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Solitary Confinement in the Occupation Prisons and its Long-Term Psychological Effects on Prisoners

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Abstract

The study aims to identify the long-term psychological effects of solitary confinement on the released prisoners who had experienced it for long years. The study examines the case of a released prisoner who had spent eighteen consecutive years in solitary confinement and exhibited severe psychological disorders after his liberation. To evaluate the prisoner's condition, several tools were used for primary evaluation including semi-structured interview, the Psychological and Social Adjustment Scale, the Brief Psychiatric Rating Scale (BPRSP), and the Beck Depression Inventory (BDI-II). In addition, the American psychiatric association's diagnostic and statistical manual of mental disorders issued was used to assist in the evaluation process. the results show that the released prisoner suffers from schizophrenia and severe psychotic disorder, with severe depression and absence of psychological harmony. The patient is on medication for schizophrenia and needs continuous medical follow-up. The main direct or indirect cause of his condition is the years he spent in prison, especially the eighteen years he spent in solitary confinement. The study recommends conducting additional studies on prisoners who have spent years in solitary confinement. It also recommends preparing a comprehensive file on solitary confinement in the occupation's prisons to identify its grave psychological outcomes and communicating this issue to relevant international humanitarian and rights organizations to pressure the occupation to halt this policy and abide by the humanitarian standards stated in the international human rights charters.

Keywords: Solitary confinement; Palestinian prisoners; Psychological diseases; Schizophrenia

Introduction

Solitary confinement is one of the most severe penalties imposed upon a certain group of Palestinian prisoners in the Israeli occupation prisons. This penalty is imposed for various time periods according to the reason for which they are imposed on each prisoner. The isolation period may be as short as a day and may last for longer than ten years. As long-term solitary confinement almost certainly causes physical and psychological effects on prisoners, the study will focus on this category [1].

According to the definition of the high leadership commission for prisoners in the Occupation Prisons, solitary confinement refers to holding the prisoner in a physically and psychologically tight place, where any signs of social and human contact are kept in minimum. The aim is to keep the prisoner in continuous isolation in a small physical area and unbearable humanitarian conditions, until this isolation becomes a forced life condition that is imposed on the prisoner's body, senses, and eventually soul and mental capabilities. Solitary confinement is indeed "a prison within a prison" [2].

A prisoner in solitary confinement is considered as a prisoner who should not be allowed to live with regular prisoners, and should rather be isolated from them and kept in different life conditions under different imprisonment measures and deprived from the simple rights usually granted to regular prisoners. There are various reasons for considering a prisoner irregular, such as labeling him as "a dangerous person" that represents a danger to himself or to others. Another reason is considering the prisoner to be intellectually or financially influential, which may turn him into a role model or an example to others. Less important reasons are preventive reasons such as prisoners who are claimed to be "protected" or kept in solitary for "punitive reasons".

The term "solitary confinement" indicates social and physical isolation of the prisoner in a single cell for 22.5 to 24 hours a day. The prisoner spends the remaining time usually in isolation, but is allowed to walk, spend some time, or do exercise in a yard that is almost empty [3].

Solitary confinement in the occupation prisons is usually imposed for security reasons, psychological reasons, or as a punishment for not following "discipline" inside prison. According to occupation prison service, there are five reasons for solitary confinement: National security, prison security, safety and health of the prisoner or other prisoners, protection against true threat to life system in prison, and prevention of violence (as in organized crime or drug-related crimes). According to article 56 of the prison ordinance of 1971, a prisoner may be punished with isolation for committing one of 44 offences. The law also authorizes the occupation courts to sentence the prisoner for six months alone in a single room and with one other prisoner for 12 months. The court is also authorized by the law to extend the isolation of prisoners for infinite time periods. Security isolation is usually effected by a decision by the occupation intelligence under

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secret articles that are neither disclosed to the prisoner nor his lawyer. This prevents the prisoner from having an effective defense and causes the court hearings for isolation decisions to be merely formal, as a political decision is taken by the security bodies of the occupation. Isolation of prisoners is applied to disconnect them from the prisoners' leadership and the other Palestinian prisoners and detainees. The Israeli Prison Service practices this solitary confinement policy against the Palestinian prisoners, especially the leaders, as a punishment to shake them, submit them, weaken their organizational capabilities, divide them, and incapacitate them. The aim is to paralyze their ability to organize struggle for the rights granted to prisoners of war and freedom seekers stated in the Geneva Agreements III and IV and other human rights conventions [4].

It is only natural that long-term solitary confinement in the unbearable conditions imposed by the occupation prison administration would cause medium to severe physical and psychological damage that ranges from sleep disorders, anxiety and disorientation to depression symptoms that turn to chronic depression and loss of desire and sensation of surroundings.

Isolation causes constant fear that may develop into psychosis; a serious psychological condition accompanied with visual and audio hallucinations, acute episodes of confusion and anxiety, continuous thinking distortions and loss of sensation of time and place. The danger of isolation is that it exacerbates the condition of prisoners who already suffer from psychological problems and causes the healthy and psychologically-balanced ones to have these disorders that are incurable even after the prisoner is returned to regular imprisonment conditions, or even freed from imprisonment.

According to American psychiatrist, Stuart Grassian, who has examined many prisoners in solitary confinement in the United States, solitary confinement usually leads to psychosis [5]. Even the prisoners who do not develop frank psychosis report having symptoms similar to those of psychosis, such as inexplicable stress, delusions and confusion, difficulty to concentrate, memory problems, exaggerated response to external stimulators, cognitive distortion, hallucinations, primary aggressive hallucinations, persecutory delusions, motor overstimulation, and violent and self-distorting reactions. Some show rapid resolution of symptoms once the isolation is terminated. Grassian calls this set of symptoms "the solitary confinement syndrome" [6].

Psychiatrist Richard Korn confirmed symptoms similar to those listed by Dr. Grassian in females with no history of any psychiatric diseases who were subjected to long-term solitary confinement in the solitary confinement unit at an American prison. The list of symptoms mentioned by Korn included claustrophobia, general fatigue, apathy, loss of appetite, chronic rage, simple to severe suppressed depression, hallucinations, defensive psychiatric withdrawal, exacerbation of pre-existing health problems, and heart palpitations. While some of the psychological effects caused by isolation may resolve after the isolation is terminated, others are incurable. This means that the prisoners may enter the solitary confinement with perfect psychological health and leave it with permanent psychological disability that can cause the inability to deal with the community after their release.

The damage surpasses the psychiatric damage, because solitary confinement as proved by definite studies and medical reports causes diseases of the digestive system, the heart and blood vessels, and the genitourinary system. Isolated prisoners also suffer from trembling, migraine, chronic fatigue, heart dysrhythmias, difficulty breathing and severe sweating. Studies show that social isolation increases mortality rate by 26%-32% and leads to the physical health problems common with solitary confinement. Symptoms include heart palpitations, chronic headache, sensitivity to light and noise, dizziness, visual impairment, problems of the digestive system, problems of the genitourinary system, fatigue, excessive sweating, loss of appetite, muscle and joint pain, trembling hands, and weight loss [7].

Palestinian prisoners in the Israeli occupation prisons are, thus, prone to all these health problems, as hundreds or even thousands of them have been subjected to various forms of solitary confinement throughout the long years of struggle since 1967. Many of the prisoners were held in solitary confinements for years (more than twenty years in some cases). This gravely affected their physical and psychological health, with psychiatric disorders ranging from simple to severe. Among these prisoners is the released prisoner under study, who spent over 18 years in solitary confinement. When he was released, he clearly exhibited severe psychiatric disorders, thus representing a convenient case for research to investigate the outcomes of solitary confinement [8].

Case Presentation

Study method

The study is in line with the case study method, which is an extensive investigation about a person, a group of people, or a single unit through examining data relevant to a set of variables on the case. The aim is to conclude a generalization suitable for various groups stated in the research. A case study is defined as an extensive analysis of a unit, which may be a person or a community, based on development factors in the environment of the unit. As such, it is a detailed study of a person or a group that represent an example of a medical, social, or psychological phenomenon [9].

This study is an explanatory case study which focuses on relationships between cause and outcomes. This method is applied to conduct causative investigations, in which researchers look into the factors that may have caused a certain phenomenon [10].

Study population

The study population includes all Palestinian prisoners in occupation prisons who have spent years in solitary confinement cells for any reason [11].

Study sample

The study sample is an ex-prisoner who had spent about 18 years in solitary confinement in the Israeli occupation prisons and was released in the prisoners exchange deal between the Palestinian resistance and the occupation government in 2011 [12].

Study hypothesis

The study hypothesis is that Palestinian prisoners in the occupation prisons who have been held in solitary confinement and have experienced its severe conditions for long times have suffered from mild to severe physical and psychological disorders as per the nature and duration of the isolation and the way the prisoner adjusted with this isolation [13].

Study tools

- Case History
- Semi-structured Interview
- Beck Depression Inventory (BDI-II)
- Psychosocial and Social Adjustment Scale
- Brief Psychiatric Rating Scale (BPRS)

Case history: The case history tool refers to all the information related to the case; be it a person, a group, a social system or a local community; since the inception of the phenomenon until its current condition [14].

Semi-structured interview: It is an intentional verbal interaction that is conducted in person, and in which the interviewer attempts to provoke the information, opinions, or beliefs of the interview to obtain objective data. This technique allows the collection of qualitative information that help identify people's positions and orientations regarding an aspect of their life. It aims to facilitate expression for the interviewee through directing him/her towards topics that are essential for the study, while granting him a certain level of independence [15].

Psychosocial and social adjustment scale: This scale, developed by Dr. Zeinab Shuqair, head of psychological health department at Tanta university, is one of the most commonly applied psychosocial scales prepared in Arabic, as it is convenient for the Arabian environment. The scale is validated and its reliability has been proved.

The author managed to conclude essential dimensions of psychological adjustments: Personal adjustment, health adjustment, family adjustment, and social adjustment. In total, the scale includes eighty items that measure the general psychosocial adjustment and are distributed to the four dimensions. The total score ranges from zero to 160. The higher the score, the better the psychosocial adjustment in its four dimensions. Equally, the lower the score, the worse the psychosocial adjustment in its four dimensions. The scale is useful for all people from late childhood to elderly.

Beck Depression Inventory (BDI II): It was developed by Aaron T. Beck and was first published in 1961. It is a self-scored scale of 21 multiple-choice questions. The author relied on the negative cognition distortion theory as a center of depression. The scale is among the most commonly applied tools to measure depression, as it was a revolutionary turning point among specialists, who had always perceived this disease from a dynamic perspective instead of seeing that it was inherent to the patient's thoughts.

The tool was developed in 1996 in response to the criteria of diagnosing depressive disorders in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). Beck's depression inventory is composed of 21 paragraphs that describe the patient's feeling throughout the previous week about a certain topic. Each question presents four choices of gradual intensity and represents a depression symptom. The mechanism of the scale is that each answer is given a score from 0 to 3. At the end, the total sum is calculated and the degree of depression is evaluated according to a key that determines the severity of the depression, as follows: 0-9 indicates a minimum level of depression, 10-18 indicates mild depression, 19-29 indicates moderate depression, and 30-63 indicates severe depression. The scale was tested several times for validity and reliability, and the tests showed improved validity and reliability over the primary edition of the scale.

Researcher Gharib Abdul Fattah Gharib translated the questions of the BDI-II into Arabic under practical standards and applied it on a sample from the Egyptian environment. The researcher conducted the reliability test through the retest method, the Cronbach's alpha test, and the validity test through construct validity, convergent validity, differential validity, and factor validity.

Brief Psychiatric Rating Scale (BPRS) expanded version (4.0): This scale, in its fourth edition, is valid and reliable. It is widely used to evaluate the positive, negative, and emotional symptoms of people with psychotic disorders, especially schizophrenia. It is also used to measure the effectiveness of medications on psychotic patients and the progress of recovery through several stages. The fourth edition of the scale includes 18 psychological symptoms related to the positive and negative symptoms of schizophrenia. Each item is graded from 1 (not present) to 7 (extremely severe). The higher the total score, the more severe the symptoms.

Results

- Name: A. Mohammed K. (A. K.)
- Date of Birth: 07/07/1963
- Nationality: Palestinian
- Social status: Divorced directly after his arrestment in 1988. He has three siblings
- Education: High school
- Children: Two (a boy and a girl)
- Profession: Unable to work
- Social and economic level: Intermediate

Case history

A. K. was arrested for performing resistance acts against the Israeli occupation on 02/10/1988 in a few-hours-long chase after he had pulled out an operation against a military vehicle of the occupation near his home in Sheikh Redwan neighborhood in the north of Gaza city. At that time, he was in perfect mental and physical health. He underwent harsh interrogation that included various physical and psychological torture techniques. A few months after he had been arrested, one of the occupation's military courts gave him a double life sentence. He spent about four years in regular prison divisions at Ashkelon Prison. These years witnessed disharmony between him and other prisoners as well as behaviors that were not in line with imprisonment conditions. Therefore, the prison administration transferred him to solitary confinement from 1992 until he was released on 25/10/2011 under the prisoners exchange deal between the Islamic Resistance Movement (Hamas) and the Israeli occupation government. This means that he spent 18 years of his 23 years of imprisonment in solitary confinement. After less than four years of his arrestment, his family members, who regularly visited him, noticed changes in his personality and presence of some psychological disorders.

Since he was arrested, he began to exhibit some traits such as social withdrawal. He could not stand social settings and preferred to stay alone. He was detached from his surroundings, and he presented with apathy, oversensitivity, feeling of guilt, appetite issues, visual and audio hallucinations, sleep disturbances, insomnia, delusions, non-insight, anger tantrums, and disorganized speech and thoughts. He was admitted to the psychiatric hospital in Gaza several times between 2014 and 2016, with the last admission being from 13/07/2016 until 04/08/2016. He was diagnosed with chronic schizophrenia paranoid schizophrenia. He was given many medications including Leponex 100 mg, Risperidone 10 mg, and Aripiprazole 20 mg.

Semi-structured interview

The patient's health condition only allowed a few-minute interview that was of no benefit, because he was undesirous and incapable of responding. The patient was skinny, and when he was addressed, he only smiled and repeated simple welcoming words without any ability to converse.

Therefore, a long interview was conducted with his son (A), who described his father to be like a child who only asked for food, drink, or cigarettes and sometimes made his own coffee. That is all he could do. He could not receive any guests, not even his first-degree relatives. The patient is detached from and unaware of his surroundings, even when there are sounds of bombardment at times of escalation by the occupation against the Gaza strip. He lives alone in his room, where he prays the fiver prayers each day. He fasts for an entire month, but not in Ramadan. For instance, he fasted an entire month between January and February instead of Ramadan, which was in April.

The patient's only son (A) describes the moment he met his father for the first time, "I was so eager to see my father. It felt like a dream coming true to finally meet my father, whom I had never seen before. I could not believe it was happening. When I saw the buses, I ran to find him, until I finally found the bus on which he was. They told me this was my father, so I ran to hug him and kiss him. However, he gave me strange looks, as if he could not recognize me. His hands were shivering. I had mixed feelings at that moment; I was happy to see him, but I felt sorry for him. He was in shock, as if he was trying so hard to remember that he had a son. It was difficult for him, especially that he was in a bad health condition due to torture and isolation, which caused him to lose his memory. The people around him told him I was his son, but I will never forget his confusion and the look of surprise on his face".

The son confirmed that his father's condition was extremely difficult at the beginning such that he was unable to leave the house alone, but with time he got better and became able to recognize people. He added that his father felt like a stranger with his own family and could not fit in at all. In addition, he could not eat or drink when he was first released, as he suffered from frequent vomiting that resulted in body wasting. After examination, he was diagnosed with peptic ulcer, so he was given the necessary treatment and fully recovered in few months.

The ex-prisoner's brother (A.K.) said, "My sick brother faces difficulty sitting in a chair. He spontaneously changes his position into squatting, because he was used to this position in the small solitary confinement cells, where a prisoner could not find space to stretch his legs." He added, "My brother suffers from many physical and psychological disorders that resulted from the inhuman practices of the Zionist prison administration against him." He confirmed that the prison administration followed a slow-execution policy against his brother. The ex-prisoner's brother reported that his brother was diagnosed with peptic ulcer, duodenal inflammation, a hernia in the chest area, and a kidney stone.

The brother's wife (F. K.) said, "He was arrested by the occupation in 1988. When he was still young, we used to visit him. Since 1992, however, he began to refuse to see us, so we stopped visiting. We were told by the other prisoners about his psychological breakdown." She added that his fellow prisoners attributed his condition to solitary confinement and the interrogation methods inside prison. She also said, "After his release, we noticed that he closed all windows, listened to Hebrew radio stations, and locked himself in his room. He would rarely accept to see visitors or leave his room. He probably wants to relive the condition of his 25 years of imprisonment, of which he spent 18 years in solitary confinement where the only sounds he would hear were the voices of Israeli guards".

Results of the psychosocial and social adjustment scale

This tool was applied through the patient's family, especially his only son, who was entirely responsible for taking care of him. Upon calculating the values of the four psychosocial and social adjustment dimensions both individually and in summation, the results showed that the patient suffered from maladjustment to a bad or a very bad degree. The total score was only 27 out of 160, knowing that 41-80 indicates poor adjustment, 81-120 indicates intermediate adjustment, and 121-160 indicates high adjustment. Each of the personal, health, and social dimensions showed bad adjustment, while family adjustment was intermediate. For each dimension, a score of 0-10 indicates bad adjustment, a score of 11-20 indicates poor adjustment, a score of 21-30 indicates intermediate adjustment, and a score of 31-40 indicates high adjustment (Table 1).

Dimension	Dimension degree	Total score	Adjustment level
Personal adjustment	9	40	Bad adjustment 10-0
Health adjustment	6	40	Poor adjustment 20-11
Family adjustment	12	40	Intermediate adjustment 30-21
Social adjustment	0	40	High adjustment 40-31
General psychological adjustment	27	160	Low adjustment 80-41
			Intermediate adjustment 120-81
			High adjustment 160-121

Table 1: Results of the four dimensions of the psychosocial adjustment scale.

Results of the beck depression inventory II

The beck depression inventory II was applied through the patient's family, especially his son. The total score was 39 of 60, which indicates acute depression, according to the scale's intensity key. The

score is interpreted as follows: 0-9 indicates minimum depression, 10-18 indicates mild mood swings, 19-29 indicates moderate depression, and 30-63 indicates severe depression (Table 2).

Item number	Score	Paragraph number	Score	Depression intensity indicator	
1	2	12	3	Score	Depression level
2	3	13	3	9-0	Minimum depression
3	3	14	0		
4	2	15	3	18-10	Mild depression
5	0	16	1		
6	0	17	3	29-19	Moderate Depression
7	3	18	0		
8	3	19	3	63-30	Acute depression
9	2	20	0		
10	0	21	3	-	-
11	2	-	-	-	-
Total	20	-	19	-	-
Final total	39			-	

Table 2: Results of beck depression inventory-II.

Results of the Brief Psychiatric Rating Scale (BPRS) expanded version (4.0)

The brief psychiatric rating scale was applied by the patient's family, especially his son who is solely responsible for taking care of him. The scale application protocol was followed in terms of the time schedule, the specific definition of the symptoms, and the directions for each symptom. The total score was calculated on a 1-7 point scale. The fifth item was unanswered, and was given the average point of 5.7. The total score was 108.7 of 126 (18X7). In other words, the severity of the symptoms was as high as (86.3%), indicating clear and severe symptoms of psychotic disorders (Table 3).

Item No.	Score	Total Score	Indicator of psychotic symptoms intensity	
1	1	7	Score	Psychosis level
2	6	7	0	Unassessed
3	7	7		
4	6	7	1	Not at all
5	5.7	7		
6	7	7	2	Very mild
7	7	7		
8	5	7	3	Mild
9	6	7		
10	4	7	4	Moderate
11	7	7	5	Moderately severe
12	7	7	6	Severe
13	6	7	7	Extremely severe
14	7	7	-	-

15	7	7		
16	7	7		
17	7	7		
18	6	7		
Total	108.7	126		

Table 3: Results of brief psychiatric rating scale.

Discussion

Examining the condition of the released prisoner according to the applied criteria and disregarding the effect of medication shows that the patient suffers from bad psychological and social adjustment, severe depression, and severe psychotic symptoms. According to the interviews conducted with his caregivers, who had also been in direct contact with him during his early years of imprisonment, and with his doctors, the patient suffers from the following symptoms:

- Social withdrawal
- Visual and audio hallucinations
- Disorganized thoughts and speech
- Delusions
- Detachment from reality
- Depressive mood
- Inability to withstand social sittings and preference to stay alone all the time
- Oversensitivity
- Lack of will
- Sleep disturbances, Insomnia
- Non-Insight
- Anger tantrums
- Appetite disturbances
- General weakness and body wasting

Therefore, it is highly probable that the patient suffers from schizophrenia. This diagnosis is in line with the standards of the American psychiatric association in its Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5), which requires the patient to suffer from:

- Delusions
- Hallucinations
- Disorganized speech (repeated, disorganized, or disconnected speech)
- Negative symptoms (lack of will, affective blunting)

The patient must suffer from two or more of the symptoms of delusions, hallucinations, and disorganized speech for a relatively long period throughout a month. Negative symptoms refer to all negative symptoms, disorganized behaviors and catatonic behavior. There should also be a defect in the social and functional performance represented in degradation of one or more aspects of daily activities; such as personal relationships, self-care and work; for a relatively long period since the first presentation of disorders, when compared with the individual's performance before the symptoms.

According to DSM-5, diagnosing a patient with schizophrenia requires two or more diagnostic criteria that are each present most of the time during at least a month with a significant effect on the social and professional performance for at least six months. The released prisoner, patient A. K., had never suffered from any psychiatric symptoms or disorders before he was arrested in 1988 but showed mild psychological symptoms in the early years of his imprisonment. In addition, there is no history of similar symptoms in his first-degree relatives. Therefore, the first reasonable hypothesis is that the patient was subjected to a severe psychological shock during interrogation, especially as interrogation encompasses a long list of harsh physical and psychological methods that last for weeks or even months, and that the solitary confinement conditions deepened this shock. The second hypothesis is that the patient has genetic predisposition and that the interrogation and the years of solitary confinement accelerated the presentation of his current symptoms.

The third hypothesis is that the solitary confinement harsh conditions for 18 years caused the psychopathological condition from which he currently suffers. The common factor among the three hypotheses is solitary confinement, be it the direct or indirect cause. Even if the patient had genetic predisposition or was subjected to a severe shock during interrogation; the lack of care, medication, and behavioral follow-up in solitary confinement (as is the case in solitary confinement in the occupation prisons) would inevitably result in the current severe psychopathological condition of the patient.

This finding is in line with the findings of several studies that investigated the relationship between solitary confinement and a large spectrum of psychological disorders. For instance, indicated that prisoners held in solitary confinement were 3.2 times as likely to commit self-harm acts per 1000 days at some time during their incarceration, relative to prisoners who were not held in solitary confinement. The same study added that prisoners subjected to solitary confinement were 2.1 times as likely to commit self-harm act during the days they were in solitary confinement and 6.6 times as likely to commit self-harm acts during the days they are outside solitary confinement, relative to inmates who had never been assigned to solitary confinement.

Perhaps the world health organization and the UN Office on Drugs and Crime gave clearer description of the physical and psychological effects of solitary confinement based on a great deal of previous studies and research. The report issued in 2013 stated perceptual distortions; oversensitivity; hallucinations; detachment from reality; visual, audio, sensory and olfactory hallucinations; distortions in time and place; and oversensitivity to noise and smells. Possible psychotic conditions range from paranoia to full-blown psychosis and include schizophrenia, psychotic depression, persecutory thoughts, megalomania, recurrent and persistent thoughts (often of a violent and vengeful character), and depression. Depression may range from low mood to clinical depression and includes mood swings, despair, social withdrawal, apathy, lethargy, loss of initiation spirit, and severe depression.

In the same vein, attempted to evaluate the psychological outcomes of solitary confinement in over 200 prisoners across the fifty prisons of the United States. He concluded that solitary confinement exacerbated pre-existing diseases and caused severe psychological disorders in previously healthy patients. He found that more than one half of the prisoners were unable to tolerate regular stimulators, while one third of them reported hearing noises and strange sounds of scary things. This indicates perceptive distortions that include hallucinations and delusions. More than half of the prisoners also reported unjustified panic attacks and distortions in thoughts, memory, and concentration. Nearly half of the prisoners reported having uncontrollable violent delusions such as the desire to mutilate the prison guards to take vengeance and enjoy torturing them. They also reported persecutory thoughts and megalomania. Almost half of the prisoners reported losing control over their emotions and causing unjustified quarrels and violent acts.

Numerous studies indicated that those who were subjected to the isolation experience reacted in various ways and degrees to solitary confinement. This reflects the variation in short and long-term psychological and physical effects of solitary confinement on inmates. It is evident that individuals who enjoy good health, strong personalities, at least average intelligence level, and good daily life style are more capable of resisting the negative effects of solitary confinement. On the other hand, individuals who have history of psychological disorders, have limited cognitive capabilities, have an impetuous nature, or have an unsound internal emotional status are much more prone to the danger of severe psychological disorders due to solitary confinement.

The psychological outcomes of solitary confinement also vary according to other personal and environmental factors such as personal background and pre-existing health problems. Environmental issues may include the conditions of the solitary confinement cells and the whole solitary confinement system such as the free time outside the cell, the level of human contact, and the reason for isolation which includes punishment, personal protection, obligatory/non-obligatory, political, and criminal reasons.

Despite the varied psychological response by individuals to solitary confinement, many develop serious health problems, regardless of the nature and conditions of the confinement and regardless of time, place, or any pre-existing personal factors. The main negative characteristic of solitary confinement is the minimized effective social contact, which leads to reduced social and psychological alertness, and consequently undermines their chances of maintaining good psychological and physical health. Almost every prison around the world has special divisions for solitary confinement for rebels, individuals who break prison laws and regulations, and sick individuals who may harm guards or other inmates. For example, the number of inmates held in solitary confinement each year is 80 thousand to 250 thousand prisoners, according to a report issued by the law school at Yale University.

Nevertheless, solitary confinement in many of the Israeli occupation prisons is quite different from that in other prisons around the world in terms of conditions and objectives. The released Palestinian prisoners who were assigned to long-term solitary confinement in the occupation prison cells almost unanimously agree that solitary confinement is the harshest tool for torturing and punishing prisoners. Isolation in regular prisons outside the occupied lands is usually a punitive measure for specific discipline offences. However, in the occupation prisons, isolation can be for political or security reasons based on the prisoner's history before arrestment. Occupation's Prison Law of 1971 allows isolating a prisoner for security purposes. This has turned isolation into a lawful tool in the hand of prison wardens and guards and the Shin Bet officials.

Dozens of Palestinian released prisoners who were subjected to solitary confinement stated that the nature and conditions in some solitary confinement divisions are so horrific they will inevitably leave psychological and physical outcomes that may last for years or even a lifetime even after the prisoner leaves isolation. Perhaps the worst among all solitary confinement divisions is one of the three solitary confinement divisions at Beersheba prison in the south of occupied Palestine called the "Seenuk" meaning "the small cell". Its cells are more like graves; the area of each is the area of a sleeping mattress. The cell is entirely closed with no ventilation or lighting. A prisoner cannot make any movements in these cells; he sleeps with his head against the wall and his feet against the cell gate.

One of the released prisoners who spent 23 years in occupation prisons and was assigned to the "Sinuk" isolation said it was 210 cm wide and 110 cm long, and it has no restroom, water, or windows. All it has is an iron bed and a dim light. One is allowed to use the toilet only once a day, when the jailor decides to open the gate for him. The prisoner, then, has to walk quickly with his hands cuffed carrying a water bottle to use for relieving himself. As such, the prisoner is completely isolated from the world, knowing nothing about what happens inside or outside prison walls. He is not even allowed to have a watch to tell the time.

Open solitary confinement is somewhat better than the sinuk isolation, as the cell is 1.8 m long and 2.7 m wide. It has a toilet and a water closet, but it has no room for walking or keeping any of the prisoner's possessions. The cells have poor ventilation and high humidity and can have two prisoners. The isolation cell has one small window near the ceiling. The door has a small eight-by-eight cm^2 window. The prisoner is allowed to leave to the cage-like yard, called the "fawra", for only one hour a day, during which he barely sees the sun. such short period is certainly not enough, let alone the fact that the timing of the "fawra" is not constant. It is, rather, subject to the choice of the prison administration. It can be as early as six a.m. on a cold rainy day. If the prisoner dares to ask to put off the fawra for one or more hours, he may lose his right to go out for the whole day.

According to a report issued by the Palestinian prisoner's society in January 2023, 40 Palestinian prisoners are held in solitary confinement in the occupation prisons under terrible conditions. Among these are seven prisoners who suffer from very bad physical and psychological conditions that are continuously worsening due to isolation. Prisoner Mohammed Jubran Khalil (39 years old) of Mazra'a Gharbiya in the north west of Ramallah who has been imprisoned since 2006 has spent the longest period in isolation, which is 15 years. The prisoner is spending a life sentence in the occupation prisons.

Prisoner Hassan Salameh has spent 17 years moving from one cell of solitary confinement to the other under security pretexts such as forming a danger to the Israelis and their security. Prisoner Mahmoud Issa spent a total of 13 years in solitary confinement, 11 of which were consecutive. Finally, prisoner Jamal Abdul Salam Abu Al-Higa spent about 10 years in isolation. Among the released prisoners who have experienced solitary confinement and its negative psychological implication is of Khursa village in the south of the occupied West bank. He was released upon completing his 17-year sentence. Having spent 13 years in solitary confinement, Al-Shahatit suffered from

memory loss and could not identify any of his family members, as stated by his father Yousef Al-Shahatit to the media.

International organizations concerned with human rights and torture realized the damage caused by solitary confinement. Therefore, the UN human rights committee, the UN committee against torture the UN special rapporteur on torture, as well as many international conventions and human rights experts stated that solitary confinement may be considered to exercise inhuman or cruel treatment and is a definite violation of the international covenant on civil and political rights and the convention against torture and other cruel, inhuman or degrading treatment or punishment of the United Nations and the European Union.

Solitary confinement is one of the psychological torture forms prohibited under article 1 of the convention against torture signed in 1984. It is also considered among the inhuman and degrading treatment methods prohibited under article 7 of the international covenant on civil and political rights. Additionally, the conditions of solitary confinement do not match the minimum healthcare standards of prisons and arrestment centers as stipulated in articles 91 and 92 of the Geneva Agreement IV. The isolation policy practiced in the occupation prisons is a direct violation of the fifth article of the universal declaration of human rights and of the seventh article of the covenant on civil and political rights, both of which absolutely prohibited torture and inhuman, cruel, and degrading treatment.

Therefore, in order to avoid losing more victims from among the Palestinian prisoners to solitary confinement, the Israeli prisons' administration must abide by the principles of international and human laws regarding the Palestinian prisoners or war captives and make drastic changes in their solitary confinement policies. These principles include:

- Article 5 of the universal declaration on human rights of 1948, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."
- Article 3 of declaration on the protection of all persons from being subjected to torture and other cruel, inhuman or degrading treatment or punishment, "No state may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment."
- Rule 31 of the standard minimum rules for the treatment of prisoners, "In no circumstances may restrictions or disciplinary sanctions amount to torture, corporal punishment or other cruel, inhuman, or degrading treatment or punishment such as placement in a dark cell."
- Rule 32/1 of the minimum rules, "The following practices are prohibited: Solitary confinement or reduction of a prisoner's diet without examination by the physician."
- Article 7 of the basic principles for the treatment of prisoners, "Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged."
- Principle 6 of the body of principles for the protection of all persons under any form of detention or imprisonment, "No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. No circumstance whatever may be invoked as a justification for torture or other cruel, inhuman or degrading treatment or punishment."
- Article 16/1 of the convention against torture and other cruel, inhuman or degrading treatment or punishment of 1987, "Each state party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment."

Conclusion

Solitary confinement in occupation prisons is one of the main tools applied by the prison administration to punish the prisoners and isolate them from other prisoners for various reasons, the most common of which are probably security and political factors related to the history of the prisoner prior to his imprisonment. Solitary confinement can last for few to more than ten years.

Considering the cruel conditions that the prisoner suffers from in solitary confinement cells, the negative physical and psychological implications are an inevitable result, though at varying degrees, for numerous prisoners. Cases of acute and chronic psychological conditions were reported among the released prisoners. Among these is the prisoner chosen as an example for this case study: A released prisoner who spent 23 years in prison, 18 of which were in solitary confinement. Through examining the released prisoner in person, conducting interviews with his first-degree relatives, and contacting dozens of released prisoners who knew him during his stay in prison; he suffers from schizophrenia with its typical symptoms (audio and visual hallucinations, delusions, disorganized speech, and negative symptoms such as lack of will and affective blunting) according to clinical examination and applied tools. As the patient had never exhibited any psychological disorders before his imprisonment, and as the schizophrenia symptoms were clear the day he was released after 18 years in solitary confinement; solitary confinement, with its well-known conditions and absence of follow-up and treatment, was the only or at least the main reason for his schizophrenia.

The researcher recommends conducting other studies on other Palestinian prisoners who have experienced solitary confinement for years in the occupation prisons to further investigate the relationship between the harsh conditions of solitary confinement in the occupation prisons and the physical and psychological disorders. The study also recommends making a comprehensive human rights file on solitary confinement in occupation prisons and its severe psychological outcomes and urging all competent bodies to communicate the issue to the international human rights organizations to pressure the occupation to halt this policy or at least mitigate its terms in line with the civil and political rights granted by the international and human rights law.

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