so here and now. There is an odd temporality at work. At the moment the 'contract' comes into effect, it references a time that is not-yet, for a subject who is out of time. And spatially, it operates through a place that is no-place, for a subject who is nowhere.

Conclusion

Even in its solitude, the thing, like the thinker, never stands alone (Malpas 2012, p. 231).

There is no way, with empirical certitude, to fully account for the sociocultural history of bodies that live and die within the attenuated atmosphere of race and racism, or with the suffocating stigma of mental illness. This does not mean that we need not respond. We must. But the response must attend to what is at stake. It might be in kind, it may even be symbolic, and it may well acknowledge that it is sure, in some respects, to fail. It is difficult, if not impossible, to locate, to name, the disappeared subject of seclusion—and to imagine a subject, in that place, who could resist such subjugation. There is no subject who resists subjugation anymore than there is a single individual who subjugates him or her within this nexus of historical, social, and institutional forces; the subject is a lived-body, a cipher for a wider set of relations, who

takes up a singular place vis-à-vis those others with and through whom he or she is reflected, with and through whom he or she returns from the vanishing point in the mirror. In an ethical vein, we might call this 'responsibility': we are responsible for that which we cannot claim full responsibility, and for that which we cannot fully know (Butler 2005), for institutions and for structures, for those conditions in and through which the lived-body takes place, where its subjectivity is made meaningful, and personhood and ethics are properly conceived. This cannot and must not be reduced to a biopsychiatric, or pharmacological, intervention; care is more than this. It is the relationship between lived-bodies that have complex histories, are culturally situated, and produced as racialized, ill, delinquent, and so forth. Indeed, *refusing* to recognize these intersectional dimensions constitutes a veritable crisis in the phenomenological sense, forcibly misrecognizing the body-in-seclusion as an object of liberal law, penalty, and psychiatric power-knowledge.

The lived-body is not simply an object among other objects. It is subject; it stands-with, subject to and subject for, others. It does not live and breathe in cartographic space but inhabits a place and takes place, living in and through that place. As Merleau-Ponty (1962) argues, place 'is not a setting (real or logical) in which things are arranged, but the means whereby the position of things becomes possible' (p. 284). We must be responsible for these means because seclusion undermines the possibility of positioning oneself, and psychiatry often turns seclusion into a treatment program (when used in conjunction with BMPs) that forecloses upon the very thing it is purported to foster. In other words, seclusion is the foreclosure of that place in and through which the person assumes a place, and takes place. Legal and psychiatric rituals of civil death, within prisons or hospitals or increasingly in hybrid spaces, capture what Goffman (1961) terms being *mort au monde*—literally, dead to the world, dead to civil society. The civilly dead person is dead to the law (*civilliter mortuus*) but alive in fact, objectified biological life that is dispossessed of social and civic ties, displaced from the world. For it is the world, in a capacious phenomenological sense, that provides context and meaning for the lived-body and a life lived. It is this shared world that is lost in seclusion, which is no place, a placeless place, the absence of place, heterotopic. We have termed this 'seclusive space', a processual space that serves the double function of both providing and causing existential seclusion. In the first sense, being locked up provides (sometimes welcome) seclusion from others, which is obvious enough. In a second sense, however, isolation extends beyond objective bodily confinement, causing the seclusion of oneself in oneself, civil death.

In this sense, the subject is not just locked up but also locked in on him- or herself, unhinged from those intersubjective anchors that make the world a meaningful place, a condition of human personhood and ethics.

As researchers who live our lives on the outside, it is tempting to qualify—and perhaps dismiss—our intervention as (merely) an external critique. We are guilty, it might be said, of importing our external categories and applying them through righteous indignation. This is no doubt partly true. Fassin (2012) explains: 'For some, the task is to unveil. For others, it is to translate. Those on the outside denounce the social order. Those on the inside offer a grammar of social worlds' (p. 245). Ultimately, inside and outside might represent a false binary. We have denounced, but have attempted to straddle both positions in this chapter. Inasmuch as we have sought to 'translate', to provide a 'grammar of social worlds', this has as much as possible emerged through the crisis of the secluded body and an understanding of the ways that lived-bodies take place in an embodied social world—a world that is made and made meaningful through a human intersubjectivity that we all share. A phenomenological approach bridges—or at least problematizes—our commonsense understanding of inside and outside, interiority and exteriority, just as a critical appraisal of the structural social and historical conditions of human being does, since it references the place of a shared world rather than a movement of some interior ideational 'content' that would be exteriorized as 'truth'. Finally, it points to something real, essential, that resists, in the end, a regime of visibility and quantification.

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7 Normalizing Exceptions: Solitary Confinement and the Micro-politics of Risk/Need in Canada

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Extreme forms of prison management including the use of force, restraints, and solitary confinement have become de facto behavior management strategies for prisoners struggling with mental health issues in Canada. This chapter focuses specifically on the use of solitary confinement (segregation) in Canadian female federal prisons to illustrate how extreme forms of penal control are becoming increasingly normalized in Canadian prisons (Zinger 2013), thus exacerbating the overall pains of imprisonment.² According to the Office of the Correctional Investigator of Canada's 2013 report, approximately 24.3 percent of the federal prison population has spent some time in segregation. Much of the increase in the prison population being subjected to segregation is limited to certain classes of offenders, especially those with mental health issues.

Despite the critical attention directed at extreme institutional practices including segregation, organizational apathy persists regarding the development of alternatives and the implementation of numerous recommendations stemming from a recent coroner's inquest, OCI annual and special reports, and older task force reports about the use of administrative segregation (TFAS 1997; Arbour 1998). In this chapter, we focus on the case of 19-year-old Ashley Smith, who died from self-inflicted injuries in segregation in one of Canada's gender-responsive federal women's facilities. In this chapter, we explore why, despite the overwhelming evidence that exposure to long-term segregation has devastating mental health outcomes, Correctional Service of Canada (CSC) continues to use segregation routinely as a preventative and punitive tool to manage women who self-injure.