Locked In: Conditions of Carcerality Within Psychiatric Treatment Centers and Their Implications

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Abstract

There is little existing sociological research that analyzes how and to what effect psychiatric institutionalization in its entirety operates as a carceral system, and how the practices of these institutions function in a way that systematically strips patients of their autonomy, leading to further harm. The purpose of this study is to fill gaps in sociological research surrounding psychiatric institutionalization by providing detailed qualitative data derived by storytelling via autoethnography and in-depth interviews with persons who have previously been admitted to such psychiatric facilities. Connections drawn between the practices of psychiatric treatment centers and that of the prison system, such as the use of surveillance, confinement and restraints, and stratified level systems show that the psychiatric system instead functions as a carceral system, often to the detriment of patients.

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Introduction

At fifteen years old, I was involuntarily admitted to an inpatient psychiatric ward for the first time. I arrived in an ambulance, restrained to a gurney at my wrists and ankles, and was wheeled into the nurse's station where I was forced to strip down bare, squat, and cough in front of two strangers. Prior to this, I had only ever heard of strip-searches and the squat-and-cough method being utilized in correctional facilities–on *inmates* and detainees who were going through the booking process. This initial search was the first time of many in which I found my child-body naked under the interrogative eyes of strangers, "take off your clothes," they say callously, "everything".

From that moment forward, I spent days in a row curled up in the day-room, or the milieu[1], as it was referred to, in which clients are socialized with one another. What stood out to me most throughout the duration of my admissions was the fact that very quickly, patients learn that the fastest, easiest–and seemingly only–way to escape the institution is to lie and deny about the feelings and behaviors that brought them there in the first place. "If you perceive the environment as a prison — and prisons are a place of punishment — then you can't help but think you are being punished, whether consciously or unconsciously," stated Dr. Charles Herrick, chair of psychiatry for the Western Connecticut Health Network, in a New York Post Associated Press article (2019).

There is negligible existing literature surrounding psychiatric institutionalization that focuses on how and to what effect psychiatric institutionalization in its entirety operates as a carceral system. Additionally, there is little research detailing how this system can further traumatize vulnerable populations who are seeking treatment. Due to the fact that psychiatric

[1] **Milieu** is a term that refers to a person's physical and social surroundings or environment, and is commonly utilized in psychiatric treatment facilities in reference to the main living room or day-room area.

patients and those living with mental illness are a vulnerable and protected population in social research, there is little detailed, reputable sociological qualitative data derived by the actual lived experience of being admitted to a psychiatric institution. Through autoethnography and interviews, I intend to fill this gap in the sociological research around psychiatric institutionalization by providing detailed qualitative data.

The word *iatrogenesis* is defined as physician-originated harm (Black & Calhoun, 2022), and refers to instances in which health care causes harm to patients. Though iatrogenesis is typically used to describe instances of harm caused to patients within more general medical settings, I argue that this term can be extended and further applied to harm inflicted within psychiatric settings. Persons diagnosed with serious mental illnesses experience an average of 142 instances of physical harm per 100 hospitalizations, which sits in stark contrast to average patients, which experience 49 harms per 100 hospitalizations (Black & Calhoun, 2022, 782). It is well-documented that the risk for suicide peaks in the months following discharge from inpatient psychiatric care, and there exists sufficient evidence for suggesting that iatrogenic harm contributes to increased post-discharge suicide risk (Jones et al., 2021). Through my research, I intend to highlight the specific practices that psychiatric institutions utilize as a means of caring for and controlling their populations, and show that under the guise of providing care, these practices cause iatrogenic harm to patients who are seeking treatment.

The process of medicalization occurs across various spheres and social locations, and it transforms formerly non-medical aspects of human life into medical problems under Foucault's 'medical gaze' (Alexander, 2018, p. 12). Physicians and medical professionals are typically the only people with the power to medicalize, however, the patient-doctor dynamic and modern medical training has shifted this greatly. As time moves forward, medicalization is increasingly

driven by external forces, such as: pharmaceutical companies, insurance companies, socio-political movements, and shifting physician-patient relationships (p. 12).

For this study, I utilize interviews and autoethnography as methods to highlight the practices that psychiatric institutions and correctional facilities similarly utilize as a means of keeping complete control over their respective populations, leading to iatrogenic harm. The levels of psychiatric treatment addressed in this study include inpatient[2] and residential[3]. In order to investigate the experiences of and interactions between patients, staff, and other patients within psychiatric treatment centers directly from the people who have been impacted by institutionalization the most, I elected to conduct 1:1 in-depth semi-structured interviews alongside a personal autoethnography. This combination can provide rich and detailed qualitative data and in situ knowledge to fill gaps in sociological research surrounding psychiatric institutionalization.

In the following pages, I first address the convoluted history of, and mutually reinforcing linkages between, the carceral state and psychiatric industries in the United States. Next, I call upon Foucault's panopticon model and Repo's concept of carceral layers to discuss the use of constant surveillance within psychiatric institutions. Then, I focus on the restriction of patients' movement through the use of spatializing practices, isolation, and physical and chemical restraints. Finally, utilizing Goffman's concept of total institutions, I move on to analyze the systems of punishments and privileges that these institutions utilize in response to behaviors deemed deviant or defiant. Through my analysis, I argue that connections drawn between the policies and practices of psychiatric treatment centers and that of the prison system, such as the

[2] **Inpatient** treatment describes any hospital-based program with psychiatric, medical, and social services for the assessment/ treatment of a person with a mental illness diagnosis, including 24/7 programs for adults and adolescents at general hospitals, private psychiatric hospitals, and state psychiatric facilities.

[3] **Residential** treatment describes a single-site residence or house-based program that provides 24/7 supervision, generally for a minimum of 30 days, for adults and adolescents.

use of surveillance, restraints, isolation and seclusion, and stratified level systems show that the psychiatric system instead functions as a carceral system to the detriment of patients.

Literature Review

Historical Context: The Intersection of Incarceration and Mental Health

There are statistically more people in the United States experiencing mental illness within prisons and jails than anywhere else (Wallis, 2015; Wolff, 2017), which suggests that the U.S. correctional system is therefore the largest provider of mental health services in the country. From the 1970s through the 2000s, reports of large numbers of mentally ill persons in U.S. jails and prisons began to rise as a result of the 1971 U.S. War on Drugs, which initiated a policy shift toward punitive sentencing practices and reduced tolerance for the use and sale of illegal substances, and resulted in a dramatic increase in the population of individuals incarcerated for drug offenses (Wolff, 2017). Research suggests (Wilson & Wood, 2014; Orta et al, 2023) that the widespread trend of mass incarceration following the War on Drugs has contributed to and perpetuated a correctional system that is overburdened and not well-situated to meet the needs of its populations.

The term "criminalization of the mentally ill" was coined in 1972 to describe the growing rates of arrest and prosecution of persons with mental illness that came as a result of these changes in policy (Wolff, 2017). Prisons have been essentially deemed as *the new asylums,* because when comparing numbers of individuals with serious mental illness at correctional facilities versus mental health facilities, state prisons and county jails hold 10 times the number of people with serious mental illnesses than state mental hospitals (Orta et al, 2023). There exists considerable evidence (Wilson & Wood, 2014; Orta et al, 2023) that persons with mental illnesses are overrepresented among correctional populations, specifically those with substance

use disorders, mood and impulse control disorders, anxiety, schizophrenia, and other psychotic disorders (Wolff, 2017).

The ratio of incarcerated individuals living with a serious mental illness is disproportionate in comparison to that of the general U.S. population, and at any given time, there are over one million (Wilson & Wood, 2014) to two million (Hall et al, 2019) seriously mentally ill individuals under correctional supervision–in contrast, there are an estimated 50,000 residents in, and 189,000 admissions to, state and county psychiatric hospitals each year (Wilson & Wood, 2014). In the U.S. 5.7% of adults are living with a serious mental illness, whereas the prevalence rates in state and federal prisons and local jails are estimated to be 14% and 26%, respectively (Orta et al, 2023).

The increased rates of mental illness and substance abuse that are omnipresent within U.S. correctional settings stem from numerous factors. The majority of people in the U.S. experiencing serious mental illness and substance use disorders do not receive treatment due to the limited availability of mental health treatment resources. Risk factors that put people with serious mental illness at a greater likelihood of interacting with the criminal justice system include: housing, education, and employment needs alongside addiction, adherence to medication regimens, and trauma (Pope, 2016).

The U.S. criminal justice system not only disproportionately criminalizes individuals with mental illness, but also systematically and unjustly overrepresents individuals of Black, Latino, and Indigenous backgrounds (Wang, 2022), which are groups that already experience documented disparities in access to mental and physical health care–creating a double-burden of mental health and incarceration for these populations (Handunge, 2022).

Arrests of people with mental illness commonly involve behaviors that are seemingly bizarre or aggressive, as well as minor crimes such as trespassing, loitering, and public lewdness (Wolff, 2017). In contrast to popular belief, the presence of mental illness is not associated with an elevated rate of violence or violent crime–people who are mentally ill are more likely to be the victims of violent crime than the perpetrators (Wolff, 2017).

When entering custody, existing medication regimes and the autonomy that naturally comes with self-administration of medication are immediately disrupted by the policies of the prison, and this disruption can add to prisoners' anxiety, distrust of staff, and sense of helplessness while incarcerated, and can discourage incarcerated individuals from taking greater responsibility for their conditions (Bowen et al, 2009). The lived experience of incarceration is closely associated with long-term depression, bipolar disorder, and substance use post-incarceration, and incarcerated persons are three times more likely to die from suicide than a person in the general population (Handunge, 2022). Punitive segregation units and isolation are known to have serious repercussions on mental health, including: anxiety, depression, anger, cognitive disturbances and perceptual distortions, obsessive thoughts, paranoia, psychosis, and suicide (Wolff, 2017).

In *Harper v. Washington* (1990), the United States Supreme Court established the right of states to involuntarily medicate incarcerated individuals, without a court order, in emergency situations where an inmate is considered to be a danger to themself or others–essentially determining that federal and state interests could outweigh an individual's right to liberty within such contexts (Orta et al, 2023). This court decision has led to discourse surrounding what staff in correctional facilities deem as an emergency, and whether or not this exemption is used inappropriately as a chemical restraint in an attempt to control inmates (Orta et al, 2023). There

are a wide range of potential harms associated with chemically restraining people who are incarcerated, including the primary trauma of being medicated against one's will, as well as feeling like one's personal fundamental human right to bodily autonomy has been violated (Orta et al, 2023).

Surveillance

Building upon Foucault's panopticon model and Repo's concept of carceral layers, I argue that various policies implemented in psychiatric institutions operate like carceral systems wherein patients are constantly surveilled and controlled. Indeed, previous research about enclosed institutions argues that carceral layers overlap and accumulate within institutions and create some spaces that are more carceral than others (Repo, 2019, Page 188). Carceral layers are strongly related to power–particularly to the power relations that occur between administration, staff, and patients–and are linked to the laws, regulations, and practices of an institution.

The *law* or policies of a psychiatric institution determine when a person can be treated without their consent, and what kinds of coercive measures can be used, such as restraint and seclusion. "These coercive measures can sometimes change into carceral practices which are extended beyond the norms and implemented alongside with normative practices, and thus create overlapping carceral layers inside institutions" (Repo, 2019, Page 190). Carceral layers have both spatial and temporal aspects–characteristics related to time, duration, and the physical location in which they are actualized–because they tend to accumulate over time within specific places such as closed institutions, and specific spaces inside institutions, such as seclusion rooms within a psychiatric ward.

The panopticon is an architectural model of surveillance that can be applied to various forms of institutions, including psychiatric: at the outermost area, a ring-shaped building divided into cells, each expanding the width of the building; at the center, a tower with wide windows that open onto the inner side of the ring; the cells of the peripheral building each have two windows, one on the inside corresponding with that of the tower, and one on the outside to light in (Foucault, 2008, Page 5).

The Panopticon is described as "a machine for dissociating the see/being seen dyad: in the peripheric ring, one is totally seen without ever seeing; in the central tower, one sees everything without ever being seen" (Foucault, 2008, Page 6). Every occurrence within the panopticon is observed, written down, and transmitted by staff to higher-ups through a system of permanent registration and recordkeeping. For the model to function, the *inmate* must never know whether or not he is being watched at any moment, inducing a conscious state of permanent visibility that allows for the automatic functioning of hierarchical powers (Foucault, 2008, Page 6). Because the patient never knows whether or not they are being surveilled, they are inclined to feel and act as if they are always being watched.

The penetration of regulation and hierarchy into the details of everyday life creates a constant binary division between the normal and abnormal; the mad and sane (Foucault, 2008, Page 5). This constant state of surveillance is utilized by institutions as a mechanism for social control. This use of continuous active and passive surveillance within psychiatric institutions depicts a key feature of Foucault's panopticon model, and helps shape and perpetuate the carceral layers found within these institutions.

Restriction of Movement

The restriction of patients' movement through the use of spatializing practices, isolation, and physical and chemical restraints helps further shape the power imbalances between patients and staff within psychiatric institutions. Berkhout et al. argue that various elements create the conditions of carcerality found in institutions, including restriction, confinement, and control (Page 77).

A central feature of total institutions is the breakdown of the physical and cognitive barriers that ordinarily separate sleep, play, and work. Closed institutions are social hybrids, meaning they create and maintain a tension between the home-world and institutional-world through tight scheduling, regimentation, and bureaucratic rules, and utilize this tension as leverage for managing and disciplining *inmates* (Goffman, 1961, Page 317).

Within total institutions, there is a split between a larger class of individuals who live in and have restricted contact with the outside world–*inmates*–and a smaller group that supervises and surveilles them–*staff*–who are socially integrated into the outside world (Goffman, 1961, Page 315). Spatial partitioning is used to separate the *inmates* and guards–or within psychiatric institutions, the patients and staff–and only those in positions of power are able to move about freely (Foucault, 2008, Page 1). Total institutions are all-encompassing, meaning their character is symbolized by the barrier to social intercourse with the outside world, which is physically and tangibly built into the institution through locked doors, high walls, fences, and so forth (Goffman, 1961, Page 313).

Restraint is defined as any physical or chemical method of restricting someone's movement, physical activity, or normal access to their own body; *chemical restraint* is the inappropriate use of a sedating psychotropic drug to control behavior; and *seclusion* is the

involuntary confinement of a patient alone in a room (Zun, 2005). The use of psychotropic drugs as a first-line treatment is discouraged for patients displaying dangerous behavior, because it is difficult to distinguish between the use of these medications as a therapeutic invention versus a means of controlling agitated or violent behavior (Zun, 2005).

Seclusion and restraint both pose risk, and the use of these practices is permitted only when the risks outweigh the benefits, such as when a patient is immediately at risk of harming themself or others; these interventions should not be utilized for punishment, lack of resources or convenience, preventing a voluntary patient from leaving, drug reactions; a history of self-injury or aggression; or maintaining an orderly treatment environment (Zun, 2005). Complications from the use of restraint can include: psychological harm, injuring self or others, hostility or increased agitation, loss of dignity, damage to the therapeutic alliance, elimination problems, aspiration pneumonia, circulatory obstructions, cardiac stress, wounds, decreased appetite, dehydration, and death (Zun, 2005).

The restriction of patients' movement creates a self-serving loop: it is justified by them being a possible risk or unpredictable due to mental distress, and yet the confinement then contributes to further agitation, reinforcing the need for ongoing disciplinary practices (Berkhout et al, 2021, page 81). In other words, the authors argue that though a patient is isolated because they pose a risk to themselves or others, the confinement of a patient in distress only further compounds and furthers the distress that they are experiencing. The restriction of patients' movement through the use of spatializing practices, isolation, and physical and chemical restraints helps shape the power imbalances found between patients and staff, further strengthening conditions of carcerality.

Systems of Punishments and Privileges

The systems of punishments and privileges implemented within psychiatric institutions also serve as disciplinary functions, however they operate in overt ways. Within total institutions, a privilege system exists where the *inmate*, or patient, begins to receive formal instruction through three basic elements. First, there are house rules–a formal set of pre- and proscriptions that lay out the main requirements of conduct. Second, a number of clearly defined rewards or privileges are held out in exchange for obedience to staff. Privileges are not rewards, but a simple absence of depravations. Third, there are punishments for breaking the rules, such as the temporary or permanent withdrawal of privileges (Goffman, 1961, Pages 320-321).

Goffman (1961) theorized that within total, enclosed institutions, there is an authority system functioning on three basic principles: first, any member of staff has certain rights to discipline any member of the *inmate* class; second, the authority of coercive sanctions is directed to a multitude of constantly occurring items of conduct, such as dress, social, intercourse, and manners; third, misbehaviors in one sphere of life are held against one's standing within all other spheres (Goffman, 1961, Pages 318-319).

Upon entrance, the *inmate* goes through a process of *systematic mortification,* by which they are stripped of their supports, personal identity equipment, and possessions, and institutional items are provided as supplements (Goffman, 1961, Page 317). Following this, *standardized defacement* occurs, wherein family and occupational ties are severed and a stigmatized label is stamped upon the *inmate*. All areas of autonomous decision that the *inmate* once had are eliminated through the scheduling of collective activities by authority, and all channels of communication with the outside world are cut (Goffman, 1961, Page 318).

These punishments and privileges applied through the privilege system act as modes of organization within the total institution. Through the privilege system, staff are able to obtain cooperativeness from people who have just cause to be uncooperative, such as those who have been involuntarily admitted. Goffman (1961) explains that this institutional arrangement created by punishment and privilege systems causes a small number of easily-controlled privileges to hold massive significance to the persons being controlled; this same arrangement constructs a terrible significance to the withdrawal of such privileges (Page 321). The utilization of punishment and privilege systems within psychiatric institutions act as modes of organization and deterrents for defiant behavior, directly influencing the ways in which patients interact with staff and peers.

Methods

This research utilizes autoethnography and interviews as methods to highlight the practices that psychiatric institutions and correctional facilities similarly use as a means of keeping complete control over their respective populations, leading to iatrogenic harm.

I. Interviews

In order to investigate the experiences of and interactions between patients and staff within inpatient psychiatric treatment centers, 1:1 in-depth semi-structured interviews[4] were utilized as the primary research methodology guiding this study. Due to psychiatric patients being widely considered a vulnerable and protected population, they are often completely omitted from participating in research–the firsthand accounts of the unique lived experiences of these patients are rarely highlighted and often discredited. The stories shared by people who have previously been institutionalized can provide detailed qualitative data from the patient's

[4] This research has gained ethical approval from the Institutional Review Board (IRB) at Purchase College, State University of New York.

end–a perspective that is often dismissed and overlooked. Data accumulated from these interviews can provide valuable in situ knowledge and fill the gap in sociological data surrounding psychiatric institutionalization.

The proposed study sample included 10 or more participants aged 18 or older who have previously been admitted into any form of inpatient or residential psychiatric treatment center, and have been discharged from their most recent treatment experience a minimum of 3 years prior to their scheduled interviews. Due to psychiatric patients and persons deemed seriously mentally ill being widely considered a vulnerable and protected research class, this 3 year parameter was set with the intention of protecting respondents from experiencing unnecessary emotional distress, however, it also had the secondary impact of severely limiting the number of respondents eligible to participate in the study. Over half of the prospective respondents who filled out the sign-up form attached to the recruitment flier were excluded on the basis that less than 3 years had passed since their most recent admission, leaving only 12 total eligible respondents.

In order to gather respondents, a combination of purposive and snowball sampling was used via a recruitment poster that included a QR code, which was shared virtually on social media as well as physically posted across the SUNY Purchase College campus. The QR code links the person scanning to an interview sign-up form for respondents to provide necessary information to ensure participant eligibility. Following the submission of this form, eligible respondents were contacted in order to schedule one interview lasting 30 to 45 minutes. Responses to the sign-up form submitted by persons deemed ineligible were immediately erased. Interviews were conducted between February and April of 2024, and took place both in person at SUNY Purchase College and via telephone.

During the interviews, respondents were asked various open-ended questions from an interview guide [see Appendix A] about the program they were admitted to, how many times they have been admitted, the length of their stay, and their experiences on the ward. Respondents were also asked if the program they attended worked on a progressive leveling system, and how that might have influenced their interactions with the program, staff members, and other clients. Additionally, respondents were asked to share details surrounding to what extent patients were supervised, as well as any experiences relating to how staff members reacted to perceived misbehavior or noncompliance with the program rules. Finally, respondents were asked to share personal stories or anecdotes and given the open-ended opportunity to talk freely about any relevant topics that weren't touched upon. Following the interviews, all respondents were provided with free and relevant mental health crisis resources. The interview guide was carefully worded as to prevent bias and leading within the interviews, and the specific research questions guiding this study were not disclosed to respondents until the cessation of interviews.

The interviews were transcribed using Otter.ai[5], a software application that utilizes audio recordings in order to generate interview transcripts. Notes and data from the interviews were cleared of any personal identifiers immediately following transcription–all names were changed and recorded as a pseudonym–and audio recordings from interviews were deleted promptly following the completion of the transcript. All coding and analyses were performed through Taguette[6], an open-source document tagging tool for qualitative data analyses.

For this particular study, my positionality as both the researcher and a person who has previously been institutionalized has been incredibly instrumental in crafting an interview

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[5] **Otter.ai** is a speech to text transcription software that utilizes audio recordings, artificial intelligence, and machine learning. Otter allows researchers to develop transcriptions in real time.
[6] **Taguette** is an open-source web-based document tagging tool utilized for qualitative data analyses, which allows researchers to upload multiple documents, create tags, and annotate documents with tags and notes.

environment in which participants were able to feel comfortable, safe, and vulnerable, which in turn, allowed them to feel comfortable opening up about taboo topics and emotional memories.

II. Autoethnography

Within this study, autoethnography was used as a supplementary methodology to interviews because it provides rich and detailed qualitative information derived directly from the lived experiences of a social researcher, who has previously been institutionalized multiple times within the psychiatric system. All data collected for this autoethnography are presented through the lens of the lived experiences of a female-presenting teenager and young adult. This autoethnographic data was collected from 2023-2024 from past events taking place between June of 2014 and November of 2018 which occurred within various levels of psychiatric treatment centers in New York, Connecticut, and Massachusetts.

Following data collection, I went on to retroactively apply analysis utilizing grounded theory methods, which provide a set of strategies for conducting detailed qualitative research, enabling the researcher to develop a cogent analysis of the data collected (Charmaz, 1996, page 27). In, "Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care," the authors utilized a constructivist approach within grounded theory to enable the in-depth exploration of peoples' lived experiences in psychiatric treatment centers. From these interviews, the researchers performed a ground-up analysis of emergent themes in order to further understand the impacts of involuntary hospitalization on pathways to care following discharge (Jones et al., 2021). In this study, I built upon Jones' methods and utilized grounded theory to perform a ground-up analysis and coding of emergent themes from the collected autoethnographic data using Taguette.

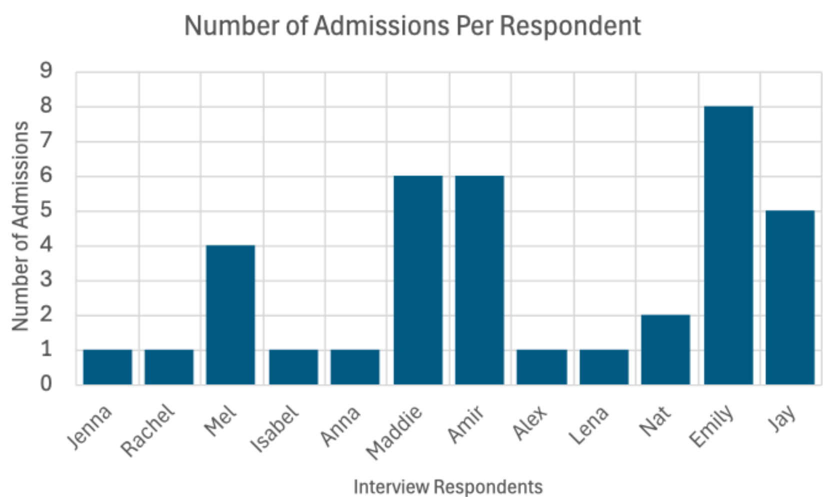
Data

The study sample included 12 total interview respondents with ages ranging from 18 to 28 years, with an average of 23 years and a median of 24 years old. Within the sample, eight or 66.67% of respondents identified as women, three or 25% as non-binary, and one or 8.3% identified as agender–the sample included zero men.

Of the 12 respondents, 7 or 58% identified as white; 2 or 16% identified as Hispanic/ Latinx; and 3 or 25% of respondents identified themselves as being of mixed race. Of the respondents who identified as being of mixed race, one identified as white and Chinese/ East Asian; one as white, Japanese, and Egyptian; and one as white, Colombian, and Spanish. One or 8.3% of respondents identified as Indian/ South Asian, and one or 8.3% identified as Peruvian.

Of the 12 respondents, 8 or 66.7% were admitted to inpatient or residential psychiatric treatment only as an adolescent, one or 8.3% was admitted only as an adult, and three or 25% were admitted both in adolescence and adulthood. Out of the 12 respondents, 6 or 50% were admitted only to a psychiatric inpatient program; 3 or 25% were only admitted only to residential treatment for eating disorders; 2 or 16.7% were admitted to both psychiatric inpatient and residential treatment; and 1 or 8.3% were admitted only to a wilderness-based therapy program.

Respondents reported being admitted from a range of 1 to 8 separate times with an average of 3.08 admissions per person. Of the 12 respondents, 6 or 50% were admitted only one time; the remaining 6 or 50% of respondents were each admitted between 2 and 8 times.



When asked about the nature of their admission processes and the extent to

which their decision to be admitted was voluntary and informed, 5 out of 12 or 41.6% of respondents indicated having experienced at least one completely voluntary admission, whereas 6 or 50% reported having experienced at least one completely involuntary or uninformed admission. Out of the 12 respondents, 5 or 41.6% openly described the nature of one or more of their admission processes in this regard as “complicated” or “confusing”.

Surveillance

Interview respondents were asked numerous questions pertaining to the ways in which they were supervised while in inpatient and residential psychiatric treatment. These questions touched upon topics including the program rules; to what extent patients were permitted to move freely throughout the ward; whether or not patients were able to go outside; how closely patients were watched during the day and night; and what methods staff would utilize to supervise patients.

When asked about the role that supervision played in their treatment experiences, all 12 respondents agreed, stating that supervision was extremely tight. Out of the 12 respondents, 5 or 41.6% stated that staff members would check up on them at a minimum of every 10-15 minutes throughout the day and night, independent of the facility or level of treatment that they were admitted to. Out of the 12 respondents, 5 or 41.6% of respondents spoke about the regular use of security cameras within facilities as a means of supervision, with one respondent, Mel, stating that even when you are not being directly watched, you are being watched through security cameras at all times. She further argued that this intense supervision was to make sure that “patients hadn’t killed themselves or something horrible like that”.

While all respondents expressed experiencing a high level of supervision, the extent of this surveillance varied depending upon both the level of treatment–inpatient versus residential–as well as the specific program that they were admitted to, and whether it was a public or private facility. Respondents noted significantly more intense levels of surveillance at the inpatient level of psychiatric treatment, wherein the treatment occurs within a ward of a larger hospital or facility.

Restriction of Movement

Interview respondents were asked a variety of questions relating to how staff would respond to different issues within the facility, such as patients having breakdowns, breaking the rules, acting out, or becoming violent. Respondents were also asked to what extent patients were permitted to move freely throughout the building or ward, as well as whether or not they were allowed to go outside during their treatment.

When asked if patients were allowed to move freely, Emily stated that the doors to the inpatient ward for adolescents had locks on them because kids would often try to escape. Maddie similarly stated that at two different inpatient programs, patients were "Locked in behind glass doors and unable to physically leave…We weren't allowed to see the light of day, we didn't even have real windows".

When asked about how staff responded to issues on the ward, such as a patient having an emotional outburst, 7 out of 12 respondents recalled the use of empty or padded isolation rooms, most commonly referring to them as quiet rooms, calm rooms, or isolation. Isabel stated that at inpatient treatment, if patients misbehaved or acted out, or tried to hurt themselves or others, "A bunch of nurses would come and put you in–I guess a timeout, but they would strap you down". Similarly, Emily recalled the use of injectable sedatives, or *booty juice*, stating that depending on

the intensity of the situation, there would be a takedown and an injection, and then the patient would be brought into the quiet room, which was a padded area. Amir recalled being put in the quiet room, but explained that they were never strapped down.

Punishments and privileges

During the interviews, respondents were asked multiple questions relating to the rules and level systems that are implemented within inpatient and residential treatment facilities. Respondents were asked what rules were implemented within the program(s) that they were admitted to, as well as how staff would respond if patients broke the established rules. Respondents were also asked whether or not the program(s) in which they were admitted to utilized a leveling system. Following this, they were asked how the system functioned, what would get patients moved up or down a level, and how they personally felt about the system in place.

Jay made a generalization that almost every program–whether inpatient or residential–follows a leveling system, however, each facility implements the system differently. In both the adolescent psychiatric inpatient unit and residential treatment, there were levels depending on patients' length of stay and the progress that they were making, however, the level system was "pushed more" in residential, likely due to the longer average length of stay for residential treatment centers. Jay recalled that in residential patients had a weekly contract group where they would find out their levels and get behavior contracts, assignments, observation levels, and privileges for the following week. They stated that patients are admitted on entry or pre-phase level contracts with constant 1:1 observations and zero privileges for the first few weeks, and as they move through the levels, they gain more privileges and freedom.

Anna recalled that when patients behaved well, staff awarded them points, and every time

patients acted out, staff wouldn't give them points for the day. In order to do certain activities, such as going outside, patients had to have behaved well enough for a certain period of time prior to the activity.

The Insurance Factor and the Cost of Care

Without prompt, 6 out of 12 or 50% of respondents talked about insurance during their interviews. Some respondents reported having little or no issues navigating treatment and insurance, stating, "Yes, they covered it, which was very helpful". Few interview participants recalled having little issue obtaining treatment with insurance, however despite differences in experiences, all respondents similarly recollected insurance being a major factor of contention and stress in psychiatric treatment settings. Despite facing minimal difficulties when dealing with insurance and cost, Amir, a non-binary 24 year-old, recalled that the second time they went to inpatient, their parents were trying to get them a bed on the ward and the hospital declined, stating that their family could opt to pay out-of-pocket for "like $3,000 a night," but otherwise, there was a week-long waitlist for admissions.

Other respondents expressed that they felt as if they didn't have enough time in treatment before insurance "cut" or discharged them from the program. Emily, a 27 year-old, emphasized the importance of talking about the insurance problem because her parents didn't finish paying off the hospitalizations until 6 years later, and when it came to getting coverage, she felt that she had to "give them a reason". She was discharged after a week from her first stay at inpatient treatment due to insurance purposes, and emphasized that this was not because she felt ready or wanted to leave. Emily explained, "They said I was fine and discharged me, but I was was put back in less than two days later for two weeks; and then I was released and put into an outpatient

program for about a month; and then I went back inpatient for another two weeks; and that kind of went on back and forth".

Mel, a 21 year-old who was admitted to inpatient psychiatric treatment as an adolescent, stated that when she was admitted, insurance would only agree to pay for a few days at a time unless it was approved by the doctor to stay longer. Insurance would "argue on the phone" with her psychiatrist, who tried to push for her to stay, and she recalled that insurance was a big factor in terms of how much money they would cover for different medications and therapies. She summarized that insurance would essentially "dumb it down," stating, "Insurance really wanted an impersonal, basic–okay, are you going to kill yourself or not–and if not, you're fine".

Rachel, a 27 year-old in recovery from an eating disorder, stated, "I think one of the biggest issues when it comes to eating disorder treatment as a whole is insurance coverage, and I think with the way that insurance is always pulling back, it could feel a lot more entrapping, like you have to move faster through the program…I was always panicking about the next step in residential, and not being where I was at presently…I kept saying I wasn't ready to leave, but that wasn't taken into account".

Lena, a 19 year-old who was admitted into an inpatient psychiatric ward as an adolescent, stated that while she was in treatment, her father told her about the financial cost of the inpatient treatment center that she was in. She recalled that even though insurance covered a portion of the cost, the total was still high, at about $8,000 per night. She said that because the treatment center was so expensive, her father said, "If you don't need to be here, you need to leave".

Nat, an agender 25 year-old who was involuntarily placed in a wilderness therapy program as an adolescent, recalled that their treatment was a big expense that was paid out-of-pocket by their family. Their family hired an educational consultant who recommended

the program, so they believe that many of these mental health programs have a lot of private financial deals and that they all refer patients to one another, stating, "It's a business, that's the truth".

Alex, a nonbinary 28 year-old who was admitted to a residential treatment center, expressed both a combination of frustration and gratefulness for the insurance element within psychiatric facilities. They further explained that they would've even considered going to residential treatment had they not been on their stepfather's insurance, stating, "I think I would've been shit out of luck otherwise, or I would've put my family in massive loads of debt".

Jay, a nonbinary 24 year-old who was admitted to both inpatient and residential treatment, stated that they would've never been able to obtain treatment if it weren't for their parent's insurance, however, it wasn't easy. They stated that in order to obtain treatment, one has to prove to the insurance company that they require that level of treatment that they're being admitted into, which can prove difficult. Recalling their first experience in residential at 16 years old, Jay shared that they were pushed for an early discharge because they weren't "making significant enough improvements". They expressed frustration with the current mental health system in the US, stating, "Insurance is difficult because they're some outside, all-knowing voice that decides your fate. They're not there in treatment with you, they aren't in your therapy sessions, and don't know you, but they have the final say".

Discussion

Here, I discuss the significant themes that emerged whilst analyzing and coding data derived from my autoethnography and semi-structured interviews. First, calling upon Foucault's panopticon and Repo's concept of carceral layers, I address how the use of constant surveillance on patients within psychiatric treatment centers operates as a method of social control. Then, I

discuss how the restriction of patients' movement through the utilization of spatializing practices, isolation, and physical and chemical restraints helps shape the power imbalances between patients and staff within psychiatric institutions. Finally, utilizing Goffman's concept of total institutions, I move on to discuss how the systems of punishments and privileges used within psychiatric facilities directly influence the ways in which patients interact with staff and their peers.

A major limitation of this study is that the majority of interview respondents were white, female, or both; none of the respondents were Black, and none were male. These bare areas in demographics can be attributed to numerous different factors. Due to the use of purposive and snowball sampling in order to gather respondents, it is likely that the majority of respondents were female and non-binary because as the researcher and person gathering respondents, all of the inpatient and residential treatment facilities I have previously been admitted to were strictly female-only wards. Certain cultures are less less likely to seek out and obtain comprehensive and culturally-relevant mental health treatment services (Durham, 2022), which adds difficulty to to the process of gathering respondents.

Moving forward, I would aim to gather an over-representative sample for Black, Indigenous, and male respondents. Alongside this, I would also collect more specific data relating to sexual orientation and socioeconomic status in order to better analyze those factors in relation to respondents' experiences, as multiple respondents noted these as influential factors on how staff would interact with patients in treatment settings and to what extent patients were surveilled. I would also aim to obtain more respondents who have been admitted to wilderness therapy programs and therapeutic boarding schools, as this study only includes one person from that realm.

Surveillance

Building upon Foucault's panopticon model and Repo's concept of carceral layers, I argue that the use of constant surveillance within psychiatric institutions creates a carceral environment wherein patients are constantly surveilled and controlled.

Foucault (2008) introduces the panopticon as an architectural model of surveillance that can be applied to various forms of institutions, including psychiatric. When applying the panopticon to psychiatric institutions, *inmates'* cells refer to patients' rooms, and the nurses' station operates as a central tower of surveillance. The nurses' station is set at the center of the panopticon, and is typically dome-shaped for high visibility. Patients are expected to present themselves at the nurses' station throughout the day for various reasons, such as for medication, vital signs, roll call, and to make phone calls to family and friends. *Inmates'* cells represent patients' rooms, and are lined up along the hallways with two wire-reinforced, locked windows in each room–one on the door so that staff can see into the room, and the other to let light in from outside. At the end of each hallway, there is a locked and guarded door to outside that only staff members are able to pass through freely.

Foucault (2008) further describes the panopticon as a "machine for dissociating the see/being seen dyad," wherein those in the peripheral ring are totally being seen without ever seeing; those in the central tower see all without ever being seen (Page 6). Within total institutions, every occurrence is observed, noted down, and transmitted by staff to higher-ups through a system of permanent registration (Foucault, 2008, Page 6) in which the patient never knows whether or not they are being surveilled, and therefore, patients are inclined to both feel and behave as if they are always being watched, creating an automatic functioning of the hierarchical powers of the institution.

When reflecting on the extent to which respondents were supervised in inpatient treatment, the majority of respondents stated that they were heavily supervised, and further went on to describe the contexts and methods of the supervision they experienced. Isabel, a 20 year-old who was admitted as an adolescent to an inpatient psychiatric unit, stated that there were nurses everywhere throughout the ward, and you could see both ends of the hall from wherever you were standing–someone was always watching. She recalled that when a patient is first admitted, "They watch you all the time, but usually they start to taper back after a couple weeks".

When asked about rules on the inpatient ward, Emily stated that the bed must be made, clothes must be put away, basic hygiene, and medication compliance. In agreement with this, Lena stated that taking medications "as they were prescribed" was a rule, as well as that patients weren't allowed to have laced shoes; there were room checks every 15 minutes; no food was allowed in patients' rooms. She recalled that in order to go outside, patients had to participate in group therapy, and stated, "You had to go to the meals, eat your food, and just follow along. Try not to make too many waves".

Maddie described her residential treatment facility as having an outside area where patients were allowed to go "relatively unsupervised" under the condition that they notified staff prior and stayed nearby. Alex noted that when they were first admitted to residential they were put in a wheelchair were not allowed to go outside unless taken by a staff member, whom they would have to personally seek out and ask, stating "I didn't want to fucking do that, they were always busy". They went on to explain that later on in their stay they had supervised walks as a group, and that some people were given permission to go out to walk by themselves, "But if you were doing something sketchy or you were out there for a bit too long, you would get noticed".

The panopticon model can also be seen as a mechanism to carry out experiments and monitor their effects, to alter behavior, and to train or correct individuals (Foucault, 2008, Page 8), more specifically those who are other-ed as deviant or defiant. The penetration of regulation into the details of everyday life by a hierarchy of power creates an individualization of the excluded, and a constant binary division between the normal and abnormal; the staff and patients (Foucault, 2008, Page 5).

Time	Client Status
10:00pm	S
10:15pm	S
10:30pm	S
10:45pm	S
11:00pm	S
11:15pm	S
11:30pm	S
11:45pm	S
12:00am	S
12:15am	S
12:30am	S
12:45am	S
01:00am	S
01:15am	S
01:30am	S
01:45am	S
02:00am	S
02:15am	S
02:30am	S
02:45am	S
03:00am	S
03:15am	S
03:30am	S
03:45am	S
04:00am	S
04:15am	S
04:30am	S
04:45am	S
05:00am	S
05:15am	S
05:30am	S
05:45am	S
06:00am	A
06:15am	

The transmission of information from staff to higher-ups in psychiatric treatment settings occurs primarily through patient logs that are filled out by staff throughout the day and night, typically every 15 minutes or so. If a patient is laying in bed, a staff supervisor will shine a flashlight onto their bed in order to check for movement. If a patient is not moving, the staff member marks "S" for "sleeping" on the log. If a patient is moving and therefore deemed awake, the staff member marks "A" for "awake" on the patient log and notes down what the patient is doing at that moment, which is shown through an excerpt from my overnight log while on 1:1 observations, which was pulled from my 2016 medical records from a residential treatment center in Connecticut.

When asked about the role that supervision played in their treatment experiences, all 12 interview respondents agreed, stating that supervision was extremely tight and further detailing the ways in which they were surveilled by staff. Jay, who has previously been admitted to inpatient and residential psychiatric treatment as an adolescent and an adult, recalled that when a patient is first admitted to a program, they never have a moment to themselves. They further explained that during this time, staff members are "always watching you, writing down notes in

your chart, and redirecting you," and that in both inpatient treatment as an adolescent, patients were intensely and continuously surveilled, and had essentially no privacy or time alone. They recalled, "Someone is always watching you, and if it's not a person, it's a camera. Nothing went unnoticed, because someone watches you eat, sleep, piss, shit…Everything".

The use of constant surveillance–both actively and passively–within psychiatric institutions is a key feature of Foucault's panopticon model, and helps shape the carceral layers found within these institutions. 41.6% of interview respondents spoke without prompt about the regular use of security cameras within facilities as a means of supervision, with one respondent recollecting that when you are not being directly watched, you are being watched through security cameras at all times. Similarly, Maddie, a 24 year-old who was admitted to inpatient treatment as an adolescent, also recalled intense surveillance during her admission. While she was occasionally granted permission to go to another room to play the guitar, the room had a security camera, and there was security behind a desk watching the cameras at all times.

Some respondents noted that this supervision was sometimes for good reason, including Mel, who believed that this intense supervision in psychiatric treatment centers was justified to an extent, as it was to "make sure you hadn't killed yourself, or something horrible like that". On a similar note, Rachel recalled that in a residential treatment center for adults, patients had to use the bathroom under supervision, stating, "I do understand that, at least for somebody in my case [who purges] because I could've gone in there and used behaviors. It was a bit much though, especially when there was a male counselor supervising in a women's facility".

While all interview respondents expressed experiencing high levels of supervision, the extent of this surveillance varied depending upon both the level of treatment–inpatient versus residential–and the specific program that they were admitted to. Respondents overwhelmingly

noted significantly more intense levels of surveillance at the inpatient level of psychiatric treatment in comparison to residential treatment. When asked about the extent of supervision in inpatient treatment, Maddie recalled that for patients with eating disorders who were suspected of not following behavioral redirections:

> *They would put ankle trackers on them to track their heart rate and number of steps…It was just insane levels of encroachment of trust and like, peering in on you and coming into your room almost like they're sneaking up on you to make sure you weren't doing anything, even though there were security cameras everywhere.*

Jenna recalled that when she was in residential eating disorder treatment as an adolescent, there were a lot of rules involved with physicality because staff had to carefully monitor us in order to make sure patients were not over-exercising. She recalled that patients had to sit on their butts, and that they weren't allowed to run at all, or even stand for too long. There were also rules about triggering other patients by talking about weight, sizes, or calories in the milieu.

Building upon this, Rachel stated that one of the biggest rules in residential treatment was that you couldn't stand for too long regardless of your weight, because staff assumes that any time patients are standing it's because they're trying to lose weight, "and no matter how many times you tell them that's not why, they insist". In alignment with this, Jay recalled that if patients were caught walking around too much, standing for too long, or shaking their legs too much, "You would get redirected, or basically reprimanded and told to knock it off". While both of these situations suggest a level of distrust between patients and staff as well as infantilization being inflicted upon patients by staff, these themes are amplified by the fact that both Rachel and Jay were adults when they experienced this treatment. These data further illustrate the loss of autonomy that many patients experience while institutionalized–whether as an adolescent or an

adult–in residential and inpatient psychiatric facilities.

Amir, who was admitted to inpatient as an adolescent, recalled being placed on "Status One," which is the highest level of security, wherein, "You had to keep your arms up above breast level and someone has to be watching you at all times–someone watches you shower, someone watches you shit, someone watches you sleep…Someone is always watching you". His main factor of discontent rested in, "having people watch you and be really up in your business, it's a lot of invasions of privacy," and he further explained that the majority of his punishments were simply increased observations–being surveilled even more closely.

When asked about the rules on the inpatient ward for adolescents, Amir summarized, "The rules were pretty much just don't do anything…Don't touch each other, don't talk about why you're there, don't talk back, don't skip groups, and don't just sit around in your room all day". Lena recalled that touching other clients was not allowed, and Alex answered in agreement with this, stating that there were multiple rules about patients being in each other's rooms and the amount of physicality that patients had with one another. Though they are non-binary, the residential facility they were admitted to was specifically for females, and they remembered an instance in which they were hugging a friend for a moment too long, and were caught by staff who felt suspicious and asked what they were doing. Adding to this, Jay stated that there were rules enforced around physical contact (or "PC") with other patients, and, "Especially if they knew you were LGBTQ+, they would watch more closely".

While the rules in residential and inpatient psychiatric treatment are extremely strict, many respondents reported finding ways to work around the rules in order to find solace. Jay recalled that by rules, patients on the adolescent ward weren't allowed to pass around notes or write cards to one another because they didn't want anyone having private conversations or

sharing contact information, "But obviously we did, we were all teenagers," they stated. To a similar tune, Emily disclosed that the constant supervision didn't completely deter patients from sneaking around and having secret relationships, because, "You can't always be watched at all times". Adding to this, when Lena was at inpatient treatment, staff members did room checks every day, "But I definitely found ways to hide snacks…One girl even brought in a bag of weed–I didn't believe her but she dropped it in front of me, so I took it".

In contrast to this, Nat stated that supervision within their wilderness therapy program was very tight, and that "Clients weren't allowed to be out of earshot from a staff member at any point. They didn't want us having any private conversations with other clients because you could be conspiring to run away". The supervision was even more intense if you were on run watch, which Nat explained was when a client was required to be within arms reach of a staff member at all times, and had to sleep wrapped up in a tarp so they were unable to run away.

Restraint

In the following section, I discuss the use of physical and chemical restraints, as well as the spatializing practices that are used within psychiatric institutions. The restriction of patients movement within psychiatric institutions occurs through a variety of methods, however my analysis focuses mainly on the use of spatializing practices, isolation, and physical and chemical restraints. Berkhout et al (2021) assert that the utilization of restraint, confinement, and control strengthen the carceral layers found within closed institutions. I build upon the authors' ideas of what factors determine the carcerality of institutions to argue that these conditions of carcerality can be found, and often thrive unchecked, within psychiatric institutions, causing further harm to patients.

These common methods of restricting patients' movement add to the power imbalances found between patients and staff, further strengthening conditions of carcerality and serving as disciplinary functions within inpatient and residential psychiatric treatment settings, independent of whether or not they are carried out with the specific intent of punishment.

When asked if patients were allowed to move freely, Emily stated that the doors to the inpatient ward for adolescents had locks on them because kids would often try to escape, joking, "Code yellow!" in reference to the hospital code called over the intercom when a psychiatric patient attempts to run away. Maddie similarly stated that at two different inpatient programs, patients were "Locked in behind glass doors and unable to physically leave…We weren't allowed to see the light of day, we didn't even have real windows".

When calling upon her experiences from adolescence in inpatient psychiatric treatment, Anna recalled that being "locked up" in a facility wherein you can't leave felt like "having your rights stripped from you". She relates her experience on the ward to that of a prison inmate, stating that the facility "felt like a prison, and that's what it really was to be honest". Anna asserted that not being allowed to go outside made her mental state worse, and with a pang of sarcasm, stated, "Anything you could do inside is just little things like painting and drawing. But what does that really do for your mental health? Nothing, it's not going to give you sunlight, vitamin D, things that you actually need".

Lena stated that in inpatient treatment as an adolescent, staff would gather and take all of the patients who were granted permission outside at the same time, stating that the outdoor area was a "dingy prison courtyard" for patients to go under supervision to get a breath of fresh air. Alex recalled not being allowed to go outside when they were first admitted to residential treatment, however later on in their admission they went on supervised group walks. Amir

recalled that over two separate inpatient admissions in adolescence, they were only allowed outside one time, and further explained, “When we went out, it was a big cage–a literal cage”. They described the outdoor area as a miniature courtyard with a fence that went up high overhead, “like we were going to crawl out over it somehow as 15 year-old girls”. In comparison, he recalled that at a different hospital they were allowed outside more often because patients had to go between buildings for lunch and school, however, “There was absolutely no other time outside, it was just the minute you were walking to the building and the minute you walked back”.

In addition to maintaining control via surveillance, the restriction of patients’ movement deprives patients of personal autonomy and can cause psychiatric patients further harm under the guise of protection. In inpatient and residential psychiatric treatment, the restriction of patients’ movement occurs through the use of involuntary admissions, spatializing practices, isolation, and physical and chemical restraints–these methods of controlling a person's body within a space help shape the power imbalances between patients and staff within psychiatric institutions.

Carceral social work is defined as a form of social work that relies on social control and white supremacy to use coercive and punitive practices to manage BIPOC, immigrants, queer and transgender people, youth, the elderly, people with disabilities, and poor communities–enacting these logics and practices alongside the penal arm of the state by condoning and collaborating with police, prosecutors, jails, prisons, and juvenile and criminal courts (Jacobs et al, 2021, Page 39). Carceral social work serves as a method of providing care through controlling and disciplining bodies that don’t fit normative standards set out by society, and leans upon the practices of U.S. correctional facilities in order to carry this out. This

carcerality within the field and practice of social work is especially evident when examining involuntary admissions to psychiatric institutions.

Carceral layers are strongly related to the power relations between administration, staff, and patients–and are linked to the laws or rules of an institution (Repo, 2019). The law, or the adopted policies and practices of psychiatric institutions, determines when and how a person can be treated without their consent, as well as what coercive measures can be used (Repo, 2019), such as restraint and seclusion. Coercive measures can transform into deeply embedded carceral practices, and such measures have both spatial and temporal aspects (Repo, 2019), meaning characteristics related to time, duration, and the physical location in which they are actualized–because they tend to accumulate over time within specific spaces inside institutions, such as seclusion rooms within a psychiatric ward. Such carceral measures and practices serve as disciplinary functions within the ward, independent of whether or not they are carried out with the specific intent of punishment.

An overt, easily identifiable layer of carcerality found in psychiatric wards is the use of physical constraints to contain an individual whose actions are believed to likely inflict harm on themselves or others in the setting (Berkhout et al, 2021, Page 77), whereas a covert layer would be the spatializing practices–locked doors, glass, or high fences–that control and constrict the movement of individuals within a ward (Foucault, 2008). Together, these layers of carcerality compound to create overall conditions of carcerality and control of patients within a ward, wherein only those who hold positions of power and are deemed *normal* and *sane* are able to move without constraint. Berkhout et al (2021) move on to assert that the restriction of patients' movement creates a self-serving loop: the restriction is justified by the patient being a possible

risk or unpredictable due to mental distress, and yet the confinement often then contributes to further agitation, reinforcing the need for further disciplinary practices (Page 81).

If a patient is unable to calm down on their own, staff will move on to apply further restraints, such as straps, belts, and chemical sedatives such as Haldol–often referred to as "booty juice" as the injection is typically done at the rear end. During my first admission to a psychiatric ward in 2015, a member of staff asked me, "Are you trying to get booty-juiced?" in response to a half-hearted joke I made to a peer about wanting to leave. In this instance, the threat of chemical sedation was used to gain my compliance.

Multiple interview respondents recalled the utilization of booty juice and isolation rooms when asked how staff would respond to different issues within the facility, including patients acting out, breaking the rules, having emotional breakdowns, and exhibiting violent behavior towards themself or others. Most concisely, Emily explained, "We called it booty juice–they got an injection. Depending on how bad the situation was, there would be a takedown by one or two staff members and then they'd get injected and put in the quiet room, which is a padded area. We wouldn't see them for like another four hours, and usually they'd be completely out of it afterwards".

The use of psychotropic drugs as a first-line treatment is discouraged for patients displaying dangerous behavior, because it is difficult to distinguish between the use of these medications as a therapeutic invention versus a means of controlling agitated or violent behavior (Zun, 2005). Seclusion and restraint both pose risk, and the use of these practices is permitted only when the dangers of not acting outweigh the benefits, such as when a patient is immediately at risk of harming themself or others. These interventions should not be utilized for punishment;

lack of resources or for convenience; preventing a voluntary patient from leaving; a history of self-injury or aggression; or maintaining an orderly treatment environment (Zun, 2005).

Previous research about enclosed institutions argues that carceral layers are closely tied to power relations, and that these layers overlap and accumulate in specific areas within institutions, creating some spaces that are more carceral than others (Repo, 2019, Page 188). Within closed psychiatric institutions, carceral layers overlap most significantly in areas such as seclusion, "quiet", or "calm" rooms. When a patient is in distress, it is common practice to place them into a secluded room in an attempt to keep them, and other patients, safe from harm. Typically, these rooms are completely empty aside from a frameless mattress, and are decorated with padded walls and floors for the safety of the patient. Chemical and physical restraints are often used simultaneously with seclusion rooms.

When asked about how staff responded to issues on the ward, such as a patient having an emotional outburst, the majority of respondents recalled the use of empty or padded isolation rooms, most commonly referring to them as quiet rooms, calm rooms, or isolation. Isabel stated that at inpatient treatment, if patients misbehaved or acted out, or tried to hurt themselves or others, "A bunch of nurses would come and put you in–I guess a timeout, but they would strap you down". Similarly, Emily recalled the use of injectable sedatives, or *booty juice*, stating that depending on the intensity of the situation, there would be a takedown and an injection, and then the patient would be brought into the quiet room, which was a padded area. Amir recalled being put in the quiet room, but explained that they were never strapped down.

When a patient is moved to a seclusion room, they are typically unable to bring in any personal items with them due to a risk of harm. Unfortunately, this means that patients are unable to bring with them any sort of support, distractions, or coping mechanisms–this includes

books, journals, fidget toys, art supplies, and so forth. A patient is not removed from a seclusion room until they are deemed safe by staff, however if you remove all forms of external support, it is unlikely that they will calm down on their own in a reasonable amount of time. Often, patients are further agitated by the forced removal of support and isolation from any social interaction.

Lena stated that if staff at inpatient deemed a patient as dangerous or disruptive, or if they were acting out, staff would have to “lock them” in the isolation room. She recalled that this was just a room with a mattress that staff could lock from the outside to “Calm him down so he wasn't such a danger”. Mel shared a story wherein another patient picked up a chair above his head and was planning on throwing it, but then he was restrained by staff. She remembered that the staff made him put down the chair and brought him into a separate room. Mel stated that there were a couple of different instances like that in which people ended up getting restrained.

When asked how inpatient staff would respond to patients in emotional distress, Maddie recalled, “I was having a panic attack, and their response was to lock me in an isolation room…I was having an episode and was inconsolable and I was rocking, banging my head, the whole shebang, and as a result, they tried to sedate me, and I was like no, so I just shut up so they wouldn’t give anything to me…I come to a place for therapy and their response is to lock me in a room and say that I am unable to regulate my emotions–it’s so backwards”.

Maddie shared that the restrictions placed on movement in inpatient wards for eating disorders are for more “medically justified” reasons–such as not being allowed to go outside and walk–it was usually because your vital signs were weird, and was done in a “more objective and less punitive way”. She recalled that when she wasn’t completing her meals while inpatient for an eating disorder, she was forced to sit at a table with a meal supplement in front of her until she finished it. Because she had refused so many meals, staff would bring her another supplement

the second she would complete one. She remembers not being allowed to get up to use the bathroom or to get a drink, and it got to the point where she felt afraid to do anything, stating, "I would get up and walk across the room to get a book and they'd yell, Maddie, you're walking too much, if you get up one more time, we're going to supplement you".

The power imbalances between patients and staff in inpatient units are endemic to their carceral design (Shields and Beidas, 2022). Patients may be involuntarily admitted, which is a constraint on choice. Patients may be unable to self-advocate due to their condition, which is amplified by the fear of punishment and perceived lack of credibility amongst staff. Patients who attempt to refuse voluntary admission are often threatened with the possibility of, or faced with, involuntary admission by staff through coercion, making the so-called choice of admission simply an illusion for the patient.

When asked about the nature of their admission processes, 41.6% of respondents indicated having experienced at least one completely voluntary admission; 50% reported having experienced at least one completely involuntary or uninformed admission; 58.3% described the nature of one or more of their admission processes in this regard as "complicated" or "confusing". Nat stated that their admissions were both involuntary because they didn't have a choice, but voluntary to the extent that they were compliant. Both Maddie and Alex described their admissions as theoretically voluntary, but logistically involuntary, with Maddie explaining that though it was voluntary, if she had refused, her family would've admitted her involuntarily. Alex found themself in a similar boat, stating that their "family would've broken apart on the spot". Others, including Jay, had a combination of both voluntary and involuntary admissions, and further explained the role of their family in the admissions processes.

In the following section, I move on to analyze the explicit systems of punishments and privileges that are used within psychiatric treatment centers as a means of gaining compliance from and control over patients who are deemed deviant or defiant.

Leveling Systems of Punishments and Privileges

A foundational feature of total institutions is the breakdown of barriers that ordinarily separate sleep, play, and work. Closed institutions are all-encompassing social hybrids, meaning their character is symbolized by the barrier to social intercourse with the outside world, and they construct and maintain a tension between the home-world and institutional-world (Goffman, 1961). This tension is created through tight scheduling, hierarchical powers, and rules, and is utilized in order to manage and discipline inmates, or patients. According to Goffman's concept of total institutions, privilege systems serve as a method of formal instruction through three basic elements: house rules, rewards, and punishments (Goffman, 1961, Page 320-321).

Leveling systems typically include: entry or pre-phase level, levels 1 through 4, and discharge level. Upon entrance to the program, all clients are placed on pre-phase or entry level. This level is the most highly surveilled–typically, patients on pre-phase or entry level are on 1:1 constant observations, meaning they are accompanied by a member of staff for all 24 hours of the day. Clients on pre-phase or entry level are ineligible for privileges, outings, and lessened-observations until they are given a level 1 contract, usually one or two weeks into their admission, and depending on their compliance with the program. Upon entrance to a total institution, the *inmate* goes through a process of *systematic mortification,* by which they are stripped of their supports, personal identity equipment, and possessions, and institutional items are provided as supplements (Goffman, 1961, Page 317). This occurs when a patient first arrives at an institution. All personal belongings are revoked, searched, and stored away methodically;

patients are stripped from their street clothes and given, typically, a paper gown to wear during the introduction to their stay. As patients advance through the levels, they are awarded more privileges–in other words, depravations are lessened and they are given allowance for things they would typically have access to, such as time outside or the use of a phone to call friends or family.

Through the level system, staff is able to gain compliance from patients in exchange for privileges and more freedoms–this transactional relationship between patients' compliance and the withholding of privileges by staff is an indication of the social control utilized within these institutions. Lena recalled that the level system at inpatient was a red-yellow-green traffic light system, stating that there were both things that she was *forced to do*, and things she had the *opportunity to do*. When discussing rules on the ward, she stated that patients were granted privileges to go outside–under supervision–only when they are deemed safe enough and not a danger to themselves or others. When it came to gaining rewards and privileges, patients had to regularly attend group and individual therapy and scheduled activities, which would show staff that they were peaceful and willing to cooperate, and encourage staff to be more lenient with those patients.

Punishments and privileges applied through the level system act as modes of organization and deterrents for defiant behavior within total institutions, and are utilized in response to behaviors deemed deviant or defiant. Through the privilege system, staff are able to obtain cooperativeness from people who have just cause to be uncooperative, such as those who have been involuntarily admitted. These methods of organization and control utilized by staff and administration within psychiatric treatment facilities directly influence the ways that patients interact with staff and their peers. Although level systems are implemented within psychiatric

institutions in order to keep patients engaged, motivated, and on track towards discharge from the program, here, I assert that these systems also operate as coercive sanctions to keep patients 'in line'.

Emily stated that while at an inpatient ward for adolescents, patients weren't allowed to go outside until they reached a certain level. Upon admission she felt furious and frustrated, until a staff member told her that she wouldn't be allowed outside until she followed the rules and went to groups and activities. Emily explained that attending group meetings, going to and participating in the activities, and interacting with the other patients in a positive way would get patients moved up a level; what would get them moved down was if you interacted with others in a negative or oppositional way, refused medications, or didn't talk to your therapist or the group. She stated, "You'd have a sheet with a routine and tasks, and if you followed the schedule you'd go up a level; if you didn't follow the schedule you'd go down a level". Similarly, Isabel stated that in inpatient treatment, patients had to follow a strict schedule from the moment they woke up to the moment they went to sleep.

Jenna believed that the level system was helpful for her at residential, because the majority of the benefits for leveling up were getting reduced observations for the bathroom and more freedoms, which would make her more inclined to do what she was supposed to do. She recalled that if patients were caught using eating disorder behaviors or self harming, those were the major things that would get patients moved down a level. Rachel explained that the level system included privileges that dictated whether or not you could go upstairs during the day in residential treatment, as well as whether or not you could use the bathroom privately versus under the observation of staff.

When reflecting on her stay at inpatient treatment, Mel recalled that while patients were

not necessarily mandated to attend and participate in all groups and activities, the psychiatrist would still check to see whether or not patients went, and “If you do go, they feel more of an incentive to discharge you”.   Anna felt as if patients had to act a certain way in order to participate in scheduled activities. Due to this dynamic, to her, engaging with the leveling system felt like putting on an act that she was okay in order to be discharged as quickly as possible, and stated, “All it did was teach me how to pretend”. Similarly, Isabel shared that she quickly figured out that good behavior could get you out earlier, so she tried to act as “mentally stable” as she could in order to leave the facility. Isabel further detailed how she was able to do this, stating, “I showed signs that I wasn’t depressed, that I wasn’t going to hurt myself or others, I told them I was great…So in that way, I just kind of figured it out”.

Amir stated that there was both a status and a reward system for adolescents in inpatient psychiatric treatment, and that you had to reach a certain status in order to start earning your rewards. They recalled never earning any privileges and never putting in any effort towards earning privileges, stating, “I don't think it was really an act of rebellion, it was more that I was so depressed that I couldn't be bothered…I hated the system because I wasn’t able to do certain things, and I hated that privileges got taken away”.

Alex shared that in residential treatment there were four or five levels, stating, “I thought and still think it was bullshit. I understand that everyone is at different points, but it felt very competitive”. They recalled that while on level 1 and confined to a wheelchair, they were ordered to be wheeled around the building by staff, however, there were never enough staff members present in order to do that. Due to this lack of available staff, Alex would get up and walk to where they were supposed to be, but they got yelled at for that. They explained that they were not moved up from level 1 until their last two weeks of treatment, stating, “I felt like I

needed to rise up in the hierarchy, and anything not related to that–like having a hard time–would keep me where I was, in a fucking wheelchair 24/7, not getting to go outside, being someone else's responsibility".

Maddie found the leveling systems implemented in residential and inpatient treatment centers somewhat patronizing, recalling that many of the privileges that were being awarded were "basic human things that everyone should be allowed to do," especially because things like going outside or doing schoolwork aren't a central part of most people's eating disorders, she stated. She went on to share an experience in which she was knocked down a level for struggling and having a panic attack because she was demonstrating an inability to self-regulate her emotions, and explained, "No shit I can't, that's why I'm here". Alongside this, other occurrences that would get patients lowered a level uncluded emotional distress or crying excessively; not heeding instructions or disrespecting staff; and not finishing meals or snacks without redirective comments on your behavior from staff.

House rules are a formal set of pre- and proscriptions that lay out the major requirements of conduct, including: dress codes, general expectations of conduct, protocols, house chores, and so forth. Rewards or privileges are clearly defined and held out in exchange for obedience to staff and compliance with the program. Privileges are not necessarily awards, but instead an absence of depravations of things one would typically have access to in the outside world. For example, privileges might include: time outside, ability to use technology, personal items or clothes, etc. Punishments, then, would include the temporary or permanent withdrawal of one's privileges in response to disobedience (Goffman, 1961).

Examples of other common practices that can be conceptualized as punishments, specifically after an episode of self injury or violence, include being obligated to: wear a paper

gown or hospital scrubs at all times; eat alone with a staff member for all meals and snacks, separate from the community; be absent from group therapy and scheduled therapeutic recreational activities, such as going outside, and so forth. From this, it is clear that privilege systems found within institutions serve as mechanisms for social control and obtaining compliance from patients.

At inpatient treatment, because patients faced the risk of being dropped down a level or experiencing other disciplinary repercussions for expressing negative thoughts or emotions to staff members, the utilization of leveling systems encourages Maddie and others to "Fake it until you make it and pretend everything's fine…Just put on a face that you're doing well so you don't get basic human privileges taken away, which is a *great* therapeutic model for healing,". Lena stated that the privilege of going outside was contingent upon her behavior throughout the days and weeks, meaning she had to ensure that she "didn't act up or do anything out of line" in order to continue to utilize it. She recalled having her privileges revoked for a few days because she was being mischievous with friends, however, "They gave them back pretty easily". According to Lena, staff members were significantly more strict on the "Problematic patients," the ones who were putting up fights and not cooperating.

When Nat was admitted to a wilderness therapy program, they were placed on Acclimation Phase, meaning they weren't allowed to interact with other clients whatsoever for that time period. In order to move up from Acclimation, clients had to complete certain therapy and school assignments alongside hard skills like firemaking and whittling–different survival skills were all intertwined with the levels.

When asked about the leveling system, Jay recalled that patients could be moved down a level for "not doing what you were supposed to do," such as not completing meals and snacks,

doing therapy assignments, going to groups, or participating in activities. Patients could also get moved down a level for acting out or using behaviors, self harming, talking back to staff, or getting into it with other clients. Amir recalled being bumped down a level multiple times on the adolescent psychiatric unit, once because they ran away from the hospital, which got them put back on status one. They stated that speaking back to staff, physical contact with other patients, and talking about self harm or suicide attempts would get patients placed on peer restriction with one another. They further explained this through a story of being placed on peer restriction with a friend, and they were unable to see or talk to each other anymore because staff believed that they were “feeding into each other's illnesses”.

Conclusions and Next Steps

Literature surrounding psychiatric institutionalization is lacking in sociological perspectives and data derived from the stories and lived experiences of people who have been institutionalized. Through my research, I intend to fill this gap in knowledge and provide detailed qualitative data and critical sociological perspectives through storytelling around the often dark, vulnerable, and personal experience of being institutionalized.

My interest in this topic stems from my own previous lived experiences in various psychiatric inpatient and residential treatment facilities as an adolescent and young adult. In the years following my admissions, I began to reflect upon and ask critical questions about my experiences. I wondered what factors influenced the ways in which different patients are treated within these settings, and felt critical of the notion that *all* of these applied practices–direct and indirect surveillance, restraint, rules, and ranking systems–were set with the sole intention of providing care for psychiatric patients. I began to notice the seemingly larger patterns within our overarching institutions–and industries–of the correctional and psychiatric systems, such as not

treating the real root systemic, experiential, and socioeconomic issues that often set the foundation for mental illnesses to fester and grow; the medicalization of emotions and experiences; and discrediting and ignoring the stories of those with relevant lived experiences.

In order to investigate how inpatient and residential psychiatric treatment operates in a way that surveilles, confines, and controls vulnerable patients seeking treatment, 12 interviews were conducted and analyzed. Through this research and based on the testimonies of those interviewed, I hope to highlight the practices that psychiatric institutions utilize as a means of caring for and controlling their populations, showing that under the guise of providing care, these practices can cause iatrogenic harm to patients seeking treatment, even leaving them at a more disadvantaged position than where they started.

Findings of this study support the findings of the literature review which discussed how institutions utilize various practices as mechanisms of social control, often inadvertently causing iatrogenic harm to patients, and directly influencing and manipulating the ways in which patients interact with psychiatric services, providers, and other patients. Overarching emergent themes within the study included punishment, loss of personal autonomy, and power imbalances between patients and staff. Based on the interview data collected for this study, it is clear that the use of surveillance, restraints, and stratified leveling systems function as modes of control over their populations. The utilization of social control within psychiatric institutions furthers iatrogenic harm experienced by patients, and directly–and often negatively–influences the ways in which patients interact with psychiatric services and service-providers, as demonstrated within the accumulated interview data.

Many of the main safeguards put in place by psychiatric institutions end in inadvertently causing emotional harm to the exact same people whom they are claiming to serve. Psychiatric

patients are in a disadvantaged position when it comes to social credibility due to stigma and misconceptions about the mentally ill, however, their testimonies and perceptions on lived experiences can offer detailed qualitative data in order to inform future research and, possibly, institutional decisions or policy.

The process of medicalization transforms non-medical aspects of human life into medical problems under Foucault's 'medical gaze', and is heavily driven by external forces, including pharmaceutical and insurance companies, socio-political movements, and shifting physician-patient relationships (Alexander, 2018, p. 12). Diagnosis and labeling is an essential part of medicalization, and is typically done through our established insurance-based healthcare system. Medicalization is pushed within a variety of different social locations, however, political and social medicalization campaigns towards prevention or harm reduction may broaden health inequalities, because certain diagnoses disproportionately affect people from lower socioeconomic backgrounds, who tend to also be less responsive to voluntary interventions (p. 14). Healthcare providers should view diagnosis as more than a trivial task of their work, but rather as something that directly impacts the human lived experience for these people. When a patient is stamped with a diagnosis–or multiple–this comes with the potential for inflicting iatrogenic harm on patients.

The carceral logic and punitive methodologies–including the use of constant direct and indirect surveillance, restraint, and stratified leveling systems–that are weaponized in order to gain compliance from vulnerable, mentally unwell children and adults lead to undesirable consequences when it comes to a person's trust for the psychiatric system that we have in place in the United States. Data derived from this study, while non-generalizable, demonstrate a desperate need for progressive change in the ways that we tackle emergency mental

healthcare–and more specifically in the ways in which facilities treat their patients on a socio-emotional level. Treating mental health is not a one size fits all approach, however the detailed experiences of people who have been institutionalized–if more widely researched and valued–can offer the most relevant knowledge for changing our approach.

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Appendix A: Interview Question Guide

1. To the best of your remembrance, how many separate times have you been admitted into an inpatient or residential treatment center?
2. What form of program were you admitted to? Was it in a hospital environment or a residential home? How did you feel in the environment?
3. Were you admitted as an adolescent, an adult, or both? If you have been admitted as both, how did the experiences differ?
4. Did the program/s you were admitted to follow a leveling system? How do you remember feeling about the system, and why? What did you have to do to move up a level? What would get someone moved down a level? If you've been moved down a level, what was that experience like?

Within this study, the term 'leveling system' is used to reference the levels or phases that patients are assigned as they progress through the program. Typically, patients are admitted at an entry level, and move through levels until reaching discharge or exit level before leaving the program. As patients progress through the levels, they are awarded more privileges within the program.

5. At the program, what kinds of rules were in place? What would happen if someone broke the rules or acted out? What actions did staff take, and how did they make you feel? Do you feel like all clients were held to the same standards when it came to following rules?
6. Were you allowed to move freely throughout the ward or building? Were you allowed to go outside? Did staff have to supervise you?
7. Are there any topics or ideas I haven't asked about that you feel could be important? Do you have any relevant stories from your time in treatment that you wish to share?

Additional probing questions were asked, which varied depending upon participants' responses.