

1993 MENTAL HEALTH IN CORRECTIONS SYMPOSIUM

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JUNE 9-11, 1993

KANSAS CITY, MISSOURI

ADAM'S MARK HOTEL

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MENTAL HEALTH IN CORRECTIONS SYMPOSIUM

Agenda

TUESDAY		ROOM
10:00 am	Tours of U.S.P. Leavenworth and the U.S. Disciplinary Barracks	Directors
12:00 pm	Registration opens	Players
7:00 pm	Presenter's reception	
WEDNESDAY		
7:00 am	Registration opens and continues throughout the day.	Directors
9:00 am	WELCOMING COMMENTS - <u>O.C. Jenkins</u> , Warden, U.S. Penitentiary, Leavenworth, KS; <u>Colonel Gregory Lowe</u> , Commandant, U.S. Disciplinary Barracks, Ft. Leavenworth, KS; <u>Mark Skrade</u> , Psy.D., Symposium Steering Committee	Grand ABCD
9:15 am	OPENING REMARKS - Calvin R. Edwards, Regional Director, Federal Bureau of Prisons	
9:30 am	OPENING COMMENTARY - Hans Toch, Ph.D.	
10:00 am	BREAK	
10:30 am	GENERAL SESSION - <u>Terence Gorski</u> - Preparing inmates for a successful reintegration into society.	Grand ABCD
12:00 pm	LUNCH	Grand EF&G
1:00 pm	Track A: <u>Terence Gorski</u> : An overview of recovery and relapse prevention in the criminal justice system and the CENAPS model of recovery and relapse prevention.	Grand ABC
	Track B: <u>Yossef Ben-Porath</u> , Ph.D.: MMPI-2 Review of new developments.	Grand D
	Track C: <u>B. Kathleen Jordan</u> , Ph.D.: Mental health problems of convicted women felons.	Royal 12&3
	<u>Laura Whaley</u> , MSW: Women in military corrections.	
2:30 pm	BREAK	
3:00 pm	Track A: <u>Terence Gorski</u> : Chemical dependency - A biopsychosocial model.	Grand ABC
	Track B: <u>Yossef Ben-Porath</u> , Ph.D.: Advanced MMPI-2 topics including minority issues.	Grand D
	Track C: <u>Gregory Jarvie</u> , Ph.D.: Stress symptoms among the mental health staff at a prison undergoing dramatic change: The Georgia Women's Correctional Institution story.	Royal 12&3
4:00 pm	Track C: Poster session begins	
4:30 pm	Tracks A & B conclude	Grand E
	Reception begins	
6:30 pm	Royals vs Yankees baseball game	
THURSDAY		
7:00 am	Registration opens and continues throughout the day.	Directors
8:00 am	Track A: <u>Terence Gorski</u> : Recovery from chemical dependency and the relapse process.	Grand ABC
	Track B: <u>Yossef Ben-Porath</u> , Ph.D.: MMPI-2 case presentations.	Grand D
	Track C: <u>Dwayne Walker</u> , MSW: Incarcerated fathers and their families.	Royal 1&2
	<u>Robert Briody</u> , Ph.D. & <u>Gail Williams</u> , M.D.: Life without parole: Adaptation as a process of grief.	
	Track D: <u>Delores Jankovich</u> , M.A.: Using art therapy in prison.	Royal 3
9:00 am	Track D: <u>Gilbert Sanders</u> , Ed.D. Using the MMPI-2 to predict treatment success in substance abuse treatment.	Royal 3
9:30 am	BREAK	

10:00 am	Track A: <u>Terence Gorski</u> : The criminal personality - Biopsychosocial and developmental models.	Grand ABC
	Track B: <u>Kevin Moreland, Ph.D.</u> : MMPI-2 development and overview.	Grand D
	Track C: <u>Dean Fritzler, Ph.D., Warden Harold Nye, Major Roxey Smith, Jacqueline Buck, Ph.D.</u> : Psychological assessment in a correctional facility for the acutely and chronically mentally ill.	Royal 1&2
	Track D: <u>Gregory Jarvie, Ph.D.</u> : Post-Traumatic Stress Disorders and Dissociative Disorders in a correctional setting: After diagnosis, then what?	Royal 3
11:00 am	Track D: <u>Chester Sigafos, Ph.D.</u> : A Post-Traumatic Stress Disorder treatment program for Vietnam veterans in prison.	Royal 3
12:00 pm	LUNCH	Grand EF&G
1:00 pm	Track A: <u>Terence Gorski</u> : Recovery from criminal personality - a developmental model.	Grand ABC
	Track B: <u>Kevin Moreland, Ph.D.</u> : Using the MMPI-2 in treatment planning and interventions.	Grand D
	Track C: <u>Kenneth Robinson, Ed.D. & Gregory Little, Ed.D.</u> : Cognitive-behavioral relapse prevention for offenders: Moral reconnection therapy.	Royal 1&2
	Track D: <u>Mark Skrade, Psy.D. and Glenn Crook</u> : Non-traditional approaches to traditional inmate therapy.	Royal 3
2:00 pm	Track C: <u>Bruce Leeson, Ph.D.</u> : Anatomy of an incident: Revisiting May 1992.	Royal 1&2
2:30 pm	BREAK	
3:00 pm	Track A: <u>Terence Gorski</u> : The relapse process for the criminal personality.	Grand ABC
	Track B: <u>Kevin Moreland, Ph.D.</u> : Synthesizing the MMPI-2 with other assessment techniques.	Grand D
	Track C: <u>Carv Mack, Ph.D. and Federal Bureau of Prisons panel</u> : Developing a mental health delivery system for Cuban detainees.	Royal 1&2
	Track D: <u>Roy Clymer, Ph.D.</u> : Goal directed threats of self-harm: Self-protection for practitioners.	Royal 3
4:00 pm	Track D: <u>Clyde Martin, M.D., M.A., J.D., F.A.P.A.</u> : Accreditation of forensic facilities by the Joint Commission on Accreditation of Health Care Organizations.	Royal 3
5:00 pm	Day concludes	

Evening activities: Plaza shuttle leaving at 6:30 pm. Contact the bell stand for trips to the Woodlands for dog racing and other Kansas City attractions.

FRIDAY

7:00 am	Registration opens and continues throughout the day.	Foyer
8:00 am	Track A: <u>Terence Gorski</u> : The relationship between chemical dependency and the criminal personality and using appropriate treatment methodologies.	Grand ABC
	Track B: <u>Kevin Moreland, Ph.D.</u> : Case presentations using the MMPI-2.	Grand D
	Track C: <u>Hans Toch, Ph.D.</u> :	Grand F
	Track D: <u>Thomas White, Ph.D.</u> : An assessment protocol for suicide evaluations.	Grand G
10:00 am	BREAK	

10:30 am	Track A: <u>Terence Gorski</u> : Program models for primary recovery and relapse prevention.	Grand ABC
	Track B: <u>Dennis Schimmel, Ph.D.</u> : The Federal Bureau of Prisons Values Program: STEPS to freedom.	Grand D
	<u>William Marek, Ph.D.</u> : Using logotherapy with drug abusing and/or "Lifer" inmates.	
	Track C: <u>Ned Rollo</u> : Maps to freedom.	Grand F
	<u>Tom Gibson</u> : The Seven Step program at the United States Disciplinary Barracks.	
	Track D: <u>James DeGroot, Ph.D.</u> : Identification of unresolved issues with the early memory procedures: Assessing violence potential.	Grand G
	<u>Richard Fredrick, Ph.D.</u> : Multiple measures of malingering on a forced-choice test of cognitive ability.	
12:00 pm	LUNCH	Grand E
1:00 pm	GENERAL SESSION - Delivery of mental health services to inmates into the 21st century.	Grand ABCD
	<u>Daniel Cowell, M.D.</u> : Using a community mental health model in the delivery of mental health services in the Federal Bureau of Prisons;	
	<u>LTC Thomas Schmitt</u> : An integrated systems approach to mental health service delivery in corrections.	
2:30 pm	SYMPOSIUM CONCLUDES	

**MENTAL HEALTH IN CORRECTIONS SYMPOSIUM
CONTINUING EDUCATION FORM**

In order to receive Continuing Education (CE) credits or a Certificate of Attendance, you must do the following:

- a) sign-in on the attendance sheet in the morning and again in the afternoon;
- and
- b) complete and return the attached forms by the end of the symposium.

Circle the Track you attended during the time period indicated and list 2 elements of information you learned during each half day component.

Wednesday AM

GENERAL SESSION: Terence Gorski. Preparing inmates for a successful reintegration into society.

- 1. _____
- 2. _____

Wednesday PM

Track A: Terence Gorski

Track B: Yossef Ben-Porath, Ph.D.

Track C: Kathleen Jordan, Ph.D.; Laura Whaley, M.S.W.; Gregory Jarvie, Ph.D.; Roy Clymer, Ph.D.

- 1. _____
- 2. _____

Thursday AM

Track A: Terence Gorski

Track B: Yossef Ben-Porath, Ph.D.; Kevin Moreland, Ph.D.

Track C: Dwayne Walker, M.S.W.; Robert Briody, Ph.D. & Gail Williams, M.D.; Delores Jankovich, M.A.; Dean Fritzler, Ph.D., Warden Harold Nye, Major Roxey Smith, Jacqueline Buck, Ph.D.; Clyde Martin, M.D.

Track D: Delores Jankovich, M.A.; Gilbert Sanders, Ed.D.; Gregory Jarvie, Ph.D.; Chester Sigafos, Ph.D.

- 1. _____
- 2. _____

Thursday PM

Track A: Terence Gorski

Track B: Kevin Moreland, Ph.D.

Track C: Kenneth Robinson, Ed.D. & Gregory Little, Ed.D.; Bruce Leeson, Ph.D.; Cary Mack, Ph.D.

Track D: Mark Skrade, Psy.D. & Glenn Crook; Roy Clymer, Ph.D.; Clyde Martin, M.D.

- 1. _____
- 2. _____

Friday AM

Track A: Terence Gorski

Track B: Kevin Moreland, Ph.D.; Dennis Schimmel, Ph.D.; William Marek, Ph.D.

Track C: Hans Toch, Ph.D.; Ned Rollo; Tom Gibson

Track D: Thomas White, Ph.D.; James DeGroot, Ph.D.; Richard Fredrick, Ph.D.

- 1. _____
- 2. _____

Friday PM

General Session: Delivery of mental health services to inmates into the 21st century.

- 1. _____
- 2. _____

MENTAL HEALTH IN CORRECTIONS SYMPOSIUM **LEARNING OBJECTIVE ASSESSMENT**

The learning objectives for this symposium are:

1. Discuss and elucidate policy issues relevant to the delivery of mental health services in correctional settings.
2. Explain and describe the processes involved in relapse prevention strategies with incarcerated populations.
3. Describe theory and application of the Minnesota Multiphasic Personality Inventory-2 in the treatment of incarcerated individuals.
4. Obtain information about and understand the psychology of violence and its application to disturbed and violent offenders.
5. Gain confidence and increase skills in working with incarcerated and potentially violent individuals.

1. The symposium discussed and elucidated policy issues relevant to the delivery of mental health services in correctional settings.

1	2	3	4	5	6	7
Not at		Not		Somewhat		Completely
All		Really				

2. The presenters explained and described the processes involved in relapse prevention strategies with incarcerated populations.

1	2	3	4	5	6	7
Not at		Not		Somewhat		Completely
All		Really				

3. Symposium presenters described relevant theory and applications of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) in the treatment of incarcerated individuals.

1	2	3	4	5	6	7
Not at		Not		Somewhat		Completely
All		Really				

4. I obtained information about and understand the psychology of violence and its application to disturbed and violent offenders.

1	2	3	4	5	6	7
Not at		Not		Somewhat		Completely
All		Really				

5. I have gained confidence and increased my skills in working with incarcerated and potentially violent individuals.

1	2	3	4	5	6	7
Not at		Not		Somewhat		Completely
All		Really				

**MENTAL HEALTH IN CORRECTIONS SYMPOSIUM
WORKSHOP SATISFACTION EVALUATION**

Are you staying at the Adams Mark: YES NO

Please rate each of the following on a scale of 1 to 5;

1 = STRONGLY DISAGREE, 2 = DISAGREE, 3 = NEUTRAL, 4 = AGREE, 5 = STRONGLY AGREE

1. Instructors were well prepared:	1	2	3	4	5
2. Instructors presented their concepts clearly:	1	2	3	4	5
3. Instructors were responsive to questions:	1	2	3	4	5
4. Symposium presentation titles were accurate:	1	2	3	4	5
5. Symposium presentations provided new information:	1	2	3	4	5
6. The teaching styles used were appropriate:	1	2	3	4	5
7. The content level was appropriate to the audience:	1	2	3	4	5
8. There was enough interaction between instructors and participants:	1	2	3	4	5
9. Audio-visual equipment was used appropriately:	1	2	3	4	5
10. Handouts were current:	1	2	3	4	5
11. Handouts were useful:	1	2	3	4	5
12. Symposium learning objectives were met:	1	2	3	4	5
13. This workshop met my expectations:	1	2	3	4	5
14. I would attend this symposium next year:	1	2	3	4	5
15. April is a good time for me to attend this symposium: (A better time would be: _____)	1	2	3	4	5
16. Registration was smooth and efficient:	1	2	3	4	5
17. On-site services were helpful and responsive:	1	2	3	4	5
18. The Adam's Mark is a good location for this symposium:	1	2	3	4	5
19. Other comments: _____					
20. What topic or subject would you like to see in next years symposium?					

21. What changes should be made for next years symposium? (Additions/deletions)

22. I would like more information on the American Association of Correctional Psychologists YES NO

23. I would like more information on the American Correctional Health Services Association YES NO

See you in Kansas City in 1994 for the combined Mental Health in Corrections Symposium and American Correctional Health Services Association convention on April 7 - 10 at the Plaza Hilton. Information will be sent to all Symposium participants.

MENTAL HEALTH IN CORRECTIONS SYMPOSIUM GENERAL OVERVIEW

STEERING COMMITTEE: Mark Skrade, Psy.D., Symposium Coordinator; Donald Denney, Ph.D., Symposium Chairman; Bruce Leeson, Ph.D., Agenda Planning; Hodges Glenn, Ph.D., Vender & Continuing Education Coordinator; SSgt Ed Silverhardt, Logistical Support.

Faculty Selection Criteria

Vita of all presenters will be forwarded to the Symposium Steering Committee. All presenters must demonstrate in their written materials and vita the level of competence and professional experience that suggests expertise.

Needs Assessment

Issues for the Mental Health in Corrections symposium will be based upon previous symposium feedback, institutional input, professional experience and the opinions and preferences of both the steering committee and the agenda planning committee. A needs assessment will be conducted in conjunction with the current symposium.

Participation/Satisfaction Evaluation

The attached feedback form will be provided to each participant during the registration process. Summary data will be collected and reported within two weeks of the completion of the symposium (June 28, 1993). Copies to be forwarded to steering committee members and the Chief Executive Officers from the hosting agencies.

Learning Assessment

Participants will be provided with a list of learning objectives for each presentation and will be asked to assess the accomplishment of these objectives.

Use of Evaluations to Improve Program

At the conclusion of the symposium, each participant will be asked for their suggestions for the 1994 symposium. This feedback will be integrated into the 1994 symposium.

Development of Learning Objectives

Each presenter will be asked to provide a list of learning objectives. These objectives will be reviewed by the agenda planning committee.

Sample Certificate

The certificate that will be used to document the number of Continuing Education credits earned can be obtained by contacting any member of the Steering Committee. A Certificate of Attendance will be provided to those not requiring Continuing Education.

Grievance Policy

A list of grievance policies will be posted at the registration desk. The grievance policy is attached.

MENTAL HEALTH IN CORRECTIONS SYMPOSIUM GRIEVANCE POLICY

The Mental Health in Corrections Symposium is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. The Mental Health in Corrections Symposium will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Symposium Coordinator from the United States Penitentiary, Leavenworth, Kansas in consultation with the Clinical Training Director for Psychology Services, Federal Bureau of Prisons and the Mental Health in Corrections Symposium steering committee.

While the Mental Health in Corrections Symposium goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the symposium staff which require intervention an/or action on the part of the symposium staff. This procedural description serves as a guideline for handling such grievances.

When a participant, either orally or in written format, files a grievance and expects action on the complaint, the following actions will be taken.

1. If the grievance concerns a speaker, the content presented by the speaker or the style of presentation, the individual filing the grievance will be asked to put his/her comments in written format. The Symposium Coordinator or a member of the Symposium steering committee will then pass on the comments to the speaker, assuring the confidentiality of the grieved person.
2. If the grievance concerns a workshop offering, its content, level of presentation, or the facilities in which the workshop was offered, the Symposium Coordinator or a member of the symposium steering committee will mediate and will be the final arbitrator. If the participant requests action, the symposium steering committee will:
 - a. attempt to move the participant to another workshop;
 - b. provide a partial or full refund of the workshop fee. A written note documenting the grievance for recording keeping purposes is necessary. The note need not be signed by the grieved individual.
3. If the grievance concerns the Mental Health in Corrections symposium in a specific regard, the Symposium Coordinator or steering committee members will attempt to arbitrate.

REINVENTING OFFENDER REHABILITATION

BY
HANS TOCH

REINVENTING OFFENDER REHABILITATION*

Hans Toch

I tried to play hard to get when I was invited to this symposium, without much success. One reason is that my advertised reluctance was transparently fraudulent, especially to a clinician. I would have walked -- or at least, taken the bus -- to get to see you and talk with you, because I know that some of you find occasions such as this therapeutic, uplifting, meaningful and revivifying.

There is no mystery about why this is so. Some among you sit in small windowless offices, or offices with dirty barred windows looking out on dreary compounds, and you tend to feel very lonely, and disheartened or discouraged. I know it is not supposed to occur, since I have read the same rousing job descriptions that you have read. In the last issue of the *Federal Prisons Journal*, for example, I read that

psychologists in the Federal prison system have many opportunities to use their training and pursue their professional interests.... In contrast to the stereotypes surrounding prison work -- that it is the same routine, year in and year out -- prison psychology practice offers a varied and challenging professional environment (p. 15).

For some psychologists, the Federal system has indisputably offered a varied and challenging professional environment. (I suspect, for example, that such was the case for Kathleen Hawk.) But even careers that are studded with self-actualizing opportunities must include junctures at which one experiences self-doubt or despondency, or helpless frustration in the face of obdurate and uncaring bureaucracy. At such junctures it helps to go somewhere where one can be among one's own kind, to know that others are in the same boat (or in similar boats), and are persevering against comparable odds. It helps to know that others have had similar ideals and analogous hopes of impact, and that these ideals and aspirations have survived in the closets of their cynical minds. And it helps to know that there is a cause out there -- a set of things we aim for and try to accomplish in the plenitude of time -- which

*Prepared for delivery at the Mental Health in Corrections Symposium, June 9, 1993, Kansas City, Missouri.

makes jobs more than days we put in for our paychecks. Occasions like these remind us of why we became what we became and why we do what we do, and suggest that it has been worthwhile, evidence notwithstanding.

For this reason I feel privileged to be here this week. And for this reason, I have had a hard time deciding what to say as an excuse for being here taking up your time. I am the wrong age for an inspirational sermon on "marching bravely into the future." I am the age for a sermon on "marching into the past," but that sounds mildly anachronistic.

Now, as it happens, a walk through the past is not as silly as it sounds, for history has a way of repeating itself, as far as you and I are concerned. We are all at the inception of a renewed thrust in correctional rehabilitation, inspired by the influx of drug-related offenders in most systems, and by a philosophy of peremptory programming that is becoming popular. This fact, combined with increments in proportions of disturbed offenders in prisons, has made our work more relevant than it has been for some time. But our work has been relevant before, and it behooves us to attend to an eclectic dictum that says that those who ignore history are fated to reinvent the wheel. At least, that is my excuse for talking of past events in the systems in which you work.

Let me further capitalize on my advanced age by starting with a war story. It is literally a war story drawn from my distinguished career defending the beaches of San Diego against hostile atheistic communists who might have decided to invade us. Beside single-handedly winning this war, I had the distinction of being the only sailor in the Navy with a Ph.D., though there were other draftees in our unit with advanced degrees. This fact made it incumbent on the Navy to provide us intellectuals with proper stimulation, and they organized two educational field trips for our group. One consisted of a day on a wooden mine sweeper, where I discovered that mine sweepers make you very sea sick. The second expedition was a trip to the Naval Retraining Command, Camp Elliott. *Time* magazine visited Camp Elliott at the time I did (July 25, 1955). and described it as "high wire fences (that) take in 40 square miles of desert scrublands northeast of San Diego, and keep in 885 grey-uniformed men" who

violated "one of the hundreds of 'Rocks and Shoals' (Navy regulations)." They characterized Camp Elliott as a "military purgatory" in which marines and sailors "run through a routine of work details, formations, exercise and orientation lectures."

The folks from *Time* and our group went to Camp Elliott to see what had become known as the Camp Elliott Experiment, which was run by J. Douglas Grant, a creative psychologist. *Time* wrote that Grant was "a burly, six-foot Stanford graduate, with an infectuous grin and a saddle-tanned bald head." They forgot to mention that he was a former football player and ex-boxer, and made a perfect martini.

But our group did not get to see Doug Grant. After the usual welcome by a braided officer, we were hosted by a Marine sergeant. The sergeant was on Doug Grant's staff. He worked with court martialled offenders, some of who were also on Doug Grant's staff. The sergeants spent six to nine weeks eating, sleeping, working, recreating and frequently meeting with offenders in closed Living Groups of twenty. Each group had a consulting psychologist, who worked with the men individually and in group sessions. We had not envisaged anything like this happening in the military -- or, for that matter, in prisons. But the psychiatrist Maxwell Jones had heard of it. He wrote about Camp Elliott that

The introduction of a role for prisoners (or psychiatric patients) which involves active collaboration with trained staff personnel in an attempt to better social understanding and circumstances (or treatment) is the distinctive quality of a therapeutic community. The prisoners (or patients) now become actively involved in studies and tasks usually limited to trained personnel; and in the process renounce the more passive recipient role of the conventional prison (or hospital) (p. 308).

For Max Jones to say that the Navy had therapeutic communities was the equivalent of the Pope certifying a person as a Catholic. But the Camp Elliott Experiment was innovative in many ways. Its therapeutic communities were distinctive in their definition of social learning. Doug Grant wrote that his Living Groups were "an attempt to create in a correctional situation a program which would produce in the subjects a challenging uncomfortableness without rigidifying panic" (p. 489). The uncomfortableness arose from having to deal with others in a close, intimate setting in which everything was up for scrutiny. The scrutiny was more

intensive than in most therapeutic communities. The Experiment was committed to the concept of self-study, and to systematic inquiry, including research. Inmates studied their personalities, and those of other inmates. Custody studied custody. Grant recalls that

Three times a week, three professional members of the staff meet separately with three maximum security groups (which include all maximum security prisoners), for an hour and a half discussion. The custodial staff are included in these discussion groups. Once a week the maximum security custodial staff meet with the three professional staff members and a research representative for self-inquiry discussions concerning their maximum custody work (p. 304).

Herbert Quay's classification scheme, which is used in the federal system and in Navy brigs, was influenced by Camp Elliott. Grant's group evolved a differential treatment approach. This approach was transactional. Inmates were classified by the sort of interventions they could tolerate and benefit from, treatment staff (including nonprofessional treatment staff) by the sort of approach they felt comfortable using and were good at using. This made it possible to pair intervention agents and targets in ways that were effective and congruent with the inmate's stage of development. The inmate who needed structure and benevolent control got structure and benevolent control. The high-anxiety, conflict-ridden inmate got all the empathy and insightful exploration he could use. Grant referred to the drill sergeants who had that sort of capability as "junior psychiatrists." The behavior modifiers he called "coaches."

Camp Elliott was an exciting place and those who worked there found it exciting, because they learned a lot and felt they were making a difference. Over half of the Camp Elliott graduates were successfully restored to duty. This outcome is particularly valued in wartime. You may know that before World War II, the Disciplinary Barracks at Fort Leavenworth was the only correctional facility operated by the U.S. Army. Between 1940 and 1950, fifteen barracks were in operation at one time or another (Gray, 1970). In 1942, rehabilitation centers were established in nine service commands. Between 1940 and 1946, 84,245 new commitments arrived in these institutions; of the 70,000 who graduated by 1946, 42,373 were restored to duty -- the equivalent of three infantry divisions (*Ibid*). In my day,

Camp Elliott could man two large aircraft carriers with a nine-year cohort of its alumnae (*Time*). The military took rehabilitation very seriously, because -- as John Morris Gray put it -- "manpower was our most precious resource during the war years, and every possible effort was expended to rehabilitate the maximum number of general prisoners" (p. 111). It would be nice if a similar philosophy prevailed in military corrections of the future.

Studies showed that military corrections could point to dramatic successes, in the aggregate and in individual cases. Gray contacted unit commanders and received many rave reviews. Most of these are standard military commendations, but some are encomia to rehabilitation. One officer, for example, described a soldier as "an excellent example of a man who has rehabilitated himself through his own determination" (p. 121). He might have added, "with a little help from dedicated staff."

The Navy didn't take me on a field trip to any federal correctional facility, but I have made such trips on my own. I know -- as you know -- that there are many Camp Elliotts in the history of the Bureau -- places like FCI Morgantown, FCI Butner, FCI Lexington and FCI Fort Worth. Other institutions -- even Marion -- have had moments in the sun. In these places battles were won in a war that remains to be won.

As some of you know, the history of military corrections and the federal prison system have been linked. The first federal prison was the United State Penitentiary at Leavenworth, which physically occupied the grounds of Fort Leavenworth, on loan from the Army. This happened in 1895, and I was not there. The Army got the place back in 1905, when the feds moved one mile down the road.

By World War I, all three (count them) federal prisons had become severely overcrowded, thanks to an influx of newly defined drug offenders and of violators of prohibition laws. You may ask what else is new, and you may be surprised to learn that in 1920 the Wickersham Commission suggested classifying the inmates, to separate violent from nonviolent prisoners.

In the late twenties the feds repossessed Fort Leavenworth, and used it to hold narcotics offenders. They also built two specialized reformatories, one for women (in Alderson, West Virginia), and one for youthful offenders (in Chillicothe, Ohio). Both targeted institutions emphasized rehabilitation and education. They thus presaged the preeminence that the "feds" later achieved in offender rehabilitation. The formula the feds evolved was a marvelous one: Classify the prisoners in treatment-relevant terms, and sort them into homogeneous enclaves that would be run by teams of congruent staff members. In each enclave, offenders would present comparable problems: some could be predatory men, for instance, and others, vulnerable. Inmates with special needs would be accommodated with tailor-made regimes, including specialized services. The staff teams would have autonomy to evolve and exercise professional expertise in working with their clients. They would get to know their inmates, and each other. They would be supported by modern resources, such as vocational and training facilities.

The Federal Bureau of Prisons was authorized in 1930. I was born the same year (which is probably a coincidence), and both the BOP and I have mellowed in six decades. Some people would say that the adventurous spirit of the Bureau's youth -- its effervescence and self-actualizing inventiveness -- have dissipated. Uncontestably, the BOP's mission is now much less glamorous than in the past, if one listens to mission statements. But mission statements do not neatly fit everything one does. If an agency sponsors a proliferation of therapeutic communities for substance abusers, it cannot claim to be in the sole business of humane warehousing or civilized management.

I once drafted an essay about unit management, and the editor in Washington relayed observations of BOP staff. He wrote that "the comment that I regard as most substantive came from our Research section. The reviewer felt that the article should try to capture the 'shift in focus of FUM (functional unit management) from a treatment and training device to basically a management device' as well as the shift 'from innovation to routinization.'" I infer that the researcher not only saw such shifts, but viewed them with benevolent approval.

The saving grace is that shifts such as these can be more semantic than real.

Routinization need not kill innovation; it can simply mean that smart innovators must translate what they do into acceptable bureaucratic language and leave a protective paper trail. As for "management," the term can be narrowly or generously used. I suspect that whenever one uses a narrow connotation of the term, one acts like one has never seen an inmate. To take an example, the journal that contains the encomium to psychologists, also contains an article on protective segregation. The author writes that we must turn back inmates who cannot identify or name their enemies. He does not recognize the fact that protection can be psychological, and that it can be a mental health-related disposition. The custodial view of management that is thus exemplified is short-sighted, and can get people killed.

Management as custody is a simplistic equation. Even punitive segregation is redolent with mental health-related problems such as that of the self-destructiveness of chronic acting-out patients and the vulnerability of prisoners to stresses of segregation. In many instances, punitive dispositions occur by default, despite the obvious pathology of prisoner misbehavior. Any sensible reading of the situation tells us that we do what we do because we lack viable alternate management options.

On my way to Scotland last year, I was grounded by a heart attack. The Scottish experience I most missed was a day at Peterhead Prison. The session was listed in my itinerary as a "discussion with G Hall prisoners (currently 12 prisoners who are on 'lockdown'; we will see the worst 3 together for tea and biscuits and then we will see Tommy McCulloch who has been held in a small individual unit by himself for the last 14 years with three officers with him at all times." It may be hard to convey to the governor of Peterhead, and to Tommy McCulloch, how management as a goal applies to their scenario. The problem that the governor and I see, and that we hope McCulloch might see, is that a custodial Mexican Standoff spells bankruptcy.

A mistake that has been admitted by the BOP is the infamous START program, which "started" at the Medical Center for Federal Prisoners in Springfield, in September 1972.

START was supposed to be a retraining program for incorrigible prisoners. Such an intervention would be a tremendous exercise if the inmates had been enlisted in a Camp Elliott-type self-study program designed to extricate them from self-defeating contests with obdurate disciplinary tribunals, and from continued deprivation. But the START program relied on assignment to a compliance-oriented regime. It rested on the assumption (spelled out in a working paper) that participation must be forced, that

A voluntary program could be expected to be used by those prisoners who find themselves distressed by their situation, not by those who are causing extreme distress to others but are little inconvenienced themselves (p. 468).

Distress to others and distress to self are compatible presenting conditions, and we must recognize that they can be conjointly addressed in a civilized conception of management.

But is offender rehabilitation alive in an Age of Management? No conceptual shift has been better advertised than the transmutation of corrections agencies from a rehabilitation-oriented philosophy to a management-oriented one. A discussion of this shift occurred at a 1991 conference on the history of the Bureau of Prisons. This landmark conference featured a panel of directors of BOP, who were asked to discuss the end of the infamous "medical model." Director Alexander pointed out that "I never heard it called the Medical Model until after I retired. We simply called it 'training/management classification.'" Director Carlson -- who presided over the demise of the alleged Model -- talked of the discovery "that we in corrections could not coerce change," and said

we could facilitate change, certainly, and we had that obligation. But somehow the notion had escaped many people that we just could not force people to change their behavior.... We can offer assistance and guidance, and we can provide programs, but it is up to the individual offender himself or herself to take advantage of those programs if they are to have any meaningful impact on their lives.

J. Michael Quinlan added that "the responsibility of corrections agencies is to provide solid programs," but "prisoners have a responsibility, too" and "the prisoner is going to make the ultimate decisions when he or she is released."

If leaders of the so-called corrections transmutation talk this way, it is hard to see what the revolution consists of, since there are few rehabilitators (other than the progenitors of

START) who see their job as "coercing change," and offender rehabilitators who think they are in the disease-curing business exist only in sociology texts. As a final piece of irony, we are moving across the country in directions opposite to those advertised. Prisoner program involvements such as drug education, remedial reading and work assignments are increasingly being tied to peremptory incentives, which constrain prisoner voluntariness.

The question remains: Has there been a sea change in corrections, as advertised? Did we delete offender change as our goal? If we did this, is the pendulum swinging again, in our direction? Has the time now come for new adventures for us, such as Morgantown and Lexington -- for new Camp Elliotts?

I cannot answer this question, but you can. I am hoping to listen to what you say. Later, I shall talk to some of you again. I shall return to issues of management and mental health, and to the role of mental health staff, as I think of it. I see much to discuss in this area, but shall confine myself to a few points. These points include intemperate observations which cause people not to invite me for return engagements. I trust you will provide the exception to this rule.

The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Developed By
Terence T. Gorski
President
The CENAPS Corporation

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*Published Materials About
Treating Chemically Dependent Criminal Offenders
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The Chemically Dependent Criminal Offender Recovery And Relapse Prevention In The Criminal Justice System

Developed By Terence T. Gorski, President (© Copyright, T. Gorski, 1993)

The CENAPS Corporation, 18650 Dixie Highway, Homewood, IL 60430, 708-799-5000

Course Description:

In order to successfully treat chemically dependent criminal offenders, professionals need to be armed with special skills. The CENAPS Model of Recovery and Relapse Prevention, a powerful treatment system which integrates the disease model of chemical dependency with recent advances in cognitive, affective, behavioral, and social therapies, provides those skills.

This course provides a powerful new model which integrates the diagnosis and treatment of both chemical dependency and the common criminal personality traits that often coexist in criminal offenders. The material is clear, concise, practical, and easy to use in the real world of the criminal justice system.

Participants will learn how to use a *Biopsychosocial Assessment Grid (BAG)* to identify and differentiate between the symptoms of chemical dependency and criminal personality. They will learn how to use a *Developmental Model Of Recovery (DMR)* to describe the recovery progression from both disorders and develop appropriate treatment plans. They will also learn special *Relapse Prevention Therapy (RPT)* methods based upon the CENAPS Model that are effective in reducing the frequency, duration, and severity of relapse episodes of both chemical use and criminal behavior.

Practical guidelines will be presented for developing *Primary Treatment Programs* designed for offenders who are in treatment for the first time and *Relapse Prevention Programs* designed for offenders who have completed treatment and have returned to either chemical use, criminal behaviors, or both. The integrated use of the psycho-education program, problem solving group therapy, individual counseling, and self help groups will be described.

This course will provide participants with cutting edge knowledge of the application of the CENAPS Model of Recovery and Relapse Prevention in the criminal justice system.

Course Objectives

Upon completion of this course, participants will be able to:

1. Understand the basic principles of the CENAPS Model of Recovery and Relapse Prevention and be able to apply those principles to the treatment of the chemically dependent criminal offender. (Sessions 1 and 2)
2. Use a *Biopsychosocial Model Of Assessment* to identify and differentiate between the symptoms of chemical dependency and antisocial personality traits that often coexist in chemically dependent criminal offenders. (Sessions 3, 4, and 5)
3. Use a *Developmental Model Of Recovery* in the treatment of both chemical dependency and criminal personality. (Sessions 6 and 7)
4. Use special *Relapse Prevention Therapy* methods in the treatment of both chemical dependency and criminal personality. (Sessions 8 and 9)
5. Understand the basic principles for developing effective treatment programs for chemically dependent criminal offenders. (Session 10)
6. Understand how to develop a continuum of care consisting of an Assessment/Stabilization Program, A Motivational Counseling Program, A Primary Recovery Program, A Relapse Prevention Program, and an Advanced Recovery Program. (Session 11 and 12)

Agenda

Day One:

**9:00 - 10:15 a.m. Session 1: An Overview Of Recovery And
Relapse Prevention In The Criminal Justice System**

In this session, participants will review:

- The purpose of the course, objectives, and agenda.
- Statistics on chemical dependency and criminal personality and their application to chemically dependent criminal offenders
- The relationship between crime, chemical dependency, and criminal personality, including the principles of mutual predisposition, symptom reinforcement, reciprocal relapse, and concurrent treatment.

**10:45 - 12:00 p.m. Session 2: The CENAPS Model Of Recovery And
Relapse Prevention**

In this session, participants will review:

- The CENAPS Model of Recovery and Relapse Prevention
- The integration of the disease model and abstinence based treatment with cognitive, affective, behavioral, and social therapies
- The application of the CENAPS Model to the treatment of chemically dependent criminal offenders in the criminal justice system

Day One (continued):

1:00 - 2:15 p.m. Session 3: Chemical Dependency - A Biopsychosocial Model

In this session, participants will learn how to:

- Describe chemical dependency as a biopsychosocial disease
- Distinguish between chemical abuse and chemical dependence disorders
- Understand the biopsychosocial symptoms presented by chemically dependent patients

**2:45 - 4:00 p.m. Session 4: The Criminal Personality:
A Biopsychosocial Model**

In this session, participants will learn how to:

- Explain the criminal personality as a biopsychosocial disorder
- Understand the common DSM-III-R personality and mental disorders that are often associated with the criminal personality
- Describe the common characteristics of the criminal personality that need to be addressed in treatment

Day Two:

**9:00 - 10:15 a.m. Session 5: The Biopsychosocial Assessment Grid For
Chemical Dependency And The Criminal Personality**

In this session, participants will learn how to:

- Describe chemical dependency and the criminal personality as two coexisting disorders that need to be simultaneously treated
- Use A Biopsychosocial Assessment Grid (BAG) for differential diagnosis and treatment planning
- Develop a concurrent treatment plan that addresses both disorders simultaneously

Day Two (continued):

**10:45 - 12:00 Noon.....Session 6: Recovery From Chemical Dependency:
A Developmental Model**

In this session, participants will learn how to:

- Describe recovery from chemical dependency as a developmental process progressing through six stages
- Describe the common recovery tasks associated with each stage
- Describe the common relapse warning signs associated with each stage

**1:00 - 2:15 p.m. Session 7: Recovery From Criminal Personality:
A Developmental Model**

In this session, participants will learn how to:

- Describe recovery from the criminal personality disorder as a developmental process progressing through six stages
- Describe the common recovery tasks associated with each stage
- Describe the common relapse warning signs associated with each stage

2:45 - 4:00 p.m. Session 8: The Relapse Process For Chemical Dependency

In this session, participants will learn how to:

- Understand relapse to chemical dependency as a progressive process that begins before a chemically dependent person begins to drink or use drugs
- Describe the common relapse warning signs that lead a person from stable abstinence back into chemical use

Day Three:

**9:00 - 10:15 a.m. Session 9: The Relapse Process For
The Criminal Personality**

In this session, participants will learn how to:

- Understand relapse to chemical dependency as a progressive process that begins before a chemically dependent person begins to drink or use drugs
- Describe the common relapse warning signs that lead a person from stable abstinence back into chemical use

**10:45 - 12:00 p.m. Session 10: Basic Treatment Principles For
Chemically Dependent Criminal Offenders**

In this session, participants will learn how to:

- Describe 15 basic principles for the effective treatment of chemically dependent criminal offenders
- Refer and coordinate self help group involvement with the treatment process

1:00 - 2:15 p.m. Session 11: Continuum Of Care - Part 1

In this session, participants will learn how to:

- Describe the primary treatment modalities used in program for chemically dependent criminal offenders
- Describe the goals, and phases of Assessment/Stabilization Programs, Motivational Counseling Programs, and Primary Recovery Programs

2:45 - 4:00 p.m. Session 12: Program Models For Relapse Prevention

In this session, participants will learn how to:

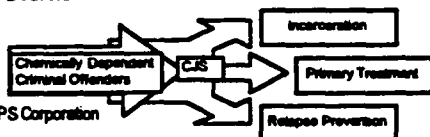
- Describe the goals, and phases of Relapse Prevention and Advanced Recovery Programs
- Describe how to integrate a long-term continuum of care into the Criminal Justice System

The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 1: An Overview

Developed By
Terence T. Gorski
President, The CENAPS Corporation



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CDC001 1

In This Session We Will Review ...

1. The Purpose Of The Course
2. The References Used In Developing This Course
3. The Course Objectives And Session Schedule
4. The Problem Of Chemical Dependency With Criminal Offenders
5. An Overview Of The CENAPS Model And Its Applications To The Criminal Justice System

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CDC001 2

Exercise - Part 1

1. Stand Up. Organize Materials. Push Chairs Under Table.
2. Meet Three People You Don't Know
 - Name And Type Of Work
 - Professional Reasons For Attending
 - Personal Reasons For Attending

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CDC001 3

Exercise - Part 2

1. Divide Into Groups
2. Sit So You Can Easily Meet As A Group
3. Settle Down For First Lecture

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CDC001 4

Purpose Of The Course

- To Teach Participants To Successfully Treat Chemically Dependent Criminal Offenders
- By Applying The CENAPS Model Of Recovery And Relapse Prevention

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CDC001 5

Course Objectives

To Apply The CENAPS Model To The Treatment Of Chemically Dependent Criminal Offenders:

1. The CENAPS Model (1 & 2)
2. The Biopsychosocial Assessment Grid (BAG) (3, 4, & 5)
3. The Developmental Model Of Recovery (DMR) (6 & 7)
4. The Relapse Prevention Therapy (RPT) (8 and 9)
5. Treatment Programming (10)

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Time Schedule

Session 1	09:00 - 10:15 AM
Break	10:15 - 10:45 AM
Session 2	10:45 - 12:00 Noon
Lunch	12:00 - 1:00 PM
Session 3	01:00 - 2:15 PM
Break	02:15 - 2:45 PM
Session 4	02:45 - 4:00 PM

Each Session Will Consist Of ...

1. Lecture 60 Minutes
2. Small Group Exercise 15 Minutes

- It Is Important Not To Miss Sessions
- Information Is Presented In Building Blocks
- If You Miss A Session You Will Not Have Information Necessary For Latter Sessions



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Session Schedule - Day 1

1. Overview Of Recovery And Relapse Prevention In The Criminal Justice System
2. The CENAPS Model Of Recovery And Relapse Prevention
3. Chemical Dependency - A Biopsychosocial Model
4. The Criminal Personality - A Biopsychosocial Model



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Session Schedule - Day 2

5. The Biopsychosocial Assessment Grid (BAG) For The Chemically Dependent Criminal Offender
6. Recovery From Chemical Dependency - A Developmental Model
7. Recovery From Criminal Personality - A Developmental Model
8. The Relapse Process For Chemical Dependency



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Session Schedule - Day 3

9. The Relapse Process For Criminal Personality
10. Treatment Programming For Chemically Dependent Criminal Offenders



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The Basis Of This Course

- This Course Integrates Previous Work In The Treatment Of Chemical Dependency, Relapse Prevention, And The Treatment Of Personality Disorders
- A Complete Bibliography Is Available In The Training Manual

Special Acknowledgment To ...

- Gary G. Forrest, Ed.D., Ph.D.
- Samuel Yochelson Ph.D., M.D.
- Stanton E. Samenow Ph.D.

Participants Will Learn How To Use ...

1. A Biopsychosocial Assessment Grid (BAG)
 - To Identify And Differentiate Between Chemical Use Disorders And Criminal Personality.
- 2.
- 3.

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Participants Will Learn How To Use ...

1. A Biopsychosocial Assessment Grid (BAG)
2. A Developmental Model Of Recovery (DMR)
 - To Describe The Recovery Process From Both Disorders And Develop Appropriate Treatment Plans.
- 3.

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Participants Will Learn How To Use ...

1. A Biopsychosocial Assessment Grid (BAG)
2. A Developmental Model Of Recovery (DMR)
3. A Relapse Prevention Therapy (RPT) Model
 - To Reduce The Frequency, Duration, And Severity Of Relapse Episodes To Both Chemical Use And Criminal Behavior.

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Participants Will Learn Practical Guidelines For Developing ...

1. Primary Treatment Programs
 - For Offenders In Treatment For The First Time
2. Relapse Prevention Programs
 - For Previously Treated Offenders Who Have Returned To Chemical Use, Criminal Behaviors, Or Both.

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Participants Will Learn How To ...

Develop A Structured Recovery Program By Combining The Use Of ...

1. Psychoeducation Programs
2. Problems Solving Group Therapy
3. Individual Counseling
4. Family Programs
5. Self Help Groups

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Alcohol Use Is Common In USA

	% Of Adults	% Alcohol Consumed
1. Abstainers	33%	00.0%
• Consume No Alcohol		
2. Light Drinkers	34%	07.9%
• 0.01 - 0.21 Oz Per Day		
3. Moderate Drinkers	24%	26.3%
• 0.22 - 0.99 Oz Per Day		
4. Heavy Drinkers	09%	65.8%
• 1.0 Oz Per Day		

Source: Hammond, R. L., The Bottom Line On Alcohol In Society, Vol 7, No. 3, Fall 1986

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Chemical Dependency Is Common In The USA

1. Alcohol Dependent 10%
2. Drug Dependent 5%
3. Chemically Dependent 15%

Source: National Institute Of Drug Abuse, 1989

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Alcohol And Drug (A/D) Use Is Common Among Criminal Offenders

- A/D Drug Users 100%
- A/D Related Crimes 70%

70% Of Criminal Offenders
Have Serious Problems With
Alcohol And Drugs

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Alcohol Use At Time Of The Crime

1. Violent Crime 54%
2. Property Crime 40%
3. Drug Crime 29%
4. Public Order Crime 64%
6. Total 48%

Source: Alcohol And Health Status Report To Congress, 1987

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Alcohol Use At Time Of The Crime

1. Violent Crimes 54%
 - A. Murder 49%
 - B. Manslaughter 68%
 - C. Rape/Sexual Assault 52%
 - B. Assault 62%

Source: Alcohol And Health Status Report To Congress, 1987

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Types Of Alcohol And Drug (A/D) Problems Among Criminal Offenders

1. Chemical Abuse Disorders
 - 28% Of All Inmates
 - 40% Of Inmates With A/D Related Crimes
2. Chemical Dependency Disorders
 - 42% Of All Inmates
 - 60% Of Inmates With A/D Related Crimes

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Profile Of Chemically Dependent Criminal Offenders

1. Crime Is A Symptom Of The Non-Addictive Use Of Illegal Drugs In Persons Who Do Not Have Chemical Use Disorders Or Criminal Personality (5%)
2. Crime Is A Symptom Of Chemical Dependency (15%)
3. A/D Use Is A Symptom Of Criminal Personality (15%)
4. Crime Is A Symptom Of Both Chemical Dependency And Criminal Personality (65%)

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Conclusion ...

Most Criminal Offenders
Who Commit Alcohol And Drug Related Crimes
Have Serious Chemical Use Disorders

Few Criminal Offenders
Are Social Drinkers Or
Recreational Drug Users

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Alcohol And Drug Problems Are Related To Criminal Recidivism

1. Most Repeat Criminals Have Chemical Use Disorders
2. A/D Use Among Parolees Is Associated With ...
 - Breaking Parole And Probation
 - Renewed Criminal Behavior
 - New Arrests And Convictions

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Antisocial Behavior Is Common Among Criminal Offenders

- Commit Antisocial Acts 100%
- Habitual Criminals 75%

Most Habitual Criminals
Have A
Criminal Personality Disorder

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Incidence Of Antisocial Personality Disorder (ASPD)

1. General Population
 - Males 04%
 - Females 01%
2. Alcoholic Males 15%
3. Alcoholic Females 10%
4. Male Narcotics Addicts 32%
5. Prison Inmates 50% - 80%

Source: Ferrel, G. G., Chemical Dependency And Antisocial Personality Disorder, Hawthorn Press, New York, 1983

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Criminal Personality Disorders

DSM-III-R Cluster B Personality Disorders

1. Antisocial (Rule Breakers)
2. Narcissistic (Egotistical And Self-Centered)
3. Histrionic (Disruptive Attention Seekers)
4. Borderline (Chaotic And Volatile)

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Punishment Alone ...

1. **Will NOT** Stop Criminals With Chemical Use Disorders From Using Alcohol And Drugs
2. **Will NOT** Stop Criminals With Criminal Personality Disorders From Committing New Crimes

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Effective Alternatives To Incarceration Must Be Found

1. Jails Are Overcrowded
2. Criminal Behavior Is Expanding And Reaching Epidemic Proportions
3. Punishment Alone Does Not Deter Future Crime
4. Treatment Alternatives To Incarceration Are Proving Effective

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For Treatment Alternatives To Work ...

Criminal Offenders Must Be Screened And Concurrently Treated For ...

1. Chemical Use Disorders
2. Criminal Personality Disorders
3. Mental Disorders

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Diagnostic And Treatment Procedures Must Be Integrated Into The Criminal Justice System

1. Screening Prior To Sentencing
2. Treatment Concurrent With Punishment
 - Treatment During Incarceration
 - Ongoing Treatment As A Condition For Parole Or Probation
 - Break In Treatment Results In Return To Jail

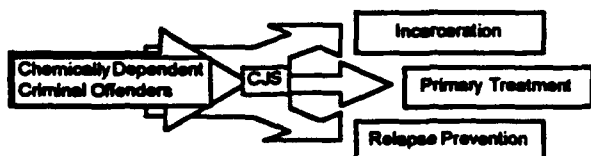
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This Course Focuses Upon ...

Developing Treatment Alternatives To Incarceration For Criminals With ...

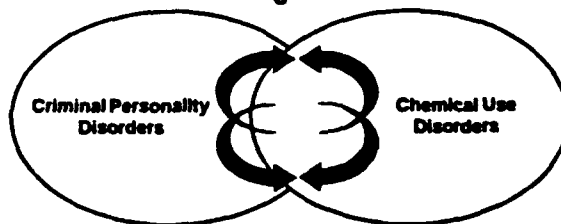
- Criminal Personality Disorders (CPD)
- Chemical Use Disorders (CUD)



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Criminal Personality Disorders And Chemical Use Disorders Are Coexisting Disorders



Both Must Be Treated Together

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Relationship Between CD And CPD

1. Mutual Predisposition
 - CPD Increases Risk Of CD
 - CD Increases Risk Of CPD
2. Symptom Reinforcement
 - CPD Promotes A/D Abuse
 - A/D Abuse Promotes Antisocial Behavior
3. Reciprocal Relapse
 - A/D Triggers Criminal Behaviors
 - Criminal Behaviors Triggers A/D Use

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This Relationship Requires ...

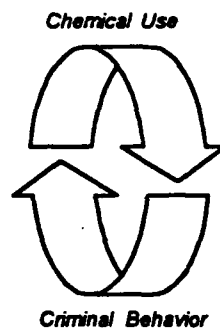
1. Concurrent Diagnosis And Treatment
2. Abstinence From Alcohol And Drug Use
3. Abstinence From Criminal Behaviors
4. Change Of A/D And Criminal Centered Lifestyle Patterns
5. Use Of Holistic Recovery Program

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Reciprocal Relapse

- Relapse To A/D Drug Use Causes Renewed Criminal Behaviors
- Relapse To Criminal Behaviors Causes Renewed Alcohol and Drug Use



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Concurrent Treatment Requires ...

1. Availability Of Treatment Alternatives
2. Incorporation Of Treatment Alternatives Into Sentencing
3. Integration Of Treatment Alternatives With Incarceration, Probation, And Parole
4. Use Of Legal Force To ...
 - Initiate Treatment
 - Maintain Treatment
 - Intervene Upon Relapse

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For Further Information
Recovery And Relapse Prevention
Of The Criminal Justice System

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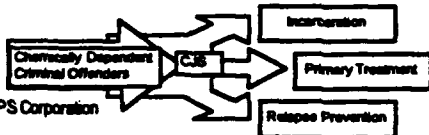
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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 2: The CENAPS Model

Developed By
Terence T. Gorski
President, The CENAPS Corporation



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CDC002-1

Session Goals

This Session Will Describe ...

1. An Overview Of The CENAPS Model
2. A Description Of How The CENAPS Model Can Be Applied To Chemically Dependent Criminal Offenders



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CDC002-2

The CENAPS Model

A System For The ...

- Diagnosis
- Treatment

Of ...

- Chemical Use Disorders
- Criminal Personality Disorders
- Codependency



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CDC002-3

The CENAPS Model Combines ...

- A Biopsychosocial Disease Model Of Chemical Dependency
- With Criminal Personality Theory
- To Create A Practical System For Treating Chemically Dependent Criminal Offenders



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CDC002-4

The CENAPS Model Integrates ...

1. Cognitive Therapy
 - To Change Addictive And Criminal Thinking
- 2.
- 3.
- 4.



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CDC002-5

The CENAPS Model Integrates ...

1. Cognitive Therapy
2. Affective Therapy
 - To Cope With Unmanageable Feelings That Drive Addictive And Criminal Behaviors
- 3.
- 4.



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The CENAPS Model Integrates ...

1. Cognitive Therapy
2. Affective Therapy
3. Behavioral Therapy
 - To Change Drug Seeking And Criminal Behaviors
- 4.

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The CENAPS Model Integrates ...

1. Cognitive Therapy
2. Affective Therapy
3. Behavioral Therapy
4. Social Systems Therapy
 - To Change Addiction-Centered And Crime-Centered Social Networks

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Components Of The CENAPS Model

1. Biopsychosocial Disease Model
 - For Diagnosis And Assessment
2. Developmental Model Of Recovery
 - For Long-Term Treatment Planning
3. Relapse Prevention Therapy Model
 - For Dealing With The Problem Of Recidivism

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CDC002-9

The CENAPS Model Has Been Expanded To ...

Meet The Needs Of The Criminal Justice System
By Integrating The Diagnosis And Treatment Of ...

1. Chemical Use Disorders
 - Abuse
 - Dependency
2. Criminal Personality Disorders

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CDC002-10

The CENAPS Model Is...

1. Compatible With Twelve Step Principles
2. Practical And Easy To Use
3. Adaptable To Inpatient, Residential, And Outpatient Programs
3. Oriented To The Real World Of ...
 - The Criminal Justice System
 - Psychiatric Treatment Programs
 - Chemical Dependency Programs

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CDC002-11

The CENAPS Model

Provides Diagnostic And Treatment Methods For ...

1. Transitional Patients
 - Involuntary Patients With Strong Denial
- 2.
- 3.
- 4.

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CDC002-12

The CENAPS Model

Provides Diagnostic And Treatment Methods For ...

1. Transitional Patients
2. Primary Patients
 - Who Lack Recovery Planning Skills
- 3.
- 4.

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CDC002-13

The CENAPS Model

Provides Diagnostic And Treatment Methods For ...

1. Transitional Patients
2. Primary Patients
3. Relapse-Prone Patients
 - Unable To Stay In Recovery In Spite Of Previous Treatment
- 4.

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CDC002-14

The CENAPS Model

Provides Diagnostic And Treatment Methods For ...

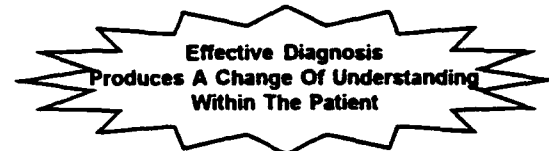
1. Transitional Patients
2. Primary Patients
3. Relapse-Prone Patients
4. Family Members
 - Who Relapse Into Codependent Behaviors

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CDC002-15

Diagnosis

An Organized System
For Identifying The Symptoms
Of A Disease Or Disorder

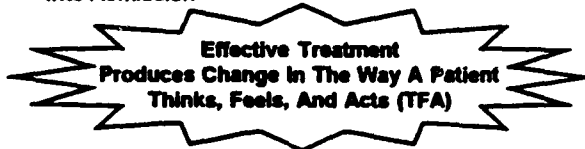


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CDC002-16

Treatment

An Organized System
For Bringing The Symptoms Of Identified
Disease Or Disorder
Into Remission



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CDC002-17

Chemical Use Disorders

Regular And Heavy Use Of Alcohol And Drugs Resulting In ...

- Psychosocial Dependence
- Personal, Social, And Occupational Impairments

1. Abuse Disorders
 - No Physical Dependence
2. Dependence Disorders
 - Physical Dependence Resulting In Tolerance, Withdrawal, And Illness

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CDC002-18

Chemical Use Disorders

1. The Pathological Use Of Alcohol And Other Mood Altering Drugs
- 2 That Results In The Development Of Problems
 - Physical
 - Psychological
 - Social

If A Person Has Problems
With Chemical Use
And Continues To Use
In Spite Of The Problems
He/She Probably Has A
Chemical Use Disorder



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CDC002-18

Chemical Abuse Results From ...

Chemical Use In Psychosocially Predisposed
Persons That Causes:

- Personality Disorganization
- Life Style Problems

Chemical Abuse Is Often A Symptom
Of Antisocial Personality Disorder



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CDC002-20

Chemical Dependency Result From ...

Chemical Use In Genetically Predisposed
Persons That Causes:

1. Brain Dysfunction
 - Tolerance
 - Withdrawal
2. Personality Disorganization
3. Life Style Problems
4. Biopsychosocial Deterioration



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CDC002-21

Progression To Chemical Dependence

Genetically Predisposed People
Who Use And Abuse Chemicals
Become Addicted

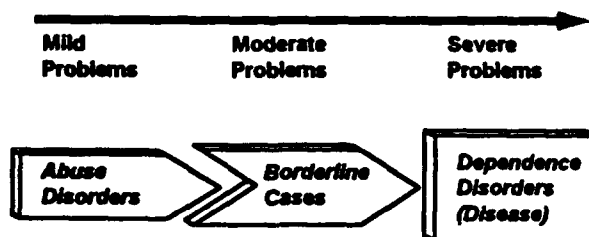
Chemical Abuse
Can Progress To
Chemical Dependence



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CDC002-22

The Continuum Of Alcohol And Drug Problems



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CDC002-23

The Term Chemical Dependency ...

1. Will Be Used To Describe Both ...
 - Chemical Abuse Disorders
 - Chemical Dependence Disorders
2. Rationale ...
 - The Treatment Principles Are Essentially The Same For Both



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CDC002-24

Basic Treatment Principles

Recovery From Chemical Dependency Requires ...

1. Abstinence From Alcohol And Drugs
2. Identifying And Changing ...
 - Addictive Thoughts, Feelings, And Behaviors
 - Addiction Centered Lifestyle Patterns
3. Deep Personality And Value Change

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CDC002-26

Criminal Personality Is ...

An Habitual Way Of Perceiving, Thinking,
Feeling, Acting, And Relating To Others

That Results In ...

1. Opposition To Authority
2. Acting Out Against Others
3. Rule Breaking And Criminal Behavior

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CDC002-28

Criminal Personality Disorders

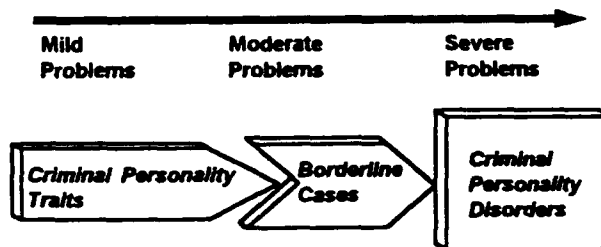
DSM-III-R Cluster B Personality Disorders

1. Antisocial (Rule Breakers)
2. Narcissistic (Egotistical And Self-Centered)
3. Histrionic (Disruptive Attention Seekers)
4. Borderline (Chaotic And Volatile)

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CDC002-27

The Continuum Of Criminality



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CDC002-28

Codependency Is

1. A Self-defeating Personality Style
2. That Results From Living In A Committed Relationship
3. With Someone Who Is Suffering From ...
 - Chemical Dependency
 - Criminal Personality Disorder

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CDC002-29

Types Of Codependency

1. Adult Onset
 - Normal Childhood
 - Codependency Develops As Adult
2. Child Onset
 - Codependency Develops In Childhood
 - Caused By Parental CD Or CPD

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CDC002-30

Symptoms Of Codependency

1. Habitual Self-Defeating Response To
Chemical Dependency Or Criminal Personality
 - Blaming
 - Enabling
 - Controlling
2. Preoccupation Causing ...
 - Excessive Caretaking
 - Lack Of Self Care
 - Loss Of Self Identity

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CDC002-31



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CDC002-32

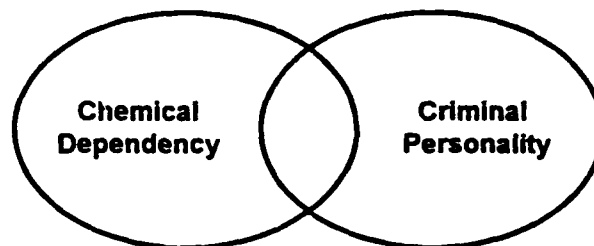
Recovery Is ...

- A Long-Term Process
Of Biopsychosocial Rehabilitation
- That Progresses In Stages
- With Different Recovery Needs
In Each Stage

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CDC002-33

The CENAPS Model Integrates The Treatment Of ...



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CDC002-34

Components Of The CENAPS Model:

1. Biopsychosocial Model
 - Recognition & Acceptance Of Chemical
Dependence And Criminal Personality
- 2.
- 3.

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CDC002-35

Biopsychosocial Assessment Grid (BAG)

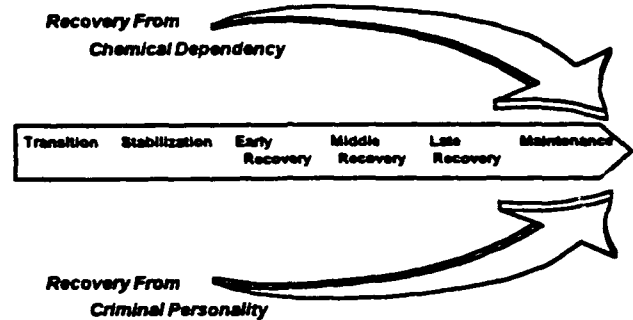
	Chemical Dependence	Criminal Personality
Physical	Toxic Effects Of A/D	Cognitive Impairment
Psychological	Dependence On A/D	Dependence On Criminal Excitement
Social	A/D Centered Living	Criminal Centered Living

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CDC002-36

Components Of The CENAPS Model:

1. Biopsychosocial Addiction Model
2. Developmental Model Of Recovery (DMR)
 - Long Term Recovery Planning
- 3.



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CDC002-37

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CDC002-38

Components Of The CENAPS Model:

1. Biopsychosocial Addiction Model
2. Developmental Model Of Recovery (DMR)
3. Relapse Prevention Therapy
 - Warning Sign Identification And Management

Relapse Prevention Therapy

A Systematic Method For Preventing ...



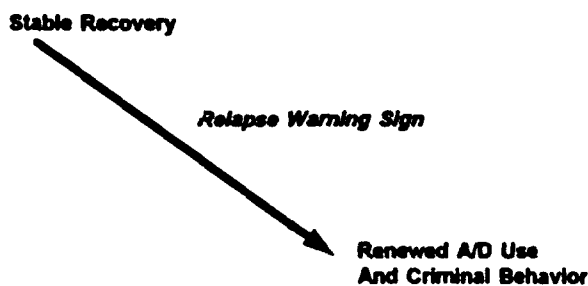
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CDC002-39

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CDC002-40

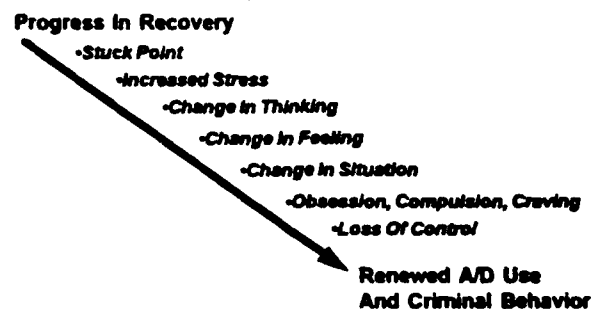
The Relapse Progression



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CDC002-41

The Relapse Progression



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CDC002-42

Relapse Prevention Therapy

1. Assessment
 - *Relapse-Prone Lifestyle Patterns*
2. Warning Sign Identification
 - *Specific Steps That Lead To Relapse*
3. Warning Sign Management
 - *Successfully Coping With The Warning Signs*
4. Recovery Planning
 - *Scheduled Activities That Help Identify And Manage Warning Signs*



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CDC002-43

Remember ...



There Is Hope !!!

- Chemically Dependent Criminal Offenders Are Difficult To Treat
- They Are Not Impossible To Treat
- Recovery Is Possible If Both Disorders Are Concurrently Addressed In Long-Term Treatment



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CDC002-44



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CDC002-46

The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 3: Chemical Dependence A Biopsychosocial Model

Developed By
Terence T. Gorski
President, The CENAPS Corporation

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CDC003 1

Types Of Alcohol And Drug (A/D) Problems Among Criminal Offenders

1. Alcohol And Drug Related Crimes
 - 70% Of All Criminals
2. Chemical Abuse Disorders
 - 28% Of All Criminals
 - 40% Of Criminals With A/D Related Crimes
3. Chemical Dependence Disorders
 - 42% Of All Criminals
 - 60% Of Criminals With A/D Related Crimes

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CDC003 2

The Relationship Between Crime And Chemical Use

1. Crime Is A Symptom Of The Non-Addictive Use Of Illegal Drugs In Persons Who Do Not Have Chemical Use Disorders Or Criminal Personality (5%)
2. Crime Is A Symptom Of Chemical Dependency (15%)
3. A/D Use Is A Symptom Of Criminal Personality (15%)
4. Crime Is A Symptom Of Both Chemical Dependency And Criminal Personality (65%)

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CDC003 3

Alcohol And Drug Problems Are Related To Criminal Recidivism

1. Most Repeat Criminals Have Chemical Use Disorders
2. A/D Use Among Parolees Is Associated With ...
 - Breaking Parole And Probation
 - Renewed Criminal Behavior
 - New Arrests And Convictions

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CDC003 4

Conclusion ...

- 80% Of All Criminals
- Need Treatment
- For Chemical Dependency



Few Criminal Offenders
Are Social Drinkers Or
Recreational Drug Users

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CDC003 5

Punishment Alone ...

- Will Not Stop Criminals
- With Chemical Use Disorders
- From Using Alcohol And Drugs

**Treatment Alternatives
Are Needed**

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CDC003 6

Treatment Alternatives Require ...

An Accurate Understanding Of ...

1. Chemical Use Disorders As Biopsychosocial Conditions
2. Diagnostic Criteria For Use In Differential Diagnosis Of ...
 - Abuse Disorders
 - Dependence Disorders(The Disease Of Chemical Dependence)



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CDC003 7

Chemical Use Patterns

1. Chemical Use
 - No Problems Result From Use
2. Chemical Use Disorders
 - Problems Result From Use



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CDC003 8

Chemical Use Disorders

1. The Pathological Use Of Alcohol And Other Mood Altering Drugs
- 2 That Results In The Development Of Problems
 - Physical
 - Psychological
 - Social

If A Person Has Problems
With Chemical Use
And Continues To Use
In Spite Of The Problems
They Probably Have A
Chemical Use Disorder



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CDC003 9

Chemical Use Disorders

Regular And Heavy Use Of Alcohol And Drugs Resulting In ...

- ☒ Psychosocial Dependence
- ☒ Personal, Social, And Occupational Impairments

1. Abuse Disorders
 - No Physical Dependence
2. Dependence Disorders
 - Physical Dependence Resulting In Tolerance, Withdrawal, And Illness



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CDC003 10

Chemical Abuse Results From ...

Chemical Use In Psychosocially Predisposed Persons That Causes:

- ☒ Personality Disorganization
- ☒ Life Style Problems

Chemical Abuse Is Often A Symptom
Of An Underlying Personality Disorder

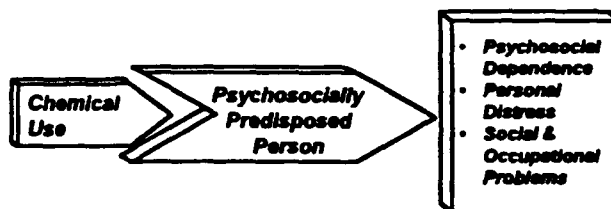


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CDC003 11

Chemical Abuse

Causes Psychosocial Problems



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CDC003 12

Chemical Dependency Result From ...

Chemical Use In Genetically Predisposed
Persons That Causes:

1. Brain Dysfunction
 - Tolerance
 - Withdrawal
2. Personality Disorganization
3. Life Style Problems
4. Biopsychosocial Deterioration

**Chemical Dependency
Is A Disease**

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CDC003 13

Genetically Influenced Tendencies

1. Biological Reinforcement
 - *Positive Mood And Personality Change*
2. High Tolerance
 - *Heavy Use Without Intoxication*
3. Hangover Resistance
 - *Minimal Illness The Day After Use*
4. Brain Damage Sensitivity
 - *Brain Dysfunction Builds With Regular Use*

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CDC003 14

Chemical Dependence

A Biopsychosocial Disease

1. Bio = Biological (Of The Body)
 - Brain Dysfunction Caused By Addictive Use
In Genetically Predisposed People
- 2.
- 3.

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CDC003 15

Chemical Dependence

A Biopsychosocial Disease

1. Bio = Biological (Of The Body)
2. Psycho = Psychological (Of The Mind)
 - Personality Change Caused By Brain
Dysfunction
- 3.

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CDC003 16

Chemical Dependence

A Biopsychosocial Disease

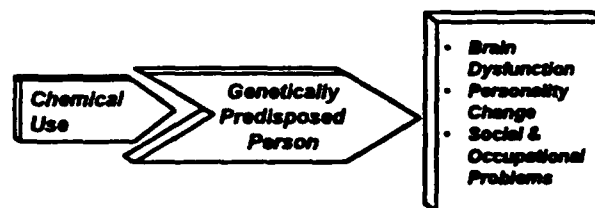
1. Bio = Biological (Of The Body)
2. Psycho = Psychological (Of The Mind)
3. Social = Relationships (Of Society)
 - Lifestyle Problems Caused By The
Personality Changes

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CDC003 17

Chemical Dependence

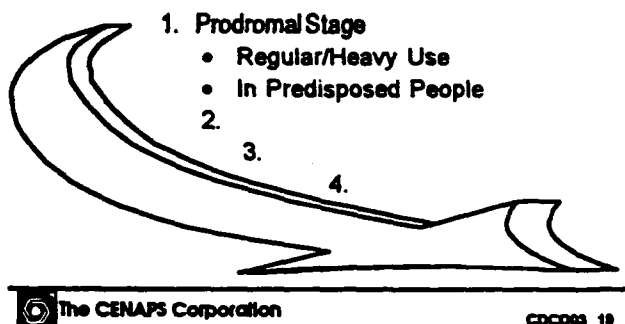
Causes Brain Dysfunction



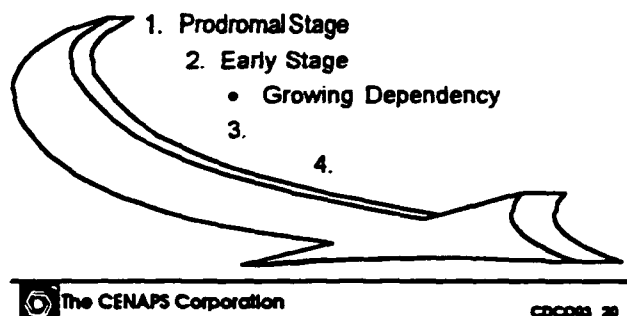
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CDC003 18

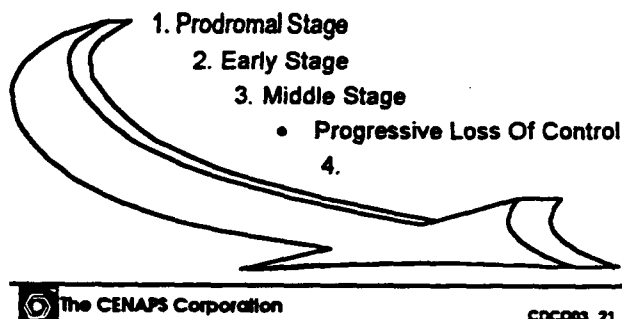
Progression Of Chemical Dependence



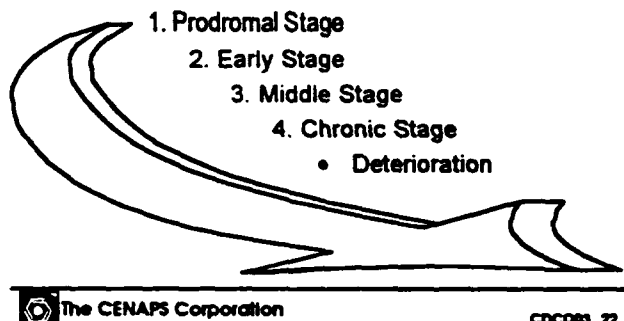
Progression Of Chemical Dependence



Progression Of Chemical Dependence



Progression Of Chemical Dependence



Personality And Chemical Dependence

1. Preaddictive Personality
 - Childhood Personality Present Before Addiction
2. Addictive Personality
 - Personality Changes Caused By The Addiction

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Progressive Brain Dysfunction

1. Disorganizes Preaddictive Personality
2. Creates Secondary Addictive Personality

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CDC003 24

Addictive Personality Characteristics

1. Obsession
 - Out Of Control Thinking About Alcohol And Drug Use
- 2.
- 3.
- 4.
- 5.
- 6.

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CDC003 25

Addictive Personality Characteristics

1. Obsession
2. Compulsion
 - Irrational Urge To Use In Spite Of Adverse Consequences
- 3.
- 4.
- 5.
- 6.

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CDC003 26

Addictive Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
 - Inability To Predict Behavior While Using Alcohol And Drugs
- 4.
- 5.
- 6.

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CDC003 27

Addictive Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
4. Personality Change
 - Altered Values, Attitudes, And Beliefs
- 5.
- 6.

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CDC003 28

Addictive Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
4. Personality Change
5. Secondary Life Problems
 - Lifestyle Problems Caused By Addictive Use
- 6.

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CDC003 29

Addictive Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
4. Personality Change
5. Secondary Life Problems
6. Denial Of Addiction
 - Addictive Use Blamed On Life Problems

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Addictive Personality Causes ...

1. Social Impairment
2. Occupational Impairment
3. Subjective Distress
4. Continued Use In Spite Of Consequences

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CDC003 31

Progression To Chemical Dependence

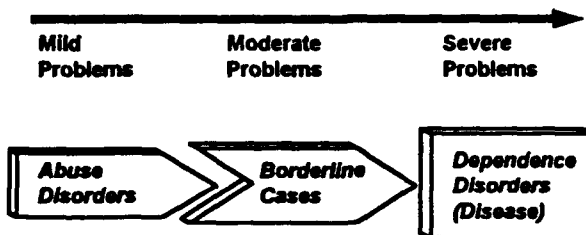
Genetically Predisposed People
Who Use And Abuse Chemicals
Become Addicted

Chemical Abuse
Can Progress To
Chemical Dependency

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CDC003 32

The Continuum Of Alcohol And Drug Problems



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CDC003 33

The Term Chemical Dependency ...

1. Will Be Used To Describe Both ...
 - Chemical Abuse Disorders
 - Chemical Dependence Disorders
2. Rationale ...
 - The Treatment Principles Are Essentially The Same For Both

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CDC003 34

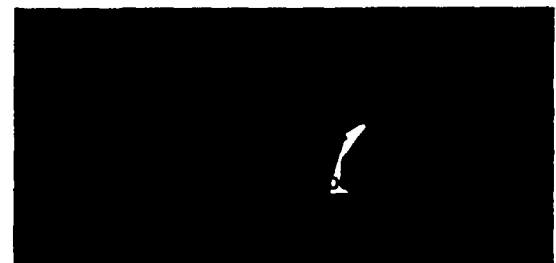
Basic Treatment Principles

Recovery From Chemical Dependency Requires ...

1. Abstinence From Alcohol And Drugs
2. Identifying And Changing ...
 - Addictive Thoughts, Feelings, And Behaviors
 - Addiction Centered Lifestyle Patterns
3. Deep Personality And Value Change

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CDC003 36

The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 4: The Criminal Personality A Biopsychosocial Model

Developed By
Terence T. Gorski
President, The CENAPS Corporation

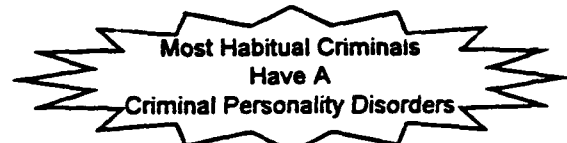
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CDC004 1

Antisocial Behaviors Are Common Among Criminal Offenders

- Commit Antisocial Acts 100%
- Habitual Criminals 75%



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CDC004 2

Criminal Personality Disorders

DSM-IIIIR Cluster B Personality Disorders

1. Antisocial (Rule Breakers)
2. Narcissistic (Egotistical And Self-Centered)
3. Histrionic (Disruptive Attention Seekers)
4. Borderline (Chaotic And Volatile)

*Antisocial Personality Disorder
Is Most Common*

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CDC004 3

Incidence Of Antisocial Personality Disorder (ASPD)

1. General Population
 - Males 04%
 - Females 01%
2. Alcoholic Males 15%
3. Alcoholic Females 10%
4. Male Narcotics Addicts 32%
5. Prison Inmates 50% - 80%

Source: Forrest, G. G., Chemical Dependency And Antisocial
Personality Disorder, Hawthorn Press, New York, 1993

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CDC004 4

Profile Of Chemically Dependent Criminal Offenders

1. Crime Is A Symptom Of The Non-Addictive Use Of
Illegal Drugs In Persons Who Do Not Have Chemical
Use Disorders Or Criminal Personality (5%)
2. Crime Is A Symptom Of Chemical Dependency (15%)
3. A/D Use Is A Symptom Of Criminal Personality (15%)
4. Crime Is A Symptom Of Both Chemical Dependency
And Criminal Personality (65%)

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CDC004 5

Criminal Personality Disorders (CPD) Are Related To Criminal Recidivism

1. Most Repeat Criminals Have Criminal
Personality Disorders (CPD)
2. CPD Among Parolees Is Associated With ...
 - Breaking Parole And Probation
 - Renewed Criminal Behavior
 - New Arrests And Convictions

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CDC004 6

Conclusion ...



80% Of All Criminals
Need Treatment
For Criminal Personality
Disorders

Few Criminal Offenders
Have
Healthy Personalities

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CDC004 7

Punishment Alone ...

Will Not Stop Criminals
With Criminal Personality Disorders
From Committing Antisocial Acts

***Treatment Alternatives
Are Needed***

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CDC004 8

Treatment Alternatives Require ...

An Accurate Understanding Of ...

1. Personality Disorders As Biopsychosocial Conditions
2. The Relationship Of Personality Disorders To ...
 - Criminal Behavior
 - Alcohol And Drug Use
3. Diagnostic Criteria For Use In Differential Diagnosis
4. Treatment Guidelines Compatible With The Criminal Justice System

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CDC004 9

In This Session We Will ...

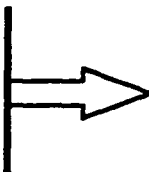
1. Define Personality
2. Differentiate ...
 - Healthy Personality Traits
 - Self-defeating Personality Traits
 - Personality Disorders
3. Define Criminal Personality As A Biopsychosocial Disorder

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CDC004 10

Definition Of Personality

Enduring And Deeply Entrenched Habits Of ...

- Perceiving
 - Thinking
 - Feeling
 - Acting
 - Relating
- 
- Self
 - Others
 - The World

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CDC004 11

Personality Is ...

- Developed In Childhood
- Unconsciously Repeated In Adulthood

Personality Forms
The Primal Template Of Experience
The "Truth As We Know It"
All Perceptions
Are Shaped By This Template

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CDC004 12

Personality Traits Are ...

1. Pervasive
 - *Affect All Areas Of Life*
2. Persistent
 - *Compel Us To Act Out*
3. Resistant To Change
 - *Are Difficult To Modify Or Eliminate*

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CDC004 13

Personality Variation

1. Healthy Personality Traits
 - *Feel Good / Function Well*
2. Self-defeating Personality Traits
 - *Feel Bad / Function Adequately*
3. Personality Disorders
 - *Feel Bad / Dysfunctional*

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CDC004 14

Healthy Personality Traits Are ...

1. Flexible
 - *Able To Change*
2. Adaptive
 - *Adjust To Meet Current Needs*
3. Functional
 - *Produce Desired Outcomes*
 - *Do Not Create Problems*

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CDC004 15

Self-defeating Personality Traits Are ...

1. Inflexible
 - *Rigid And Unchangeable*
2. Maladaptive
 - *Do Not Adjust To Meet Current Needs*
3. Dysfunctional
 - *Do Not Produce Desired Outcomes*
 - *Create Problems*

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CDC004 16

Personality Disorders Are...

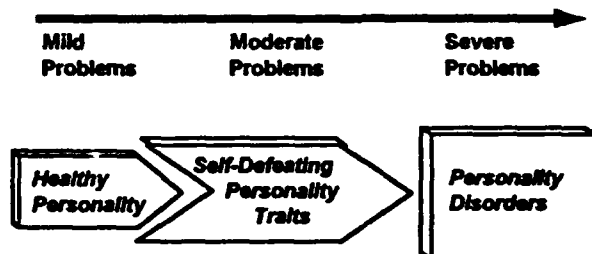
1. Extremely Self-Defeating Personality Traits
2. That Consistently Produce ...
 - *Subjective Distress*
 - *Social Impairment*
 - *Occupational Impairment*



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CDC004 17

The Continuum Of Personality Problems



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CDC004 18

Personality Disorders

1. The Repetitive Use Of ...
 - Irrational Thinking
 - Self-defeating Behaviors
2. That Results In The Development Of Problems
 - Physical
 - Psychological
 - Social
3. That Continue In Spite Of The Problems

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CDC004 19

Personality Results From ...

A Complex Interaction Between ...

1. Genetically Inherited ...
 - Temperaments
 - Traits
2. Early Childhood Experiences
3. Transformative Adult Experiences
 - Positive (Corrective)
 - Negative (Debilitating)

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CDC004 20

Personality Is Biopsychosocial

1. Bio = Genetically Influenced Preferences
2. Psycho = Learned Patterns Of ...
 - Thinking
 - Managing Feelings
 - Acting
3. Social = Established Relationships
 - Work
 - Social
 - Intimate

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CDC004 21

Criminal Personality Is ...

A Biopsychosocial Disorder ...

1. Bio = Biological (Of The Body)
 - Brain Functioning That Predispose To Self-Centered And Antisocial Behavior.
- 2.
- 3.

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CDC004 22

Genetically Influenced Personality Preferences

1. Active $\longleftrightarrow$ Passive
2. Independence $\longleftrightarrow$ Dependence
3. Extroversion $\longleftrightarrow$ Introversion
4. Thinking $\longleftrightarrow$ Feeling

*Criminal Personalities Tend To Be
Active, Independent, Extroverted, Feelers*

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CDC004 23

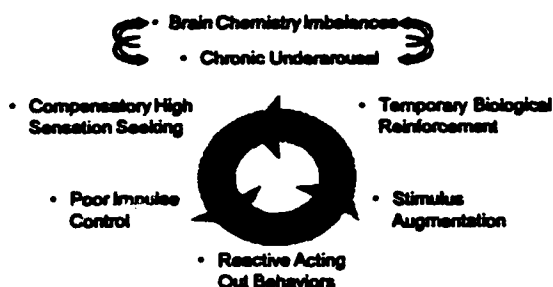
Genetic Predisposition For Criminal Personality Disorder

1. High Sensation Seeking
2. Poor Impulse Control
3. Preference For Concrete Thinking
4. Difficulty With Abstract And Symbolic Learning
5. Insensitive To Others

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CDC004 24

Biological Dynamics Of CPD



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CDC004 25

Learning From Experience Is Inhibited By ...

1. Preference For Concrete Thinking
 - Focus Upon Immediate Situation Only
2. Difficulty With Abstract And Symbolic Learning
 - Failure To Detect Core Issues And Repetitive Patterns
3. Insensitivity To Others
 - Blocking Or Disregarding Feedback

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CDC004 26

This Cycle Creates ...

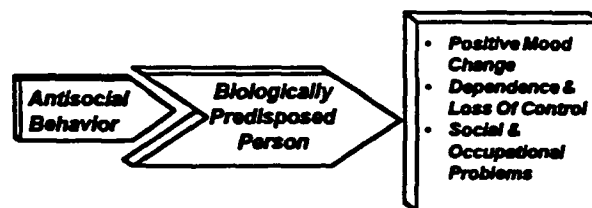
1. Biological Reinforcement
 - Intense Euphoria And Mood Alteration From Criminal And Sexual Thrill Seeking
2. High Stress Tolerance
 - Ability To Thrive On Intense Situations
3. Hangover Resistance
 - Rapid Recovery From Excessive Stress

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CDC004 27

Criminal Personality Disorder

Role Of Antisocial Behavior



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CDC004 28

Criminal Personality Is ...

A Biopsychosocial Disorder

1. Bio = Biological (Of The Body)
2. Psycho = Psychological (Of The Mind)
 - Personality Constructed Around Antisocial Thrill Seeking And Pathological Indifference
- 3.

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CDC004 29

Criminal Personality Characteristics

1. Obsession
 - Out Of Control Thinking About Antisocial Thrill Seeking
- 2.
- 3.
- 4.
- 5.
- 6.

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CDC004 30

Criminal Personality Characteristics

1. Obsession
2. Compulsion
 - Irrational Urge To Engage In Antisocial Thrill Seeking In Spite Of Adverse Consequences
- 3.
- 4.
- 5.
- 6.

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Criminal Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
 - Inability To Resist Urges To Use Antisocial Behavior
- 4.
- 5.
- 6.

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Criminal Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
4. Secondary Life Problems
 - Lifestyle Problems Caused By Antisocial Behavior
- 5.

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Addictive Personality Characteristics

1. Obsession
2. Compulsion
3. Loss Of Behavioral Control
4. Personality Change
5. Secondary Life Problems
6. Denial Of Criminal Personality
 - View Of Self As An Innocent Victim Of An Unfair World

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Criminal Personality Is ...

A Biopsychosocial Disorder

1. Bio = Biological (Of The Body)
2. Psycho = Psychological (Of The Mind)
3. Social = Relationships (Of Society)
 - Lifestyle Preferences That Support Antisocial Behavior

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Criminal Personality

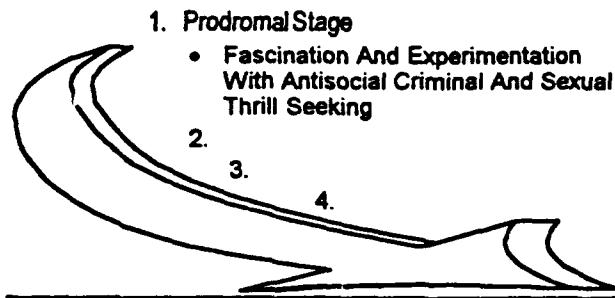
Social Symptoms ...

1. Antisocial Isolated Lifestyle
2. Unstable Work History
3. Intimate Relationship Problems
 - Sexual Exploitation And Abuse
 - No Emotional Bonding
4. Friendships
 - Short Term
 - Mutually Exploitive

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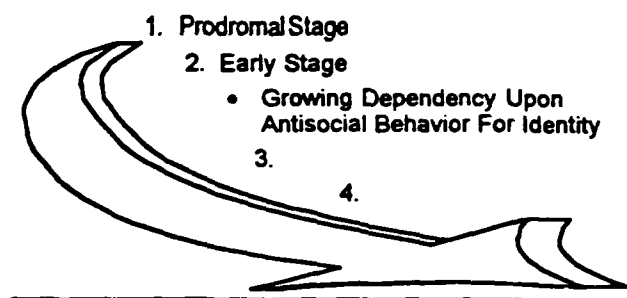
Progression Of Criminal Personality



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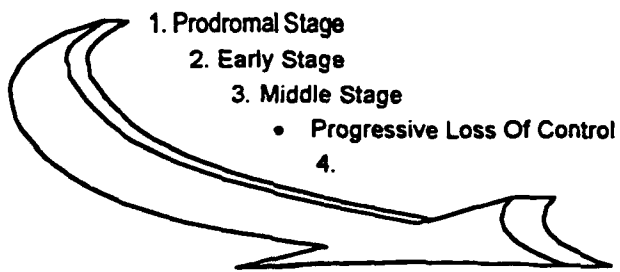
Progression Of Criminal Personality



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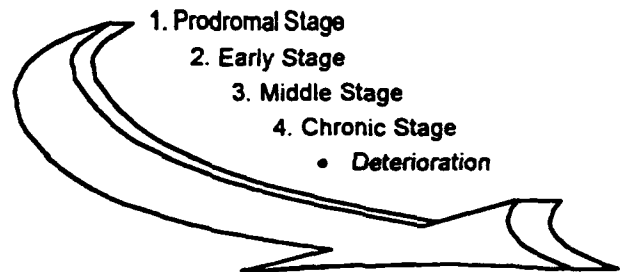
Progression Of Criminal Personality



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Progression Of Criminal Personality



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Progression To Criminal Personality

- Biologically Predisposed People
- Who Use Antisocial Thinking And Behaviors
- In A Socially Reinforcing Environment
- Develop Progressive Antisocial Personality Traits

*Social And Environmental Factors
Can Accelerate Or Retard Progression*

*Environmental Constraints
Are Necessary For Change*

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Antisocial Personality Disorder DSM-III-R Criteria

1. Conduct Disorder
 - Prior To Age 15
2. Pattern Of Antisocial Behavior
 - Since Age 15

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Conduct Disorder - Prior To Age 15

Criteria: Three Or More

1. Frequent Truancy
2. Overnight Runaway (Twice Or More)
3. Frequent Physical Fights
4. Use Of Weapon In Fight (More Than Once)

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Conduct Disorder (Continued)

5. Forced Sexual Activity
6. Physical Cruelty To Animals
7. Physical Cruelty To People
8. Vandalism And Destruction Of Property

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Conduct Disorder (Continued)

9. Deliberate Fire Setting
10. Frequent Lying
11. Theft Without Victim Confrontation (Twice Or More)
12. Theft With Victim Confrontation

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Antisocial Behavior Since Age 15

Criteria: Four Or More

1. Inconsistent Work (Academic) Pattern
 - A. *Unemployment When Able To Work And Work Is Available*
 - B. *Unexcused Absences And Tardiness*
 - C. *Irresponsible Job Abandonment*
2. Law Breaking And Violations Of Social Norms (Whether Arrested Or Not)

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Antisocial Behavior (Continued)

3. Irritable And Aggressive
 - A. Physical Fights And Assaults
 - B. Child Or Spouse Beating
4. Default On Financial Obligations
 - A. Failure To Pay Back Debts
 - B. Failure To Pay For Support Of Dependents

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Antisocial Behavior (Continued)

5. Impulsive, Fails To Plan Ahead
 - A. Prolonged Aimless Traveling
 - B. No Fixed Address For More Than One Month
6. Dishonest, Nor Regard For The Truth
 - A. Repeated Lying
 - B. Use Of Aliases
 - C. Conning For Profit Or Pleasure

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Antisocial Behavior (Continued)

7. Reckless Behavior That Endangers Self Or Others
 - A. Driving While Intoxicated
 - B. Speeding And Reckless Driving

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Antisocial Behavior (Continued)

8. Irresponsible Parenting
 - A. Malnutrition Of child
 - B. Child's Illness Resulting From Lack Of Hygiene
 - C. Failure To Provide Medical Care For Seriously Ill Child
 - D. Failure To Provide Food Or Clothing
 - E. Failure To Arrange Child Care
 - F. Repeated Squandering Of Money Required For Household Necessities

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Antisocial Behavior (Continued)

9. Never Sustained Monogamous Relationship For More Than A Year
10. Lacks Remorse
 - A. Feels Justified In Antisocial Behaviors
 - B. Blames Victims For Offenses

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The Manipulative Personality - Functional Antisocials -

1. Have Antisocial Personality Traits
2. Smart Enough To Avoid Getting Caught
3. Direct Those Traits Into Socially Acceptable Outlets
4. Experience Subjective Distress, Social, And Occupational Problems
5. Without A Criminal Record

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Pseudo (ASPD)

Symptoms Mimicking ASPD Caused By ...

- A/D Intoxication
- A/D Withdrawal
- Organic Personality Disorders Produced By Chronic A/D Poisoning

*Patients Must Be Detoxified
Before A Definitive Diagnosis
Can Be Made*

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CDC004 53

Basic Treatment Principles For CPD

Recovery From CPD Requires ...

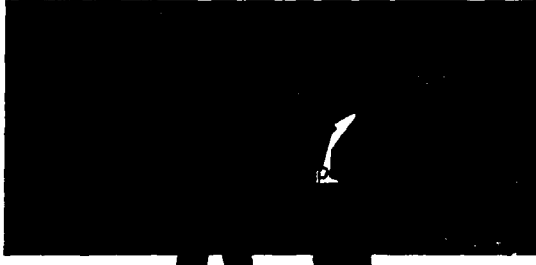
1. Abstinence From
 - Antisocial Behaviors
 - Alcohol And Drugs
2. Identifying And Changing ...
 - Antisocial Thoughts And Feelings
 - Antisocial Lifestyle Patterns
3. Deep Personality And Value Change

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708-799-5000

The Chemically Dependent Criminal Offender
Session 4: Criminal Personality - A Biopsychosocial Model
By Terence T. Gorski (Copyright, T. Gorski, 1993)



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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention
In The Criminal Justice System

Session 5: The Biopsychosocial Assessment Grid (BAG)
For Chemical Dependence And
Criminal Personality Disorder

Developed By

Terence T. Gorski

President, The CENAPS Corporation

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Biopsychosocial Assessment Grid (BAG)

Complete Profile Of A Disease Or Disorder

1. Biological

- *Physical Aspects*

2. Psychological

- *Mental And Emotional Aspects*

3. Social

- *Relationship And Societal Aspects*



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BAG - Biological

- A. Genetic Predisposition
- B. Biological Reinforcement
- C. High Tolerance
- D. Hangover Resistance
- E. Brain Damage Sensitive
- F. Progression



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BAG - Psychological

- A. Higher Self
- B. Perception
- C. Imaging
- D. Thinking
- E. Feeling
- F. Acting



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CDC005 4

BAG - Social

- A. Work
- B. Friendship
- C. Intimate/Sexual
- D. Family
- E. Legal



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CDC005 5

In This Session We Will ...

Review The BAG Criteria For ...

- 1. Chemical Dependence (CD)
- 2. Criminal Personality Disorder (CPD)
- 3. The Chemically Dependent Criminal Personality Disorder (CDCPD)



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1. BAG-CD: Biological

A. Genetic Predisposition

Metabolism Of Drug Of Choice Makes It ...

1. A Powerful Psycho-Active Medication
2. A Cause Of Brain Dysfunction

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1. BAG-CD: Biological

B. Biological Reinforcement

Use Of The Drug Of Choice Produces ...

1. Intense Euphoria
2. Positive Mood Alteration

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1. BAG-CD: Biological

C. High Tolerance

Heavy Use Without ...

1. Intoxication
2. Dysfunction

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1. BAG-CD: Biological

D. Hangover Resistance

- Rapid Recovery From
- The Adverse Aftereffects

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1. BAG-CD: Biological

E. Brain Damage Sensitivity

Drug Of Choice Produces ...

1. Increased Brain Dysfunction
2. Prolonged Recovery Time
3. Progressive Brain Dysfunction

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1. BAG-CD: Biological

F. Progressive Addiction Symptoms

The Addiction Progresses In Stages

1. Early Stage
 - Growing Dependence
2. Middle Stage
 - Progressive Loss Of Control
3. Chronic Stage
 - Deterioration

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2. BAG-CD: Psychological

A. Higher Self

1. When Abstinent ...
 - *Excessively Critical And Judgmental*
2. When Using
 - *Permissive And Self-Accepting*

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2. BAG-CD: Psychological

B. Perception

Experiences With Drug Of Choice ...

1. Positive Experiences Are Locked Onto And Exaggerated
2. Negative Experiences Blocked Out

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2. BAG-CD: Psychological

C. Imaging

1. When Abstinent
 - *Repressed And Inhibited*
2. When Using
 - *Vivid And Lucid*

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2. BAG-CD: Psychological

D. Thinking

Addictive Thinking Patterns That Protect ...

1. *The Right To Use Alcohol And Drugs*
2. *The Image Of Self As Social Drinker Or Recreational Drug User*

In Spite Of Evidence That ...

1. *It is Unsafe To Use A/D*
2. *Symptoms Of Addiction Are Present*

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2. BAG-CD: Psychological

E. Feeling

Pattern Of ...

1. Repression
2. Overreaction
3. Remorse

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2. BAG-CD: Psychological

F. Acting

Alcohol And Drug Seeking Behaviors

1. Preparation For Use
2. Use
3. Recovery From Aftermath Of Use

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3. BAG-CD: Social

A. Work

A/D Use ...

1. Interferes With Effective Functioning
2. Creates Problems

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3. BAG-CD: Social

B. Friendship

A/D Use Creates ...

1. Problems With Friends
2. A/D Centered Living
3. Addictive Isolation

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3. BAG-CD: Social

C. Intimate/Sexual -

A/D Use Interferes With ...

1. Intimate Sharing
2. Emotional Bonding
3. Sexual Performance
4. Maintaining Intimate Responsibilities

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3. BAG-CD: Social

D. Family

A/D Use Interferes With ...

1. Effectively Meeting Family Responsibilities
2. Maintaining Effective Family Roles

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3. BAG-CD: Social

E. Legal

Legal Problems From Alcohol And Drug ...

1. Intoxication
2. Withdrawal

That Result In ...

1. Poor Judgment
2. Out Of Control Behavior
3. Irresponsibility Due To Incapacitation

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1. BAG-CPD: Biological

A. Genetic Predisposition

1. High Sensation Seeking
2. Poor Impulse Control
3. Preference For Concrete Thinking
4. Difficulty With Abstract Thinking And Symbolic Learning
5. Self-Absorption And Insensitivity To Others

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1. BAG-CPD: Biological

B. Biological Reinforcement

Thrill Seeking

1. *Criminal*
2. *Sexual*

That Results In ...

1. *Intense Euphoria*
2. *Mood Alteration*
3. *Temporary Personality Change*

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1. BAG-CPD: Biological

C. High Tolerance

Long Periods Of Intense Excitement
Without ...

1. *Dysfunction During Acute Stress*
2. *Stress Degeneration Or Burn Out*

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1. BAG-CPD: Biological

D. Hangover Resistance

Rapid Recovery From ...

- *The Excessive Stress Of Criminal Thrill Seeking*

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1. BAG-CPD: Biological

E. Brain Damage Sensitivity

- *Not Applicable*

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1. BAG-CPD: Biological

F. Progressive Antisocial Behaviors ...

1. Early Stage

- *Growing Dependence Upon Antisocial Behaviors For Self-Esteem*

2. Middle Stage

- *Progressive Loss Of Control*

3. Chronic Stage

- *Deterioration Of Lifestyle*

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2. BAG-CPD: Psychological

A. Higher Self

1. *Lacks Capacity For Objective Self Evaluation*
2. *During Responsible Behavior ...*
 - *Diminished Sense Of Self*
3. *During Criminal Behavior ...*
 - *Exaggerated Sense Of Self*

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2. BAG-CPD: Psychological

B. Perception

Experiences With Criminal Behavior ...

1. Positive Experiences Are Locked Onto And Exaggerated
2. Negative Experiences Are Blocked Out Or Minimized

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2. BAG-CPD: Psychological

C. Imaging

1. During Responsible Behavior ...
 - *Repressed And Inhibited*
2. During Criminal Behavior ...
 - *Vivid And Lucid*

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2. BAG-CPD: Psychological

D. Thinking

Thinking Based Upon Protecting ..

1. *The Right To Act Out In Antisocial Ways*
 2. *The Self Image Of Being A Good Person Who Is Victimized By Others*
- In Spite Of Evidence That Behaviors Are ...
1. *Victimizing Others*
 2. *Destroying Own Life*

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2. BAG-CPD: Psychological

E. Feeling

Pattern Of ...

1. Exaggeration
2. Conversion To Anger
3. Acting Out
4. Blaming Others

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2. BAG-CPD: Psychological

F. Acting

1. Preparation For Criminal Behavior
2. Overcoming Deterrents
 - *Internal*
 - *External*
3. Acting Out
4. Coping With The Aftermath Of Use

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3. CPD: Social

A. Work

CPD Causes ...

1. Devaluation Of Work
2. Conscious Irresponsibility
3. Occupational Problems

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3. CPD: Social

B. Friendship

CPD Causes ...

1. Intrusive Excessive Demands For Friendship
2. Devaluing And Manipulation Of Others
3. Criminal Isolation

3. CPD: Social

C. Intimate/Sexual

CPD Results In ...

1. Sexualizing All Intimacy
2. Dominating, Manipulating, And Controlling Sexual Partners

3. CPD: Social

D. Family

CPD Causes ...

1. Voluntary Withdrawal From Family
2. Manipulation And Abuse Of Family Members

3. BAG-CPD: Social

E. Legal

Legal Problems Result From ...

- Voluntary Use Of Antisocial Behavior

Relationship Between CD And CPD

1. Mutual Predisposition
 - CPD Increases Risk Of CD
 - CD Increases Risk Of CPD
2. Symptom Reinforcement
 - CPD Promotes A/D Abuse
 - A/D Abuse Promotes Antisocial Behavior
3. Reciprocal Relapse
 - A/D Triggers Criminal Behaviors
 - Criminal Behaviors Triggers A/D Use

This Relationship Requires ...

1. Concurrent Diagnosis And Treatment
2. Abstinence From Alcohol And Drug Use
3. Abstinence From Criminal Behaviors
4. Change Of A/D And Criminal Centered Lifestyle Patterns
5. Use Of Holistic Recovery Program

1. BAG-CDCPD: Biological

A. Genetic Predisposition

The Drug Of Choice Is ...

1. *A Powerful Psycho-Active Medication*
2. *A Cause Of Brain Dysfunction*

Personality Tendencies Are ...

1. *High Sensation Seeking*
2. *Poor Impulse Control*
3. *Preference For Concrete Thinking*
4. *Difficulty With Abstract Thinking And Symbolic Learning*
5. *Self-Absorption And Insensitivity To Others*



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1. BAG-CDCPD: Biological

B. Biological Reinforcement

Use Of Drug Of Choice Causes ...

1. *Intense Euphoria*
2. *Positive Mood Alteration*

Criminal And Sexual Thrill Seeking Causes ...

1. *Intense Euphoria*
2. *Mood Alteration*
3. *Temporary Personality Change*



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1. BAG-CDCPD: Biological

C. High Tolerance

Heavy Use Without ...

1. *Intoxication*
2. *Dysfunction*

Intense Excitement Without ...

1. *Dysfunction Under Acute Stress*
2. *Stress Degeneration Or Burn Out*



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1. BAG-CDCPD: Biological

D. Hangover Resistance

Rapid Recovery After Excessive ...

1. *Alcohol And Drug Use*
2. *Criminal Thrill Seeking Behaviors*



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1. BAG-CDCPD: Biological

E. Brain Damage Sensitivity

Drug Of Choice Produces ...

1. *Increased Brain Dysfunction*
2. *Prolonged Recovery Time*
3. *Progressive Brain Dysfunction*



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1. BAG-CDCPD: Biological

F. Progressive Symptoms

1. Early Stage

- *Growing Dependence On A/D Use*
- *Antisocial Behaviors*

2. Middle Stage

- *Progressive Loss Of Control*

3. Chronic Stage

- *Deterioration In Health And Lifestyle*



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2. BAG-CDCPD: Psychological

A. Higher Self

1. Lacks Capacity For Objective Self Evaluation
2. When Abstinent ...
 - *Excessively Critical And Judgmental*
 - *Diminished Sense Of Self*
3. When Acting Out ...
 - *Permissive And Self-Accepting*
 - *Exaggerated Sense Of Self*

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2. BAG-CDCPD: Psychological

B. Perception

Experiences With A/D Use And Criminal Acting Out ...

1. *Positive Experiences Are Locked Onto And Exaggerated*
2. *Negative Experiences Are Blocked Out*

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2. BAG-CDCPD: Psychological

C. Imaging

1. When Abstinent From A/D And Criminal Behaviors
 - *Repressed And Inhibited*
2. When Using A/D And Criminal Behaviors
 - *Vivid And Lucid*

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2. BAG-CDCPD: Psychological

D. Thinking

Thinking Patterns Based Upon Protecting ...

1. The Right To Use A/D And Criminal Behaviors
 2. The Image Of Self As ...
 - *Social Drinker Or Recreational Drug User*
 - *A Good Person Who Is Victimized By Others*
- In Spite Of Evidence That ...
1. *It Is Unsafe To Use A/D*
 2. *Symptoms Of Addiction Are Present*
 3. *Antisocial Acts Are Victimizing Others And Destroying Self*

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2. BAG-CDCPD: Psychological

E. Feeling

Vacillating Patterns Of ...

1. *Repression, Overreaction, Remorse*
2. *Exaggeration, Conversion To Anger, Acting Out, And Blaming Others*

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2. BAG-CDCPD: Psychological

F. Acting

A/D And Criminal Thrill Seeking Behaviors

1. *Preparation To Use And Act Out*
2. *Overcoming Deterrents (Internal And External)*
3. *Use And Acting Out*
4. *Coping With The Aftermath*

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3. BAG-CDCPD: Social

A. Work

1. Devaluation Of Work
2. Conscious Irresponsibility
3. A/D Use Interferes With Preferred Work Functioning
4. A/D Use Creates Unwanted Problems



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3. BAG-CDCPD: Social

B. Friendship

1. Intrusive Excessive Demands For Friendship
2. Devaluing And Manipulation Of Others
3. A/D Use Interferes With Effective Manipulation Of Friends
4. A/D And Crime Centered Living
5. Addictive And Criminal Isolation



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3. BAG-CDCPD: Social

C. Intimate/Sexual

1. Sexualizing All Intimacy
2. Dominating, Manipulating, And Controlling Sexual Partners
3. No Intimate Sharing Or Emotional Bonding
4. A/D Use Interferes With Control Of Sexual Partners
5. Violating Intimate Commitments



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3. BAG-CDCPD: Social

D. Family

1. Voluntary Withdrawal From Family
2. Manipulation And Abuse Of Family Members
3. A/D Use Interferes With Continued Manipulation of Family Members



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CDC005 08

3. BAG-CDCPD: Social

E. Legal

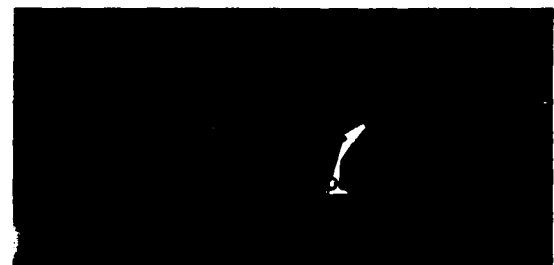
Legal Problems Result From

1. Voluntary Use Of Antisocial Behavior
2. Poor Judgment, Out Of Control Behavior, and Irresponsibility Due To Intoxication And Withdrawal



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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 6: Recovery From Chemical Dependency A Developmental Model

Developed By
Terence T. Gorski
President, The CENAPS Corporation

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CDC006 1

Developmental Model Of Recovery (DMR)

1. Describes Six Stages Of Recovery
2. Identifies Stage Specific...
 - Recovery Themes
 - Recovery Tasks
 - Causes Of Relapse
 - Relapse Warning Signs



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CDC006 2

Stages Of Recovery (DMR)

1. Transition
 - Recognition Of Addiction
- 2.
- 3.
- 4.
- 5.
- 6.



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CDC006 3

1. Transition Tasks

1. Motivating Problems
2. Normal Problem Solving
3. Controlled Use
4. Abstinence



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CDC006 4

Transition

- Major Cause Of Relapse:
- Denial Of Addiction



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1. Transition: Relapse Warning Signs

1. Doubts About Being Addicted
 - "I Am A Social/Recreational User!"
2. Euphoric Recall
 - "Remember The Good And Block The Bad!"
3. Awfulizing Sobriety
 - "Notice The Bad And Ignore The Good!"



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1. Transition: Relapse Warning Signs

4. Magical Thinking About Use
 - *"Addictive Use Can Fix Me!"*
5. Obsession, Compulsion, Craving
 - *"I Want And Need Addictive Use!"*
6. Loss Of Control
 - *"I Cannot Stop Myself From Using!"*

Developmental Model Of Recovery

1. Transition
2. Stabilization
 - *Detoxification And Crisis Management*
- 3.
- 4.
- 5.
- 6.

2. Stabilization Tasks

1. Accept Help
2. Manage Withdrawal
3. Resolve Crisis
4. Break Addictive Preoccupation
5. Manage Stress
6. Develop Hope And Motivation

2. Stabilization

Major Cause Of Relapse:

- Cognitive Impairment Caused By ...
 1. Acute Withdrawal
 2. Post Acute Withdrawal
 3. Stress Degeneration

2. Stabilization: Relapse Warning Signs

1. Confusion And Overreaction
 - *"I Cannot Think Or Manage Feelings!"*
2. Poor Management Of Situations
 - *"I Cannot Cope With Problems!"*
3. Progressive Life Problems
 - *"One Thing Leads to Another!"*

2. Stabilization: Relapse Warning Signs

4. Stress Cycles
 - *"I Cannot Calm Down Or Relax!"*
5. Self-Condernation
 - *"I Must Be Crazy!"*
6. Onset Of Denial
 - *Warning Signs Of Transition*

2. Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
 - *Change Addictive Thoughts, Feelings, And Actions*
- 4.
- 5.
- 6.



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3. Early Recovery Tasks

1. Understanding
2. Recognition
3. Acceptance
4. Non-Addictive Coping
5. Sober Values



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3. Early Recovery

Major Cause Of Relapse:

1. Failure To Recognize That Recovery Requires Changes In ..
 - *Thinking*
 - *Emotional Management*
 - *Behavior*
2. Failure To Resolve ...
 - *Addiction-Related Trauma*



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3. Early Recovery: Relapse Warning Signs

1. Addictive Flashbacks
 - *Painful Memories From Addictive Use*
2. Addictive Thinking And Emotional Management
 - *Old Patterns Of Thinking And Feeling Return*
3. Addictive Behaviors And Lifestyle
 - *Renewed Contact With Addictive People, Places, And Things*



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3. Early Recovery: Relapse Warning Signs

4. Overwhelmed By Pain And Problems
 - *"I Can't Cope!"*
5. Emergence Of PAW
 - *"My Brain Turns Off!"*
6. Onset Of Cognitive Impairment
 - *Warning Signs Of Stabilization*



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Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
 - *Lifestyle Repair And Balance*
- 5.
- 6.



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CDC006 18

4. Middle Recovery Tasks

1. Demoralization Crisis
2. Repair Lifestyle Damage
3. Self-Regulated Recovery
4. Lifestyle Balance
5. Manage Change

Middle Recovery

Major Cause Of Relapse:

- Failure To Repair Lifestyle Damage Caused By Addiction

Middle Recovery: Relapse Warning Signs

1. Failure To Repair Addictive Damage
 - *Refusal To Fix Life Problems!*
2. Unresolved Issues Affect Sobriety
 - *"I'm Stuck And Cannot Move On!"*
3. Chronic Low-Grade Emergency
 - *"I Am Uncomfortable All The Time!"*

Middle Recovery: Relapse Warning Signs

4. Circular Problem Solving
 - *"I Discuss Problems With No Resolution!"*
5. Demoralization
 - *"Nothing Will Work! Why Bother?"*
6. Build Up Of Stress And Pain
 - *"I Hurt So Bad That I Can't Stand It!"*
7. Onset Of Cognitive Impairment
 - *Warning Signs Of Stabilization*

Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
5. Late Recovery
 - *Deep Personality Change*
- 6.

5. Late Recovery Tasks

1. Recognize Current Personality Problems
2. Link Current Problems To Training In Family Of Origin
3. Examine Childhood And Identify Values, Attitudes, And Coping Style
4. Apply To Current Problems
5. Change Lifestyle

5. Late Recovery Tasks

Major Cause Of Relapse:

Unresolved Childhood Issues
That Interfere With Establishing
A Meaningful And Comfortable Sobriety

5. Late Recovery: Relapse Warning Signs

1. Inner Pain, Dissatisfaction, And Despair
 - *Chronic Shock Syndrome (PTSD)*
 - *Self-Defeating Personality*
2. Seeks External Sources Of Relief
 - *"I Want Someone Or Something Else To Fix Me!"*

5. Late Recovery: Relapse Warning Signs

3. Dysfunctional Lifestyle
 - *"I Develop New Problems In Recovery!"*
4. Inner Pain, Dissatisfaction, And Despair
 - *"There Is No Way Out!"*
5. Onset Of Lifestyle Problems
 - *Warning Signs Of Middle Recovery*

Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
5. Late Recovery
6. Maintenance
 - Growth And Development

6. Maintenance Tasks

1. Maintain Recovery Program
2. Daily Coping
3. Growth And Development
4. Cope With Life Transitions

6. Maintenance

Major Cause Of Relapse:

- Complacency Causing Neglect Of Recovery
- Complicated By Life Crisis

6. Maintenance: Relapse Warning Signs

1. Over-Confidence And Complacency
 - *"I Am Cured!"*
2. Stop Personal Growth
 - *"I Don't Need To Grow Or Change!"*
3. Focus On Others Instead Of Self
 - *"I Will Help Others Instead Of Self!"*

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6. Maintenance: Relapse Warning Signs

4. Life Crisis Or Transition
 - *"I Experience Serious Problems!"*
5. Inability To Cope Or Ask For Help
 - *"I Will Handle It Myself!"*
6. Onset Lifestyle Problems
 - *Warning Signs Of Middle Recovery*

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Stages Of Recovery

1. Transition → Recognition Of Addiction
2. Stabilization → Withdrawal & Crisis Management
3. Early Recovery → Change Addictive Thoughts, Feelings, And Actions
4. Middle Recovery → Lifestyle Repair And Balance
5. Late Recovery → Deep Personality Change
6. Maintenance → Growth And Development

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Relapse Prone Coping Style

Denial And Evasion

- E = Evade/Deny*
- S = Stress*
- C = Compulsive Behavior*
- A = Avoid Others*
- P = Problems*
- E = Evade, Deny, And Recycle*

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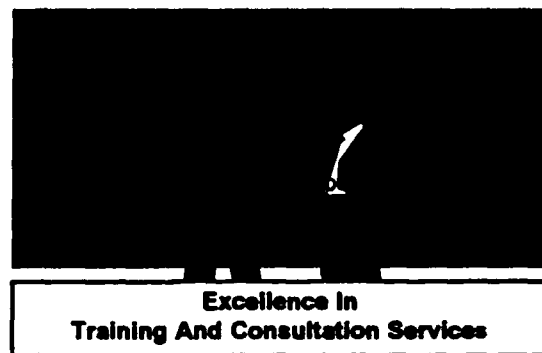
Recovery Prone Style

Recognition And Problem Solving

- R = Recognize*
- A = Accept*
- D = Detach*
- A = Ask For Help*
- R = Respond With Action*

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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 7: Recovery From Criminal Personality Disorder A Developmental Model

Developed By
Terence T. Gorski
President, The CENAPS Corporation

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This Presentation Will Review ...

1. The Core Issues
 - *That Need To Be Addressed In The Treatment Of Criminal Personality Disorder*
2. A Developmental Model Of Recovery (DMR)
 - *That Provides A General Time Line For Addressing The Core Issues*

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Core Issues In Criminal Personality Disorder (CPD)

1. Denial Of Criminal Personality Traits
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

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1. Denial Of Criminal Personality Traits

- A. Absolute Denial
 - *"I'm Normal. Everyone Else Has Problems."*
- B. Minimizing
 - *"My Antisocial Behaviors Are Not That Bad!"*
- C. Rationalizing
 - *"I Act This Way Because People Or Circumstances Force Me To!"*

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Core Issues In Criminal Personality Disorder (CPD)

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

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2. Criminal Preoccupation

- A. Euphoric Recall
 - *Exaggerate Good, Minimize Deny Bad!*
- B. Awfulizing "The Straight Life"
 - *Exaggerate Bad, Minimize Deny Good*
- C. Magical Thinking
 - *Criminal Lifestyle Can Fix Me!*
- D. Obsession
 - *Out Of Control Thinking About Antisocial Acts*
- E. Compulsion
 - *Irrational Urge To Act Out In Antisocial Ways*

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**Core Issues In
Criminal Personality Disorder (CPD)**

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
3. Habitual Dishonesty
- 4.
- 5.
- 6.
- 7.
- 8.

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3. Habitual Dishonesty

- A. Manipulate
 - *Pretending To Conform To Gain Advantage*
- B. Lie
 - *Say Things That Are Not True!*
- C. Cheat
 - *Attempt To Con And Get Away With Things!*
- D. Steal
 - *Take Things That Don't Belong To Them!*
- E. Live A Secret Life
 - *To Hide Their Dishonesty*

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**Core Issues In
Criminal Personality Disorder (CPD)**

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
3. Habitual Dishonesty
4. Protecting The Right To Act Out Antisocially
- 5.
- 6.
- 7.
- 8.

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**4. Protecting The Right To Act Out
Antisocially**

Projecting The Image Of Being A "Good
Person" Who Is Victimized By Others
And Uses Antisocial Behaviors To
Defend Self From Victimization

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**Core Issues In
Criminal Personality Disorder (CPD)**

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
3. Habitual Dishonesty
4. Protecting The Right To Act Out Antisocially
5. Low Levels Of Moral Development
- 6.
- 7.
- 8.

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5. Low Levels Of Moral Development

- Level 1: Unqualified Self-Interest
- Level 2: Qualified Self-Interest
- Level 3: General Social Interest

People With CPD
Operate Out Of Unqualified Self-Interest
Until Caught
When Caught They Temporarily Use
Qualified Self-Interest To Avoid Consequences

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**Core Issues In
Criminal Personality Disorder (CPD)**

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
3. Habitual Dishonesty
4. Protecting The Right To Act Out
Antisocially
5. Low Levels Of Moral Development
6. Impulse Control Problems
- 7.
- 8.

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6. Impulse Control Problems

1. Exaggeration (Overreaction)
2. Conversion To Anger
3. Acting Out
4. Blaming Others

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**Core Issues In
Criminal Personality Disorder (CPD)**

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
3. Habitual Dishonesty
4. Protecting The Right To Act Out
Antisocially
5. Low Levels Of Moral Development
6. Impulse Control Problems
7. Poor Problem Solving Skills
- 8.

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7. Poor Problem Solving Skills

- A. Problem Identification
- B. Problem Clarification
- C. Identification Of Alternative Solutions
- D. Projection Of Logical Consequences
- E. Decision Making
- F. Action (Decision Implementation)
- G. Evaluation Of Outcome

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**Core Issues In
Criminal Personality Disorder (CPD)**

1. Denial Of Criminal Personality Traits
2. Criminal Preoccupation
3. Habitual Dishonesty
4. Protecting The Right To Act Out
Antisocially
5. Low Levels Of Moral Development
6. Impulse Control Problems
7. Poor Problem Solving Skills
8. Low Frustration Tolerance

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8. Low Frustration Tolerance

- A. Restless And Easily Bored
- B. Hyperactive
- C. Difficulty In Concentrating
- D. Lack Of Persistence

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Developmental Model Of Recovery (DMR)

1. Describes Six Stages Of Recovery
2. Identifies Stage Specific ...
 - Recovery Themes
 - Recovery Tasks
 - Causes Of Relapse
 - Relapse Warning Signs

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Stages Of Recovery (DMR)

1. Transition
 - Recognition Of CPD
- 2.
- 3.
- 4.
- 5.
- 6.

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1. Transition Tasks

1. Motivating Problems
2. Antisocial Problem Solving
3. Caught By Circumstances
4. Compliance With Treatment

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Transition

Major Cause Of Relapse:

- Denial That Antisocial Behavior Is A Problem

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1. Transition: Relapse Warning Signs

1. Doubts About Being Antisocial
 - *"I Am A Normal Person Being Victimized By Others!"*
2. Euphoric Recall
 - *"Remember The Good And Block The Bad!"*
3. Awfulizing "The Straight Life"
 - *"Notice The Bad And Ignore The Good!"*

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1. Transition: Relapse Warning Signs

4. Magical Thinking About Antisocial Behavior
 - *"The Antisocial Lifestyle Can Fix Me!"*
5. Obsession
 - *Out Of Control Thinking About Antisocial Outlets*
6. Compulsion
 - *The Irrational Urge To Act Out In Antisocial Ways*
7. Loss Of Control
 - *"I Cannot Stop Myself From Acting Out!"*

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Developmental Model Of Recovery

1. Transition
2. Stabilization
 - *Breaking Criminal Preoccupation And Crisis Management*
- 3.
- 4.
- 5.
- 6.

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2. Stabilization Tasks

1. Accept Help
2. Comply With Structured Recovery Program
3. Stabilize Presenting Crisis
4. Break Criminal Preoccupation
5. Manage Stress

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2. Stabilization

Major Cause Of Relapse:

- Refusal To Comply With Structured Recovery Program

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2. Stabilization: Relapse Warning Signs

1. Confusion And Overreaction
 - *"I Cannot Think Or Manage Feelings!"*
2. Poor Management Of Situations
 - *"I Cannot Cope With Problems!"*
3. Progressive Life Problems
 - *"One Thing Leads to Another!"*

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2. Stabilization: Relapse Warning Signs

4. Stress Cycles
 - *"I Cannot Calm Down Or Relax!"*
5. Self-Condernation
 - *"I Must Be Crazy!"*
6. Onset Of Denial
 - *Warning Signs Of Transition*

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2. Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
 - *Change Criminal Thoughts, Feelings, And Actions (TFA)*
- 4.
- 5.
- 6.

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3. Early Recovery Tasks

1. Understanding CPD As A Disease
2. Recognition That Antisocial Behavior Is Not Normal, Healthy, Or Effective
3. Acceptance Of The Need For Responsible Thinking And Living
4. Develop Responsible Coping Skills
5. Develop Responsible Values

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3. Early Recovery

Major Cause Of Relapse:

1. Failure To Recognize That Recovery Requires Changes In ..
 - *Thinking*
 - *Emotional Management*
 - *Behavior*

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3. Early Recovery: Relapse Warning Signs

1. The "Zero State"
 - *Believing That "I Am Nothing And Everyone Knows It!"*
2. Addictive Thinking And Emotional Management
 - *Old Patterns Of Antisocial Thinking To Restore Self Esteem*
3. Renewed Antisocial Lifestyle
 - *Contact With Antisocial People, Places, And Things*

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3. Early Recovery: Relapse Warning Signs

4. Overwhelmed By Pain And Problems
 - *"I Can't Cope!"*
5. Refusal To Comply With Recovery Program
 - *Warning Signs Of Stabilization*

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Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
 - *Lifestyle Repair And Balance*
- 5.
- 6.

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4. Middle Recovery Tasks

1. Demoralization Crisis
2. Repair Lifestyle Damage
3. Self-Regulated Recovery
4. Lifestyle Balance
5. Manage Change

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Middle Recovery

Major Cause Of Relapse:

- Failure To Repair Lifestyle Damage Caused By Antisocial Behavior

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Middle Recovery: Relapse Warning Signs

1. Failure To Repair Damage Caused By Antisocial Behavior
 - *Refusal To Fix Life Problems!*
2. Unresolved Issues Affect Recovery
 - *"I'm Stuck And Cannot Move On!"*
3. Chronic Low-Grade Emergency
 - *"I Am Uncomfortable All The Time!"*

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Middle Recovery: Relapse Warning Signs

4. Circular Problem Solving
 - *"I Discuss Problems With No Resolution!"*
5. Demoralization
 - *"Nothing Will Work! Why Bother?"*
6. Build Up Of Stress And Pain
 - *"I Hurt So Bad That I Can't Stand It!"*
7. Refusal To Comply With Recovery Program
 - *Warning Signs Of Stabilization*

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Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
5. Late Recovery
 - *Deep Personality Change*
- 6.

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5. Late Recovery Tasks

1. Recognize Current Personality Problems
2. Link Current Problems To Training In Family Of Origin
3. Examine Childhood And Identify Values, Attitudes, And Coping Style
4. Apply To Current Problems
5. Change Life Goals

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5. Late Recovery Tasks

Major Cause Of Relapse:

Unresolved Childhood Issues
That Interfere With Establishing
A Meaningful And Comfortable Sobriety

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5. Late Recovery: Relapse Warning Signs

1. Inner Pain, Dissatisfaction, And Despair
 - *Chronic Shock Syndrome (PTSD)*
 - *Self-Defeating Personality*
2. Seeks External Sources Of Relief
 - *"I Want Someone Or Something Else To Fix Me!"*

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5. Late Recovery: Relapse Warning Signs

3. Dysfunctional Lifestyle
 - *"I Develop New Problems In Recovery!"*
4. Inner Pain, Dissatisfaction, And Despair
 - *"There Is No Way Out!"*
5. Onset Of Severe Lifestyle Problems
 - *Warning Signs Of Middle Recovery*

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Stages Of Recovery

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
5. Late Recovery
6. Maintenance
 - Growth And Development

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6. Maintenance Tasks

1. Maintain Recovery Program
2. Daily Coping
3. Growth And Development
4. Cope With Life Transitions

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6. Maintenance

Major Cause Of Relapse:

- Complacency Causing Neglect Of Recovery
- Complicated By Life Crisis

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6. Maintenance: Relapse Warning Signs

1. Over Confidence And Complacency
 - *"I Am Cured!"*
2. Stop Personal Growth
 - *"I Don't Need To Grow Or Change!"*
3. Renewed Self-Centered Lifestyle
 - *"I'll Take Care Of Myself!"*

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6. Maintenance: Relapse Warning Signs

4. Life Crisis Or Transition
 - *"I Experience Serious Problems!"*
5. Inability To Cope Or Ask For Help
 - *"I'll Handle It Myself!"*
6. Onset Lifestyle Problems
 - *Warning Signs Of Middle Recovery*

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Stages Of Recovery

1. Transition → Recognition Of CPD
2. Stabilization → Breaking Criminal Preoccupation & Crisis Management
3. Early Recovery → Change Antisocial Thoughts, Feelings, And Actions
4. Middle Recovery → Lifestyle Repair And Balance
5. Late Recovery → Deep Personality Change
6. Maintenance → Growth And Development

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Relapse-Prone Coping Style

Denial And Evasion

E = Evade/Deny
S = Stress
C = Compulsive Behavior
A = Avoid Others
P = Problems
E = Evade, Deny, And Recycle

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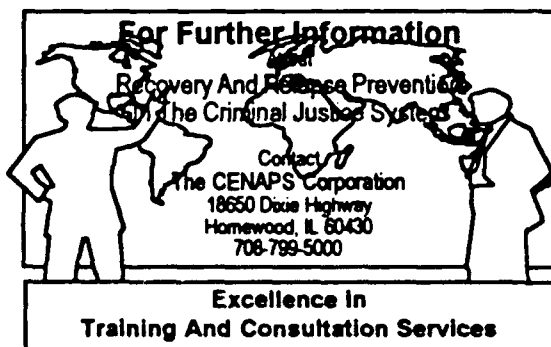
Recovery-Prone Style

Recognition And Problem Solving

R = Recognize
A = Accept
D = Detach
A = Ask For Help
R = Respond With Action

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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention
In The Criminal Justice System

Session 8: The Relapse Process For Chemical Dependency

Developed By
Terence T. Gorski
President, The CENAPS Corporation

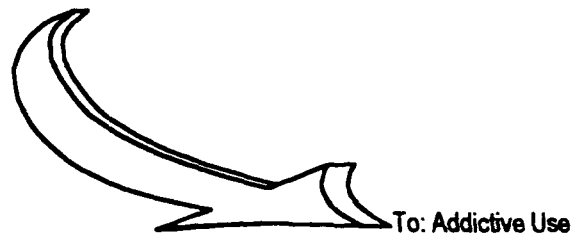
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Relapse Implies A Progression

From: Stable Recovery



To: Addictive Use

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Effective Warning Sign Models

1. Clearly Describe The Progression From Stable Recovery To Addictive Use
2. Are Simple And Easy To Understand
3. Accurately Reflect Experiences Of Relapse-Prone People

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Brief Warning Sign Models

1. Attitude Change Model
2. Progressive Dysfunction Model
3. Stress Model
4. Craving Model

Can Be Quickly And Easily
Explained To Patients

Summarize The Detailed
Warning Sign Progression

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Attitude Change Model

1. Change In Attitude
 - Recovery Is No Longer A Priority
2. Change In Behavior
 - Old Ways Of Acting Return
3. Change In Situation
 - I Put Myself Around People, Places, And Things That Support Addictive Use
4. Addictive Use

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Progressive Dysfunction Model

1. Internal Change
 - Addictive Thinking And Feelings
2. External Change
 - Irresponsible Addictive Behaviors
3. Progressive Life Problems
 - Overwhelming Problems In Sobriety
4. Addictive Use

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Stress Model

1. Change
2. Stress
3. Cognitive Impairment (PAW)
4. Emotional Mismanagement
5. Behavioral Loss Of Control
6. Addictive Use

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Craving Model

1. Trigger Event
2. Obsession
 - Out Of Control Thinking About Use
3. Compulsion
 - Irrational Emotional Urge To Use
4. Craving
 - Tissue Hunger For The Drug
5. Addictive Use

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Comprehensive Warning Sign List

1. Developed In 1973
2. 118 Relapse Histories

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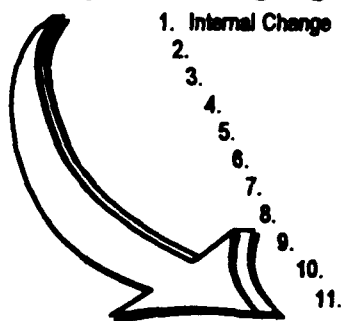
Warning Sign Progression

3. Patients Studied ...
 - Completed 21-28 Day Program
 - Recognized And Accepted Addiction
 - Attempted To Use Recovery Program
 - Returned To Addictive Use

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Relapse Warning Signs



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1. Internal Change

Difficulty In ...

1. Thinking Clearly
2. Managing Emotions
3. Remembering
4. Managing Stress
5. Sleeping Restfully
6. Physical Coordination



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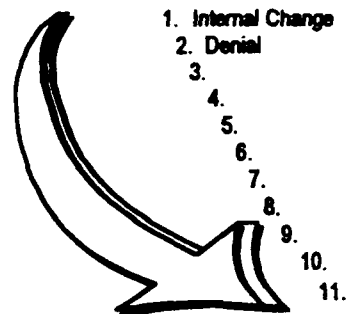
1. Internal Change

1. Thinking
 - Rational → Irrational
2. Feeling
 - Manageable → Unmanageable
3. Acting
 - Responsible → Irresponsible

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Relapse Warning Signs



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2. Denial

*I'm Fine!
Nothing Is Wrong With
My Recovery!!!*

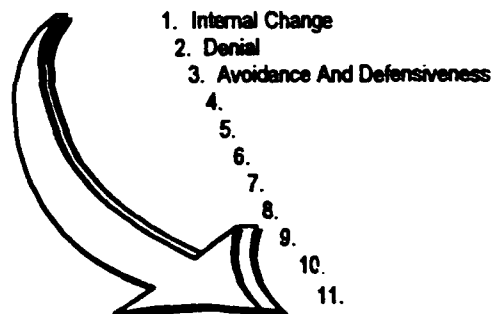
1. Concern About Well Being
2. Denial Of The Concern



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Relapse Warning Signs



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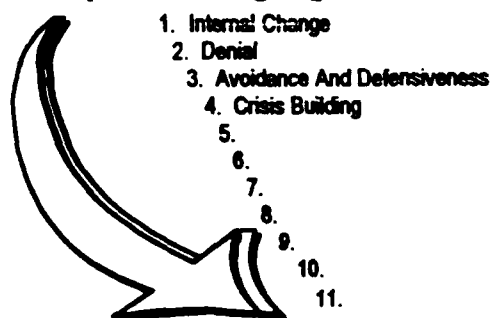
3. Avoidance And Defensiveness

1. Believing "I Will Never Use Again"
2. Over Involved With Others
3. Defensiveness
4. Compulsive Behavior
5. Impulsive Behavior
6. Loneliness

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Relapse Warning Signs

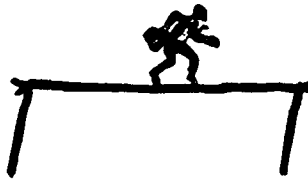


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4. Crisis Building

1. Tunnel Vision
2. Minor Depression
3. Loss Of Constructive Planning
4. Plans Begin To Fail

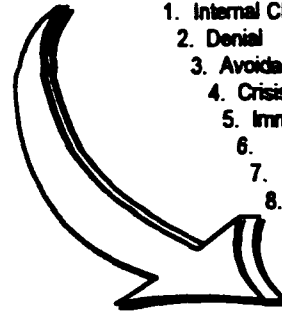


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Relapse Warning Signs

1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.

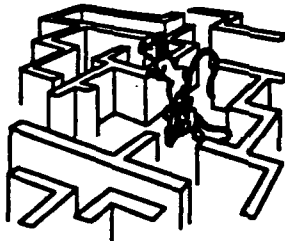


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5. Immobilization

1. Daydreaming And Wishful Thinking
2. Feelings That Nothing Can Be Solved
3. Immature Wish To Be Happy

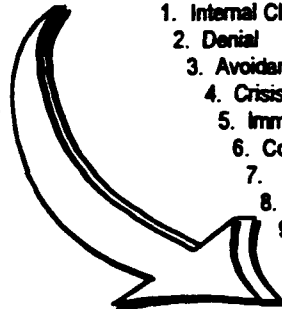


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Relapse Warning Signs

1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
6. Confusion And Overreaction
- 7.
- 8.
- 9.
- 10.
- 11.



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6. Confusion And Overreaction

1. Periods Of Confusion
2. Irritation With Friends
3. Easily Angered

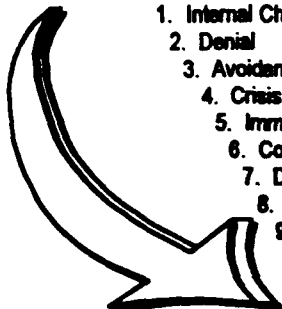


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Relapse Warning Signs

1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
6. Confusion And Overreaction
7. Depression
- 8.
- 9.
- 10.
- 11.



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7. Depression

1. Irregular Eating Habits
2. Lack of Desire To Take Action
3. Irregular Sleeping Habits
4. Loss Of Daily Structure
5. Periods Of Deep Depression

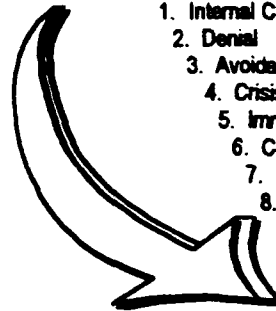


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Relapse Warning Signs

1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
6. Confusion And Overreaction
7. Depression
8. Loss of Control
- 9.
- 10.
- 11.



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8. Loss of Control

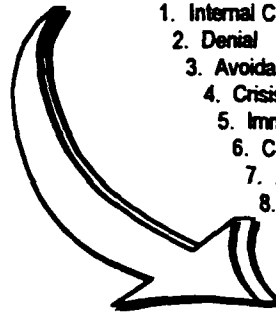
1. Irregular Attendance At AA And Treatment Meetings
2. Develop An "I Don't Care" Attitude
3. Open Rejection Of Help
4. Dissatisfaction With Life
5. Feeling Powerless And Helpless

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Relapse Warning Signs

1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
6. Confusion And Overreaction
7. Depression
8. Loss of Control
9. Break In Denial
- 10.
- 11.



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9. Break In Denial

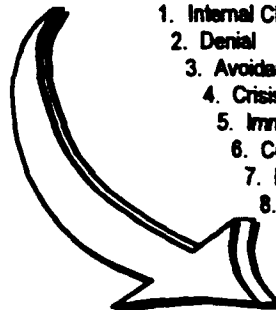
1. Self Pity
2. Thoughts Of Controlled Use
3. Conscious Lying
4. Loss Of Self Confidence

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Relapse Warning Signs

1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
6. Confusion And Overreaction
7. Depression
8. Loss of Control
9. Break In Denial
10. Option Reduction
- 11.



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10. Option Reduction

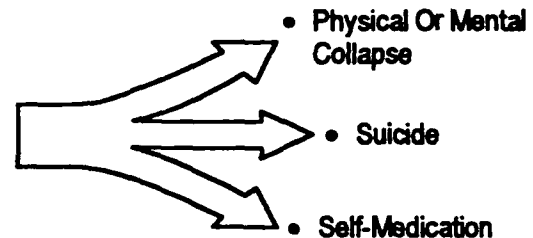
1. Unreasonable Resentments
2. Discontinues All Treatment
3. Overwhelming ...
 - Loneliness
 - Frustration
 - Anger
 - Tension



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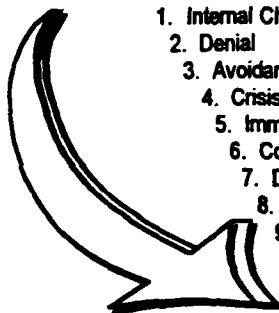
Perceived Options



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Relapse Warning Signs



1. Internal Change
2. Denial
3. Avoidance And Defensiveness
4. Crisis Building
5. Immobilization
6. Confusion And Overreaction
7. Depression
8. Loss of Control
9. Break In Denial
10. Option Reduction
11. Addictive Use

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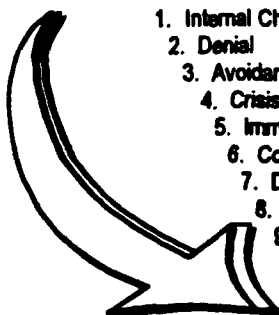
11. Addictive Use

1. Controlled Use
2. Loss Of Control
3. Life And Health Problems
4. Renewed Recovery Or Death

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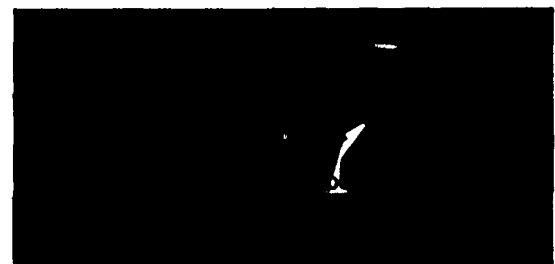
Relapse Warning Signs



1. Internal Change
2. Denial
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8. Loss of Control
9. Break In Denial
10. Option Reduction
11. Addictive Use

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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 9: The Relapse Process For Criminal Personality

Developed By

Terence T. Gorski And John M. Kelley
The CENAPS Corporation

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CDCO08 1

Special Acknowledgment

This List Is Adapted From

The Work In Criminal Thinking And Behavior

By

Stanton E. Samenow
Samuel Yochelson

The Work In Chemical Dependency Relapse

By

Terence T. Gorski



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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

- *Changes In Thinking And Feelings Unnoticed By Others*

Phase 2:

Phase 3:

Phase 4:



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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

Phase 2: External Dysfunction

- *Changes In Behavior And Situation That Are Noticed By Others*

Phase 3:

Phase 4:



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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

Phase 2: External Dysfunction

Phase 3: Loss Of Control

- *Inability To Self-Regulate Behavior*

Phase 4:



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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

Phase 2: External Dysfunction

Phase 3: Loss Of Control

Phase 4: Criminal Behavior, Alcohol, And Drug Use

- *A Reciprocal Relapse Occurs*



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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

- *Changes In Thinking And Feelings Unnoticed By Others*

Phase 2:

Phase 3:

Phase 4:

Phase I: Internal Dysfunction

1. Worry About The Future
2. Deny That I'm Worried
3. Believe I Will Never Get In Trouble Again



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Phase I: Internal Dysfunction

4. Feeling Uncomfortable Around "Straight" People
5. Stop Making An Effort
6. Bored And Crave Excitement



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Phase I: Internal Dysfunction

11. Building Up For A Fall
12. Don't Plan Ahead
13. Make Bad Decisions
14. Nothing Is Going My Way



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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

Phase 2: External Dysfunction

- *Changes In Behavior And Situation That Are Noticed By Others*

Phase 3:

Phase 4:

Phase II: External Dysfunction

15. Getting Back
16. Being Alone
17. Bummed Out
18. Deny The Fear
19. Envious Of Criminals

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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

Phase 2: External Dysfunction

Phase 3: Loss Of Control

- *Inability To Self-Regulate Behavior*

Phase 4:

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Phase III: Loss of Control

20. Avoid Responsibility
21. Want To Use Alcohol/Drugs
22. Old Criminal Friends

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Phase III: Loss of Control

23. Missing Appointments
24. Saying "I Can't" When I Really Don't Want To
25. Feeling Like A Victim
26. Don't Understand How I Hurt Others

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Phase III: Loss of Control

27. Petty Crimes And Rule Breaking
28. Pushing Others Away
29. Always Right
30. Want What I Want, When I Want It
31. Losing My Temper
32. Winning Means Everything

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Relapse Warning Signs For Chemically Dependent Criminal Offenders

Phase 1: Internal Dysfunction

Phase 2: External Dysfunction

Phase 3: Loss Of Control

Phase 4: Criminal Behavior, Alcohol, And Drug Use

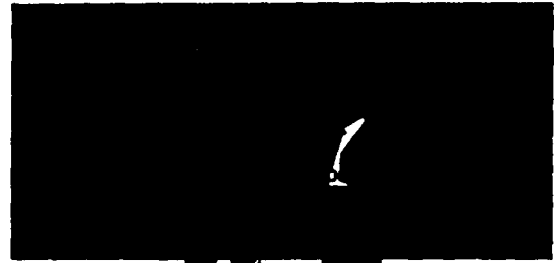
- *A Reciprocal Relapse Occurs*

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**Phase IV: Criminal Behavior, Alcohol,
And Drug Use**

- 33. Just This Time
- 34. Things Get Worse
- 35. Getting Caught



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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 10: Basic Treatment Principles

Developed By
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Principle #1: Chemical Use Disorders And Criminal Personality Disorders Are Common

Among Criminal Populations ...

1. Chemical Use Disorders 70%
 - Abuse Disorders 28%
 - Dependence Disorders 42%
2. Criminal Personality Disorders (CPD) 50%
3. CD And CPD 50%



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Principle #2: Punishment Alone ...

1. **WILL NOT** Stop Criminals With Chemical Use Disorders From Using Alcohol And Drugs
2. **WILL NOT** Stop Criminals With Criminal Personality Disorders From Committing New Crimes



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Principle #3: Effective Alternatives To Incarceration Must Be Found

1. Jails Are Overcrowded
2. Criminal Behavior Is Expanding And Reaching Epidemic Proportions
3. Punishment Alone Does Not Deter Future Crime
4. Treatment Alternatives To Incarceration Are Proving Effective



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Principle #4: For Treatment Alternative To Work ...

Criminal Offenders Must Be Screened And Concurrently Treated For ...

1. Chemical Use Disorders
2. Criminal Personality Disorders
3. Mental Disorders



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Principle #5: Diagnostic And Treatment Procedures Must Be Integrated Into The Criminal Justice System

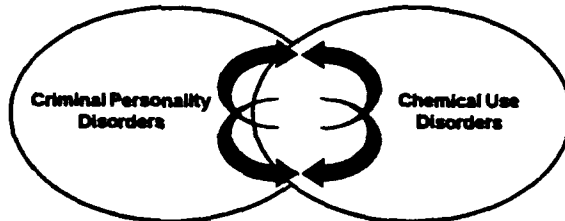
1. Screening Prior To Sentencing
2. Treatment Concurrent With Punishment
 - Treatment During Incarceration
 - Ongoing Treatment As A Condition Parole Or Probation
 - Break In Treatment Results In Return To Jail



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Principle #6: Criminal Personality Disorders And Chemical Use Disorders Are Coexisting Disorders That Must Be Treated Together



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Principle #7: There Is A Dynamic Relationship Between CD And CPD

1. Mutual Predisposition
 - CPD Increases Risk Of CD
 - CD Increases Risk Of CPD
2. Symptom Reinforcement
 - CPD Promotes A/D Abuse
 - A/D Abuse Promotes Antisocial Behavior
3. Reciprocal Relapse
 - A/D Relapse Triggers Criminal Behaviors
 - Criminal Relapse Triggers A/D Use

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Principle #8: Recovery From Chemical Dependence Requires ...

1. Abstinence From Alcohol And Drugs
2. Identifying And Changing ...
 - Addictive Thoughts, Feelings, And Behaviors
 - Addiction Centered Lifestyle Patterns
3. Deep Personality And Value Change

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Principle #9: Recovery From Criminal Personality Requires ...

1. Abstinence From ...
 - Antisocial Behaviors
 - Alcohol And Drugs
2. Identifying And Changing ...
 - Antisocial Thoughts And Feelings
 - Antisocial Lifestyle Patterns
3. Deep Personality And Value Change

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Principles #10: Basic Treatment Principles For Integrated CD and CPD Treatment ...

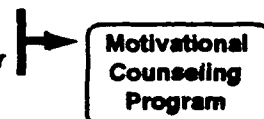
1. Concurrent Diagnosis And Treatment
2. Abstinence From Alcohol And Drugs
3. Abstinence From Criminal Behaviors
4. Change Of A/D Centered And Criminal Centered Lifestyle Patterns
5. Deep Personality And Value Change

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Principle #11: Recovery Requires Four Separate Skills

1. Getting Motivated To Abstain From ...
 - A/D Use
 - Criminal Behavior
- 2.
- 3.
- 4.



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Principle #11: Recovery Requires Four Separate Skills

1. Getting Motivated To Abstain
2. Learning How To Get Abstinent From ...
 - A/D Use
 - Criminal Behavior
- 3.
- 4.

Primary
Recovery
Program

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Principle #11: Recovery Requires Four Separate Skills

1. Getting Motivated To Abstain
2. Learning How To Get Abstinent
3. Learning How To Stay Abstinent From ...
 - A/D Use
 - Criminal Behavior
- 4.

Relapse
Prevention
Program

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Principle #11: Recovery Requires Four Separate Skills

1. Getting Motivated To Abstain
2. Learning How To Get Abstinent
3. Learning How To Stay Abstinent
4. Ongoing Growth And Development
 - Lifestyle Repair
 - Holistic Lifestyle Balance

Advanced
Recovery
Program

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Principle #12: Major Goals Of Therapy

1. Total Abstinence From ...
 - Alcohol And Drug Use
 - Antisocial (Criminal) Behavior
2. Stopping Addictive And Criminal Preoccupation
3. Stopping Addiction And Crime Centered Lifestyle
4. Crisis Stabilization And Life Problem Resolution
5. Balanced Living And Quality Of Life Improvements

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Principle #13: Success Requires A Balanced Use Of Therapeutic Processes

1. Cognitive Restructuring: *Insight*
 - A Change In Thinking About A/D And Criminal Behavior
- 2.
- 3.
- 4.

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1. Cognitive Restructuring

A Change In Thinking Involving A Shift From...

- Addictive Thinking → Sober Thinking
- Criminal Thinking → Responsible Thinking

This Change In Thinking Reflects
An Underlying Change In Values

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**Principle #13: Success Requires A
Balanced Use Of
Therapeutic Processes**

1. Cognitive Restructuring
2. Affective Restructuring
 - *Learning To Manage Feelings Without Using A/D Or Antisocial Behaviors*
- 3.
- 4.

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2. Affective Restructuring

A Change In Managing Feelings And Emotions ...

- Recognizing Inner Experiences
- Differentiating Thoughts, Body Sensations, Emotions
- Learning An Emotional Vocabulary
- Accurately Labeling Inner Experiences
- Communicating Both Verbally And Nonverbally
- Managing Unpleasant Emotions
- Resolving Core Issues Causing Unpleasant Emotions

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**Principle #13: Success Requires A
Balanced Use Of
Therapeutic Processes**

1. Cognitive Restructuring
2. Affective Restructuring
3. Behavioral Restructuring
 - *A Change In Action*
- 4.

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3. Behavioral Restructuring

A Change In Behavior That Involves ...

- Identifying High Risk Situations
- Clarifying Old Self-Defeating Coping Strategies
- Identifying New More Effective Strategies
- Overcoming Resistance To Using New Strategies
- Learning To Resist Urges To Act Out Old Self-Defeating Strategies

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Behavioral Restructuring Involves ...

1. Verbal Description
2. Mental Rehearsal
3. Role Playing
4. Practice



- Old Self-Defeating Strategies
- Intervention Points
- New More Effective Strategies

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**Principle #13: Success Requires A
Balanced Use Of
Therapeutic Processes**

1. Cognitive Restructuring
2. Affective Restructuring
3. Behavioral Restructuring
4. Social Restructuring
 - *A Change In Relationships*

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4. Social Restructuring

A Change In Relationships And Lifestyle
That Improves...

1. Work/Employment Skills
2. Intimacy/Relationship Skills
3. Social/Friendship Skills
4. Development Of A Balanced Holistic Lifestyle



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Principle #14: Success Requires The Integrated Use Of Four Treatment Elements

1. A Structured Recovery Program

- A Regular Schedule Of Therapeutic Activities

- 2.
- 3.
- 4.



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1. Structured Recovery Program

A Schedule Of Therapeutic Activities That ...

- A. Provides Social Reinforcement For Responsible Behavior
- B. Sets Protective Limits Against Antisocial Acting Out
- C. Imposes Consequences To Structure Violations That Are ...

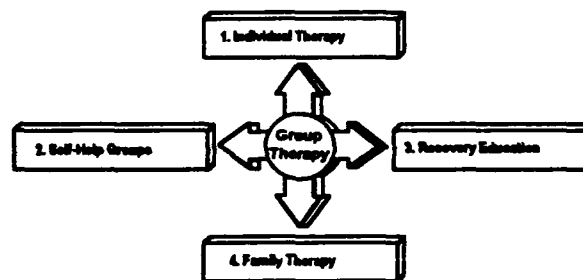
- Immediate
- Specific
- Tangible
- Relevant



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Recovery Program Components



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Principle #14: Success Requires The Integrated Use Of Four Treatment Elements

1. A Structured Recovery Program
2. A Long-Term Therapeutic Relationship
 - Consistent Interaction With A Therapist
- 3.
- 4.



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2. Long-Term Therapeutic Relationship

- A. Role Modeling
 - Immediate Experience With A Socially Responsible Adult
- B. Relationship Training
 - Forces Patients To Learn And Use Interpersonal Skills
- C. Consistent Direct Positive And Negative Feedback
 - Psychological Visibility From Consistent And Trusted Figure



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Principle #14: Success Requires The Integrated Use Of Four Treatment Elements

1. A Structured Recovery Program
2. A Long-Term Therapeutic Relationship
3. Consistent Peer Group Support
 - *Regular Attendance At Problem Solving Group Therapy Sessions*
- 4.

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3. Consistent Peer Feedback In Problem Solving Group Therapy

- A. Breaks Pattern Of Social Isolation
- B. Forces Social Interest
- C. Provides Experimental Laboratory For New Behaviors
- D. Reinforces Responsible Behavior Patterns
- E. Provides Source Of "Credible" Confrontation

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Principle #14: Success Requires The Integrated Use Of Four Treatment Elements

1. A Structured Recovery Program
2. A Long-Term Therapeutic Relationship
3. Consistent Peer Group Support
4. Program Of Wholistic Health Care
 - *Commitment To Develop A Lifestyle That Promotes Biopsychosocial Health*

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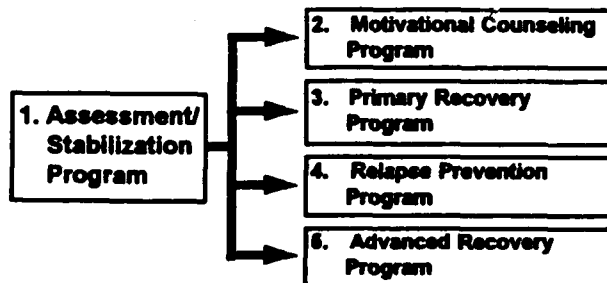
4. Program Of Holistic Health Care

- A. Healthy Diet
- B. Aerobic Exercise
- C. Stress Management
- D. Recreation
- E. Spiritual Program

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Principle #15: Success Requires A Continuum Of Care



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CDC010 36

The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 11: Continuum Of Care - Part 1: Assessment, Motivational, And Primary Programs

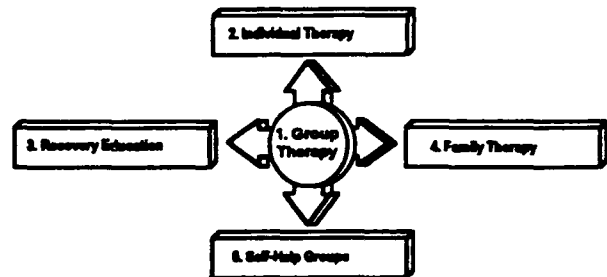
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CDC011 1

Treatment Modalities For Chemically Dependence Criminal Offenders



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CDC011 2

Treatment Modalities

1. Problem Solving Group Therapy
- 2.
- 3.
- 4.
- 5.

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1. Problem Solving Group Therapy

The Central Modality That ...

1. Coordinates Other Treatment Approaches
2. Tracks Therapeutic Assignments
3. Measures Progress
4. Identifies And Resolves Problems

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Basic Group Responsibilities

1. Come Prepared
2. Give A Reaction
3. Work On Issues
4. Report On Assignments
5. Listen To Others
6. Ask Questions
7. Give Feedback
8. Complete Closure Exercise

**This Is Not Optional
Failure To Meet
Basic Responsibilities
Is Grounds For
Termination**

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Group Rules

1. Basic Responsibilities
2. Freedom Of Participation
3. Right Of Refusal
4. Confidentiality
5. No Physical Violence
 - *The Threat Is As Good As The Act*
6. No Dating, Romantic, Or Sexual Involvement
7. Communication Prior To Termination

**Violation
Of Group Rules
Is Grounds For
Termination**

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Standard Group Agenda

- *Therapy Team Preparation*

1. Opening Procedure
2. Reactions To Last Session
3. Report On Assignments
4. Setting The Agenda
5. Problem Solving Process
6. Closure Exercise

- *Therapy Team Debriefing*



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Treatment Modalities

1. Problem Solving Group Therapy
2. Individual Therapy
- 3.
- 4.
- 5.



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2. Individual Therapy

The Primary Goals Are ...

1. Consistent One-To-One Therapeutic Relationship With The Offender
2. Preparation For Group
3. Trouble Shooting Group Problems
4. Assessment Procedures
5. Family And Employer Coordination



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2. Individual Therapy

Standard Agenda:

1. Reactions To Last Session
2. Recovery Check
3. Assignment Review
4. Group Preparation
5. Daily Inventory Review
6. Topic Oriented Conversation



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Treatment Modalities

1. Problem Solving Group Therapy
2. Individual Therapy
3. Recovery Education Programs
- 4.
- 5.



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3. Recovery Education Programs

A. Content...

- (1) Symptoms Of CD And CPD
- (2) Recovery From CD And CPD
- (3) Relapse Prevention Strategies

B. Session Agenda

- (1) Pre-Test
- (2) Lecture
- (3) Educational Exercise
- (4) Discussion
- (5) Post-Test



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Treatment Modalities

1. Problem Solving Group Therapy
2. Individual Therapy
3. Recovery Education Programs
4. Family Programs
- 5.

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4. Family Programs

Need To Teach Family Members To ...

1. Understand CD and CPD
2. Protect Themselves From The Offender
3. Communicate Effectively With The Offender
4. Recover From Codependency
5. Support Recovery Of The Offender
6. Intervene If Warning Signs Develop Or Relapse Occurs

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Treatment Modalities

1. Problem Solving Group Therapy
2. Individual Therapy
3. Recovery Education Programs
4. Family Programs
5. Self-Help Groups

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CDCO11 15

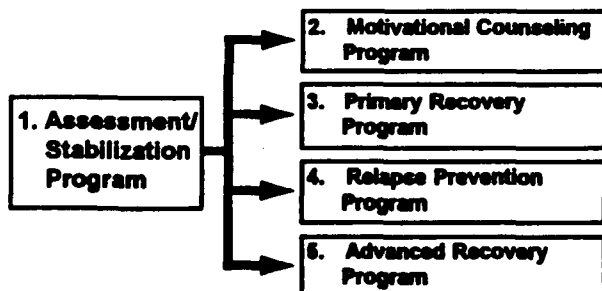
5. Self-Help Programs

1. Must Support ...
 - Abstinence From Alcohol And Drugs
 - Abstinence From Antisocial Behaviors
 - Biopsychosocial Health
2. Must Be Inexpensive And Readily Available
3. Recommended Self-Help Programs
 - Twelve Step Programs
 - Rational Recovery
 - Women For Recovery

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Continuum Of Care



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CDCO11 17

1. Assessment/Stabilization Program

- A. Assessment
- B. Detoxification
- C. Crisis Stabilization
- D. Referral

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2. Motivational Counseling Program

A. Education About The Disease Process

- *Chemical Dependency*
- *Criminal Personality Disorder*

B. Self-Assessment

- *Presenting Problems*
- *Life History*
- *Addiction And Criminal History*
- *Current Behavioral Patterns*

2. Motivational Counseling Program

C. Interruption Of Addictive And Criminal Preoccupation

- *Euphoric Recall*
- *Awfulizing Abstinence*
- *Magical Thinking*
- *Obsession And Compulsion*

2. Motivational Counseling Program

D. Motivation To Comply And Cooperate With Other Programs

- *Diagnostic Presentation*
- *Program Recommendation*
- *Program Requirements*
- *Voluntary Treatment Contract*

The Treatment Contract

1. Present ...

A. Program Goals

- *Personality And Lifestyle Change*
- *Not Reduction In Sentencing*

B. Program Structures

- C. Attendance And Behavioral Requirements
- D. Consequences Of Non-Compliance

The Treatment Contract

2. Ask For ...

- Voluntary Admission
- Sign Statement Of Rights And Responsibilities

*Don't Try To
Convince Or Persuade
Explain That The Program Requires Hard Work
Many People Are Not
Willing Or Able To Complete It*

Counselors Must Have ...

1. Concrete And Enforceable Rules

2. Clear Behavioral Participation Standards

3. Disciplinary Authority To Transfer ..

- *Back To Motivational Program*
- *Back To Jail*

3. Primary Recovery Program

Phase 1: Reinforcement Of Diagnosis

Phase 2:

Phase 3:

Phase 4:

3. Primary Recovery Program: Phase 1 Reinforcement Of Diagnosis

A. Understanding ...

The Ability To Accurately Describe The
Dynamics Of ...

- *Chemical Abuse And Dependence*
- *Criminal Personality Disorder*

3. Primary Recovery Program: Phase 1 Reinforcement Of Diagnosis

B. Recognition: The Ability To ...

1. Accurately Self-Apply Information About ...

- *Chemical Abuse And Dependence*
- *Criminal Personality Disorder*

2. Describe Personal Symptoms

3. Defend When Challenged

3. Primary Recovery Program: Phase 1 Reinforcement Of Diagnosis

C. Acceptance: The Ability To ...

- *Think About And Talk About CD and CPD*
- *Without Shame, Guilt, Pain, Or Denial*

3. Primary Recovery Program

Phase 1: Reinforcement Of Diagnosis

Phase 2: Behavior Change

Phase 3:

Phase 4:

3. Primary Recovery Program: Phase 2 Behavior Change

A. Internal: The Ability To ...

- *Recognize And Stop Addictive And Criminal Thoughts And Emotional Management Strategies*
- *Replace With Sober And Responsible Thinking And Emotional Management Strategies*

3. Primary Recovery Program: Phase 2
Behavior Change

B. External: The Ability To ...

- *Recognize And Stop Addictive And Criminal Behaviors And Situations*
- *Replace With Sober And Responsible Behaviors And Situations*

3. Primary Recovery Program

Phase 1: Reinforcement Of Diagnosis

Phase 2: Behavior Change

Phase 3: Recovery Program Development

Phase 4:

3. Primary Recovery Program: Phase 3
Recovery Program Development

1. Schedule Of

- A. Professional Therapy Activities
- B. Self-Help Group Meetings
- C. Holistic Health Activities

2. Resolution Of Resistance And Inner Dissonance

3. Primary Recovery Program

Phase 1: Reinforcement Of Diagnosis

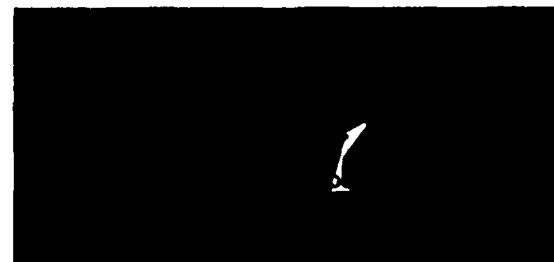
Phase 2: Behavior Change

Phase 3: Recovery Program Development

Phase 4: Lifestyle Integration

3. Primary Recovery Program: Phase 4
Lifestyle Integration

- 1. Meeting Conditions Of Probation/Parole
- 2. Abstinent From A/D And Criminal Behaviors
- 3. Consistent Recovery Program
- 4. Gainful Employment
- 5. Functional Social Life And Relationships



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The Chemically Dependent Criminal Offender

Recovery And Relapse Prevention In The Criminal Justice System

Session 12: Continuum Of Care - Part 2: Relapse And Advanced Recovery Programs

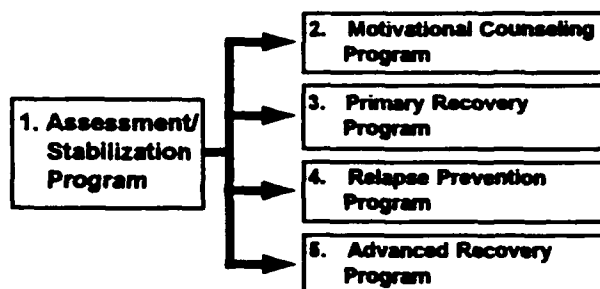
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CDC012 1

Program Configuration



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CDC012 2

4. Relapse Prevention Program

Phase 1: Assessment

Phase 2:

Phase 3:

Phase 4:

Phase 5:

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4. Relapse Prevention Program: Phase 1 Assessment

1. Review Most Recent Relapse Episode
 - A. Determine Need For Detoxification And Crisis Management
 - B. Confirm Diagnosis And Inability To Control
 - C. Resolve Shame, Guilt, And Pain
 - D. Interrupt Denial

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4. Relapse Prevention Program: Phase 1 Assessment

2. Establish Immediate Relapse Prevention Plan

- A. Support Persons
- B. High Risk Situations And Management Strategies
- C. Relapse Justifications And Rational Challenges

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4. Relapse Prevention Program: Phase 1 Assessment

3. Establish Relapse Early Intervention Plan
 - A. Self-Regulated Intervention
 - B. Network Intervention

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4. Relapse Prevention Program

- Phase 1: Assessment
- Phase 2: Warning Sign Identification
- Phase 3:
- Phase 4:
- Phase 5:



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4. Relapse Prevention Program: Phase 2 Warning Sign Identification

- 1. Warning Sign Review
 - A. Review Composite List Of Warning Signs
 - ☒ For Chemical Dependency
 - ☒ For Criminal Behaviors



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4. Relapse Prevention Program: Phase 2 Warning Sign Identification

- 2. Initial Warning Sign List
 - Select Three Warning Signs From ...
 - Chemical Dependency Warning Sign List
 - Criminal Behavior Warning Sign List



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4. Relapse Prevention Program: Phase 2 Warning Sign Identification

- 3. Warning Sign Analysis
 - A. Description Of Personal Warning Sign Indicators
 - Internal (Thoughts And Feelings)
 - External (Behaviors And Situations)
 - Hidden Warning Signs

- 1. What Do You Start Doing Differently?
 - 2. What Do You Stop Doing?



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4. Relapse Prevention Program: Phase 2 Warning Sign Identification

- 3. Warning Sign Analysis
 - A. Description Of Past Experience
 - Hidden Warning Signs
 - B. Description Of Future Experience
 - Hidden Warning Signs
 - C. Sentence Completion Exercise
 - Hidden Warning Signs



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4. Relapse Prevention Program: Phase 2 Warning Sign Identification

- 4. Final Warning Sign List
 - A. Fill In Gaps In The Action
 - B. Backtrack To Core Issues
 - C. Project Ending Into Use Of Alcohol, Drugs, And Criminal Behaviors
 - D. Identify Sequence Of Addictive Thinking



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4. Relapse Prevention Program

- Phase 1: Assessment
- Phase 2: Warning Sign Identification
- Phase 3: Warning Sign Management
- Phase 4:
- Phase 5:

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4. Relapse Prevention Program: Phase 3 Warning Sign Management

- 1. Select Three Critical Warning Signs
 - A. Occur Early Enough To Intervene
 - B. Readily Recognizable
 - C. Motivated To Effectively Manage

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4. Relapse Prevention Program: Phase 3 Warning Sign Management

- 2. Situational Management Strategies
 - A. Review Episode Of Past Mismanagement
 - B. Identify Three Possible Intervention Points
 - C. Develop Alternative Management Strategies

1. Verbal Description	3. Role Playing
2. Mental Rehearsal	4. Practice

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4. Relapse Prevention Program: Phase 3 Warning Sign Management

- 3. Thought Management
 - A. Identify Irrational Thoughts (Addictive And Criminal) That Drive The Warning Signs
 - B. Develop Rational Challenges (More Effective Ways Of Thinking)

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4. Relapse Prevention Program: Phase 3 Warning Sign Management

- 4. Feeling Management
 - A. Identify Unmanageable Feelings That Drive The Warning Signs
 - B. Review Past Emotional Mismanagement
 - C. Develop More Effective Emotional Management Strategies

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4. Relapse Prevention Program: Phase 3 Warning Sign Management

- 5. Action (Behavior) Management
 - A. Identify Action Urges That Drive The Warning Signs
 - B. Develop More Effective And Responsible Behavioral Responses

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4. Relapse Prevention Program

- Phase 1: Assessment
- Phase 2: Warning Sign Identification
- Phase 3: Warning Sign Management
- Phase 4: Recovery Planning
- Phase 5:

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4. Relapse Prevention Program: Phase 4 Recovery Planning

- A. Initial Recovery Plan
- B. Testing The Recovery Plan
- C. Revising The Recovery Plan

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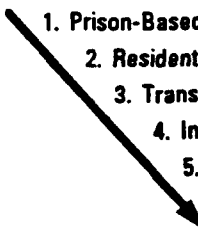
4. Relapse Prevention Program: Phase 5 Advanced Recovery Program

- A. Deep Personality Change
- B. Ongoing Recovery Program
- C. Ongoing Warning Sign Identification And Management
- D. Continued Growth And Development

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Integration Into Criminal Justice System *Treatment Duration: 3 - 5 Years*

- 
- 1. Prison-Based Programs (3 - 6 Months)
 - 2. Residential Treatment (6 Months - 1 Year)
 - 3. Transitional Living (6 Months - 1 Year)
 - 4. Intensive Outpatient (6 Months - 1 Year)
 - 5. Ongoing Outpatient (1 - 2 Years)
 - 6. Maintenance (Life-Long)

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Policies To Guarantee Success

- 1. Attendance And Full Participation Required At Sentencing
- 2. Refusal To Attend Or Comply With Basic Rules And Responsibilities Results In Discharge And Return To Prison
- 3. Chemical Relapse Results In Rapid Stabilization In Appropriate Level Of Care

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Integration Into Criminal Justice System

- 1. Prison Based Programs
 - A. Designate Cell Blocks As Secure Rehabilitation Facilities
 - B. Screen All Inmates And Appropriately Place
 - C. Require Successful Completion Of 90 To 180 Days Rehabilitation Prior To Probation Or Parole

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Integration Into Criminal Justice System

2. Residential Treatment

- A. Duration: 6 Months To 1 Year
- B. Discharge Offenders To Residential Treatment Facilities After Release
- C. Integrate Treatment With Community-Based Self-Help Groups



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Integration Into Criminal Justice System

3. Transitional Living Programs

- A. Duration: 6 Months To 1 Year
- B. Transfer To Transitional Living Programs Operating In Halfway Houses
- C. Goal Of Full Time Employment With Supervised Living And Continued Recovery Activities



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Integration Into Criminal Justice System

4. Intensive Outpatient Treatment

- A. Duration: Six Months To One Year
- B. Intensive Evening Sessions Three Times Per Week Plus Self-Help



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Integration Into Criminal Justice System

5. Ongoing Outpatient Treatment

- A. Duration: 1 To 2 Years
- B. Group Therapy Once Per Week Plus Self-Help
- C. Individual Therapy Twice Per Month
- D. Ongoing Self-Help Groups And Holistic Health Program



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Integration Into Criminal Justice System

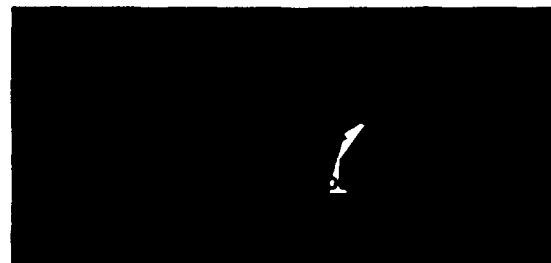
6. Maintenance

- A. Maintain A Life-Long Ongoing Recovery Program
- B. Monitor For And Intervene Upon Relapse Warning Signs
- C. Rapid Stabilization And Renewed Treatment Should Relapse Occur



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Relapse Warning Signs For The Chemically Dependent Criminal Offender

Developed By Terence T. Gorski and John M. Kelley

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This relapse warning sign list will help you to understand how you return to alcohol and drug use and breaking the law, even though you don't want to. This list describes the thoughts, feelings and actions that offenders experience before returning to alcohol or drug use or committing a crime. Read the following relapse warning signs. Place circle any that have happened to you. Place a question mark next to any that you don't understand. Underline any words that cause you to have thoughts or feelings, or make you want to do something. This list was adapted from the work of Terence T. Gorski and Stanton E. Samenow, PH.D..

Phase 1: Internal Dysfunction: My thinking and feelings begin to change and I know it but I hide it from others and they don't notice it.

- _____ 1-1. *Thinking Different:* A part of me starts to think that the straight and sober life is boring and isn't worth the effort. I start thinking about getting back into the old lifestyle and I know that this thinking will eventually get me into trouble.
- _____ 1-2. *Feeling Different:* I start to feel bad about being straight and sober. I get bored and feel bad about having to give up the old lifestyle. I keep these feelings to myself and don't tell anyone about them.
- _____ 1-3. *Acting Different:* I go through the motions of my recovery program but I am privately disillusioned and I start to feel like a phony. I play the game and look like I am doing what I am supposed to do but underneath I know that it is all a con.
- _____ 1-4. *Getting Stressed:* I start to feel stressed out and I want to get some relief but nothing I do seems to work. I start craving for some excitement or rush that could make the feeling go away but I don't tell anyone what I am feeling.

Phase 2: Return Of Denial: I lie and tell myself that everything is going fine and at times I start to believe myself.

- _____ 2-1. *Worrying About Myself:* I get worried about the old way of thinking and feeling that is coming back. I get afraid that I won't be able to handle the straight and sober life. The thought of having to be responsible and accountable gets me down.
- _____ 2-2. *Denying That I'm Worried:* I tell myself it will all work out. I pretend everything is all right even though I know that its not. If people ask me about my problems, I tell them that everything is OK. I lie to myself so well that at times I believe it.

Phase 3: Avoidance And Defensiveness: I begin to avoid anyone or anything that will force me to face how messed up my thinking and behavior is getting. If I do get confronted I get defensive.

____ 3-1. *Believing I'll Never Get In Trouble Again:* I convince myself that I learned my lesson and I will never do anything illegal again. I tell my friends, family, counselor and probation officer, "I've really learned this time," even though I don't have a plan for how to change.

____ 3-2. *Needing To Have It My Way:* I think things should go my way because I want them to. I think because other people want me to do well and because I want to do well, things should happen the way I want them to.

____ 3-3. *Privately Putting Others Down:* I make myself feel better by putting others down. Sometimes I tell people that they don't know anything or are dumb. Most of the time, I just think it, but don't say it. I tell myself how stupid other people are.

____ 3-4. *Feeling Uncomfortable Around "Straight" People:* I feel uncomfortable around people who are not involved in illegal activities. They seem boring and dull. I get nervous and jumpy.

____ 3-5. *Being Alone:* I start avoiding people and spending more time alone. I feel other people are more trouble than they are worth. I wander around alone or go places by myself. Even when I am with other people I feel alone and don't tell anyone what is going on with me. I feel lonely and isolated and start to think that nobody cares.

Phase 4: Crisis Building: I am so isolated and alone that it is easy for me to start setting myself up to get into trouble.

____ 4-1. *Bored And Craving Excitement:* I feel bored with the straight and sober life. I want more excitement and I start remembering how exciting the old days were and wishing I could have them back again.

____ 4-2. *Compulsive Behavior:* I start doing things compulsively to get my mind off of my loneliness and my problems. I keep myself too busy to think or notice what I am feeling.

____ 4-3. *Building Up For A Fall:* I feel like I must be the best or I will be nothing. I decide that I will be very successful at everything I do. I get excited and build up in my mind how successful I must be. I feel like if I don't do everything right, I will fail.

____ 4-4. *Not Planning Ahead:* I don't plan the future. When people ask me what my plans are, I tell them what I think they want to hear. I don't know what will happen and I don't really care.

____ 4-5. *Making Bad Decisions:* I make decisions on the spur of the moment without thinking about what might happen. I think afterwards, "I really screwed up."

- _____ 4-6. *Nothing Is Going My Way:* When things don't go my way I over react and blow things out of proportion. I feel like nothing is going my way and nothing will ever be right.

Phase 5: Immobilization: I get so burned out that I stop trying.

- _____ 5-1. *Bummed Out:* I feel depressed, lonely and angry. I don't think other people understand. I start having problems sleeping or don't eat regularly and eat junk food. I start to feel afraid and hopeless but believe I can't tell anyone about it.
- _____ 5-2. *Stop Making An Effort:* I will not do things that I don't like or that are boring or hard for me. I find excuses for not doing things. I don't look into jobs or other things that might help me. I don't feel like maintaining my recovery program.
- _____ 5-3. *Feeling Like A Zero:* I feel like I am nothing and that I will never be anything and that everyone knows it.

Phase 6: Confusion And Overreaction: I begin to get confused, not know why things are going wrong and loosing my temper for no reason.

- _____ 6-1. *Feeling Put Down:* When other people don't agree with me, don't trust me, or tell me things that I don't want to hear I see it as a personal put down and I get angry. I think people should trust me no matter what I may have done in the past or how irresponsibly I am currently acting.. I tell them I have changed and expect them to believe me without my having to prove myself. I keep my anger to myself
- _____ 6-2. *Feeling Like A Victim:* I think that other people are taking advantage of me and there is nothing that I can do about it. I fee picked on and abused. I think that other people will never be satisfied.
- _____ 6-3. *Blaming Others:* I start to believe that my problems are caused by others and it is their fault that I am feeling bad. I start resenting other people because things are going so well for them and so poorly for me
- _____ 6-4. *Getting Back:* I begin to get back at others by arguing with them, criticizing them, and putting them down. I spend time plotting ways to get even and get away with it.

Phase 7: Depression: I get depressed and bummed out. I stop feeling like doing anything to help myself.

- _____ 7-1: *Irregular Eating Habits:* I stop eating a healthy diet and start eating junk food and skipping meals. At time I compulsively over eat. At other times I'll miss meals and starve myself.

7-2: *Not Being Able To Sleep Right:* I have trouble sleeping. Sometimes I can't fall asleep. When I do sleep I have strange dreams, wake up many times in the middle of the night and don't feel rested. Sometimes I get so tired that I sleep the day away.

7-3: *Loss Of Daily Structure:* I stop following any regular daily plan. My life becomes confusing and chaotic and I don't care.

7-4: *Periods Of Deep Depression:* I have times when I feel very depressed and don't know what to do. Sometimes i think life isn't worth living or I think about killing myself.

Phase 8: Loss of Control: My feelings seem to control me. I can't seem to make myself get back on track. I feel like I can never change so why should I try.

8-1. *Feeling Afraid But Denying It:* I don't want others to know I am afraid because I think being afraid is being weak. I tell people what I think they want to hear so that they won't know how I really feel. Sometimes I tell them I am fine when I am really not.

8-2. *Avoiding Responsibility:* When things go wrong, I tell people, "I forgot," or I do what I want instead of what I told people I would do. I either don't answer them, change the subject, or don't give them an answer. Sometimes I say, "yes" when I don't really mean it.

8-3. *Envyng Others:* I start thinking about people I know who can still drink, use drugs, break the law and get away with it. I start to wish that I could do that. I wonder if there is an easier way to do things.

8-4. *Hurting Others:* I hurt other people by what I say and do. When they tell me about it I either get angry and feel picked or else I can't understand why they should feel hurt by what I did. Sometimes I brush it off and I don't care. Other times I get angry and feel like getting back at them.

8-5. *Pushing Others Away:* When people ask me what is wrong, I tell them that there is nothing wrong. If they persist, I either tell them to leave me alone, yell at them, or do something to make them leave me alone.

Phase 9: Recognition Of Loss Of Control: I begin to see that I am loosing it and that I am not able to stay in control of myself.

9-1. *Wanting To Use Alcohol And Drugs:* I want to use alcohol and drugs to make good feelings better or to get rid of bad feelings. Sometimes I feel good, but want to feel better. Sometimes I feel bad and want to escape from my feelings. I keep thinking about drinking a secret. Fear of going back to jail if I am caught is the only thing that stops me. If my probation officer, family or counselor ask me, I lie.

9-2. *Hanging Out With Old Friends*: I start to hang around people who commit crimes. I want to be comfortable and they are the only people I believe understand me. I go back to my old hangouts. I call people I was in jail or prison with. I assure myself that I am only doing this to find out how they are doing.

9-3. *Being Irresponsible*: I miss appointments with my probation officer, counselor, job interview or school. I stop attending scheduled activities on my recovery program. I make up excuses as to why I wasn't there. I begin to believe these people are out to get me and I can't trust them.

Phase 10: Option Reduction: I begin to believe that the only choices I have is to kill myself or someone else, to go crazy, or to start using alcohol, drugs and criminal behavior to feel better and get my way.

10-1. *I Want What I Want, When I Want It*: I think other people should give me what I want and if they don't, I have a right to take it. I feel angry that they won't do what I want or give me what I want. I feel like I have to teach them a lesson. I start thinking about illegal things I can do to get what I want.

10-2. *Believing I Must Win At All Costs*: I feel "high" when I come out on top, even if the fight wasn't important. I will do whatever it takes to get back at someone who I am angry with. I am willing to and do commit crimes just to make me feel on top of things.

10-3. *Refusing To Back Down*: I won't back down when other people don't agree with me even if I know they are right. I am never wrong no matter what. I feel if I admit to others that I am wrong, they will think I am weak and they will take advantage of me. Even if I prove to be wrong, I will either leave or start a fight rather than admit it.

10-4. *Loosing My Temper*: I start loosing my temper if I don't get what I want or if others don't do what I say. I believe I have the right to get angry, threaten, hurt or get even with other people because they don't understand me or do what I want.

Phase 11: Criminal Behavior, Alcohol, And Drug Use: I start drinking, using illegal drugs, and breaking the law on a regular basis. Sometimes the alcohol and drug use comes first and I use it as an excuse to break the law. At other times I plan to break the law and start using alcohol and drugs to get the courage to do it.

11-1. *Just This Time*: I decide to commit a crime "just this once." It starts with what I consider small things like getting even with someone, committing petty crimes, stealing small things, speeding, or getting into fights. The small stuff doesn't give me the kicks or the excitement that I want, so I plan bigger crimes but I pick "safe things" and plan carefully so I won't get caught.

____ *11-2: Using Alcohol And Drugs:* I start using alcohol and drugs. Sometimes I do it to get rid of the depression. At other times I do it to make good times feel better. Alcohol and drugs make it easier for me to get the courage to commit crimes.

____ *11-2. Things Get Worse:* Soon I start drinking, using drugs, and breaking the law on a regular basis. I am always thinking about how I can get away with something. Things start to get out of hand and I get scared that I will get caught. I can't stop and keep drinking, drugging and law breaking. The excitement seems worth the risk.

____ *11-3. Getting Caught:* I get caught. I get arrested, picked up on a probation or parole violation, or get hurt while drinking or committing a crime. I feel caught by the system. At first I feel like a victim and then I realize that I am right back where I started.

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Information Resources

1. National Clearinghouse For Alcohol And Drug Information (NCADI) p 1-800-729-6686
2. National Criminal Justice System Reference Service (NCJRS) - 1-800-851-3420
3. Drugs and Crime Data Center and Clearing House - 1-800-666-3322
4. The CENAPS Corporation, 18650 Dixie Hwy, Homewood IL 60430, 708-799-5000
5. Herald House Independence Press, 1-800-767-8181, 816-252-5010

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MENTAL HEALTH AND RELATED PROBLEMS OF
CONVICTED WOMEN FELONS

BY

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ABSTRACT

Mental Health and Related Problems of Convicted Women Felons

**B. Kathleen Jordan, Ph.D., William E. Schlenger, Ph.D.,
John A. Fairbank, Ph.D. and Juesta Caddell, Ph.D.**

The Women's Inmates Health Study (WIHS) is a study of the health and mental health problems, history of traumatic events, and other related problems among convicted women felons in North Carolina. It is funded by the National Institute on Drug Abuse (NIDA). The sample includes 800 women who were interviewed for approximately 2 1/2 hours a few days after entering prison. The interviews were conducted by professional interviewers employed by the Research Triangle Institute, which is not affiliated with the prison. Data of all respondents was kept confidential. The data were collected between July 1991 and November 1992.

In this presentation we will first present a demographic profile of convicted women felons in North Carolina, comparing these data with national demographic data on women inmates. The presentation will then focus on the trauma and violence women inmates have experienced and the relationship of these experiences to their own mental health problems, violence, and other problems. Particular emphasis will be on the trauma-related disorders of post-traumatic stress disorder and borderline personality disorder. The presentation will also include a discussion of antisocial personality disorder in women felons, a disorder which also may be seen to be related to a history of trauma. We will close with the implications for treatment.

Mental Health and Related Problems of Convicted Women Felons

**B. Kathleen Jordan, Ph.D., William E. Schlenger, Ph.D.,
John A. Fairbank, Ph.D. and Juesta Caddell, Ph.D.**

Description of the Study

Despite their growing numbers, little epidemiologic research has been done on women criminal offenders. The available research suggests that, as compared to women in the community, women in prison may be more likely to have a history of abuse and other trauma, often from childhood; to have mental health, drug, and alcohol problems; to have social and family problems; and to have elevated rates of AIDS risk behaviors (including IV drug use and unsafe sexual practices).

Today I will be reporting some preliminary findings from a study of women prison inmates we at Research Triangle Institute are currently conducting. The study is the Women Inmates' Health Study or WIHS, and it was funded by the National Institute on Drug Abuse. We would like to thank NIDA and its staff for their support of this research.

The primary aim of WIHS has been to comprehensively examine the nature and prevalence of specific psychiatric disorders, AIDS risk behaviors, violent behaviors, and other problems among women entering prison in North Carolina. We are also examining the correlates of these problems. A major focus of the study has been the assessment of exposure to trauma and how such exposure is related to psychiatric disorder, AIDS risk behaviors and other problematic behaviors.

Methodology

I would like to briefly discuss the methodology of the study. The main study sample is a survey sample, that is, the respondents were all interviewed by professional survey interviewers. Our survey sample includes 805 women aged 18 or over who had been convicted of a felony and who were entering prison in North Carolina at the time of the study. Except for a few months when incarcerations substantially increased, the data consists of a census of women felons entering prison in North Carolina at the time of the study. (In the months of heavy intakes, we interviewed a random sample of the entering population.)

Our data were collected between July 1991 and November 1992. Women in the survey sample were interviewed face-to-face a few days after they entered prison. The interviews lasted approximately 2 and 1/2 hours and were conducted IN PRIVATE, that is, where no one could overhear what the respondent was saying. The survey interviewer explained that participation was voluntary and promised the inmates that we will keep confidential from the prison staff, the courts, and all others the answers they give us to our

questions. Written consent was obtained for all interviews. The response rate for the survey interview was over 95%.

FIGURE 1

Briefly, the information gathered in our survey interview includes demographics; educational and employment history; problems in the inmate's family while she was growing up; family history of mental health and substance abuse problems; and the inmate's experience of physical and sexual abuse and other traumatic events. The interview also included questions on the inmate's history of alcohol and drug problems and treatment for such problems; social support; knowledge of AIDS risk; strength of her self-esteem; chronic or serious physical health problems; and past and present mental health problems and any treatment received for those problems.

FIGURE 2

The specific psychiatric disorders assessed include major depression, dysthymia, generalized anxiety disorder, panic disorder, substance abuse and dependence, post-traumatic stress disorder (PTSD), antisocial personality disorder, and borderline personality disorder. Antisocial personality disorder (ASPD) was assessed using the Diagnostic Interview Schedule (DIS); borderline personality disorder (BPD) was assessed using a survey interview modification of the BPD module of the Diagnostic Interview for Personality Disorders, Revised (DIPD-R). PTSD was assessed with Impact of Events Scale (IES). All other psychiatric disorders were assessed using the Composite Diagnostic Interview Schedule (CIDI).

In addition to the survey sample, we also have a clinical follow-up sample. This is, in fact, a subsample of 212 of the 805 the women who received a survey interview. These 212 women received a followup clinical interview in addition to their survey interview. In the followup interview, clinicians administered the Structured Clinical Interview for DSM-III-R for assessment of PTSD and the Diagnostic Interview for Borderlines-Revised (DIB-R) to assess BPD. The clinical interviews averaged 2 hours and response rate was 98%. Data from the clinical interview were used to validate the survey interview diagnosis of PTSD and BPD.

Results

1. Demographics

I would first like to present some of the demographic characteristics of the sample. These are shown in Tables 1-3. The abbreviation "ACA" in the second column stands for the American Correctional Institute's 1988 Nationwide Survey of Female Inmates. The numbers in the ACA column represent the percentage of that sample with the specified characteristic. In cases in which our data was categorized differently than the ACA data, you will note that both categorizations are given and the data reported beside

the appropriate category.

In general, there were no major racial and ethnic differences in our sample. The exceptions were that Black women were less likely to have been married and Black women also had given birth to more children.

As you can see there are some differences between our sample and the ACA sample, particularly the racial distribution. Because the South has a greater proportion of blacks than some other regions of the U.S., this is not surprising.

2. Criminal Status and History

Tables 4 and 5 show data on the criminal status and history of these women. Almost half of the sample were in prison for the first time and only 14.5% had been in jail, prison or detention before age 18. As you can see, the majority of the women were in prison for forgery, bad checks, drug use, possession or sale, and probation or parole violations. Only 11% were in prison for any kind of violent assault. In looking at their criminal histories, we see that the most common charges for previous arrests were the same as the ones they were in prison for this time, with the addition of theft/larceny. Again, only 16.4% had ever been arrested for a violent assault.

3. Prevalence of Specific Psychiatric Disorders

We have just begun our analysis on the disorders assessed with the CIDI, that is, major depression, dysthymia, panic disorder, generalized anxiety disorder and the substance abuse disorders, so results I will be presenting today are only preliminary data.

Table 6

As you can see, the substance abuse disorders were the only disorders with rates substantially higher than what you would expect in a community population.

4. Psychological Trauma and Related Disorders

One important component of our study was the assessment of psychological trauma. The Diagnostic and Statistical Manual, Revised (DSM-III-R), 3rd Edition, of American Psychiatric Association defines psychologically traumatic events as events that are out of the range of normal human experience and that would be markedly distressing to almost anyone. These include, but are not limited to, events such as rape, incest, physical assault as well as being a victim of fire, serious accident or natural disaster. In our survey we asked respondents a lengthy series of very explicit questions to determine whether or not they experienced particular types of events. For example, after defining the terms "penis" and "vagina," we asked, "Has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you. Just so there is no mistake, by sex we mean putting a penis in your vagina."

We DID NOT assess inmates being the victim of psychological or emotional abuse, nor did we examine their being a victim of child neglect.

Not surprisingly, physical and sexual assaults, including child physical and sexual abuse, were the most common types of traumatic events reported by respondents. As shown in Table 7, the majority of the women had experienced some type of traumatic event and more than half had experienced some type abuse or assault. PTSD is the syndrome that is most often thought of in connection with traumatic events. This disorder includes recurrent memories of the events and efforts to avoid thoughts and feelings about the event. Considering the rates of traumatic events reported, it is not surprising that our respondents reported many PTSD symptoms. However, we have not, to date, been able to develop a PTSD diagnosis for our survey sample that has good concordance with our clinical diagnosis of PTSD in the clinical subsample. We believe that the reason for this is that the diagnostic criteria for PTSD were originally developed using combat veterans. Recent research, including the DSM-IV field trials, suggest that the symptoms of women who have experienced a traumatic event, particularly abuse or assault, may differ in important ways from the DSM-III-R diagnostic criteria for PTSD. In fact, there has been a push toward a new diagnostic category, variously known as DESNOS, disorders of extreme stress not otherwise categorized, or complex PTSD, that would better capture these women's experiences.

Recent research and clinical experience in the area of traumatic stress suggests that two personality disorders, ASPD and BPD, may also be trauma related. As we see in Table 8, the prevalence of PTSD symptoms and BPD and ASPD are quite high in this population.

In order to be categorized as having PTSD, one must have experienced an event that meets the criteria for being psychologically traumatic. The data suggest that those who meet diagnostic criteria for BPD and ASPD also have experienced high rates of trauma. The columns in Table 9 represent two groups: those who have or have not experienced an abuse or assault trauma. The figures in column one represent the proportion of those without assault or abuse trauma who meet criteria for BPD, for ASPD, who have high PTSD symptom count, or have none of these. The figures in column two represent the proportion of those who have experienced an abuse or assault trauma and have BPD, ASPD, high PTSD symptom count, or have none of these. As you can see, a large majority (71%) of those who have not been abused or assaulted also do not have ASPD, BPD, or a high ASPD symptom count. Among those who have been abused or assaulted, however, the majority have ASPD, BPD, and/or a high PTSD symptom count.

5. Psychological Trauma, Violence, and AIDS Risk Behaviors

In our study, we have also examined the extent to which trauma and trauma related disorders are associated with violence and AIDS risk

behaviors. In the interest of time, I won't present the data, but we have found that inmates who have experienced an abuse or assault trauma reported committing many more violent acts in the past year than those who have not had such an experience. Not suprisingly, then, those with trauma related disorders tend to report committing more violent acts in the past year than those without these disorders. Inmates who have a high PTSD symptom count, for example, report committing significantly more violent acts in the past year than those without a high PTSD symptom count; and those with BPD or ASPD report committing 3 to 10 times more violent acts in the past year than those without these disorders. Those with both BPD and ASPD report committing the greatest number of violent acts.

The results with regard to AIDS risk behaviors are similar. Those who have experienced abuse or assault tend to report significantly more drug related and sex related AIDS risk behaviors than those who have not experienced such an abuse or assault. Factors which are associated with exhibiting the greatest number of AIDS risk behaviors are being sexually abused or assaulted, being abused or assaulted at a young age, and being abused or assaulted by a family member.

Summary and Conclusions

In summary, then, it appears that the some of the most common specific psychiatric disorders, such as depression and anxiety, are not highly prevalent among women felons entering prison in North Carolina. This would suggest that, in general, inmates did not tend overreport symptomatology. This low level of reporting would provide some substantiation for the very high rates of trauma and trauma related disorders we found in this population. Although we have not yet examined this, in this population it is likely that the high rates of substance abuse may be trauma related as well. Victims of trauma often use drugs and alcohol to avoid the painful memories of, and feelings about, the abuse they have experienced.

In this population we also found that trauma and trauma related disorders may also contribute to two major public health problems, AIDS and violence.

We believe that these findings suggest that treatment of women inmates for traumatic experiences and trauma related disorders has the potential not only to reduce the rates of trauma related disorders in this population, but also to reduce their AIDS risk behaviors, violent behaviors and other behaviors that are likely to result in these women returning to prison again and again. Many of the behaviors that result in these women entering prison may be seen to be sequelae to their traumatic experiences. For example, impulsive stealing, getting involved with drugs, engaging in commercial sex, committing violent assaults, being involved in serious traffic accidents, and other acts which represent impulsivity, poor self-esteem and self-control, and, even, self-

punishment, are all consistent with the behaviors of an individual suffering from traumatic experiences.

Figure 1

DOMAINS ASSESSED IN THE WIHS SURVEY INSTRUMENTATION

- Demographics
- Educational and employment history
- Problems in the inmate's family while she was growing up
- Family history of mental health and substance abuse problems
- History of alcohol and drug problems
- Treatment for alcohol and drug problems
- Social support
- Knowledge of AIDS risk
- Self-esteem
- Chronic or serious physical health problems
- Psychiatric disorder
- Any treatment received for psychiatric disorder
- Physical and sexual abuse
- Other traumatic events.

Figure 2

PSYCHIATRIC PROBLEMS ASSESSED IN THE WIHS SURVEY INTERVIEW

Past and present symptoms of psychiatric disorder - diagnostic

- Depression
- Generalized Anxiety
- Panic Disorder
- Substance Abuse and Dependence
- Antisocial Personality Disorder
- Borderline Personality Disorder
- PTSD

Past and present symptoms of psychiatric disorder -
nondiagnostic (screeners)

- Multiple Personality Disorder
- Anorexia and Bulimia
- Postpartum Depression
- Late Luteal Phase Disorder

Dissociation

Table 1**DEMOGRAPHICS: RACE AND AGE
(N=805)****Race**

	<u>N</u>	<u>%</u>	<u>ACA (%)</u>
White	289	(35.9)	53.2
Nonwhite	521	(64.1)	46.8
Black	468	(58.1)	41.5

Age

	<u>N</u>	<u>%</u>	<u>ACA (%)</u>
< 19			2.9
< = 20	50	(6.2)	
20 - 24			17.9
21 - 25	161	(20.0)	
25 - 29			28.1
26 - 29	181	(22.5)	
30 - 34	190	(23.6)	23.2
> = 35	223	(27.7)	27.9

Table 2**DEMOGRAPHICS: EDUCATION
(N=805)**

	Education		
	<u>N</u>	<u>%</u>	<u>ACA (%)</u>
< 12	431	(53.5)	57.2
12	223	(27.7)	15.9
13 - 15	129	(16.0)	22.9
> = 16	22	(2.7)	4.0

Marital Status at Time Entered Prison

		<u>ACA %</u>
Never married	327 (40.6)	36.5
Married	106 (13.2)	21.6
Separated	95 (11.8)	12.1
Divorced	89 (11.1)	21.7
Widowed	35 (4.3)	6.5
Living as married	153 (19.0)	
Other		30.0

Table 3

**DEMOGRAPHICS: NUMBER OF
BABIES AND PERSONAL INCOME
(N=805)**

Number of Babies Born Alive

	N	%	ACA (%)
0	184	(22.9)	20.9
1	193	(24.0)	24.8
2	198	(24.6)	22.6
> = 3	230	(28.6)	31.7

**Personal Income Last Year
(Before Taxes)**

	N	%
None	54	(6.7)
\$1 - \$1,999	485	(60.2)
\$2,000 - \$9,999	96	(11.9)
> = \$10,000	163	(20.2)

Table 4
CRIMINAL HISTORY VARIABLES
(N=805)

	<u>N</u>	<u>%</u>	<u>ACA (%)</u>
First time in prison	373	(46.3)	45.8
Spent time in jail or prison before age 18	117	(14.5)	
Currently serving time for:			
Burglary	60	(7.5)	3.0
Robbery	44	(5.5)	7.6
Theft/Larceny	137	(17.0)	12.0
*Trust/Pretense (forgery, fraud, <u>bad checks</u> , etc.)	210	(26.1)	
Serious Traffic Offenses	37	(4.6)	
Property Damage (arson, vandalism)	11	(1.4)	
Violent Assault (murder, manslaughter, assault and battery)	89	(11.1)	18.6
Child Abuse	10	(1.2)	
Nonviolent Offense against Persons (simple assault, child neglect)	12	(1.5)	
*Drug Possession and Use	204	(25.3)	}20.7
*Sale/Manufacture of Drugs	177	(22.0)	
Public Order Offenses (disorderly conduct, vagrancy, etc.)	12	(1.5)	
Commercial Sex	4	(0.5)	.9
*Weapons, Gambling, Contempt of Court, <u>Probation or Parole Violations</u>	143	(17.8)	
Other	59	(7.3)	

Table 5**CRIMINAL HISTORY VARIABLES
(N=805)**

	N	%
Ever arrested for:		
Burglary	114	(14.2)
Robbery	67	(8.4)
*Theft/Larceny	307	(38.1)
*Trust/Pretense (<u>forgery</u> , fraud, <u>bad checks</u> , etc.)	293	(36.4)
Serious Traffic Offenses	122	(15.2)
Property Damage (arson, vandalism)	61	(6.2)
Violent Assault (murder, manslaughter, assault and battery)	132	(16.4)
Child Abuse	13	(1.6)
Nonviolent Offense against Persons (simple assault, child neglect)	79	(9.8)
*Drug Possession and Use	295	(36.6)
*Sale/Manufacture of Drugs	228	(28.3)
Public Order Offenses (disorderly conduct, vagrancy, etc.)	59	(8.8)
Commercial Sex	25	(3.6)
* <u>Weapons, Gambling, Contempt of Court, Probation or Parole Violations</u>	245	(30.5)
Other	104	(12.9)

TABLE 6

**PRELIMINARY LIFETIME RATES OF
SPECIFIC PSYCHIATRIC DISORDERS**

DEPRESSION	8.2%
DYSTHYMLA	6.6%
PANIC DISORDER	4.7%
GENERALIZED ANXIETY DISORDER	2.7%
ALCOHOL ABUSE	33.4%
DRUG ABUSE	45.2%

Table 7

**LIFETIME PREVALENCE OF HAVING
EXPERIENCED A TRAUMATIC EVENT
(N=805)**

Any trauma	78%
Assault trauma	61%
Other trauma only	17%

Table 8

**PREVALENCE RATES
(N=805)**

Had Experienced a T.E. and had 6 or More PTSD Symptoms, Past 6 mo	30%
BPD Dx	28%
ASPD Dx	11%
None of the Above	51%

Table 9

**PREVALENCE RATE FOR 3 DISORDERS
AMONG THOSE WHO HAVE OR HAVE NOT
EXPERIENCED AN ABUSE/ASSAULT T.E.**

	Abuse Trauma	
	<u>No</u>	<u>Yes</u>
PTSD 6 mo Sx cnt of 6 or more	14%	40%
Has BPD	13%	37%
Has ASPD	4%	16%
None of the above	71%	38%

FORENSIC PSYCHIATRY

BY

JAMES B. REYNOLDS, M.D.

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FORENSIC PSYCHIATRY
WALTER REED ARMY MEDICAL CENTER
JAMES B. REYNOLDS, M.D.

FORENSIC PSYCHIATRY: A sub-specialty of the medical discipline of Psychiatry, recognized as such by the American Board of Psychiatry and Neurology, Inc., through its Certificate of Added Qualifications in Forensic Psychiatry. The sub-specialty deals with issues at the interface of the fields of Psychiatry and the Law. These include criminal responsibility and competency to stand trial, psychiatric questions that arise in civil litigation, and the mental health aspects of the correctional setting.

FORENSIC PSYCHIATRIST: A psychiatrist who has received special training in Forensic Psychiatry, or who has acquired forensic expertise by virtue of practical experience in the field. At the present time there are approximately 30 forensic fellowship programs in the U.S. and Canada, each accepting an average of two to three Fellows per year. Most programs are one year long, and are offered at the end of psychiatric residency training or in lieu of the fourth year of residency.

CORRECTIONAL PSYCHIATRY: The evaluation and treatment of mentally ill prisoners, as well as consultation on such issues as parole recommendations and conditions, rehabilitative programs, and the mental health concerns of correctional institution staff.

COMPETENCY TO STAND TRIAL: The capacity of a person to understand the nature and quality of the proceedings against him/her, and the ability to assist one's attorney in one's own defense. More rarely, the ability of a person to act as one's own counsel. There must be a *lack of capacity*, i.e., one has a right to make unwise decisions if one's *capacity* is otherwise intact.

In response to Supreme Court decisions, there is a time-limit on how long a defendant can be held as incompetent to stand trial. At the end of that period the charges may have to be dropped, and the civil commitment of the accused must be sought if he/she is still deemed dangerous due to mental illness.

CRIMINAL RESPONSIBILITY: Varies with each jurisdiction. Usually there is a "cognitive" prong, which requires that at the time of the instant offense, the individual lacked substantial capacity, by reason of mental disease or defect, to *appreciate* the criminality (in some jurisdictions "the wrongfulness") of his/her conduct.

In some state jurisdictions there is a second, "volitional," prong. At the time of the instant offense, the individual, by reason of mental disease or defect, lacked substantial capacity to conform his/her conduct to the requirements of the law.

**FORENSIC PSYCHIATRY
WALTER REED ARMY MEDICAL CENTER
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The insanity defense is uncommonly used, and rarely successful. Only about one-tenth of one percent of trials end in an insanity acquittal. In most jurisdictions, a successful insanity defense means that the accused will be committed to a mental hospital for an indefinite period of time, possibly resulting in a loss of freedom longer than the period of incarceration that would have resulted from a conviction.

CRIMINAL SENTENCING: Increasingly, psychiatrists are being called upon to evaluate the convicted individual for extenuating and mitigating factors. This is becoming especially important in death penalty appeals. The "mitigation specialist" is coming into demand. Psychiatrists may be consulted by the Court to help tailor a rehabilitative plan for a mentally disturbed, but nevertheless convicted, prisoner.

CIVIL LITIGATION: The nature and extent of psychological trauma, or psychiatric factors affecting physical trauma, are often important issues in a damage claim. A parent's fitness to raise a child, or a person's capacity to make a will, are sometimes affected, or challenged as being affected, by psychiatric illness.

CONSULTATION: The forensic psychiatrist will be utilized by attorneys, judges, physicians, and mental health professionals, as a resource for advice on legal-psychiatric issues. Psychic trauma is often very difficult to objectify and measure. The insanity defense, while uncommon, often arises in the most heinous and emotionally charged circumstances. Psychiatric expertise, a measure of skepticism, and experience with the pitfalls of the legal environment, are qualities that the forensic psychiatrist brings to the courtroom.

Pre-Release Career Counseling
Military Correctional Inmates

A Poster Presentation by
Steven A. Wendell, Major, USAR
United States Disciplinary Barracks
Ft. Leavenworth, KS
June 9-11, 1993

Court Martial Conviction as a Form of Involuntary Job Loss

The inmates of the United States Disciplinary Barracks (USDB) are all members of the Armed Forces who have been tried and convicted by Courts Martial. As such, all but a few are barred from future service in the armed forces. These men and women face many of the same concerns as their civilian counterparts who have been terminated for cause or due to plant closings, downsizings, mergers, etc. Involuntary job loss, military discharge, and release from incarceration are three types of major life transitions. Upon release, the military correctional inmate faces a combination of issues relating to each of these transitions. Each is a life change that is laden with career concerns.

A Developmental Approach to Careers and Career Change

Super (1953 & 1980) and Super, Thompson, & Lindeman (1988) propose a theory of career development which involves four major developmental stages: Exploration, Establishment, Maintenance, and Disengagement. The Exploration stage normatively involves adolescents and young adults and deals with selecting a career and finding a job in that career. The Establishment stage normatively involves young adults. It deals with getting established in one's first job and then advancing in a career field. The Maintenance stage normatively involves middle-aged persons and deals with holding on to previous gains and updating skills to stay abreast of one's field. Lastly Disengagement refers to slowing down and transitioning into retirement life.

People going through an involuntary career change must go back and redo the work of one or more of these stages before they can continue on in a new career. This is certainly true of many USDB inmates. The process of revisiting past stages is called recycling. Administration of the Adult Career Concerns Inventory (ACCI) (Super, Thompson, & Lindeman, 1988) to USDB inmates indicates that they commonly have concerns in at least two, and most often, three or four of these stages.

Job Hunting from Behind the Walls

Career counseling correctional inmates is unique in that some types of homework cannot be used. For example, inmates cannot be sent out to do networking interviews or to visit a trade convention. Inmates cannot take many of the forms of direct action that are available to persons on the outside.

It is therefore important to show the inmate what he/she can do on the inside to begin their job hunt. This headstart can make good use of time on the inside by reducing the lag between the release date and the first day on

the job. Most of the actions that can be taken relate to the Exploration stage.

Career selection can be facilitated by several means which include skillful use of counseling interviews, interest testing (Holland, 1990), and self-awareness exercises (Bolles, 1991). Inmates often have limited horizons after years of incarceration and the examination of new possibilities builds optimism about getting out.

Military inmates typically have little or no experience in the ways of the civilian job market. They can benefit greatly from practice job interviews. An alternative to a formal practice interview is to work with flash cards that contain typical interview questions. Introducing inmates to situational or open-ended interview questions makes them realize the importance of preparing for an interview and also helps them see the role self-understanding plays in selling yourself to an employer.

One of the most difficult challenges faced by many inmates is dealing with one's criminal history in a job interview. One method of dealing with this is the "Three Minute Drill" (Rollo, 1991).

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Retribution and Rehabilitation?

Implicit but Illusory Offerings of the GBMI verdict

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Abstract

The present study examined the use of the "Guilty but Mentally Ill" (GBMI) alternative. Mock jurors were presented with differing crime scenarios in which the level of mental illness of the defendant was manipulated. Jury instructions for the "Not Guilty by Reason of Insanity" (NGRI) verdict alone or in combination with the "Guilty but Mentally Ill" (GBMI) alternative were presented, and verdicts were reached. Attitudes toward these "mental health verdicts" were also measured.

Results indicate that the GBMI alternative was considerably overused. Although this option did successfully reduce the number of inappropriate insanity acquittals, there were unanticipated costs. Appropriate guilty findings as well as appropriate insanity acquittals dropped significantly with the addition of the GBMI option.

It is suggested that the desire of jurors to hold criminals responsible for their behaviors, coupled with altruistic motives to offer rehabilitation, may result in the overuse of the GBMI verdict. Such abuse of

discretion is suggested to be a partial result of misperceptions about the insanity defense as well as several erroneous beliefs about the offerings of the GBMI legislation. Specialized mental health treatment, rather than simple punitive incarceration, is implied by this alternative verdict, but as prior investigators have revealed, GBMI offenders are no more likely than their simply "guilty" counterparts to receive such treatment.

These findings have serious implications within the correctional system. Guilty defendants with no history of emotional or thought disorders are likely to become unfairly stigmatized, labeled "mentally ill" within the prison system. Additionally, seriously disordered defendants may be unsuitably incarcerated rather than placed in facilities better equipped to offer treatment.

INCARCERATED FATHERS

1993 MENTAL HEALTH IN CORRECTIONS SYMPOSIUM

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RUNNING HEAD: FATHERS

Introduction

- 1) Incarceration of Fathers
- 2) Recent Statistical Trends
- 3) Types of Incarcerated Fathers

Impact of Incarceration on the Inmate's Family

- 1) Family Dynamics and the Incarceration of the Father
- 2) Consequences for the Family
- 3) Importance of Maintaining Family Ties

Preservation of the Family During Incarceration

- 1) Obstacles to Successful Intervention and Rehabilitation
- 2) Traditional Ways of Maintaining Family Ties
- 3) Intervention Strategies

Conclusion

- 1) Perspectives for Future Planning
- 2) Discussion

There are over 700,000 men incarcerated in state or federal prisons throughout the United States. It is impossible to estimate the amount of family and significant others this many men have left behind, and more importantly, how their incarceration affects their families. Modern prison staff are equipped to deliver a variety of services to meet their population's needs. Mental health treatment, educational, vocational, religious, and drug abuse treatment programs are the most common. These programs attempt to rehabilitate prisoners and meet their needs during their incarceration. There is, however, one important aspect that is easily overlooked by prison staff--the inmate as a father and family member. For a minority of these men incarcerated, this may be the most motivating factor in behavior, mental status, and their eventual rehabilitation. Prisons which do not have provisions to provide at least basic services to this population should consider the positive effects of such programming.

Forty-five percent of prisoners in 1986 indicated being married, divorced, or separated (Bureau of Justice Statistics Source Book, 1991). The actual number of wives and children left behind is difficult to estimate. One study, done in Oregon, indicated 774 men,

who were newly committed, left over 988 children (Sack, Seidler, and Thomas). Other statistical information indicates that approximately 20% of the inmate population reported being married in 1986. Another six reported being separated, while 18% reported being divorced (Bureau of Justice Statistics Source Book, 1991). While this may be less than 50% of the inmate population, the total number of children left behind in communities would be much more significant. Men who are separated, married, or divorced all have the potential to have children and families who are connected to them or experiencing some form of hardship as a result of their incarceration.

Researchers have identified two different groups of fathers. First, there are those that come from an intact family system prior to their incarceration. Then there are those that have separated from their families after the incarceration. There is also the father who was part of an intact family system, but separated prior to the incarceration. Within these three categories of incarcerated fathers lies the potential for many different types of problems and dysfunctions. We shall attempt to review some of the more common.

The inmate who has come out of a family system who has had the support of his family throughout the

judicial process usually appears to experience the greatest amount of stress when he enters a long term incarceration. Embarrassment, frustration, and helplessness are commonly felt by these men (Carlson and Cervera, 1991). This may be partly due to the sudden cut off from their family environment. Prisoners' concern regarding the impact of imprisonment on their families may also contribute to their adjustment. However, Carlson and Cervera report that it is this concern that may be the motivating factor for the fathers to improve the quality of their fathering. As time passes, this type of father may become more motivated to follow institutional rules in order to get the maximum amount of privileges a penal system offers. On the other hand, he may become less motivated because of his circumstances and the environment in which he is living. Porporino and Zamble report, in their study of "Coping, Imprisonment, and Rehabilitation," that inmates typically report facing normal problems, such as conflicts with wives or financial difficulties, as bothering them most during the initial part of their incarceration. Only one out of ten reported problems with authorities as causing them stress during the first 90 days of their incarceration.

Inmates who experience divorce or rejection by family members, who prior to incarceration were viewed as supportive, face a stressful, perplexing situation. A sudden loss of a family after incarceration proves to be a traumatizing loss despite any responsibility the father may have had in the separation. These men must cope with imprisonment and family loss at the same time. Often the justice system is blamed for the separation or divorce. This makes it easy for individuals to escape responsibility for the actions that may have predisposed such a separation. Men who have lost their families as a result of incarceration usually experience more serious effects of rejection, anger, and fear.

Fathers who are separated prior to incarceration and have been able to keep in contact with children and ex-spouses also can experience the aftermath of family dysfunctions. This can either positively or negatively affect their imprisonment. Children often will want to seek out contact with an incarcerated father, especially adolescent males. The father faces a double bind situation. While he is usually ashamed and feels helpless to provide any role support, he usually desires contact. How the father accepts and deals with such a request will affect his incarceration and the family.

The quality of the past family relationships may also cause the father feelings of guilt and possibly perceived failure.

Staff often do not even become aware of the affects of incarceration and separation on fathers. It usually becomes known whether or not an inmate has family, and the quality of the family relationship may eventually come to light. However, the feelings of the inmate are often ignored until some sort of crisis or tragedy causes him to seek out the attention of staff. Staff are usually unaware of the inmate's family problems, partly due to the role they play in detaining the father in the prison system.

The effects of separation in wives and children have a more noticeable affect and a greater impact on society. Children who have gone through the process of arrest and incarceration with the family often display numerous behaviors after the father is incarcerated. Sack, Seidler, and Thomas report that children can experience peer teasing, loss of self esteem, social stigma, disruptive and aggressive behaviors, school phobia, and delinquent behaviors. They also write that children can become less obedient and experience a change in behavior toward each other.

Imprisonment of a child's father represents what Sack identified as a major life change with adverse effects. He further reports that children can experience crying spells, bed wetting, and a preoccupation with the loss. Sack also found in his study of male children between the ages of 6 through 13 aggressive behaviors or anti-social acts were evident within the first two months of the father's incarceration. Other family discords or dysfunctions may be concurrent with the father's incarceration; however, other studies also draw attention to the separation and incarceration itself as a major contributing factor in a child's behavior. One issue which is theorizable, but not certain, is how much a father's incarceration can be attributed toward future delinquency. According to Sack, L. N. Robbins found that a father's psychosocial adjustment was the best predictor of future anti-social behavior in children. Other theorists maintain that delinquent behavior is contributed to personality and family discord.

Children experience different types of behaviors and are affected differently by a father's incarceration. Some common to most cases are sadness, a sense of loss, and separation. Sack reports the location of the father becomes a tremendous concern to

the child. It is common for parents to avoid and delay telling a child the implications and details or timeframes of a father's incarceration (Sack, Seidler, and Thomas). When children are told about a father's incarceration, deception and distortion are often part of the explanation. This can be harmful to children in two ways. The child is forced to continue to tell the lie and play into the deception of his parents' explanation. Then the child can be unsure of the situation or whereabouts regarding the father. This may cause excessive anxiety to the child.

While the imprisonment of a child's father does involve inevitably painful experiences (Sack), other factors contribute to the total situation. The crisis that precipitates around the father's departure, along with long standing marital, financial, or social problems, are all part of the total situation that a family is faced with when the father is incarcerated.

Sack identifies an even greater effect for the male child. A boy must make sense out of a sudden change in his father's status and location. He must also deal with his internalization of his father's positive qualities, while they are threatened by his new definition of who his father is.

The spouse also faces uncertain anxiety and social stigma. The mother is usually called upon to explain the father's incarceration to the children (Sack). She also must deal with the attitudes of the community, her friends, and other family members. There is an often increased financial responsibility and guilt. In some instances, the mother is ascribed blame for the father's incarceration by the children (Sack, Seidler, and Thomas). It is difficult for a spouse to survive the crisis of imprisonment. The mother must make key decisions that will affect the family in the most significant ways. What to tell the children, how to survive, and often whether or not to separate from her husband are several choices a spouse faces.

Community counseling organizations are most usually called upon when treatment is sought by the family. Schools, juvenile officials, and police often become involved in the aftermath of an incarceration. Each family member has an unique set of circumstances that make dealing with them different. While therapists and community organizations attempt to deal with the family, often little attention is paid to the incarcerated father who can still have either a positive or negative impact from within his incarceration. Most prison programs to help inmates deal with family problems

revolve around traditional ways of inmate family interaction.

Zamble and Porporino point out in their article, "Coping, Imprisonment, and Rehabilitation," that the most likely time for participation and treatment programs for an inmate is during incarceration. Other writers point out that often fathers are motivated to improve the quality of their fatherhood (Carlson and Cervera), perhaps as a result of their absence.

Improving and maintaining relationships between the fathers and their families can be difficult. Visits, phone calls, and letters are traditional ways of maintaining a relationship during incarceration, while conjugal visits, furloughs, and other means are less common. Certain obstacles exist for inmates who want to maintain quality family relationships during their incarceration.

Institutional rules generally limit the time and quality of the visit. The environment is often less than therapeutic. Inmates often have to be financially supported in prison, increasing the hardship of the family. Money for phone calls, stamps, and other necessities must be provided by the family.

California, a state that currently offers conjugal visits, is considering cancelling the program.

Opponents cite cost and the fact that some prisoners abused their families during the visits. While conjugal visits may represent an extreme measure to help preserve the family, the direct treatment of dysfunctions cannot be underplayed. While visits are important, it is also important for institutions to develop strategies to deliver services to inmates with family needs.

In planning strategies to deal with the incarcerated father, we must consider what Zamble and Porporino have described as a "behavioral deep freeze." They state that during imprisonment, a person's set of outside world behaviors are stored until his release. This suggests little change in the inmate's behavior actually occurring. They also report that prison provides few opportunities that would lead to progressive changes in behavior. Carlson and Cervera contend that participants in a conjugal visit program were less likely to be reincarcerated. They report that a strong family relationship is associated with successful release. Perhaps the most powerful rehabilitation for an inmate would be to maintain a strong family relationship and even receive treatment for family dysfunctions during his incarceration.

Timing is an essential factor in most intervention. Timing is particularly important when

working with a family whose father is incarcerated. When inmates initially enter prison, they are likely to experience stress and at least a mild level of depression (Zamble and Porporino). It is definitely a time of change, and often crisis, for the entire family. Zamble and Porporino report that over 80% of inmates entering incarceration report having a specified, clear goal in an area which they would like to improve upon within 90 days after their incarceration. Most goals focus on education or vocational training during the imprisonment. However, the longer an inmate spends in prison, the signs of motivation, or a substitute for change, can decrease or disappear according to Zamble and Porporino. Inmate's concerns can typically change from those of the outside world to the daily grind and survival within the prison system. One program, such as the conjugal visit program, may motivate inmates to receive extra visit time or to receive visits in a conjugal setting. It may not actually change an inmate's behavior.

If evaluation, treatment, and services to incarcerated fathers are going to take place, they must be implemented early in the prison term.

Typically, when inmates enter an institution, camp, or facility, they are evaluated, classified, or

interviewed by case management staff, counselors, psychologists, and social workers. Institution staff refer the inmate to the various programs the institution offers, such as alcohol and drug counseling, educational services, etc. Staff should assess the inmate's family situation at the time. If no information is available, a comprehensive interview should be given to determine where the family members are located and what their current relationship to the inmate is. The current marital status, the family's financial and emotional situation, and any foreseen difficulties as a result of the separation and incarceration should be noted. A staff member should contact the inmate's family to verify the reported information and collect other additional firsthand information. This should be done with the inmate's knowledge early after his arrival. Documentation of contact with the inmate's family may be important for future treatment during the incarceration. Some inmates may attempt to use their family situations for other gains during their imprisonment.

Once a clear picture of the inmate's family situation has been developed by staff, visitation, contact, and program referrals can be made. Staff should work with the inmate to develop goals or a plan

of action to help the inmate accomplish and maintain the quality of relationship he would like to have with his family. Pursuing the family's cooperation in the inmate's rehabilitation treatment plan or institutional adjustment should motivate the inmate and the family. Case management staff can help the inmate by counseling him to become as financially independent as possible while incarcerated, meaning that he has a job to pay for his own phone calls, stamps, and necessities, without having to enlist family support. Identifying specific family supportive goals and incorporating them into the inmate's treatment plan must be the foundation of any program.

The importance of visits, letters, and phone contacts should not be taken lightly. It has advantages for the family and inmate. For children, it is important to know where their father is, not just that he is gone. Sack, Seidler, and Thomas report that resumption of contact with the father, regardless of the location, is the most important element in visitation. Often prisoners do not want the children visiting and procrastinate actually having a visit because they simply do not want their children to see them behind bars. Visit accommodations vary from institution to institution. It is, however, important for the father

to be able to hug or have physical contact with his children. It is also very important to the child. Phone calls, letters, and visits have several barriers--distance, lack of finances, disciplinarian actions on the part of the inmate, access to phones, and other environmental factors. Staff should have knowledge of the inmate's family system and initially assist the inmate in setting up a plan of visitation. Family contact alone cannot change maladaptive behavior or family interactions (Carlson and Cervera). Family contact may initially reduce some depression or anxiety the inmate may be feeling as a result of this new incarceration. As already noted, inmates begin focusing more on issues inside the institution as time progresses. Other measures need to be taken to ensure an ongoing program of therapy is established. Individual counseling, group counseling, and parenting education classes are three alternatives that can be utilized to meet the needs of the inmate population.

Qualified staff should be made available to hold weekly group counseling sessions where incarcerated fathers can share information and provide mutual support. Parenting education classes educate the inmate on various parenting topics, i.e., including separation and fathering roles. Individual counseling or crisis

counseling is provided by most institutions. Individual counseling with focus on fathering and family issues need to be implemented. Family contact and family therapy during visits can also be part of a more direct intervention strategy with inmates. By incorporating family issues and goals into the treatment plan, and involving the inmate's family, staff can begin addressing the inmate's release early on in his incarceration. As the release date approaches, the father should attend counseling sessions to address release issues and how the family will be affected upon his release. It has been argued that inmates who have family support during and after their incarceration have lower rates of recidivism. When the father returns home, new anxieties and experiences for the entire family, especially between the spouse and the father, can often perpetuate the family into another crisis. Adequate family preparation and continued aftercare services are essential to the successful reunification of a father and family.

Families who experience the incarceration of a father often go through an unparalleled crisis. While imprisonment is only part of the process of family upheaval (Sack, Seidler, and Thomas), it constitutes the most identified part of the crisis. As the

incarceration begins, fathers may become more motivated to change behaviors initially and work on maintaining or improving relationships with their families.

Institutions need to offer services to fathers and must be aware of the father/family situation. While some fathers may attempt to manipulate offered services to meet their own ends, the overall need and importance to outside family members is prevalent. While all family members react differently to the incarceration, male children are possibly affected greater. In the Bureau of Justice Statistics special report surveying youth in custody during 1987, a report indicates that a majority of youth in long-term juvenile institutions had family members who had been incarcerated--approximately 51.8% in 1987. Other statistics from the Bureau of Justice Source Book indicates that in 1986, 37 out of 100 incarcerated inmates in state and federal prisons reported having a family member incarcerated. Carlson and Cervera report that correctional systems need to do more to maintain family ties in order to inhibit recidivism. They also need to link with community resources to provide more comprehensive services to all members of the family. Prisons need to develop specific programs that address family issues during the incarceration. Until more research and information is

developed in these areas, we will not begin to know the full impact that incarceration has on not only the father, but the other members in the family.

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Adaptation to Life Without Parole

by

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Presentation at

THIRD ANNUAL MENTAL
HEALTH IN CORRECTIONS
SYMPOSIUM

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Kansas City, Missouri

Currently 29 states and the federal government have a specific sentence of life without parole (LWOP) and more than 10,000 inmates are now serving this sentence in the United States (Corrections Compendium, 1990). In Oklahoma 102 inmates are serving a LWOP sentence, including eight women who are the object of this preliminary study.

The steady increase of the population serving LWOP has stimulated correctional administrators to get empirically derived information regarding the short and long term psychological effects of receiving and serving this sentence. Our study is partly in response to speculations in the media about the potentially devastating effects of the LWOP sentence.

[OVERHEAD TRANSPARENCY #1]

[Our Point of View: No-Parole Sentences: A Good Move or Bad?

The Norman (OK) Transcript, November 12, 1992

Speculations: LWOP creates problems for the prison system:

1. Must prevent any concentration of in-for-life, nothing-to-lose inmates
2. There will someday be a large population of hopeless lifers with nothing better to do than to plan ways to break out of there]

[OVERHEAD TRANSPARENCY #2]

[Death Verdicts Slip as No-Parole Grows

Daily Oklahoman, November 10, 1992

DOC policy ensures that LWOP inmates are not concentrated in any one institution. "Large groups of hopeless inmates would be more willing to challenge prison authorities."

Almost half of the LWOP inmates were under 30 when they came to prison. "Staying in prison for the rest of their lives will mean a long wait."]

In contrast to these speculations by the media and some correctional administrators, the women serving LWOP in Oklahoma have adjusted well. [A parallel study in the Oklahoma DOC of male inmates with "supersentences" is revealing a similar result.] Accordingly, the authors initiated a study of the style and psychological characteristics of the adaptation of the female LWOP group [N=8]. Since LWOP is a recent sentencing option, this study can serve only as a baseline of information that can be used to formulate hypothetical questions for later testing in both male and female incarcerates.

Casual observation of the LWOP women suggested that their predominant mechanism for facing the "reality" of dying in prison, the "reality" of never getting out, is intensive denial. This psychological adaptation to confinement has been described by Graham-Camp (1980). Her model consists of five stages, denial, mourning, rebellion, adjustment, and socialization; it is based on the grief process described by Kubler-Ross (1969).

[OVERHEAD TRANSPARENCY #3]

[The Graham-Camp Model in re Long-term Confinement

DENIAL

MOURNING

REBELLION

ADJUSTMENT

SOCIALIZATION]

A standardized clinical interview format was designed to clarify the type of psychological adaptation of each inmate to imprisonment. Seven of the eight LWOP inmates at the Mabel Bassett Correctional Center, Oklahoma City, volunteered to be interviewed for this study. The eighth inmate refused on the grounds that she was too busy and could not find the time to participate, saying "I have to take care of some schoolwork to help me when I get out." The Derogatis Psychiatric Rating Scale (1992) was completed for each interviewee.

[OVERHEAD TRANSPARENCY #4]

Denial Themes of Female LWOP Inmates

1. "I'll be out of here in five years.
You know no one has ever died in here."
2. "I've got people working on my case.
I'll be out within a few years, two or three.
I don't accept this life without parole.
Some people call it denial."
3. "I've submitted a writ of habeus corpus,
so I may be leaving Friday.
At most, I'll be here five years [laughed]."

[OVERHEAD TRANSPARENCY #5]

Denial Themes (continued)

4. "I think I'll be out of here sometime in
the next couple of years.
School helps me feel better about myself,
and will help when I'm out."
5. "I'm somewhat more hopeful than I was;
I should be out in five years."
6. "I'm going for postconviction early relief.
I'm very hopeful of a time cut.
Maybe I'll be here ten more years."
7. "I should be out very, very soon.
I have an excellent chance with this appeal.
That's 90% of what keeps you going."

Comments made by each inmate were clearly indicative of denial about their LWOP sentence. There was disbelief that they will be in prison for the rest of their lives, assertions that their incarcerations will not last longer than several years, and magical thinking associated with the likelihood of their inevitable release.

Clinical symptomatology as observed clinically and as reported by the inmates on the Derogatis Psychiatric Rating Scale (PRS) was consistently low. Conspicuously absent from each of the subjects were acting-out behaviors, symptoms of severe or even moderate psychopathology, and psychoticism. On all 17 of the primary symptom dimensions of the Derogatis PRS ratings of Absent, Slight, or Mild were typically achieved.

[OVERHEAD TRANSPARENCY #6]

Global Pathology Index

Derogatis Psychiatric Rating Scale Results

DISCUSSION

[OVERHEAD TRANSPARENCY #7]

Relationship Between LWOP and Capital Punishment

<u>State</u>	<u>Number LWOP (1990)</u>	<u>Capital Punishment</u>
Louisiana	2,073	YES
Pennsylvania	1,964	YES
Michigan	1,459	NO
Florida	864	YES
California	807	NO
Alabama	604	YES
Illinois	446	YES
Massachusetts	353	YES
Iowa	331	NO
Missouri	262	YES

The second phase of the presentation will include discussion of the following topics, as time permits. Question and answer participation will be encouraged.

1. Statistics in re use of LWOP and capital punishment

2. The need for "data-driven" decision-making in Total Quality Management. Example: Do "hopeless lifers" have to be dispersed in order to minimize management problems? The data would suggest that the nonlifers need the lifers for stability and role-modeling, not vice versa.

3. Our understanding of adaptation to LWOP relates to similar challenges and strategies of living both in and out of prison:

- a. General concepts of prisonization
- b. Suicide in jails and prisons
- c. Issues of death and dying, including being on death row, or being HIV-positive
- d. The psychodynamics of the sociopath, particularly how they deal with loss, depression, grief, and hope. Basic texts in this area include

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PSYCHOLOGICAL ASSESSMENT
IN A CORRECTIONAL FACILITY FOR THE ACUTELY AND CHRONICALLY ILL

BY

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PSYCHOLOGICAL ASSESSMENT
IN A CORRECTIONAL FACILITY FOR THE
ACUTELY AND CHRONICALLY ILL

Dean E. Fritzler, Ph.D.

Harold J. Nye, Warden

Roxey Smith, Major

The Larned Correctional Mental Health Facility (LCMHF) is a unique Correctional Facility similar in design, intent and purpose to only one other in the nation in Wisconsin. This one hundred and fifty bed Correctional Facility is designed for the treatment of acute and chronically mentally ill inmates.

This facility received its first inmates January 22, 1992. We have been in operation, then, for one and one half years and have gone through various phases. The institution has gone through stages of development that have to do with Intradepartmental growth accomplished as a result of training and becoming accustomed to the new facility and learning to accomplish the mission statement of this facility. Secondly, Interdepartmental growth has taken place on a parallel track, lastly, the process of the Psychological Assessment has gone through similar stages.

The different departments consist of Security, Mental Health, Activity Therapy, Classifications with its attendant Corrections Counselors, Medical Health Clinic, Chaplain, Education, Maintenance, Food Service, Substance Abuse, Training, I & I, and Personnel. Within each department there were some personnel who had worked in their field in Correctional Facilities before. Probably the larger percentage in each department had never been employed in a Correctional Facility.

Page Two Continued

Interdepartmentally there have been several different phases of growth. Most importantly, it seems, has been the improvement in the smooth functioning of this small tightly knit working society. This has come about partly by virtue of increased knowledge of the personalities involved in the other departments. A feeling of trust, camaraderie and respect has been the end result. As those of you know who work in corrections, one is always prepared to function in a crisis setting. Probably the best and the worst of one's strengths and weaknesses are highlighted during crises. As would appear obvious, progress in interdepartmental harmony has not come without some distress and bruised egos. Nevertheless, it has occurred and we are proud and happy to have accomplished this.

Psychological Assessment for the chronic and acutely mentally ill takes place at this facility within a psychotherapeutic treatment milieu. Security MUST be guaranteed a priori. Within the parameters of good security, all members of different departments are encouraged to contribute data to the assessment, treatment and eventual preparation for release of these inmates. To assist this process each living unit (there are five living units with thirty single man cells in each) has a Treatment Team. The mental health professional (who may be a Master's Level Social Worker or a Master's Level Psychologist) is the Treatment Team leader. Department policy and procedure requires that mandatory members of the treatment team include a Corrections' Counselor, the staff Psychiatrist, the Ph.D. Clinical Director, a Psychiatric Nurse, the Living Unit Correctional Officer and the Activity Therapist responsible for that living unit. In addition, the Department of Education, the Chaplain, Substance Abuse and the Director of Nursing attend Treatment Team meetings.

Page Three Continued

To aid in the transitional process from initial transfer to the facility to eventual transfer back to General Population, LCMHF has three levels of treatment. Inmates to transfer to LCMHF come in on Level I on the Segregation Unit where they are locked down for seventy two hours for the beginning assessment process. At the end of seventy two hours they go through a Segregation Review Board. They may be recommended to move to Level II. That recommendation is then considered by the Segregation Treatment Team. The Level II program is a transition between the "infancy" of Level I and the "maturity" of Level III. On Level II the inmate continues to be assessed by the individual members of the treatment Team (particularly the Mental Health Professional on that unit). When their behavior, emotions, cognitions and attitude are becoming sufficiently stabilized they are moved to Level III. On the Level III program inmates have available to them various educational and rehabilitative program five days a week. After-hour and weekend Recreation Activities are also made available.

In terms of specific Psychological Assessment, we were initially told prior to receiving the first inmates that there would be no need for Psychological Evaluation Instruments since the evaluation was to be conducted at the Reception and Diagnostic Unit in Topeka. The year and one half transition has provided us with data that require that we have available to us time and material for a Psychological Evaluation. RDU houses inmates a relatively brief time. Within certain parameters they do an excellent job of providing a beginning assessment. At the present time, if the RDU assessment indicates that an inmate is mentally ill and is in an unstable decompensated condition, he is sent directly to LCMHF. In addition, we are receiving more inmates who

Page Four Continued

present diagnostic problems for our colleagues in the field.

What seems to be the area of greatest improvement in regard to Psychological Assessment is a feeling of self-assured confidence by the mental health professionals that they can be sensitive to interdepartmental nuances when making team decisions in a crisis situation. On December 22, 1992, we had the first meeting of the Clinical Evaluation and Review Team (CERT). This is a team where inmates who present difficult diagnostic assessment problems can be referred for an indepth work-up. Activity Therapy, Psychology, Social Work, Psychiatry, and the Medical Clinic are all represented. Since December of 1992, this team has met weekly in order to carefully assess an inmate in order to arrive at the best possible diagnosis. All the treatments including medication, milieu, individual, group, activity therapy, substance abuse, education, etc. are all coordinated for maximum effectiveness within the goal of spending minimum time in this facility.

Each inmate has an Individual Treatment Plan (ITP) developed within fifteen day of transfer to LCMHF. If the inmate remains on Level I, this treatment plan is reviewed every seven days; on Level II the ITP is reviewed every fifteen days and on Level III every thirty days. Ultimately our objective is to have each inmate evaluated by the CERT team.

A few points need to be mentioned here. This is a facility for both the acute and chronically mentally ill. We have a small proportion of inmates who have a chronic mental condition who seem unlikely ever to be able to function appropriately in the general prison population. At this point we don't accept this completely, but in fact, at any given time there may be ten to twenty out of one hundred and thirty inmates who will probably be here until their CR or MAX date.

Page Five Continued

The tools used for psychological assessment include tests for Organicity; the MMPI-2; the MCMI; the T.A.T.; the Rorschach; DAP; and the Rotter Incomplete Sentence Blanks. Indepth psychological-neurological assessments are not made at this facility at this time. There are several different theoretical orientations that guide the assessment process but primarily we view the inmates as individual with both biochemical conditions and as people with inner conflicts. As Francis L. Carney, Ph.D., has stated in his book, "Criminality and Its Treatment: The Patuxent Experience." "It seems that many of our inmates have a 'need for structure' and 'a will to fail'." Through the wisdom and flexibility of the Administration at LCMHF, any reasonable innovation is welcomed on a trial basis. For example, we are presently developing a horticulture program and have begun a pet program where a Dalmation puppy is brought in every Friday afternoon and inmates are encouraged to sign up to have supervised play with the puppy for short periods of time. Interestingly, interactions by certain inmates with this puppy have provided evaluative insights that either provide us with confirmation of diagnoses or new information that was lacking. We recently acquired a aquarium and are hoping to provide the inmates with a bird atrium in the future. We would like to have as many and varied programs as possible to provide us with assessment data which then becomes used in the treatment plan for each inmate.

As part of the evaluation process one activity therapist focuses on a Functional Needs Assessment package which is used in classes with inmates in order to help prepare them for transfer into society. Leisure time activities, hygiene and socialization skills are lacking in many of these

Page Six Continued

inmates. For the mental health professionals, a year and a half of being in business has changed dramatically the onus of being On-Call for a week. Initially the person On-Call could count on being called out after hours to handle crises. It is interesting to note that how the number of calls has decreased. I think our lack of knowledge of personalities in the other departments contributed to the number of calls and to the accompanying instability of the inmate's mental condition. We truly do function as a team and have a fair idea of how we are going to resolve a crisis when we begin approaching the crisis situation.

At the present time, with the mental health professional On-Call for one week, there are a few calls that require on-site attention, usually during the day on Saturdays and Sundays. It has been our experience that with a mental health professional (this is by scheduled choice) in the facility until eight o'clock three or four evenings a week and occasional Mental Health Professionals making up time on Saturday or Sunday, the Mental Health Professional on-call receives virtually no calls during the week.

John D. DiIulio, Jr. in his work, No Escape: The Future of American Corrections, contends that, "There is no meaningful body of social science research on corrections; second, even if there were such a body of research, it would probably not affect the way most correctional policies are made or implemented; and third, except to academics, policy analysts, consultants, and others who have a direct intellectual, occupational, or financial interest in believing (and having the rest of us believe) otherwise, it is by no means

Page Seven Continued

clear that correctional supervisees, correctional staff, or average taxpayers would be better off were a social science of corrections to exist." He contends that social scientists, "generally aim to produce statements about human affairs that are (1) empirically true, (2) intellectually interesting, and (3) practically useful." He contends that we rarely succeed in producing such statements although we often claim to have done so and often succeed in convincing others that we have done so.

In terms of summing up the transition regarding psychological assessment of the chronic and acutely mentally ill at LCMHF, I think, indeed, that we are still trying to develop an Assessment and Treatment milieu where we can develop statements that are empirically correct and practically useful. Probably the most important aspect for accomplishing this still remains having a SECURE environment in which to assess and treat these mentally ill inmates in addition to having developed a sense of trust with each other. In a crisis we now listen carefully to input from other areas, particularly those with the most data. In many cases the line officers have the most data and the different professions, of course, have differing degrees of professional expertise to bring to bear to the assessment or treatment.

As Clinical Director it has been my impression that we continue to make progress. For example, I can think of two inmates, one who is schizophrenic and well medicated and one who has organic brain damage who, through the inherent interest on the part of either an Activity Therapist or Mental Health Professional have made progress beyond what anyone would have believed possible a year ago.

Page Eight Continued

During the coming years we hope to expect more of the same. Since the climate for responsible, creative and practical innovation is valued throughout the different levels of Administration, Security and other departments, warrant for the belief is well substantiated

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POST-TRAUMATIC STRESS DISORDERS AND DISSOCIATIVE
DISORDERS IN A CORRECTIONAL SETTING:

AFTER DIAGNOSIS, THEN WHAT?

BY

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3rd Annual Mental Health in Corrections Symposium
Kansas City, June, 1993

POST-TRAUMATIC STRESS DISORDERS AND DISSOCIATIVE DISORDERS IN A CORRECTIONAL
SETTING: AFTER DIAGNOSIS, THEN WHAT?

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Although numerous articles have appeared in the scientific literature on Post-Traumatic Stress Disorders and Dissociative Disorders, there has been little information published concerning an approach to these two DSM-III categories within a correctional facility. A search of the following data bases, a) National Criminal Justice Review System, b) Sociological Abstracts, c) Criminal Justice Periodical Index, d) American Psychological Abstracts, and e) Index Medicus, covering the past ten years yielded few pertinent articles. Furthermore these areas of interest have not been addressed in the journals published by The International Society for the Study of Trauma or The International Society for the Study of Multiple Personality and Dissociation nor has the correctional context appeared in the yearly conferences sponsored by these two organizations. This subsequent gap in the professional literature leaves correctional consultants and policy makers with few guidelines on how to address these problems within a correctional context.

The purpose of this forum will be to review assessment as well as treatment issues. Particular attention will be paid to interview and self-report scales that have been developed in recent years that offer diagnostic assistance in the determination of PTSD and MPD. The merits of these instruments will be discussed as well as their feasibility in a prison setting and relevance to the population.

In an institutional setting wherein treatment often means crisis management, what can mental health counselors realistically offer in terms of therapy to these clients? What resources are generally available? The experiences of the professional audience as well as this author will be elicited in an attempt to distill what has worked and what has not worked.

Finally, there will be a discussion on how institutional politics, cost, training, and issues of security impact on diagnosis and treatment. Bias towards diagnostic categories that lend themselves to psychotropic drugs will be debated. In closing, a discussion will focus on generating interest in the professional community concerning these disorders in a correctional setting.

13rd Annual Mental Health in Corrections Symposium
Kansas City, June, 1993

STRESS SYMPTOMS AMONG THE MENTAL HEALTH STAFF AT A PRISON UNDERGOING DRAMATIC
CHANGE: THE GWCI STORY

Gregory John Jarvie, Ph.D.
Associate Professor and
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Georgia Women's Correctional Institute

In the Spring of 1992, accusations of sexual misconduct, were brought against some of the officers and staff at the Georgia Women's Correctional Institute in Hardwick, Georgia. A class action law suit followed, along with numerous civil suits, criminal charges and prosecutions, and an extensive internal investigation. These events have subsequently led to major structural and policy changes within the institution itself, changes in the department of corrections statewide, and changes in staff and inmate views of the delivery of mental health services. This paper will examine the chronology of events leading up to such changes and their impact on a relatively small team of mental health counselors who were already assigned to this facility. The difficulties encountered in trying to provide care to the inmates, attempts on the part of the Department of Corrections to supply resources and support, and the psychological toll such stress has had on the counselors will be reviewed. This paper solely represents the views of the author, who has consulted to this facility for three years and has had a unique opportunity to observe the dramatic evolution of a staff during such a stressful transition.

I arrived at GWCI as a consultant in August of 1990. The director of Mental Health Services asked that I provide advanced training to counselors in topics ranging from diagnostics to treatment programming. At that time the census of GWCI was approximately 900 women, and the mental health case load hovered around 150 (divided among 4 counselors). There was a consulting psychiatrist who visited two or three days a week and one other consulting psychologist who visited one or two days per week. My own consulting time was increased from half a day to one and a half days per week within the first year. My initial impression was that the services were based on a triage model. The most severely symptomatic cases were seen first. Treatment was almost always crisis management with little time for actual therapy. Diagnoses tended to cluster around three diagnostic groups; anxiety disorders, affective disorders, and psychosis. There appeared a bias towards these groups since they were at least eligible for psychotropic medications. There was no program to house or manage Axis II (personality disordered) inmates. Post-traumatic Stress Disorder was rarely diagnosed, and Dissociative Disorders were not diagnosed at all.

Over the three years and with the breaking of the scandal, I observed the triage system collapse and with it the subsequent burnout of a mental health team that desperately tried to survive the transitions. I have organized factors that contributed to this burn out under three general headings: 1) structural and logistical limitations within the correctional facility, 2) lack of adequate and timely resources to provide mental health care and 3) the psychological impact of constant litigation and investigation on the staff. Lastly I will comment on the symptoms of the mental health team when sampled in October of 1992 and again in May of 1993.

STRUCTURAL AND LOGISTICAL PROBLEMS
CONTRIBUTING TO BURN OUT: THE FACILITY

GWCI was not built with mental health services in mind. The physical layout of the facility hindered efficient work. Counselor offices were housed in a building physically separated from the two units which housed the mental health inmates. The actual ward (the most severely disturbed inmates) was a fifteen minute walk from the offices or the file/documentation room. The building housing milder cases was a 15 minute walk the opposite direction. Counselors often spent over an hour a day (30 minute round trip) simply commuting between the buildings. Over a period of a week the cumulative walking time approached seven hours, or almost a working day.

Once inside the buildings there were few safe and private places to meet with inmates. Most were not sound secured, and outside noises were a chronic interference. In addition to not being conducive to therapy, such an arrangement served to inadvertently separate and divide the counselors. The result was a sense of isolation and increased vulnerability.

On the mental health ward, observation rooms were poorly equipped with outdated cameras and little if any, capacity for sound recording. None were (and are still not) equipped with VCR recording devices. Inmates could easily cover the cameras. This made it difficult to monitor the inmates and necessitated the officers frequently visiting the cells to ascertain inmate status. With no recorded tapes, it was difficult for the counselor to view the previous evening's highlights and make decisions about subsequent care and service. It was also difficult for the consultants to advise staff on treatment issues. The result was the sense of uncertainty about what happened in one's absence. Few of the officers assigned to these wards were trained in mental health, so descriptions tended to be biased towards security issues.

With bed space at a premium, there were usually no single rooms where grieving inmates could rest for a night or two after hearing bad news from home. Isolation and observation rooms had to be held open for acting out and suicidal inmates. Understanding this, inmates often earned a disciplinary report (acted out) with the specific purpose in being "locked down" so they could spend the evening in the relatively quiet and hassle free isolation room. Inmates suffering from flashbacks and abreactive events had nowhere to go in order to recover and learned to threaten self-harm in order to be placed in such a room to quiet their arousal. Under such conditions inmates frequently acted out or faked self-harm. The impact on the mental health team was to force them into conducting frequent mental status exams (with follow-up) on inmates that were not actually at risk. This drew the counselors away from their crowded case loads and caused resentment from inmates whose scheduled times were "bumped" by a more or less constant flood of pseudo crises. Counselors often felt they were running "pillar to post", with little resolution, and a chronic feeling of incompleteness and confusion. Finally, there was anger on the part of the counselors, who resented an inmate's manipulation of their valuable time for secondary gain.

The mental health ward had no second or third shift counselor coverage. There was no weekend coverage. Emergencies were phoned to the counselor on call, who gave the duty officers instructions on how to proceed. If the situation was serious enough, the psychiatrist was called and instructions taken over the

phone. After Spring of 1992, counselors on call were expected to return to the institution and make decisions from actual contact with the observing officers or the inmates themselves. It was common for the counselors to return to the institution several times a night and in the early morning. Most of the inmates suffered sleep disorders and nightmares so counselor visits were frequent. This schedule of being on call (two days at a time), and the subsequent sleepless nights, created fatigue and sleep problems among the counselors.

At GWCI, once an inmate was assigned to the mental health case load, she temporarily lost her general population counselor. The general counselor typically assisted the inmate with visitation changes, parole petitions, phone calls, store privileges, resolution of interpersonal conflicts and squabbles, roommate changes, mail call, etc. Losing the general counselor meant that these duties then fell under the jurisdiction of the mental health counselor. In a system where the inmate is dependent on a staff member for this assistance, it was common for therapeutic time to be derailed by these pressing concerns.

With an understanding towards a need for security, "count time" represented a daily hassle for mental health caseworkers. Twice during the regular work day, count was taken. All inmate movement was frozen for up to an hour until the population was accounted for. In order to compensate for this event, inmates were usually called in advance of count, but also in advance of their actual appointment times. This led to inmates waiting for their appointments for 1/2 hour to 2 hours, with little to do. Often when the counselor did see the inmate, the inmate was angry at the lengthy wait. This became yet another source of resentment between the care provider and the receiver. There seemed little counselors could do to alleviate the problem.

With medical services, mental health services, and security being three distinct divisions within the institution, communication breakdowns were common. Physical separation (structure) of these areas further contributed to the problem. The result was typically a lack of closure for the mental health caseworker who was trying to coordinate medical tests and follow-up with a client. Security often saw abreactive events and flashbacks as belligerence and issued disciplinary reports. Dissociative experiences were usually seen as noncompliance at best and refusal to follow orders at worst. Thus the inmate was viewed differently by the three agencies and reacted to in ways that were seldom collaborative. Finally, there were often times when it was difficult for the outside consultants to coordinate with the in house counselors. Since none of the doctoral level people (or MDs) were full time, meetings were frequently needed to share information. The down side of frequent meetings is, of course, little time for interaction with the inmates or the required daily charting. Counselors developed a love/hate relationship with meetings. They sometimes resolved confusion but absorbed time.

LACK OF PERSONNEL AND RESOURCES CONTRIBUTING TO STRESS AND BURNOUT

It became clear to me that with so many inmates in need of psychological services, and so few counselors, that crisis management was all that was possible. Inmates who suffered quietly were seen infrequently, bumped by the more severe cases of psychopathology or by the behavior of the Axis II inmates who absorbed a disproportionate amount of counselor time with seemingly little return on the investment.

Following the break of the scandal, change in leadership at the institutional level, and policy shift in the Department of Corrections towards women's services (from an incarceration model to a treatment model) resulted in the contracting of several outside consultants to provide therapeutic services to the inmates making allegations towards staff. This was seen as a necessary response since many of these women were revictimized by the events. Despite good intentions, these outside consultants (who commuted 2 hours) were quickly booked, leaving little time for the other mental health inmates (whose ranks had by now swelled to 250). Several trauma groups were started and well attended by inmates, but such groups were long term and those involved reserved the professional's time for the duration.

Staff turnover became a problem. Within a span of a year the institution gained and lost three consulting psychiatrists. Continuity of care was disrupted, which only added to the frustration felt by both inmates and counselors. At present we have three new part time psychiatrists. Two of these consultants come in the evenings, after hours. The result is that they are not present during staff meetings the next day when cases are reviewed. Communication breakdown is common at this juncture.

In an effort to relieve the counselors of some of the work load imposed by the loss of the general counselor, the central office authorized emergency assistance in the form of a "mental health counselor assistant" (new employees without master degrees or experience). These were temporary positions, hired to assist the counselors in the nuts and bolts of inmate concerns, but they were frequently pulled away to sit with the psychiatrist during inmate interviews. This caused concern among the counselors who felt that their resource was being divided among the outside professionals. Coordination of treatment planning required frequent staffings which only further absorbed counselor time.

Appeals for more trained therapists, were heard in the central office in Atlanta. However, there is a general unwillingness to fund the amount of consultant hours necessary to meet the overwhelming need (as dictated by a therapeutic model). Full time state positions (counselor positions), have not been forthcoming. A therapeutic model is expensive, and does not enjoy taxpayer support in the state of Georgia.

Finally, there seems to be a lack of appreciation for the type of clinical work one encounters in a women's prison. The majority of women on the mental health caseload suffer symptoms related to historical trauma. The sheer number of these cases encountered by the counselors is staggering. One can only hear so many of these stories of child abuse, sexual abuse, and violence in a given day before one begins to emotionally numb. A therapist needs to decelerate and gain perspective. With such high case loads, one-on-one interaction exposes a counselor to constant vicarious trauma. Coupled with the knowledge that there are few actual services for these women, a sense of helplessness is created among the staff bearing testimony to these terrible memories and abreactions. This needs to be considered when asking an institutional staff to move from crisis management to a therapeutic format.

IMPACT OF LITIGATION AND INTERNAL INVESTIGATIONS CONTRIBUTING TO BURNOUT:

With an ongoing class action suit, and civil litigation and criminal investigations (it is a felony in the state of Georgia for a correctional employee to have sex with an inmate), the climate has become one of fear over the threat of malpractice. The mental health counselors have felt uncertain about the state's willingness to support them should they be named in a legal proceeding. Depositions and testimony in ongoing cases take time and energy, and the counselors feel intimidated by legal processes. They feel that every clinical decision is going to be second guessed by a lawyer (unfamiliar with the true working conditions and mental health services), an internal investigator, a supervisor and even the inmates themselves. Documentation becomes a fetish enterprise, in which the motivation is negative reinforcement. Increased time documenting files results in fewer inmate contact hours and further contributes to the sense of non-closure among the counselors.

The civil suit has sparked a major shift in thinking within the central office in Atlanta; however the attempt to meet demands for a standard of care demanded by the litigants' lawyer has not been easy. A rush to instill therapeutic programs did not have the proper resources to launch much less sustain, such an effort.

The highly visible presence of lawyers has raised inmate expectation about the availability of services. In reality the demand far exceeds what is possible at present. Despite some impressive new leadership in the central office, the necessary resources have still not arrived. Inmates find this frustrating and bitterly complained that services promised explicitly or implicitly aren't actually available.

With intense media coverage over the past year, and the institutions visibility in the community, several counselors feel that they are indirectly tainted by the investigations. Few will discuss their jobs or acknowledge their employment with state corrections. Many feel that they are being punished for the behavior of a few members of the staff and that their own efforts towards the delivery of services are underappreciated and held suspect.

PSYCHOLOGICAL CHANGES AMONG MENTAL HEALTH COUNSELORS: THE COST

The turmoil and increased demands of the job have resulted in the majority of mental health counselors entering into personal psychotherapy and electing to go on antidepressant medications. Work related stress has resulted in exhaustion, sleep disturbance, somatic complaints (such as ulcers, headaches, weight loss, muscular pain), extreme mood and behavioral changes, sexual dysfunction, emotional distancing, decreased emotional control, constant feelings of being trapped, and inability to concentrate. Most have felt increased anger at inmates, increased problems with marital partners and family, and social isolation from friends and peers. Cynicism, dark humor, and expressions of hopelessness and helplessness mark the mental and emotional environment of the workplace.

Too many staff and leadership changes within the past year (despite the fact that many have been for the better), work overload, too many seriously disturbed and suicidal patients, too many manipulative and para-suicidal

patients, and too little resources have taken their toll. As of this writing, one counselor has already left corrections, most others have indicated an interest in leaving the field.

As a post-script, a decision was made in the spring of this year to move GWCI to Atlanta. The move involves swapping populations with a male facility. It is of great concern that they be prepared for the transition and that resources be made available once the institution moves. As a mark of final cynicism, the counselors have unofficially estimated that the Atlanta staff won't last a full year before complete turn over in mental health.

It is hoped that the sharing of these events and their impact will prompt discussion on how departments of correction in other states can anticipate the cost of such dramatic transistions on their institutional staff, the inmates and the mental health team.

A PTSD treatment program for combat veterans in prison

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Running head: Incarcerated combat veterans

Abstract

Veterans who served in Vietnam were exposed to a set of circumstances never before experienced in modern warfare. Within this population came a not-so-new disorder, renamed to Post-Traumatic Stress Disorder (PTSD). PTSD victims suffer unique characteristics that may show a disposition to criminal activities. The Vietnam veteran comprises a subpopulation of the prison system and within this population are those who suffer from PTSD.

A treatment program for combat veterans with PTSD in prison is described. The prison setting presents a "survivor mode" environment, similar to that of Vietnam, in which incarcerated veterans may re-experience the PTSD symptoms. Further, they revert back to a "combat mode" when handling their prison life.

The "PTSD Treatment Program for Combat Veterans" focuses on three dimensions in treatment. The first dimension pertains to the group itself. In prison, the group becomes the veterans new "squad", the only entity the veteran can trust. The group progresses through 6 stages. These stages can blend together during intervention or be separated out and defined as: 1) the 2nd tour (re-experiencing life in a survival setting), 2) stress management, 3) veterans, PTSD and crime, 4) conflict resolution, 5) handling symptoms of PTSD, 6) the effects of PTSD on the family.

The second dimension is individual psychotherapy. In this dimension the veteran's unique symptom picture is treated with various techniques, dependent on the veteran's need, to include; rational emotive therapy, reality therapy, behavior modification, hypnosis and biofeedback. The third dimension is a mini-series of various video films of the Vietnam conflict. Videos would be discussed, critiqued, and the veteran's feelings examined.

Numerous legal actions have been filed on behalf of veterans suffering from PTSD. Some of these actions have included cases specifically challenging the lack of treatment programs for veterans in prison. This paper presents a model that could be used to serve this need.

Introduction

It has been estimated that between 500,000 to 1,500,000 (Walker & Cavenar, 1982) of the veterans who served in the Vietnam conflict have suffered from Post-Traumatic Stress Disorder (PTSD). PTSD victims manifest a specific constellation of characteristics which include behavioral, social, and emotional disturbances, following exposure to an identifiable stressor which "is outside the range of usual human experience" (APA, 1987). Vietnam veterans with PTSD show a composite symptom picture which may include; recurrent and intrusive recollections of events, recurrent dreams of events, distress at exposure to symbols of the events, continued efforts to avoid their thoughts and feelings, feelings of detachment from others, restricted range of affect, insomnia, a sense of a foreshortened future, hypervigilance and difficulty concentrating.

Military veterans possess a unique background of skills, such as hand to hand combat, use of weapons, survival skills, defensive tactics, and possibly specialized skills in explosives and detonation, search and destroy, infiltration, area studies, and intelligence gathering. In the context of battle, these are necessary skills which fulfill military objectives and provide for the well being of the soldier. These skills become detrimental to the veteran when taken out of the battle context and used in the context of civilian life.

The Vietnam veteran was exposed to a set of circumstances combat soldiers of previous wars had not experienced. In Vietnam, there was no front line, and in reality there was no front and back to a combat zone. The war was all around the soldier. Being in a foreign land, the soldier really did not know who were the "friendlies" and who were not. A Vietnamese barber, working in a base camp, turned out to be Viet Cong spy, who later turned on the same soldiers whose hair he cut. In order to make it out of Vietnam it was necessary for the soldier to adopt the "survivor mode" (Wilson & Ziglebaum, 1983). For some, however, once the tour in Vietnam was over, the survivor mode did not "shut off." The Vietnam veterans return home only exacerbated their psychological dysfunction. Unsupportive numbers of anti-war proponents, from all walks of life, did little to support the veteran as they attempted to reintegrate back into normal society, thus, the survivor mode continued.

PTSD Vietnam veterans have been found to show a high incidence of criminal behavior (Erlinder, 1984; Wilson & Ziglebaum, 1983). Wilson & Ziglebaum (1983) have attributed this criminal behavior to the perseveration of psychological functioning within a "survivor mode".

Out of approximately 71,000 incarcerated inmates in the Federal Bureau of Prisons, nearly 10,000 are reported to be armed services veterans (Office of Research, 1992). A conservative estimate of 10% would indicate that nearly 1,000 incarcerated veterans may suffer from PTSD. But as the above studies indicate, criminal behavior is exhibited disproportionately more often in those veterans who have PTSD. Thus, a more accurate percentage may be 20% of the inmate veteran population, or closer to 2,000 inmates.

In the last several years an attempt has been made in Congress to mandate treatment for incarcerated veterans through the house bill H.R. 1181, also known as the "Incarcerated Veterans Rehabilitation and Readjustment Act of 1991". If this bill is passed, the Federal Bureau of Prisons would become responsible for the psychological treatment of veterans incarcerated within their facilities. This paper describes an existing program of treatment for incarcerated veterans suffering from PTSD. It can be used to compare and contrast with other veteran treatment programs currently in operation in both state and federal facilities. It can also be used as a working model for

implementation in facilities without PTSD treatment programs.

Who are we dealing with

The age cohort of Vietnam veterans that could possibly commit criminal acts falls between 38 and on up. The treatment program should not be restricted to just Vietnam veterans. One of the program participants was a Prisoner of War (POW) victim of the Korean War. All of the other participants were Vietnam veterans. The participants in this program were all male. At the Federal Correctional Institution, Phoenix, Arizona, the PTSD veterans were incarcerated for various offenses to include; bank robbery, drug related offenses, terroristic threats, weapons offenses, making false statements to the Veterans Administration, aggravated assault, and bomb threats. About half of the group was married with children. Regional differences dictated the ethnic composition of the group, three were Native American, one black, the remainder caucasian, out of a total group of thirteen. All of the participants were volunteers.

Overview

The PTSD treatment program consists of three treatment dimensions. The first dimension pertains to the group. Within the group dimension are six stages, or sub-groups, which can be identified as; 1) the 2nd tour, 2) stress management, 3) handling symptoms of PTSD, 4) veterans, PTSD and crime, 5) conflict resolution, and 6) the effects of PTSD on the family. The second dimension focuses on individual psychotherapy. The third dimension utilized various videos the group used to analyze and understand the Vietnam conflict from a different perspective.

The first dimension: the group experience

In Vietnam, the squad became the soldier's sole defense against the enemy. The soldier lived with his squad 24 hours a day, sharing the same experiences, the same bunker, the same food, the same misery, and the same success. The squad was the soldier's family away from home. It provided protection from the elements and the reassurance that they would all make it out of there. A common theme stated by Vietnam veterans upon returning to the United States was that the only people they could trust were their fellow squad members.

In prison, the group becomes the veteran's new squad. The squad is the only group of men the veteran feels he can trust in prison. The bond between squad members is more than the common experiences they shared in Vietnam, that only provides for the bona fides of joining. Once their bona fides is validated, then the real reason why they bond in prison is acted upon. The fellow group member takes on the same role as the squad member, they provide protection against the elements and the reassurance that they will make it out of prison.

From a therapy point of view, the group takes on a deeper meaning. The squad members are no longer young, energetic, and pathology free soldiers. They are now older, set in pathological ways, and suffering from a traumatic condition. The group needs to cross a new boundary into the realm of enduring pain, exposing defensive fronts, providing reassurance that a fellow group member can lay open their basic vulnerabilities, and support that member in growth. This is a totally different experience from that of being a member of a squad.

A significant aspect to the cohesive running of the group was the trust and respect the group has in the group leader. It takes time, effort, and genuine concern on the part of the therapist to become part of the group. This does not mean the therapist is absent of control and leadership, but these qualities need to be put into perspective. The therapist is working with a group of veterans who will never let an outsider into their midst. The

therapist is a staff member, a representative of the same government that sent them to Vietnam and now, put them into prison. One way the therapist can overcome the obstacle of being an outsider is to maintain the following perspectives; clarity, honesty, respect and trust.

The 2nd tour

The group progressed through six stages or mini-groups. These groups can be presented as independent entities, or mixed together and blended. The stages will be presented as independent entities so as to provide a clearer conceptualization of their meaning. The first of six stages the group progresses through was "the 2nd tour." The 2nd tour was the reexperiencing of a hostile environment in which it was necessary to rely on survivor skills just to be able to exist. This was what the Vietnam veteran did the first time he was in Vietnam. A small number of veterans returned to Vietnam after rotating out of the country at the end of their normal duty. For them, they reexperienced the same hostile environment they previously served in. This return to Vietnam was called a "2nd tour" for the returning soldier.

That same experience takes place in prison. As in Vietnam, you never know where or who your enemy is. You are always in a state of possible danger. There is no front line. You are told what to do. Your life is not totally in your control, and you have a set amount of time you must serve. There is no such thing as "total relaxation."

This group focuses on the similarities between the two environments of Vietnam and prison in three realms; affect, behavior, and cognition. A particularly difficult area for men to deal with and understand is that of feelings. Once trust has been established in the group and with the therapist, the area of feelings can be explored. In the examination of initial presentations, the group discusses the etiology of fear, other feeling states, and the role of defense mechanisms. The inmate can be shown how defenses work as an adaptive mechanism to promote survival. Initial discussions of feelings can be presented in a didactic forum, but more intensive programs can be used. For example, bioenergetics provides many useful exercises that can be used to facilitate feeling states.

An important aspect of this group examines each inmate's combat ready mode. Vietnam veterans handle situations in prison in a similar manner as they handled existence in Vietnam. For example, one inmate used a passive behavioral mode of avoiding conflict in Vietnam. He handled situations in prison the same way, by avoiding them. Other inmates were constantly "combat ready", and stalked the compound like they stalked the bushes in Vietnam.

The predominant cognitive pattern was that of the survivor mode. They made it out of Vietnam because they were survivors. They made it on the street as survivors, and they see their life in prison the same way. Thinking in a survivor mode all the time establishes a self-fulfilling prophecy which is reinforced by being able to make it from day to day. If life starts going good for them, they may sabotage it so as to return to the survivor mode. Life is a recurrent pattern of existence in an atmosphere of danger.

A particular ethical dilemma presents itself. The therapist strives to provide for a healthy change in the individual, but it may be difficult to gain that given the working environment. The inmate needs to be able to "make it" in prison. The Vietnam veteran inmate is well equipped to handle the unpredictable and dangerous environment of prison. To effect change, the therapist may feel he or she has to break the veteran out of the survivor mode. But by breaking the veteran out of this mode, the therapist robs them of the only defenses they have to survive prison. A precarious dilemma is created.

Making the inmate aware of the survivor mode, and how they are using it in prison, can provide clear evidence of it's existence in them. One of the problems in psychotherapy is denying the existence of conditions. Once the inmate recognizes how he acts and thinks, it can be shown to him how he probably used the same survivor mode while on the street. Situations prior to incarceration can be compared and contrasted to the survivor mode, and the life style mode used by the inmate prior to Vietnam.

Stress management

An important aspect of the veteran's psychological dysfunction that needs to be addressed is his inability to handle stress. Some may argue that the Vietnam veteran has admirably shown how he can handle extreme levels of stress. The problem, however, is that he has adjusted to inordinate amounts of stress which has had a negative effect on his body.

Stress management provides several coping techniques the inmate can use to reduce the effects of stress on his body. It focuses on both a cognitive and behavioral/physiological components of stress. Rational emotive therapy is used to educate the veteran as to how one's irrational beliefs contribute to the production of negative feelings. Stress can be reduced when situations are appraised using more rational thoughts. Two relaxation techniques are then taught which focus on the physiological aspect of stress. The Jacobson Progressive Muscle Relaxation method is taught and practiced in a group. The inmate is guided through two or three relaxation sessions and asked to assess the change in stress. The emphasis is to become aware of the feelings of relaxation. The second relaxation method taught is that of self-hypnosis. The inmate is guided through a simple induction technique, asked to focus on a relaxing stimuli, deepened, then asked to assess the method. Some veterans have difficulty with hypnosis and imagery techniques because of an inability to prevent recurrent images of the war from invading their memories.

The inmate chooses a relaxation technique, suitable for his individual characteristics, and encouraged to practice the technique once a day. Practicing a relaxation technique presents a problem in some prison settings. It is difficult to find a quiet place in which one feels secure enough to close his eyes, and allow their body to relax. For those who are particularly paranoid, a buddy system has been used. A fellow veteran the inmate trust, keeps watch while he practices the relaxation technique. This allows the veteran the time and privacy to relax. For those familiar with corrections, inmates routinely use "lookouts" to engage in various illegal activities. Unfortunately, there is no better alternative because of manpower and room constraints. In those facilities with sufficient space, a small room could be used for individual relaxation. This room could also be equipped with bio-feedback equipment to allow the inmate additional relaxation training. A third alternative is to use "white noise" as a background to drown out the talking and noise of the prison. "White noise" can be created by having the inmate listen to pure static through his earphones on his radio. The volume is adjusted so as to cancel out the sounds of the prison. The inmate can then practice the relaxation procedure with a background of "white noise".

An additional stress management technique is cardiovascular exercise. Most prisons have exercise yards and tracks which afford the inmate the opportunity to exercise. Veterans are encouraged to maintain a program involving a level of exercise appropriate to their physical condition. Resistant inmates can sometimes benefit by working the program with a "buddy". Veterans at similar physical levels are paired with each other, and placed on a moderate exercise program. The primary components of the exercise program include stretching, calisthenics and brisk walking. More physically advanced inmates use a combination of running, weight lifting, and more intense athletics. Those capable of maintaining an exercise program are regularly asked as to their

participation in the program, the effects of the program, and encouraged to continue the program.

The final component of stress management examines the inmate's diet and the effect of food on stress. The effects of caffeine, salt, and high fat substances are presented. How the inmate eats is as important as what the inmate eats. The eating habits of the inmate are discussed, and the effect of eating regular meals on metabolism. Healthier habits are suggested dependent on the individual's needs. This could include changing the food portions, the frequency of eating, the content of the meals, and the addition of vitamin supplements.

Handling symptoms of PTSD

After the veteran is provided some tools to handle stress, the focus of the group sessions shifts more to the individual's PTSD symptom picture. The veteran discusses and relives his experiences while in Vietnam. A useful adjunct to this procedure is to video tape the inmate (Kerr, 1992). During an individual session the veteran is video taped while answering questions from the therapist about his Vietnam experiences. This video tape is then played to the group. The group's responsibility is to question the veteran on his feelings about selected aspects of his in-country experiences. The group is also tasked with identifying any changes in non-verbal or verbal messages given by the veteran.

The reactions, feelings, and thoughts of the veteran are placed in the context of Vietnam. These feelings, actions and thoughts are then explored within the context of adaptivity, survival, and military regiment (which includes training and orders). The circumstances in Vietnam are examined as the identifiable stressors preceding the formation of PTSD.

The next phase of this subgroup examines the reactions of the veteran after returning to the United States. Several of the group reported engaging in conflict with anti-war protestors in airports. The myth of the returning hero is contrasted with the political climate of the '60's and '70's. Some of the veterans were not totally familiar with the rationale of the anti-war protest. Part of the video mini-series, reviewed below, helps set the stage for an understanding of the anti-war protestors' mentality.

A significant portion of this phase is spent in examining the symptom constellation of PTSD. An important component to this examination is the connection made to the stressor and the demonstration of the individual symptom. Of particular concern is the symptom of hypervigilance. It is not difficult to find several situations in which the Vietnam veteran needed to behave in a hypervigilant mode. This is tied to the veteran's need to survive, and need to protect his fellow soldier. This same behavior is used in prison to insure survival.

Other recurrent themes presented by the veterans were their inability to sleep, nightmares, waking up with the "sweats", survival, thoughts of vulnerability and the need to be in control. The effect of the anxiety symptoms on other areas of the inmates' functional living are also examined.

The final aspect of this subgroup is to identify those external stimuli, originally experienced in Vietnam, that trigger combative reactions in the veteran. Each veteran describes his unique stimuli and their reactions to it. Other potential stimuli the veteran may react to when not in a combat situation are discussed. Any similarity of Vietnam stimulus to present day stimuli, such as gunfire from a nearby pistol range, are examined.

Veterans, PTSD, and crime

The fourth subgroup examines the criminal behavior of each veteran. Erlinder (1984) identified several behaviors veterans' with PTSD may use in criminal actions which included; thrill seeking, suicidality, and dissociation. For those veterans who utilized a similar behavioral pattern of dealing with stress as they did in Vietnam, a consistent mode of action can be shown. For example, one veteran while working through the individual experiences of combat, showed evidence of dissociation as a way to deal with external stress. His accounts of Vietnam combat raids showed a dissociative process at work. The only way he could cope with this trauma was to totally "distance himself" from the events, describing the experience as being within a "cloud like" environment. When he described his criminal activity of robbing a bank, the same dissociative experience became apparent. He felt as if he was "in a trance", prior to and while committing the crimes. What is interesting about his crimes is that they were all within a mile radius of his house. This veteran was not a sophisticated bank robber. He committed the crimes under the duress of a need for money to pay basic needs. Prior to the commission of the crimes he stated he dissociated from society, choosing a passive-aggressive stance as a mode in which to handle stressful situations.

Another, more common theme, was the need to have excitement. Vietnam provided an excitement, an "edge", that no longer existed when they returned home. Two of the veterans reported driving at dangerously excessive rates of speed. One, looked forward to the "rush" he felt while driving his motorcycle in excess of 120 miles per hour on isolated back country roads. Some of their descriptions resembled an addiction to excitement. It was as if they had an insatiable need to get "high" from a thrill.

Another veteran had several incarcerations for drug related offenses. He began using drugs, specifically heroin, in Vietnam as a way of dealing with the combat experience. This behavior started after he lost several close "buddies" during combat. He was unaware of the survivor guilt he carried because of their loss. After the war, he repeatedly overdosed on large amounts of heroin. His use of heroin was an attempt of suicide, to join his departed "buddies", and to gain forgiveness for what he perceived as his negligence resulting in their deaths.

Conflict resolution

Conflict resolution focused on alternative ways to handle and solve problems. It was a compilation of several strategies; decision making, self-acceptance and assertiveness. Many incarcerated felons have significant problems evaluating situations, setting goals, determining strategies to solve problems, then implementing those strategies. Decision making and problem solving strategies were examined, practiced, and applied to real life situations.

Resolving interpersonal conflicts was another aspect of this sub-group. For example, some of the veterans would be in a constant state of drunkenness. The alcohol would impair their decision making abilities. They would be confronted by a loved one, friend, or even a stranger, and their reaction to this confrontation would be a rage or assaultive behavior. This scenario contains many pathological aspects. In order to fully understand the dynamics involved it was necessary to understand the effects of PTSD and how the veteran self-medicated via alcohol or drugs. The veteran was shown the importance of recognizing his pathology and a need for help. Self-acceptance was promoted and if appropriate, tied into the philosophy of a 12 step program.

The final phase of this sub-group was learning how to handle problems assertively instead of through anger or repression. Exercises were provided

and daily situations examined to reinforce an understanding of assertive interpersonal processes.

The effects of PTSD on the family

The final sub-group brought in the veterans' relationship with his family. Various relationships were described by the inmates. For some, the family was a source of support, love, and contentment. For others, however, the effects of PTSD had effected the veteran's ability to maintain healthy interpersonal patterns with loved ones. Many of the veterans had numerous divorces and failed relationships with mates.

Interpersonal relationship patterns were examined. Distancing, repression, and a lack of assertiveness were common themes in the dysfunctional relationship patterns. This theme was shown to be an element consistent with the PTSD symptom picture. Another element was a change in the quality of trust in the relationship. The veteran's trust with his fellow squad members appeared to be motivated by a sense of fear. This is not the same type of motivating factor behind the trust found in normal heterosexual relationships.

Failed and successful relationship patterns are discussed in group. Scripts used in dyad interactions are examined and how the inmate replays these same scripts over and over in relationships. Healthy scripts were contrasted with those found in dysfunctional relationships. Patterns of interactions between inmates in prison are quite different from those between people outside of prison. It was thus difficult to generalize from prison to normal civilian patterns of interactions.

To help facilitate a better understanding and implementation of healthy interpersonal behavior patterns, the inmate is requested to enlist the cooperation of their mate. Those inmates participating in an ongoing relationship with someone outside the prison describe the sub-group to their mate, and obtain permission to share their letters and communication with the group. The group then applies what it has learned in script analysis, problem solving, and assertiveness, to current interpersonal relationships.

Sub-group sequence

The order of the subgroups can now be discussed. The 2nd tour is designed to let the veteran know that the feelings and mode of action he is having, when entering prison, are similar to other veterans. These are the feelings of the survivor mode originally felt in Vietnam. Stress management gives the inmate tools by which he can reduce the stress he is feeling. It also provides a way of handling the reexperiencing of the traumatic events started in Vietnam, and those that followed. The third subgroup, Handling symptoms of PTSD, returns the veteran back to the traumatic stressor. The events of the past are recast using the knowledge of today. The PTSD symptom picture is examined and how it has impacted on the veteran's life.

Veterans, PTSD, and crime examines the veteran's mechanisms for coping with the stressors of Vietnam, and whether those same mechanisms were active during the commission of their criminal acts. By this time the veteran has a better understanding of how PTSD effects his behavior and his mood. The fifth subgroup, Conflict resolution, continues the examination of the veteran's behaviors and stresses the need for self-acceptance. It provides alternative ways of handling stressful situations by being assertive instead of being assaultive. It examines how the veteran could have handled life problems in different ways, which could have resulted in more positive outcome.

The final subgroup, the Effects of PTSD on the family, uses the techniques learned above, and places them within the context of family problems. By this

time if dysfunctional interpersonal relationships exist they will have been shown. The family becomes the primary support group for the veteran. Unfortunately, with some veterans it is the family which is most harshly treated. A further reason for running this group last, is that an attempt is made to give the veteran a composite picture of what has happened to him, and how it has affected those around him.

The second dimension: individual psychotherapy

Various therapy strategies were utilized dependent on the needs of the veteran. These techniques include cognitive-behavioral therapy, reality therapy, hypnosis and biofeedback. Cognitive therapy served as the primary foundation for the individual therapy session.

During the individual sessions, the inmate's thought process and content were examined. One of the inmate's presented a dysfunctional pre-military life which contributed to his current symptom picture. The events of Vietnam reinforced irrational beliefs, reinforced unhealthy values, and negatively influenced a psychological system minimally equipped to handle the stresses of life.

The remainder of the inmates presented a satisfactory developmental life history, up to their experiences in Vietnam. None of the inmates reported a significant criminal event prior to Vietnam. Several of them reported minor law violations involving underage drinking and/or marijuana use, and several moving traffic violations. The individual sessions focused on the thinking patterns unique to each inmate, and how their maladaptive cognitions effected their behavior and feelings.

Those inmates suffering sleep disorders, and other physical effects, were taught how to relax using biofeedback. Hierarchical desensitization with the assistance of biofeedback, enabled the inmate to gain control over disruptive images, thus reducing the physical symptomology.

The third dimension: a video review

There are many videos about the Vietnam conflict. These include "The 10,000 day war" series, "Vietnam home movies", educational/documentaries, and several popular movies. These videos were used to analyze the Vietnam situation from a new perspective.

Most of the veterans entered the Vietnam conflict as young, immature men. Their life experiences entailed 18 to 20 years of life. At that time in their life, the recent high school graduate had no knowledge what Vietnam was, why we were fighting there, nor why he was being sent there. All he knew was what he was told in military training and any extra reading he may have done. All of the veterans in this group had minimal knowledge as to the political and military reasons behind the Vietnam conflict. This lack of knowledge only contributed to their sense of being used in a senseless war.

The video series, "The 10,000 day war", provides a historical understanding of what preceded United States involvement in Vietnam. This, and other documentaries, provided an education the veteran never had. The videos were reviewed and discussed by the group. One important aspect of this was developing an understanding of why some Americans protested the war. When the veteran was in Vietnam, he was not always totally aware of the rationale behind the anti-war movement in the United States, and the impetus the movement had.

Examining the war from an older, more mature, perspective, provided a necessary element to understanding the condition. In most inmates, a contrast

was created; knowledge of the war as a young man versus knowledge of a world situation in a broader perspective. When the narrow and the broader perspectives were compared, the narrow schemas, the throw-backs in time, took on a different meaning. The Vietnam conflict could be understood utilizing a more logical, historical interpretation.

The popular movies, such as "The Deer Hunter", provided an emotional review of Vietnam. Group discussions after reviewing such movies centered more on feelings and emotions. It was important to allow sufficient time for the processing of fears and feelings of anger, rage, and guilt. These movies allowed for a cathartic release, revitalizing old memories. Some of the inmates reported renewed sleep disturbances and physical complaints. Those inmates were provided additional individual therapy sessions specifically addressing the symptom picture.

Additional services

Several auxiliary treatment services were available. A significant treatment concern for this group was substance abuse. All of the inmates in this program reported a drug and/or alcohol problem. FCI, Phoenix was fortunate to have a 500 hour resident drug treatment program. Half of the PTSD group participated in the drug program. This became a significant issue for one veteran.

One of the veterans wanted to continue in therapy for his PTSD, by entering a Veteran's Administration Hospital resident PTSD program at the completion of his sentence. Contact with the local VA hospital revealed that this particular program required the prior completion of an in-patient drug treatment program before entering their PTSD group. Fortunately, this inmate satisfied that criteria by completing the Bureau of Prison's 500 hour drug treatment program.

Another valuable resource was the local Veteran's Administration Vet Center. The Vet Center provides group counseling services through their own counselors. The Vet Center of Phoenix was able to run their PTSD group for the inmates as an auxiliary to the ongoing program. This gave the inmates a another perspective to the treatment of PTSD. One which they could continue upon their release.

The Vet Center also provided access to a veteran's benefit counselor. All of the inmates had various administrative claims with the Veteran's Administration because of their PTSD condition. Of those veterans that qualified, benefits could continue to their families during their incarceration.

Another benefit available to the released inmate is rehabilitation programs. Several inmates expressed a desire to pursue these programs in an effort to gain viable work skills and reintegrate into society.

The Vet Center provides an important service in that a continuity of care can be maintained once the inmate is released to society. During the tenure of the current program several of the inmates were released to half-way houses. Prior to their release, coordination was established with the Vet Center closest to their half-way house to insure continued group and/or individual therapy. Being released from prison is similar to the returning veterans entrance back into American society. Most of the inmates in this program had negative experiences returning to society. If prison is analogous to a "2nd tour", then release from prison is analogous to being "ETS'd to the states" (Enlisted Termination of Service - discharge from the military to return to the United States).

The veteran inmate's return to society becomes a critical point in therapy. It is at this point that the inmate is most vulnerable to reinstate old coping

methods of handling stressful conditions. The coordinated effort of a "step-wise" return can minimize this problem. A "step-wise" return refers to a gradual movement from one stressful environment to another. The highest level of stress occurring at the prison, the next level at the half-way house, and the final reintegration into society as a minimum level of stress.

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GROUP THERAPY IN THE CORRECTIONAL SETTING

***NONRATIONAL APPROACHES
TO THE IRRATIONAL***

Presented at

The 3RD Annual
Mental Health in Corrections Symposium

by

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NON-RATIONAL APPROACHES TO THE IRRATIONAL

I Introductions

- a) **History of the Group - *How & why it began***
- b) **FCI Bastrop, TX., 1983-1984 - *Memo from Feb. 21, 1984***
- c) **FCI Ashland, KY., 1984-1989 - *Former group participants***
- d) **USP Leavenworth, KS., 1989-1993 - *2 letters***

II Structure for Group - Time, Day, Place, Diversity

III Rules for Group

- a) **Confidentiality**
- b) **Respect**
- c) **Education/Insight as well as change**
- d) **Tension between order and chaos - *The letter of the law versus the spirit of the law***

IV Group Participants

V Goals for the Group

- a) **Community**
- b) **Ever increasing periods of sobriety**
- c) **Recognition of the right brain/creativity/symbol/irrational**
- d) **Acceptance of a different view of time - *"Kairos vs. Chronos"***

VI Techniques for Group Goals (Presented with Dr. Skrade)

VII Conclusion and Discussion

I don't think most people believe anything important happens in a place like this..... unless you call *conflict* important. Or hate. Or love. Or fear. And, in a world where the strong survive, the end justifies the means, and only evil seems to conquer evil... well, in such a world, it's obviously difficult to keep my heart from growing hard, my emotion from growing dry. Sometimes I can't find the controls... nothing seems to be where it should be. Liars give me their word. Sociopaths extend their trust. Psychopaths are in my zone, and users want my blood. Vultures, that never leave the ground, wait for my flesh.

In the midst of all the chaos is the oasis of the "group". It helps me work up the adrenalin to get off the "killing" floor and keeps me off the track before the train comes. This place desensitizes a person ...kinda breaks down your natural resistance and makes you think all the "us & them" is the way things really are. The group builds up the thresholds so the freaks can't step over them, and for at least a couple of hours, I deal with *real* emotion, not lies and games.

Beyond teaching elements of bonding and affections, do you want to know what this group really does for me? It makes my *soul* worth fighting over. See, when I was slammin' hard on the streets, I knew I was going back to prison. I just didn't know when. It didn't seem so hard to find a way out. Just hard to give a damn. The group makes one capable of "givin' a damn", and yeah, you might say that's cold comfort. Maybe... but better than *no* comfort at all.

Echoing the need for more than vocational skills to change a person's life, Myrl Alexander, a former Director of the U.S. Bureau of Prisons, observed that it is *futile to provide marketable training to inmates and fail to deal with their other, perhaps larger, needs*. Director Alexander gives the example of a man whose criminal behavior is secondary to an anxiety neurosis. He commits crimes when his world becomes too stressful for him to manage. This man ends up in prison and is taught to weld. He emerges from prison five years later as a *neurotic welder*. From this sort of example, the need for more than the acquisition of vocational skills to build a complete person becomes apparent.

Cardinal Newman's view of the importance of **enlarging the perspective** of the student beyond what he could gain from a vocationally focused education is not dissimilar to that of Mr. Alexander. There are, however, moral implications of Newman's view that are vital for those of us who have operated our lives within the narrow parameters of self interest. Unless we acquire ways to perceive the world in broader, more enlarged ways, we are more likely to continue to make choices that harm others and harm ourselves.

It is interesting to notice that no human action is performed without a moral justification. The "do-er" of the most heinous deed imaginable feels that he is in some way *justified in his action*. This justification may be no more than a shallow, unarticulated, and reflexive focus on the promotion of self-interest above any other, but any time a person acts to another's harm, some *narrowing* of the world, some exclusion of a larger reality, is necessary. Moral reasoning is how we work. It is prior to and necessary for any human action, and if we are to create successful lives of peaceful and productive coexistence with others, we must expand, enlarge, to use Cardinal Newman's word, our world and our moral focus to include **more** than ourselves. This personal growth, this broadening of perspective, has been, however unexpected, the most important result of our education at St. Mary*. Our sense of belonging, of being part of the world, and of sharing responsibility for the future have been expanded. The boundaries of our personal morality have been broadened to include more than ourselves. This I think was what Cardinal Newman meant when he exalted *enlargement over vocation* as the best aim of education.

* St. Mary is a Catholic college contracted by USP Leavenworth to provide educational services to inmates at the USP.

GROUP THERAPY IN THE CORRECTIONAL SETTING

Abstract

This paper is a presentation of information as it pertains to the field of group therapy in a corrections setting. It is brief and non-inclusive. It presents material which seems to have been relevant in past years and material that remains in the literature and useful in practice today.

It contains both general information and hopefully information which would be useful to a group therapist in a correctional setting. A history and basic assumptions are presented first followed by basic requirements and objectives for group counseling.

There is also a section on approaches to group therapy. Last, there is a presentation of goals for either individual or group therapy in this setting. The terms counseling and therapy are used interchangeably by this writer throughout this paper.

Group Therapy in the Correctional Setting

Historical Review

Counseling did not emerge as a unique, separate program until the early 1900's. Although it is likely that since the earliest days of the penitentiary system in the United States, some form of counseling took place between religious leaders and inmates. Present day group counseling and its variations are an outgrowth of psychotherapeutic efforts developed by psychologists and psychiatrists. Slavson and Moreno both claim credit for the development of group techniques. Group therapy became more widely used following World War II when practical needs dictated that some method be developed to use the available professional talents more efficiently. Group treatments were substituted for individual ones on the basis that in a given hour of a professional's time, eight to ten more clients could be seen (Bennett, Rosenbaum, & McCullough, 1978).

Group counseling entered the prison systems of the nation sometime in the early 1940's. It was introduced in California, in 1944, into the Reception Center at San Quentin. Certified teachers with training in educational counseling conducted groups sometimes titled "social living." The procedures included lectures as well as discussions and emotional interchanges (Fenton, 1961).

By the early 1950's counseling activities were beginning to expand. A wide variety of workers conducted groups--vocational instructors, correctional officers, tradesmen, work foremen, clerical workers, and academic teachers.

By 1961 10,000 inmates and 700 employees were participating each week in group counseling in the California prison system (Fenton, 1961). By the early and mid 1960's group counseling, usually of a Rogerian orientation, had spread to those correctional systems not earlier involved (Bennett, et al., 1978).

By the early 1970's, some correctional systems came to question the "group" approach and came to question its value. In turn, these

systems started to explore new and different ways to modify the attitudes and feelings contributing to criminal behavior.

Correctional System Clients

Inmates are a heterogeneous group who show more differences than similarities. Consequently they have quite individual problems and needs. Counselors and counseling efforts have attempted to deal with such groups as the predelinquent, the juvenile offender, the young adult offender, and the "hardened" criminal. Within these groups are also the subgroups of the alcoholic, the drug abuser, the sexual offender, and the emotionally disturbed. Offenders range from the truant to the murderer, the voyeur to the rapist, the kleptomaniac to the bank robber. From the wide range of offenses and multi-dimensional causal factors of crime, it can be seen that the correctional systems are dealing with complex, multi-faceted behaviors within an infinitely diverse client population. Obviously, no single type of treatment can be expected to work in all cases (Bennett et al., 1978).

Basic Counseling Assumptions

One basic assumption underlying all counseling efforts is that offenders can and do change in behavior and their approach to life. As late as the early 1900's, labels such as "criminal types" were employed and implied constitutional defects. The individual was believed to be predisposed to crime to such an extent that any change was impossible. This perception still exists to some extent today. However, the treatment model of correctional practice now embraces the concept that most, if not all, inmates can respond to some sort of therapeutic or counseling intervention, which can bring about changes in behavior.

Freud's "talking cure," supplemented by Rogerian Theories of non-directive counseling helped shape the methodology in corrections. The transition from a Psychodynamic "therapy" to "counseling" was an

attempt to give the client the opportunity to examine a variety of alternatives to a problem solution.

Once the idea that offenders were some sort of "incurable monsters" was overcome, the next logical trap into which many people fell was that such individuals are "sick." They were characterized as being maladjusted, antisocial, and mentally ill. This model was based on the premise that if these people knew (understood) the "cause" of their sickness, they would become well. Disillusionment with the "medical model" developed due to the fact that a number of inmates seemed to develop an understanding of their problems but their behavior remained unchanged. In addition, even though some developed understanding and a change of behavior while under direct supervision, they reverted to unlawful behavior when the supervision ceased.

Currently, counselors in the field of corrections believe strongly that in most cases offenders are not inherently bad or sick but are responding to internal and situational stressors with inappropriate behaviors. They also believe that offenders can change with help.

Differences Between Group Counseling and Group Therapy

Historically, group therapy was used earlier than group counseling in correctional institutions. Fenton (1961) stated that a significant difference between the two procedures is the type of workers involved. In group counseling, an employee of any classification may be given preparatory training and approval for participation under supervision. Group psychotherapy is conducted by psychiatrists, psychologists, and social workers who are expected to have had some formal training in guiding therapeutically-oriented groups. As a form of psychiatric/psychological treatment, group therapy is concerned with more serious emotional problems than group counseling. The methods

may differ because of the greater depth of the emotional problems treated in group therapy. The number of sessions per week may be more frequent also. Harrison (1960, pp. 1 & 2) stated that:

It is not valid to expect group counselors to probe into unconscious areas, or to make dynamic interpretations in order to resolve unconscious conflicts. . . . group counseling has as its goal not major personality change but rather the development of latent strengths through healthy and constructive human relations.

Two Basic Requirements for Group Counseling

Although Fenton (1961) makes a distinction between "counseling" and "therapy," this writer will use the words synonymously. One reason for doing this is that it is felt the basic requirements or basic "therapeutic factors" for both, are the same.

Fenton (1961, p. 46) stated the first requirement is "the development of the group setting necessary for clients to feel free to discuss with security their own and each other's feelings and attitudes toward the situation in which they find themselves." This may be accomplished if the group leader is able to accept the inmates or other clients with sincere interest in their welfare, to accept them for who they are without experiencing the discomfort of conflicting attitudes about them as offenders.

The second requirement, if group counseling is to be carried on effectively, is "a condition of mutual acceptance among those in the group" (Fenton, 1961, p. 49). Not only must the group feel free to discuss their problems, but the general atmosphere in which they do so must be supportive. There must be reasonably good human relationships between the group leader and the inmates. This is especially true in the treatment of those in conflict with the law, because rejection so often seems to have played a significant role in the explanation of the origin of the symptoms of criminality.

Major Objectives of Group Counseling

When the two fundamental requirements have been met, the goals or objectives of group counseling may be pursued. The first of these is "to help prisoners adjust to the frustrations which are an unalterable aspect of life in an institution and in society" (Fenton, 1961, p. 51). Inmates may find relief in noting in other members of the group the same disturbances of feelings which they themselves have (universality). And inmates may also profit from seeing how others strive to face and deal with their problems (interpersonal learning and existential factors).

A second goal is "to enable the clients to recognize the significance of emotional conflicts as underlying criminality" (Fenton, 1961, p. 53). The examination of their own emotional disturbances and hearing about those of others in the group, and the experience of relating these feelings to criminal behavior may lead to a better understanding of how such behavior originates.

Third is the "opportunity for the client to learn from his peers about the social aspects of his personality" (Fenton, 1961, p. 53). That is, how the inmate affects others as they associate with them or, in other words, they develop socializing techniques.

A fourth goal is the advancement of self-study in the group which makes possible "a better understanding of the work of make-believe, of fantasy, and how costly may be behavioral responses to the antisocial content of day-dreams" (Fenton, 1961, p. 54). The lack of control over the antisocial actions associated with or resulting from day-dreaming is what is costly in the life of the offender.

Finally, a fifth objective of group counseling is "the improvement of the emotional climate of the institution" (Fenton, 1961, p. 55). The most advanced correctional institutions and agencies of today are places where every reasonable consideration is given to the clients as human beings with troubles.

Difficulties Encountered in the Correctional Setting

Groups can work well in correctional settings. Many of the activities in these settings involve groups, whether structured by the staff or spontaneously formed by residents. A problem encountered when inmates are left to their own devices is the formation of powerful inmate cliques. These groupings can result in intragroup misunderstandings, unnecessary tension among residents, and breakdown of interaction with staff.

Another difficulty encountered is that of the "inmate code" in youth and young adult institutions, and the "way of the con" in adult facilities which disallow free expression with staff because it can be so easily construed as "snitching." As a result, residents are quite reluctant to express their opinions openly in group counseling (Bennett et al., 1978).

Offenders also want to appear "tough" to others in order to reduce their vulnerability to peer pressure in the institution. Since residents will interpret a display of feelings as weakness, they will guard against any public show of emotion.

Another difficulty in conducting meaningful groups is that inmates may perceive them as threatening. Inmates may feel a basic insecurity regarding their own "masculinity" and a threat to a resident's "manhood" such as a public display of feelings, or even joining a group, is to be shunned.

Many inmates do not want anyone to know about their "business" and therefore will talk about everything and say nothing. The ploy is to keep conversation away from self and on to others.

Advantages of Inmate groups

Though there are apparent difficulties, Bennett et al. (1978) discussed three aspects of the corrections group that are important to and advantageous in the rehabilitation process. First, the group can be perceived as being very similar to the family. Yalom (1985) labeled

this experience the corrective recapitulation of the primary family group. Second, group problem-solving has definite advantages over individual solutions. A wider variety of problem solutions can be elicited by drawing upon the experience of several people with varying backgrounds. When a peer (inmate) poses the solution, it often carries more weight. The third advantage of group counseling has to do with identification and modeling as proposed by Bandura (1969). Briefly, inmates are more likely to model the behavior of other inmates with backgrounds similar to their own rather than model behavior of a counselor ("the man").

Approaches to Group Therapy in the Correctional Setting

Client-Centered Counseling: Basic to this theory is the belief that counseling techniques could be learned in a reasonably short period of time, and that clients could gain insight into their own emotional hangups by listening to appropriate reflections of their feelings. Unconditional positive regard is almost a byword.

Transactional Analysis: This form of therapy with its parent, adult, and child ego states is adapted with relative ease in a correctional setting. The theory allows participants to develop a useful vocabulary to describe the processes that they experienced. TA places heavy emphasis upon interactions among various individuals. TA explores the games that both staff and offenders play to hinder rehabilitation.

Reality Therapy: The emphasis in Glasser's model is to avoid elaborate discussions on the causes of behavior and center instead upon the behavior itself. According to Glasser, it is important that every individual face squarely their failures, gracefully accept the punishment due, and attempt to start off in more responsible and constructive directions.

Gestalt Therapy: This therapy is relatively new on the scene. This modality lends itself well to offenders due to its focus on the "here and now." Also, its existential underpinnings fit well with the prevalent pessimism and feeling that life has no meaning. This approach

encourages one to take responsibility for one's own feelings, behaviors, and their consequences.

Behavior Modification: The behavioral view is that antisocial behaviors are learned in the same way socially acceptable behaviors are. This conceptualization has several implications; it implies that behaviors are acquired through experience and as such can be altered by changing the contingencies which maintain and control that behavior (Bennett et al., 1978).

Family Counseling: This approach views the individual offender as part of a social network in which the family plays a leading role, and which facilitates the inmates adjustment and maladjustment. Family counseling, according to Bennett et al. (1978) will very likely represent one of the more rapidly developing areas of counseling in the correctional setting as the emphasis on community-based programs gains full momentum.

Therapeutic Community: This approach involves learning through experiencing a healthy human interaction between staff and inmates, accessibility of professionals, and mutual problem solving.

Assertiveness Training: Here the underlying assumption is that many offenders exhibit illegal behavior because of their inability to confront directly any emotionally threatening situation.

Other emerging approaches in counseling include the use of biofeedback techniques, hypnotherapy, and meditative procedures. These are adjunctive to group and individual therapies.

Counseling Objectives

In addition to the objectives already mentioned, Bennett et al. (1978) outlined the following: To prepare inmates for socially accepted lives in the community with subobjectives being (1) the creation of subcultures that will support conforming behavior and condemn illegal behavior, (2) development of peer pressure for conforming behavior, and (3) adoption of realistic and appropriate perceptions of values and expected behavior.

Other possible objectives are: (1) improving institutional climate, (2) lowering the rate of disciplinary difficulties, (3) reducing recidivism, and (4) positive shifts in personality.

Offender Intervention Scale

These content scales were developed to study treatment methods used with adolescent and young adult parolees. They were used as a rating scale by Probation and Parole officers. They are listed in this paper due to their obvious value as goals of either individual or group therapy:

1. **Reducing Delinquent or Criminal Self-Image.** Involve client in activities and interests which show promise of reinforcing a nondelinquent or noncriminal self-image. Try to extinguish, in client, the value of a delinquent or criminal self-image. Expose client to adequate males/females who are neither impressed nor taken in by "tough" or "delinquent" mannerisms.
2. **Modifying Attitudes toward Adults.** Show client that there are many adults whom he can trust. Show client that many adults are worthy of his respect, e.g., genuine appreciation, positive regard, or esteem. Try to convince client that you represent more than "the man," or more than an extension of "the establishment."
3. **Increasing Internal Controls.** Try to get client to start "thinking twice" before he acts. Teach client to cope with delay-of-gratification of his needs and wants. Try to instill in client certain basic social values and standards. Instruct client on basic do's and don'ts, as though he were a Child.
4. **Increasing Self-Awareness/Self-Acceptance.** Help client understand some of the early sources of his present

self-image. Help client change some of his beliefs regarding what and who he "should" be or "ought" to be. Help client resolve doubts about his basic adequacy and worthiness.

5. **Countering Apathy/Indifference.** Try to get client to be more evaluative and responsive to his social world. Encourage client to more actively care about what happens to him. Try to get client to be more reactive to the events in his life, to take a more active stance in determining what happens to him.
6. **Family/Parental Relationships.** Help client become aware of how the personal problems of parental figures can interact with, or have interacted with, his own development. Get client to see his parents in a realistic light--their strengths, weaknesses, and individual personalities. Increase client's understanding of the role he has played in his family (as child and sibling), and of the particular ways this might have influenced his life. Get client to see his present family (wife, children) in a realistic light--their strengths, weaknesses, and individual personalities. Increase client's understanding of the role he has played in his present family (as father and husband), and of the particular ways this might have influenced his current behavior, especially illegal activities.
7. **Peer Influence/Pressure.** Explain to client specific ways in which peers may set him up to meet their own needs at his expense. Discuss issue of "the price of loyalty" to, or "the price of going along with," peers, in various situations. Suggest to client alternatives to conforming behavior on his part when he is confronted with peer pressure, especially in relation to possible illegal activities. Serve as a counterforce to negative effects of peer influence.
8. **Everyday Practical Adjustment.** Teach client how to take care of himself and meet his needs on a practical basis. Work primarily with performance, e.g., school,

employment, living arrangements, rather than with emotions and psychological issues.

9. **Client/Worker Relationship.** Talk with client about how you and he are relating to one another, about the nature and quality of your relationship. Encourage client to begin actively thinking about the nature of, and changes in, his relationship with you. Use your relationship with client to illustrate, to client, themes and problems in the way he relates to others. Emphasize to client that you expect him to relate to you on a personal basis.
10. **Gaining Client's Confidence in Worker as Understanding/Capable.** Gain client's confidence as someone who is skilled in understanding interpersonal problems. Demonstrate to client that you can understand very personal feelings and needs on his part. Gain client's confidence in you as a worker (person, treater) who can in fact help.
11. **Expressing Personal Concern for and Acceptance of Client.** Help client feel you really do care about him in more than a formal, "it's my job" fashion. Help client feel that you accept and care for him as an individual, not only in terms of his uniqueness, but independent of his particular problems and behavior. Help client feel that his personal happiness is quite important to you. Help client feel that you do not see him as "sick," "weird," or undesirable.
12. **Exposure to Adult Models.** Expose client to same-sex, adult models whom he cannot regard as weak, incompetent, etc. For male workers with male clients, behave in a masculine manner that the client can recognize and accept or respect as such. For female workers with female clients, behave in a feminine manner that the client can recognize and accept or respect as such.
13. **Preparing Client for Specific Life Situations.** Teach client how to handle specific difficulties he may experience when he's on his own and you're not available to him. Review with client his plans for handling difficult situations, e.g.,

temptations, pressures, that may arise when you're not around. Teach client specific ways of "avoiding trouble," e.g., fights or narcotics.

14. **Ego Bolstering via Success Experiences.** Expose client to situations in which he can "win." Expose client to probable success' experiences, even if they represent menial challenges. Make sure the client gets ego-bolstering recognition from others, even for menial successes or accomplishments.
15. **Using Positive Peer Culture.** Encourage client to interact with nondelinquent or prosocial peers. Encourage client to interact with delinquents or offenders who wish to communicate nondelinquent or prosocial views.
16. **Using Authority (Legitimate Power or Force).** Give client a relatively specific set of terms or conditions which he must meet or live up to. Make client responsible for failure to follow through on his agreements with you by taking privileges or freedom from him. Provide support for those who live with client and/or are responsible for helping to control his behavior. Keep "on top of" client; don't accept any "shining-on"; let him know you're usually around and interested in what he's doing. Make sure the client sees you as the main source of power with whom he must deal when making decisions and plans. Make sure the client does not succeed in "power plays," intimidation tactics, or manipulation efforts when interacting with you.
17. **Using Internal Stress as Stimulus/Motivator.** Capitalize on distress or anxiety in the client, as a stimulus for change. Capitalize on internal pressures, e.g., anxiety or guilt, as stimuli for motivating the client in the direction of treatment or change.
18. **Doing the Unexpected.** Maintain an element of unpredictability in how you react to client under particular circumstances. Intentionally relate to client in ways that will not readily fit into his usual manner of perceiving and interpreting others. Try to prevent client from thinking he

can predict, using simple formulas, your responses to his behavior.

19. **Client's Participation in Case Planning and Decision Making.** Discuss with client your treatment rationale, plans, and goals. Involve client as an equal in case decisions. Thoroughly discuss with client any challenges and objections he has to your decisions concerning his case. Allow client to significantly determine the extent of your involvement in his life. Allow client to make nearly all his own decisions, largely without your participation. Allow client to pretty much run his own life. Discuss and review the progress of treatment, with client.
20. **Concreteness versus Abstractness of Verbalizations and Interpretations.** Avoid using adult-level concepts or explanations when talking with client. Speak to client in very concrete terms, avoiding abstractions. Repeat (more than once) any expectations you have of client, so that he will be less likely to forget them as soon as you're gone.
21. **Increasing Interpersonal Sensitivity.** Encourage client to perceive, appreciate, and respond appropriately to more individual differences among particular ways in which his unique needs and response style can manifest themselves in his interpersonal relationships. Develop what may approach a professional counseling or therapy relationship with client.
22. **Expression of Feelings.** Help client verbalize and more adequately express his feelings and emotional reactions toward others. Serve client as a source of catharsis, listening to expression of pent-up needs, emotions, or fears. Show client it is all right to direct reasonable emotion and anger at their true source, rather than displacing, suppressing, etc. Emphasize to client the importance of expressing his inner feelings directly to whom they involve, e.g., parents, spouse, peers, yourself.
23. **Self-understanding.** Try to get client to begin asking questions (at least of himself) regarding inner sources of his behavior. Use review of past life and social history events

to help client understand his behavior and feelings. Increase client's awareness of how such factors as guilt or feelings of inadequacy can be a destructive force in his life. Discuss with client particular ways in which his unique needs and response style can manifest themselves in his interpersonal relationships. Develop what may approach a professional counseling or therapy relationship with client.

24. **Recreation / Socializing.** Encourage client to participate in any of several recreational activities. Involve client in group recreational activities.
25. **Frequency of Contact.** Make sure that you and the client are in frequent contact. Maintain a regular schedule of frequent contacts with client.
26. **Informality--Lack of Social Distance.** Minimize social or personal distance between yourself and client. Talk with client about yourself and your feelings in order to let him know you on a fairly personal level.
27. **Client's Commitment to Treatment.** Let client know that he must meet you half way in the sense of committing himself to treatment, e.g., showing reasonable willingness to work on whatever main goals have been established. Let client know that your support of him is largely contingent upon his making a reasonable commitment to treatment objectives and goals.
28. **Expressing Warmth, Friendliness, Affection.** Relate to client in an interpersonally warm or affectionate manner. Express, to client, positive affection that you may feel for him. Give client warm, friendly, physical contact, e.g., pat on back or arm on shoulder.
29. **Protecting, Minimizing Demands and Pressures.** Expose client to supportive, nonthreatening, social situations. Make only minimal demands on, and establish only minimal expectations for, the client. Allow client to be childish and immature, including childish dependency. Avoid exposing client to harsh, direct, personal encounter-group situations.

Avoid exposing client to sophisticated, aggressive, or manipulative offenders.

30. **Being Forceful, Blunt.** Be willing to "tell off" the client when you feel he needs it. Be verbally forceful, even harsh, during necessary confrontations.
31. **Associating Concern with Control.** Try to convince client that controls, by you, reflect real concern for his well-being. Make sure the client understands that discipline of him, by you, is not a sign of personal rejection. Emphasize to client that being controlled by you is not the same as being emasculated by you.
32. **Familiarizing Client with Authority Figures.** Via meetings and lectures, familiarize client with goals, philosophies, and rules that underlie the thinking, and govern the activities, of police, probation officers, and judges (Palmer, 1979, pp. 189-195).

Summary

Although this paper, by necessity, is not all inclusive as it pertains to group therapy in a correctional setting, it provides an overview of effective and functional techniques for use with a correctional population. It is obvious that the eleven "therapeutic factors" outlined by Yalom (1985, p. 3) are as important in a "correctional" setting as they are in a "conventional" setting. These therapeutic factors are not always discussed in the literature in an overt manner and thus were at times elucidated for the reader. I agree with Lipton, Martinson, & Wilks (1975) in their review of the effectiveness of correctional treatment when they state

Unfortunately, most of the research studies summarized provide little information about how to implement effectively treatment programs, how to staff effectively and efficiently such programs, how to overcome resistance to change within the post adjudicatory system and the community, or how to "recruit" clients who are amenable to the planned treatment. Research must be conducted

and accumulated to establish sound methodologies for treatment implementation (p. 559).

The journal articles and books that were read in preparation for the writing of this paper seemed to have a common theme. That is that treatment of inmates, both on a therapeutic and social level, should be administered in a manner that respects and supports their rights to be treated as people with dignity and inherent value and worth.

staff effectively and efficiently such programs, how to overcome resistance to change within the post adjudicatory system and the community, or how to "recruit" clients who are amenable to the planned treatment. Research must be conducted and accumulated to establish sound methodologies for treatment implementation (p. 559).

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ANATOMY OF AN INCIDENT:
MAY 92 REVISITED

BY

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ANATOMY OF AN INCIDENT:
MAY 92 REVISITED

On May 11, 1992 a confrontation between inmates of differing races over exclusive use of a community area erupted into a fight. The immediate results were several inmates with minor wounds who were treated and released from the hospital that night and in excess of fifty inmates refusing to "lock down" in protest at lights out. The inmate protesters eventually capitulated but the stage was set for the outbreak of even greater unrest.

The next day was occasion for a general strike by the inmates. Although contained within their domicile wing areas, many inmates refused to lock down. No injuries of either staff or inmates occurred but by the time complete order had been restored three days later over \$50,000 damage was inflicted on institutional property and the environment at the USDB was undeniably altered.

One of the first questions asked was, "Who were the inmates involved in the unrest?" Closely following were speculations about generalities that might serve to describe the inmates who had participated. The question was raised in words to the effect that, "We realize that many of the inmates were African-American, at the USDB for a long time, and violent offenders, but we were wondering if any other features of active participants could be identified." Later it was speculated that at least one and possibly several identified "leaders" had a history of gang involvement prior to military service. To address these questions and issues we first turned to Military Police Investigations who were actively compiling information from video tapes, staff witnesses, and inmates in an effort to identify key and ancillary figures in the incident.

Investigations had compiled a list of some 59 inmates identified as leaders or very active participants in the unrest. While the substantiation of those allegations would await the process of disciplinary board review, we accepted inclusion on that initially generated list as criterion enough for inclusion in the "Participant" group in this study. We then proceeded to identify a comparison, "Nonparticipant," group from among those individuals who had not been identified as Participants.

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Nonparticipant subjects were matched with each identified Participant on variables of race, confining offence, and duration at the USDB in that order. Some latitude was exercised in matching individuals for confining offense, for instance an individual who committed larceny from an unoccupied building had to be paired with a writer of bad checks. In most cases confining offences were matched exactly, however, and in all cases crimes were similar in terms of assaultiveness and victim characteristics, if a victim were identified. For duration, individuals were matched within six months of each other in terms of arrival date. Thus, race, confining offense, and length of time at the USDB were not only controlled for but were also effectively eliminated from consideration as explanatory or predictor variables.

Investigations would eventually identify a number of other individuals as possibly or incidentally involved. In the six cases where individuals so identified had been previously selected as Nonparticipant group members they were eliminated and a new comparison subject was selected for each one. Four subjects in the Participant group could not be paired with matching controls. Those subjects were included without comparison matchings. Thus the final comparison groups were made of 59 individuals clearly identified as involved and 55 who clearly were not involved.

Data reference subjects' confinement history were collected from the institutional data base and additional data were solicited from the Mental Health, Academics, and Chaplaincy Directorates as well as from the 7 Steps Foundation. The assumption was made that professionals and paraprofessionals in those sections were likely to have valuable insights regarding the individuals in question. Data were gathered by soliciting input about the individuals on a single list; respondents were blind to the incident activity level of any individual on the list and the investigation results at the time were carefully restricted information.

Unfortunately, from an analytic perspective, the Chaplaincy did not keep records on inmate religious participation and potentially valuable data were not available. Similarly, the modifications recently made to the data base management of Discipline and Adjustment Board records were not yet in place. Thus, potentially salient data regarding institutional infractions were unavailable for consideration.

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Those data that were available for consideration were analyzed using SPSS-PC+, a commonly used statistical analysis package. Variables were considered independently and analyzed for between group (Participant vs. Nonparticipant) differences using chi square or ANOVA techniques as appropriate depending on the characteristics of the variable.

The Director of 7 Steps Foundation was asked to rate the level of involvement of each individual on the pooled list with respect to their involvement (0,1,2) in 7 Steps Foundation activities. This was thought to be potentially salient because 7 Steps, at least per existing mythos, tends to serve the more "hard core" inmates who are often disaffected with the perceptibly more "mainstream" programs available through the Directorates. As with most of the variables considered in this analysis, level of 7 Steps involvement had no discriminant power. Although 10 (8.8%) of the Participants were rated as quite active in 7 Steps so were 9 (7.9%) of the Nonparticipants.

Consideration of the basic demographics in the inmate data base revealed several significant or nearly significant differences between the groups. With an average age of about 29.8 years, Nonparticipant inmates were, as a group significantly older than Participants who had an average age of about 26.8 years ($p < .008$). While half (51%) of the Nonparticipants were assigned to unskilled work details 73 % of the Participants were assigned unskilled work ($p < .06$). The average Nonparticipant had lost slightly more than 14 days good conduct time while the average Participant had lost over 57 ($p < .02$).

Academics Directorate provided data that were similarly interesting. Although it might be speculated that Nonparticipants would be more likely to be involved with academic pursuits, such an inference fails to withstand any but the most superficial inspection. 30 Nonparticipants had actively pursued college courses while only 25 Participants had done so. The apparent difference may well be simply a matter of chance, however ($p < .197$). A striking observation relative to college pursuit was possible, however, when one considered failure of attempted course work. While 4 Nonparticipants had failed college courses (13% of those who had attempted college), 12 of the Participants (48% of attempters) had done so ($p < .04$).

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Case Managers within the Directorate of Mental Health (DMH) completed extensive survey sheets regarding each subject. Questions ranged from historical data to identification of the inmate's participation in structured therapeutic activities as well as subjective judgment about the inmates feelings, attitudes and beliefs. The historical data considered tended to be non-supportive of many beliefs about inmates likely to be in difficulty within an institution. There were no identifiable between groups differences in terms of: the occasion of a significant family event prior to the incident, marital status, divorce whether before or during incarceration, perceived family support or hostility, number or visibility of tatoos, urban center as home of origin, or known history of gang involvement.

Differences were apparent in DMH program involvement. Participants were significantly more likely to have been involved in a "cultural" Self Growth activity ($p < .05$). No between group differences were identified with respect to participation in therapeutically oriented Self Growth activities. Participants were more likely to be on a waiting list for, as opposed to having completed, "Non-crime Specific" therapy groups ($p < .03$). There were no between groups differences with respect to Crime Specific therapy group waiting list or completion status. Participants were identified as significantly more angry about their confinement and at the USDB as an institution ($p < .04$) than Nonparticipants. Nonparticipants, conversely, tended to be identified as accepting greater accountability for their confining offense ($p < .06$).

Intake psychometric assessments were reviewed in an effort to further identify trends and differences between the groups. Several revisions and modifications to the intake assessment battery have been made in the last several years including changing from the MMPI to the MMPI-2. MMPI-2 scores were converted to MMPI T score equivalents to allow comparison between the instruments. The vast majority of the inmates had completed valid MMPIs. If the MMPIs were invalid Nonparticipants produced more identifiably "fake good" protocols ($p < .07$) while Participants produced significantly more "fake bad" protocols ($p < .04$). A few trends were evidenced upon consideration of mean scale scores between the groups. Those trends are reflected below:

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Scale	Nonpart. T	Part. T	significance
F	48	55	.16
Pd-4	55	62	.18
Sc-8	50	58	.12
Ma-9	52	59	.16

MMPI/MMPI-2 content scales, of those scales similar enough to allow comparison, reflected tendencies for group differences as well. Participant's protocols reflected more endorsement of items with content indicating more Authority Conflict ($p < .07$), greater Psychoticism ($p < .07$), more Family Problems ($p < .11$), and significantly more Manifest Hostility ($p < .02$). As with the clinical scales, however, even in cases where one group mean was significantly higher than that of the other, both group means were essentially within normal limits.

Arguably, there seems to have been value in this exercise. There are differences that can be observed and measured between individuals who seized an opportunity to act out against an institution and those who refrained. The differences tend to be consistent with what at least some observers might predict even while they defy coarse characterizations.

A consequence of the decision to analyze the variables independently is that highly correlated variables could each be identified as important when, in actuality, to consider either one would be tantamount to considering both. For instance, suppose an inmate could hypothetically only be considered for a skilled detail assignment if they were 50 years old. In that case to find significant correlations between involvement and age and involvement and detail skill level could be no more interesting than finding a correlation between involvement and age or detail skill level, if only one of those two relationships were assessed. In this exercise, then, the analysis used runs the risk of overemphasizing differences by representing any given feature multiple times.

Some might consider it strange then, that of the dozens of the variables considered only the few mentioned above served to discriminate Participants from Nonparticipants. While it is safe to say that Participants tend to be more angry, less likely to accept responsibility for confinement, and more likely to be experiencing stress related symptoms on arrival, it is equally as important to emphasize that the differences between the groups is not extreme. The two groups tend to be more similar than dissimilar; in most respects they are alike and, as a

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population, not markedly dissimilar from the population at large. This observation, in turn, might suggest reformulating our assumptions that people who are incarcerated or even people who act out while incarcerated are somehow fundamentally different than people on the other side of the walls.

Perhaps the most significant point that can be supported by these data is that prediction of involvement in institutional disturbances requires analysis of other than intrapersonal characteristics. Like all behavior, participation in an institutional disturbance is a product of interaction between the organism and the environment. Perhaps prediction, and eventual control, of institutional disturbances awaits reformulation of the question to include careful examination of the institution as well as individuals involved.

GOAL DIRECTED THREATS OF SELF HARM WITHIN CORRECTIONS

BY

ROY CLYMER

CORRECTIONAL MEDICAL SYSTEMS
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GOAL DIRECTED THREATS OF SELF HARM WITHIN CORRECTIONS

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I. INTRODUCTION

In corrections, once a person is remanded to the custody of the State, it becomes responsible for their well being. Correctional institutions (almost always) have a policy precluding an inmate from committing suicide. That policy charges various people with the responsibility of trying to prevent inmate suicides. The legal system provides those burdened by this duty can be sued for negligence in discharging that duty.

Institutional policies and procedures, both formal and informal, are then driven by the desire to provide a safe, effective correctional environment, and to avoid legal culpability when something goes wrong. This desire may, depending on such factors as institutional history and the management style of leaders, produce an intense "CYA" mentality within an institution. Caretakers at every level may desire nothing so much as to protect themselves from a finger-pointing higher authority. To the degree such a situation exists, it will become known to the inmates of an institution. This knowledge creates an opportunity for them to exploit the caretakers' defensive stance for their own ends.

In a scapegoating, defensive institutional culture, our fear of disciplinary or legal action is a ready made tool which many inmates will unhesitatingly use to pry loose anything of value to them. Dealing effectively with inmates who may feign suicidality in order to get something, then, become a tremendously difficult challenge. Nonetheless, I believe it is possible to discharge our duty, protect ourselves, and provide clinically appropriate treatment by discriminating the truly suicidal inmate from the malingerer and treating each appropriately.

II. MOTIVATIONS FOR SELF HARM

A. Relieve Pain

In order to explore our feelings and reactions to suicide, think a moment about how you might have felt before you worked in corrections or how you feel about a non-inmates' suicide. Whenever we hear a person has taken his/her own life, we have, it seems, a natural inclination towards sympathy for the person. Almost unbidden, the image that forms within our minds is of a person despondent, despairing, and depressed. We imagine a pain so severe and a situation so hopeless that killing oneself is the only path to relive the unbearable agony. This must be so, we think, or why else would they do it?

The answer to that question may become more readily apparent when we consider the difference between attempted suicide and actual, "successful" suicide. Our attention may soon be focused on the method of the attempt, and our goal may well be to assess the "seriousness" of the attempt. Indeed, for an attempted suicide, the possibility of conflicting motives for the act springs readily to mind.

B. "Cry For Help"

Suicide attempts are not necessarily the pure act of desperation to end pain that we are inclined to suppose; instead they may in fact be engaged in order to produce some other additional effect.

Even a "serious" suicide attempt reveals itself to have a complex, interpersonal component. First, this attempt to change one's situation is somewhat coercive. The "cry for help" may also contain an indictment: Help hasn't been previously offered (or effective, or whatever). This is, we may suppose, an indictment directed towards those who are "supposed" to care about or help the victim.

Second, a cry for help, by itself, may be expected to produce some real, tangible, beneficial change in the attempters' situation. They may be relieved of burdensome responsibilities since they're now "sick" or "ill".

C. "Blackmail"

We like to see ourselves as "good" people. Part of that means being concerned for others and treating them well. If we begin to feel we are being criticized, told we haven't done enough or cared enough, it is difficult not to get defensive. We may feel coerced; compelled to do something, it is implied, we wouldn't do unless forced. No longer sympathetic, we may become defensive, angry, or worst of all, indifferent to the person's plight.

Outside of corrections, it would seem the benefits obtained from suicidal attempts are mainly the wishes for emotional responses of others. Within corrections, on the other hand, the tangible benefits to be had by threatening suicide are real, substantial and valuable. A partial listing includes: Immediately get out of your cell and see the psychologist; get sent to the MHU and come back to a new cell-mate; get taken off a segregation unit and do your seg time on the MHU; go to the MHU as a way of avoiding enemies, debts, or difficulties.

III. DETECTION

It usually takes no great clinical acumen to detect goal directed threats of self-harm in corrections. Most of the time the patient will make it perfectly clear what s/he is up to.

A. They Will Tell You

Not infrequently they will tell you directly, openly acknowledging their manipulation. "I said I was going to hurt myself in order to get ----."

B. The Give Away "If"

A common clue, almost always strong evidence of manipulation, is the use of "if": "If you don't send me there, I'll cut myself".

C. Complaints/Demands

Another strongly suggestive datum is when inmates complain or become demanding.

D. Secondary Gain

One should always be suspicious when there is a clearly identifiable goal which can be obtained by claiming suicidality.

The vast majority of the time we are confronted with clear attempts at manipulation, not true suicide, which then raises the question of what to do. I can offer several suggestions for strategies that I believe are important and effective.

IV. TREATMENT

A. Suicide Precautions

In my opinion, the single most powerful tool available for the diagnosis and treatment of malingering is properly instituted suicide precautions on an acute mental health unit. PS consists of the removal of all the inmates' property and clothes, provision of a single paper gown and paper sheet, placement in a cell with no mattress or bunk, and 15 minutes observations by staff.

It may appear that such actions indicate an indifference to the inmates' dynamics or needs, but this is not so. It is designed to be unrewarding, but not punishing.

B. Make The Distinction

1. Effective treatment also implies it is vitally important to make the distinction between suicidality and goal directed threats/acts of self inflicted injury and keep it clear.
2. Attempts should be made to establish the distinction in policy and law.

C. Frustrates The Inmates' Attempts To "Get Over"

A third useful strategy is to develop procedures, both formal and informal, to creatively frustrate the inmates' attempts to get what he wants by this means.

D. Look Out For Each Other

From a system perspective, it is extremely important that each and every element of the system look out for the well being of the entire system, not just themselves. Everyone must shoulder their share of the responsibility, not just CYA.

V. CONCLUSION

A. Stakes Are High

All concerned must take this problem extremely seriously. This is not just a matter of exposure to liability and self protection. The inmate's life is at stake.

B. Psychology's Vital Contribution

Far and away the most important aspect of the treatment response to those engaged in goal directed threats/acts of self harm is not what we do but what we don't do.

By not acting, out our feelings, we present the inmate with a truly radical response. When we don't respond with punishing anger or abandonment, we confound their expectations and open the door to the possibility of change.

FOR ADDITIONAL INFORMATION, PLEASE WRITE TO:

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GUIDELINES FOR DEALING WITH GOAL DIRECTED THREATS OF SELF HARM

- I. Take every self-injurious threat or act seriously, regardless of your assessment of the intent or manipulativenness.
 - A. His/her statements and/or acts are what authorize our actions.
 - B. S/he can say they're suicidal, but only we can say they aren't (since we're responsible).
 - C. The inmate should be taken at his/her word.
- II. Interact/Deal with the inmate.
 - A. Insist they deal with you. Let them know what they're doing does have an impact on you.
 - B. Find out what they want. See if there's an acceptable way to get it. Show them how.
- III. Protect yourself as you treat the inmate.
 - A. In communication with others (not inmate), make the diagnosis/distinction and keep it clear.
 - B. If they refuse to negotiate, they must be placed on suicide precautions. Keep them on until you're convinced it's safe. Keep them on longer (no matter what) with each subsequent admission.
 - C. Creatively frustrate their attempts to "get over".
 1. Delay, obfuscate, question, and inquire.
 2. "Be where they ain't." Be curious about options they refuse to explore. If they say it's nothing to worry about, appear worried. If they say the threat is serious but you don't believe it is, talk about all they've got to live for.
 - D. Like SCUBA diving, never do this alone. You're part of a system. Protect yourself by looking out for the rest of the system as well. Don't pass on liability you wouldn't like passed to you. Take your fair share and ask for help/consultation when necessary.

ACCREDITATION OF FORENSIC FACILITIES

BY

CLYDE V. MARTIN

JOINT COMMISSION ON ACCREDITATION OF
HEALTH CARE ORGANIZATIONS

Accreditation of Forensic Facilities
by the Joint Commission on Accreditation of Health Care Organizations
Clyde V. Martin, M.D., M.A., J.D., F.A.P.A.

The Joint Commission accredits more than 5,200 hospitals and evaluates and accredits more than 3,200 other health care programs. Joint Commission accreditation is available for general and psychiatric hospitals, nursing homes and other long term care facilities, psychiatric facilities such as substance abuse programs, community mental health centers, programs for the mentally retarded and developmentally disabled, adult and adolescent psychiatric programs and forensic programs, outpatient surgery centers, urgent care clinics, group practices and community health centers, hospices, home care organizations and managed care organizations.

The Joint Commission is governed by a 24 member board of Commissioners with members representing the American College of Physicians, the American College of Surgeons the American Dental Association, the American Hospital Association, the American Medical Association plus public members. The Joint Commission Accreditation of hospitals was founded in 1951; the name was changed to the Joint Commission on Accreditation of Health Care Organizations in 1987. More than 400 physicians, nurses, health care administrators, medical technologists, psychologists, respiratory therapists, pharmacists, durable medical equipment experts and social workers are employed by the Joint Commission to perform the surveys. Health care organizations voluntarily seek Joint Commission accreditation because it enhances community confidence, it effects medical staff recruitment, it expedites third party payment, it provides a staff educational tool, it may favorably influence insurance premiums and it may fulfill state licensure requirements.

Joint Commission accreditation is truly the community standard for quality in health care organizations. Many of the consent decrees surrounding the Civil Rights of Institutionalized Persons Act require that care be given in forensic facilities that meets the community standard. Many other settlements such as Romeo vs. Youngblood require similar standards. Very often, it is very difficult for health care workers in correctional settings to get correctional administrators to understand what needs to be done to meet community standards. My own experiences in a large correctional mental health hospital certainly brought to me the realization that such correctional administrators often see us as coddling inmates, giving undeserved extra attention to inmates and in general, falling into traps that inmates often set for individuals not working with them regularly. The Joint Commission has established a tailored survey to

meet the needs of forensic populations. These standards were written by persons who have had vast experience in correctional settings and understand the interface between the correctional staff and the mental health staff and the uniqueness of such settings. The 1992 addition of the accreditation manual for hospitals marked the beginning of a multi-year transition to standards that emphasize the application of quality improvement principals in concepts. In addition to the transition begun in the standards for hospitals, similar revisions and standards on monitoring and evaluation to facilitate a transition to quality improvement were introduced for mental health care, ambulatory care and long term care accreditation programs. The Joint Commission has embarked on a "Agenda For Change" a multi-year endeavor in which an important goal is to assist organizations in focusing on those functions that most directly and significantly impact the quality of patient care. Important functions in a health care organization are those functions that most substantially influence patient outcomes. Patient care outcomes are broadly construed to include all types of outcomes, intermediate and cumulative, biologic and psycho-social, physiological and functional, quantative and qualitative. Patient outcomes may be defined in relation to various aspects of patient care quality to wit excessibility, appropriateness, effacacy, effectiveness, timeliness, safety, continuity, acceptibility and efficiency of care. The patient experience with respect to these aspects does, in varying combinations, eventually determine patient health status, patient satisfaction with care and perceptions of value received. The performance of most such important functions involves more than one department and/or discipline; that is most such functions are cross-organizational to a greater or lesser degree. It is frequently the manner in which these departments disciplines interact that determines performance and outcomes.

In the future, Joint Commission accreditation decisions will be based on how effectively an organization is performing these important functions. In addition, the accreditation process would be further informed by data about the performance of these functions through the Joint Commissions proposed indicator monitoring system. The achievement of this goal requires that the identified important functions and the process that comprise them define the eventual content of the accreditation manual for hospitals as well as standards manuals for the other accreditation programs. This new standards context is intended to focus on what clinicians, managers, governance participants and support staff must do well and in collaboration with each other, in order to maintain and improve the quality of care. The identified important functions will also define the eventual scope and the scale of the Joint Commissions indicator monitoring system. The indicators, which measure patient outcomes and/or the process that comprise important functions are expected to be used by health care organizations as central elements of their assessment and improvement activities. Future standards revisions will require

organizations to demonstrate the effectiveness with which they are using indicator data to monitor and continuously improve their performance. The following was approved at the Joint Commission's January 1992 Board of Commissioners meeting as the recommended framework for the reorganization.

Part A

Care of the Patient

I Patient's Rights

patient's role in decision making, advanced directives, ethical issues, respect for spiritual and cultural needs, confidentiality and care of dying patients;

II Admission to setting or service

emergency care, observation, elective admission, transfer in, ambulatory service;

III Patient assessment

history and physical, examination, nursing assessment, psycho-social assessment, diagnostic imaging, pathology, clinical laboratory and consultation;

IV Nutritional Care

assessment, dietary support, perinatal and enteral nutrition;

V Non-operative treatment selection and administration

selection, administration and monitoring, use of medications and blood and blood components, mental health care, rehabilitation services;

VI Operative and other invasive procedures, selection, administration and monitoring, diagnostic procedures, treatment procedures;

VII Patient and family education

instructions to patients, self care and post discharge activities, psycho-social support;

VIII Continuity of care

coordination of care, reassessment, transfer, discharge planning and after-care.

Part B Organizational Functions

I Leadership

Communication and coordination, quality planning, strategic planning, alignment of services and resource allocation;

II Human Resource Management

Allocation of personnel, orientation training and education, qualifications of personnel, competency assessment;

III Health Information Management

Patient records, professional library, coordination with other informational systems;

IV Surveillance

prevention and control of infection;

V Environmental management

Safety management, life safety management, equipment management, utilities management, therapeutic environment, infection control, space allocation;

VI Improving organizational performance

Monitoring activities, quality control, risk management, utilization review and patient assessment of care;

Part C Essential Structural Components

I Governing body

Management and administration, medical staff and nursing.

A major goal of the Agenda For Change is to substantially upgrade and modernize the accreditation survey process. Certain changes in the survey process are necessitated by other Agenda For Change initiatives i.e., standards, revisions and the development and application of performance measures (indicators). Accreditation process changes are dictated by the requirement for more efficient and interactive processes that support meaningful on-site evaluation and education and are better tailored to the characteristics and needs of the surveyed organization. The accreditation process encompasses a range of activities that are initiated prior to the survey and extend beyond the rendering of an accreditation decision and survey report to appropriate

follow up activities. The design of the accreditation process model is intended to be responsive in substantial measure to extensive input received over the past two years through focus user groups and field questionnaires. The on-site component of the accreditation process addresses the actual survey of the organization which is the principal source of new or confirmed data and information upon which the accreditation decision rests. Related activities such as education conferences conducted on site are included in this component. Standardized sampling techniques would be developed that are appropriate to the nature of specific lap top computer technology. This would be used on-site to the greatest extent possible to support the survey team and to enhance inter-rater reliability. An important component of the Joint Commission's Agenda for Change is the development of an indicator based performance monitoring system for accredited health care organizations. This system is intended to provide information that can be used by health care organizations to improve the quality of patient care and by the Joint Commission to foster improvement in all accredited organizations. An indicator is a quantitative measure of an aspect of patient care which can be used as a guide to monitor and evaluate the quality and appropriateness of health care delivery. Indicators will be used by organizations to continuously monitor, evaluate and improve care. Indicators are not direct measures of quality but rather, screens or flags that would indicate areas for more detailed analysis. All variances in indicator data do not necessarily indicate a problem and all problems in the organization will not necessarily be exposed by variances in indicator rates or frequencies. At least three dualities are associated with indicator type:

- I Sentinel event vs. rate base
- Desirable event vs. undesirable event
- Process vs. outcome

A sentinel event indicator measures a serious undesirable and often avoidable process or outcome. Each one of which deserves more detailed analysis.

A rate base indicator measures a patient care event that requires further assesement. If the rate of event shows a significant trend within an organization over time or evidences significant differences when compared to that of peer institutions, rate base indicators may be measures of desirable or undesirable events.

Indicators may also measure a process or outcome of patient care. A process indicator addresses an activity that is performed (e.g. the care provided to the patient). Outcome indicators focus on the results of process (e.g. the resultant health of the patient after care is provided). Although there has been debate over whether

process or outcome indicators best assess quality, there is growing consensus that both types are necessary to assess the quality of care provided by an organization.

This whole system, once in place, gives clinicians, managers, persons in the governmental structure valuable information for the maintenance and improvement of quality of care, resource use and development including budgetary formations. Those of use who work in corrections need all the help we can get in order to provide quality services to our patients. The Joint Commission accreditation is a positive force to help us in this task.

Questions will be taken.

SOME SUBVERSIVE RUMINATIONS ABOUT
PRISON MENTAL HEALTH WORK

BY
HANS TOCH

SOME SUBVERSIVE RUMINATIONS ABOUT PRISON MENTAL HEALTH WORK*

Hans Toch

Let me start with one of my legendary shaggy dog war stories. One justification is that it is a cautionary tale that involves prison mental health staff. A second reason is personal: the incident is one that changed the direction of what I have been doing these past forty years.

At the time of the incident I was working in California prisons studying violence. Then, as now, I spent a great deal of time immersed in inmate records, and for several weeks I did so at the California Medical Facility in Vacaville. For the sake of convenience I would take folders to the prison library, which was deserted and friendly and quiet.

During much of the day, the sole occupant was the inmate librarian, a small, middle-aged man who knew and loved every book in the room, and never seemed to be anywhere except at his desk. The inmate had been involved in one of the most publicized crimes of the century. He had served a good part of his term on death row, and most of the rest in segregation settings outliving his reputation as a hard-core antiauthoritarian militant. By the time I got to know the prisoner, he was a charming self-educated eccentric -- a voracious reader and self-styled agnostic socialist, dated (like myself), but erudite, original and homespun, serious but self-deprecating -- a proletarian sage with

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a touch of pixy. One could sense residues of the tough time the man must have had -- he talked of conquering isolation through self-induced lapses of consciousness, and he communicated with me with unnecessary secretiveness (insisting on intimate whispers and passing notes) -- overkill, considering that we mostly had the prison library to ourselves. At the time of our acquaintance, the inmate's partner (the senior figure on his team) had been released and his own parole hearing was impending. His prospects of freedom seemed assured.

At this point in the chronology I had to leave for another prison. Before my departure I noticed protracted visits by mental health staff to the library, mostly to engage the librarian in unnecessary conversation. He wrote me, "They come to watch you drown instead of throwing you a rope."

A week later, the small librarian was dead. He had stabbed himself after the parole board had turned him down for parole. He had earlier told his assistant that he would kill himself if he was not paroled. The assistant shared the news with his wife and the prison censorship committee, who informed a psychiatrist. The psychiatrists told the parole board that the inmate was suicidal, and should not be released.

Needless to say, I felt devastated about having been unavailable to register my view, however impotently. And I resolved to spend part of my working life trying to highlight Catch 22 situations through which we compound the difficulties of troubled inmates in the system.

I have been concentrating some of my attention over time on prisoners who fall between cracks and those for whom special attention might make the difference between coping and noncoping in prison, and between surviving and going under. It is a worthwhile endeavor, and one in which you have the exciting opportunity to participate.

Pulling Switches and Pulling Strings

I conceive of two types of mental health-related thinking in prison: (1) administrative clinical, and (2) clinical. The first provides a basis for pulling switches. The second is the messy sort of thinking which tries to reflect the messiness (or complexity, if you will) of the human condition. I think of it as a basis for pulling strings. Both modes of thought are necessary and must respect each other, because each reflects a reality of consequence.

Two years ago I met with classification analysts at our reception center to talk about prison environment-related classification, but their first question was, "Does your procedure distinguish between mentally ill and non-mentally ill inmates?" I was tempted to trace overlapping circles on the board, or talk about how no one could draw that distinction with most people in that room. But I restrained myself because I knew what they were really telling me. They had a job to do, and I could not help them. I compromised by saying that if they wanted to talk about the MMPI, I was the wrong man.

That may be a flippant response, but I am serious about the need for ambidexterity. As an example, consider the fact that

most patients committed to hospital are diagnosed as suffering from some type of schizophrenia, and are discharged as schizophrenics in remission. That is as it should be, and the enterprise has integrity. But it is also true that while symptoms come and symptoms go, underlying process is more obdurate, and the word "remission" covers a great deal of ground. Mapping and somehow covering such ground is what I mean by "complexity" and complexity calls for a concern beyond discharge -- even beyond standard post-discharge recommendations such as for continued medication and follow-up interviews of the inmate.

If this assertion is confusing, let me confuse it further by confessing that I'm not sure what I mean by "clinical thinking" though I know it when I do it. The closest I can come is by recalling Adolf Meyer, whose name appeared on my doctoral comprehensive examination five decades ago. I may have pointed out then that Meyer saw mental health work as a running inventory of a person's coping capacities in relation to the sort of environment with which the person was stuck. Meyer thought of clinical work as including intervention in the environment where it taxes coping skills beyond what the person could handle. He very much thought of clinical work as keeping people from going under and helping them to adjust, and doing this flexibly over time.

What I am leading up to is clearly subversive, though I think it is constructively subversive. I am saying that once we have pulled a switch we can try to predict and affect the consequences for the inmate of what we have done, even though

he's on someone else's turf. I am advocating stretching our jobs to accommodate our vocations, which means pulling strings after we have pulled switches. Informal phone calls don't cost much, and I see nothing wrong with fraternizing with other staff in constructive conspiracies. The God of Confidentiality will not strike me if I pull a correction officer aside and tell him that I'd be concerned if Inmate Jones looks preoccupied, because chances are he's not worrying about car payments. I might suggest to the officer that he ask Jones a friendly question or two -- and call me if Jones takes time to answer, or if his answers are not completely responsive to the question(s). The point being, why wait until Jones arrives at his next switching point?

My favorite sermon has to do with prison guards. Not any old prison guards, but those guards who are puzzled about and interested in inmate behavior, would like to constructively intervene, but feel a profound sense of inadequacy -- usually about a lack of academic qualifications.

Even if such guards put up a tough front sometimes about only being concerned about the custodial impact of disturbed inmates on other inmates, there is usually a lot of mush under that front, and a desire (with which we ought to sympathize in terms of our own fate) to expand a job that can be narrow and uninteresting into a meaningful, consequential role.

Guards of this kind make greater colleagues than most of us encounter in the settings in which we work, provided there is no mutual typecasting which becomes self-fulfilling prophecy.

Real communication can take place around joint concern for the personal difficulties and adjustment problems of individual inmates whom individual staff members -- civilians and officers -- have come to know, and about whom they care because they feel that the inmates are especially worthy, or suffer more than the average inmate, or have reached some sort of turning point where they can use help and can benefit from it, and where this help matters.

Even an orthodox medical perspective suggests an obligation to cross borders. My doctor often affects what I do outside his office -- or tries to influence it. He not only dispenses prescriptions but talks to me about exercise (which I don't do) and discusses my diet (which is a mess). If I worked too hard (which I don't) he might suggest that I cut down. I have others around who try to affect my environment to preserve my health; my wife hides the salt cellars and my offspring yell at me when I light a cigar.

I am not otherworldly enough to deny or ignore the fact that interface problems exist between some prison staff and other prison staff. (Many? Some? What kinds of problems? -- I wish I knew, but I haven't seen many psychologists or chaplains in the drinking holes where C.O.s congregate after their shifts.)

I suppose I would argue that there are two opposing ways of mishandling the matter, one of which is more obvious than the other. The obvious mistake is to role-play one's assigned stereotypic role, which is for the officers to act tough and custodial and hard-bitten and practical and experienced and for

the rest of us to act academic, to wallow in jargon and to pretend we are the only people who have the inmates' interests in mind and at heart.

The opposite mistake -- it seems to me -- is for civilian staff to act cynical and talk custodial, to swagger and to regale fellow guests at cocktail parties with anecdotes about hard-bitten thugs one has known and other prison war stories, while officers take night college courses in Psychology 101. In such role reversals, it seems to me, we adapt the most dysfunctional and least flattering attributes of the other roles, while underselling the humanity that is -- or ought to be -- the common denominator of both.

In this connection it is well to guard against a deeply felt concern which is endemic among staff in prisons. This concern has to do with not being conned, corrupted or used by individual inmates, with not getting too close to an inmate because this invites being taken advantage of, on the assumption that it is a short distance from favoritism to breaches of security, given the wiliness of inmates and our relative lack of sophistication with respect to the jungles of the inmate underworld.

I say this theme is complex because it refers to a delicate balance and an individualized judgment and a precarious line it is very hard to draw, and because it is based on truth or untruth depending on whose relationship with whom is at issue, and on the quality of that relationship.

I'm not suggesting that we spend our time counseling inmates who want to gripe or explore their philosophies of life, or who

are mainline neurotics in search of exoneration. I am suggesting that we take a flexible view of our work, even if this seems to mean poking our noses into custody's business. As long as we are "mental illness staff" there is a sharp line between us and the prison system, and border conflicts are possible. But if we are mental health staff we can think of bridges instead of a frontier, and who wears what hat may become less relevant.

Clinical Classification

One reason for belaboring the issue is that forensic mental health workers are blessed -- if that's the word -- with clients who are uniquely prone to being categorized in strange ways. There are insanity acquittees and deemed incompetents and parole board referees and hospital commitments and all sorts of strange taxonomic beasts, and the problem is that few categories make sense in the only way a mental health problem can make sense -- as a description of a person in terms of the sort of service he or she could benefit from in the absence of administrative constraints.

A good example of the disjuncture is the category "suicidal" -- meaning a person someone has set aside because it is possible that the person might try to commit suicide. Now, that is not a description of a need for service. The real description would have something to do with the person being profoundly depressed and needing someone to talk with, which is not the same as being placed in an observation cell so that he or she can be observed.

A story appeared in the *APA Monitor* in 1984, about a group of Cubans in the federal system who had arrived here in 1980 and

are/were receiving mental health care before being involuntarily repatriated. According to this article,

Within the Cuban culture, clinicians learned, men may express frustration through self-injury. Some took sharp objects and cut themselves repeatedly on their arms, legs or stomachs. Emergency room personnel diagnosed them as mentally ill, but further evaluation didn't support that diagnosis.

I had lived in Cuba for six years, and had never heard of the cultural prescription at issue. I have no doubt that the Cubans who mutilated themselves had earlier been over-diagnosed, but I also have no doubt that they were later underdiagnosed, even though self-injury is the sort of language which carries no translation problems from Cuban Spanish to pigeon Spanish. I suspect that what was involved was not a cultural tradition but an overwhelming sense of impotence and frustration. It may also be that at some level we did not want to understand this last-ditch protest against what we were doing when we could think of nothing else to do, and our impotence met theirs. The closest to a cultural theme was probably the sort of plea for nurturance and assistance which we pejoratively call "attention getting" to undersell its seriousness.

The same point holds for Latin prisoners in general, who injure themselves more frequently than non-Latin whites, who in turn injure themselves much more frequently than black inmates. I know of no white culture that says that "men may express frustration through self-injury." Pseudo-anthropology has no place in prisons. Neither does the substitution of diagnoses for understanding.

I once perused the folder of a former inmate that illustrates some of the risks we incur. The man in question had been hospitalized five times; on three occasions the shipping invoice described him as a psychotic and, the receiving form classified him as a sociopath; on each occasion the invoice accompanying the shipment back to the prison diagnosed the prisoner as a malingerer. Three days after the first return shipment the man hung himself, but was cut down in time. And he did all sorts of strange things in prison that would have made it clear to the most hard-hearted hospital staff member that he had very serious problems.

Mental health staff in the prison expressed outrage and a sense of impotence through entries in the man's file. One psychiatrist noted that hospital diagnoses notwithstanding he thought that the patient was psychotic; he admitted that he could not elicit delusional thinking -- assuming, of course, that the inmate really owned a hotel in the Bahamas! To illustrate the viability of the malingerer label, the inmate described his vocational plan to the parole board as proposing to run an international pornography ring. He had accumulated samples of merchandise, and tried to sell some during his pre-parole interview.

Such ridiculous stories could not be told if we saw our business as jointly making sense of inmate difficulties, and if we pooled observations and thinking to this end alone.

The fact remains that the line between pathology and parts of the spectrum of offense and management problems is not easy to

draw, and we know it. Others know it too -- inner city school teachers, for instance. Mental health is a spectrum. If our interests gravitate toward extremes, our view of those extremes becomes obsessed with tracing borders between people who almost qualify for attention and those who unqualifiedly do. With health this makes sense; with mental health it does not. There is no such thing as almost having the measles or being a borderline host to cancer, but many of us walk around being schizy or paranoid, or depressed beyond the call of situations, or compulsively exploitive, or moody or explosive. While some wear pathologies on sleeves, others strain to put up a front to keep off mental health caseloads.

Transcending the Prison Environment

Having said all this, let me stress that many of us do a great deal of good for a great many prisoners, and our achievements are often unsung or insufficiently sung.

In this connection, I should like to briefly mention the phenomenon of pluralistic ignorance. I encountered this phenomenon first in a hospital setting. What happened is that in public meetings, clinicians to a person described the impossibility of working in the setting, the constraints posed by administration and other stultifying conditions, including the ingratitude and unresponsiveness of patients. After a certain amount of private drinking -- usually in the early morning, I heard about victories and successes, about the times when a humane or insightful intervention made a difference, about ex-

patients who kept in touch, and about things that one had learned that one hadn't known before.

But pride and idealism were the subjects of almost secret confessionals, and alienation and cynicism were the public, advertised facade -- the vociferous consensus. Of course, this meant that everyone assumed that everyone else was bitter and cynical and hard-bitten, and was just putting in time. I have later encountered this phenomenon in all sorts of settings including among correctional officers, where the themes are only slightly different.

One cannot be sure why a majority of closet idealists are somehow convinced that they are surrounded by a hard-bitten majority of jaundiced cynics. I suspect there is something about not wanting to be mushy and humane and vulnerable in a world we all know calls for realism and toughness and pessimism and a feeling of sadder-but-wiser impotence.

Postscript

I know that psychologists and psychiatrists are not falling over themselves to work in forensic settings, and I don't think it is just that they hate being poor. The forensic worker's status is strange enough to invite a psychoanalytic explanation. This is so because on the one hand, what forensic mental health workers do is more newsworthy than what other mental health workers do, and gets considerable space in mental health trade publications, and the media that reach real people.

On the other hand, one gets a feeling of second class citizenship, of being engaged in a slightly disreputable,

marginal enterprise -- a bit grubby, maybe -- something that ought to be done but it's nice that somebody else is doing it -- like garbage collecting.

I suspect the real point is twofold: (1) most mental health experts suspect they do not have the expertise to deal with offender clients, which makes them denigrate the expertise that is involved, and (2) most mental health experts are afraid of criminal justice clients and suspect they might get clobbered the first time they walked into a room with an inmate, besides not knowing what to say to the inmate. They feel similarly about the experience of walking through the gates of a prison into an incipient riot. Again, the best way of handling these feelings (beside denying them) is to downgrade the work that is performed by people who successfully handle what respectable persons like ourselves could not handle.

I hope I have convinced you that I personally do not share this view.

THE FEDERAL BUREAU OF PRISONS VALUES PROGRAM:

LIVING FREE

BY

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**THE FEDERAL BUREAU OF PRISONS VALUES
PROGRAM: LIVING FREE**

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Introduction

There is a general sense in our country that there has been an erosion of basic values over the past 30 years. Although many people have difficulty articulating exactly what has changed, and certainly disagree on the specific causes, the changes are experienced in very real ways. For the average citizen there is likely a sense of outrage and despair at the prevalence of drug abuse and crime. Despite a doubling of the prison population in the 1980's and the highest rate of incarceration in the world, it is clear that most people do not feel safer today than in years past. The media bombards them with stories of senseless violence. Their kids go to schools that are often saturated with drugs, violence, and weaponry of all types. Despite elaborate security systems, they do not feel safer in their homes. In response many have a natural reaction of "circling the wagons" and protecting themselves and their families as best they can. This reaction while understandable, does little to resolve the underlying problems and enhance a much needed sense of community.

Within the prison system we house those deemed by society to require isolation and punishment. Although the broad concept of "rehabilitation" has been in and out of vogue over the past 30 years, there is a growing realization that it has a valid role in an overall scheme of correctional intervention. There are abundant examples within the Federal Prison System of programs which offer tools of self-improvement to the inmate population (e.g., education at various levels, religious and psychology services, drug abuse education and counseling, vocational training, inmate organizations, and a variety of work opportunities through Unicor). Something that is missing is a "gateway" program that would direct, encourage, and hopefully enhance inmates' participation in the resources available for their self-improvement. Such a program must be anchored in a framework suggesting that certain core values need to accompany real change (i.e., we would be less than successful if we simply helped develop a more educated bank robber who went to church on Sunday and had a good sense of self-esteem).

The Bureau of Prisons Executive Staff recognized the importance of addressing values when it established the following bureau-wide objective for FY93:

5.12 - Implement a values development program for inmates which will assist them in developing a more socially acceptable lifestyle after release, thereby increasing public safety.

In December 1992, a group of five psychologists from the Bureau of Prisons met in Denver, Colorado to develop an outline for a pilot values program. This group's experience with offender populations totaled more than 72 years. The program they developed, entitled **Living Free**, will be "piloted" in the spring of 1993 at seven select institutions. This program draws from what was judged to be the best available material on the criminal lifestyle (Walters, 1990) and cognitive psychology (Maultsby, 1975), and just as important, on their experience working with all types of offenders in different settings and treatment programs.

Program Overview

The goals of the 8-part **Living Free** program are to have participants; 1) review their current lifestyle looking at the costs and benefits of criminality, 2) review the values reflected in their lifestyle, 3) understand how specific patterns of thinking support their values, 4) gain an understanding of the process inherent in changing values and habitual patterns of behavior, 5) see how their choices of activities and associates influence relapse into old habits, 6) gain an appreciation of the role that family and community play in their lives, and 7) as a result of the previous insights, the participants will develop a specific plan for lifestyle change. Each of these seven goals is accomplished in a group session lasting between two to three hours. The group facilitator concludes the program in an individual session with each participant. During this session the facilitator provides feedback to the inmate relative to both his/her general participation and, very importantly, to the plan for change which he/she has developed.

It is critical that any program designed to address the modification of an inmate's core values clearly outline the basic premises on which it is based. The premises of the **Living Free** program are as follows;

- For the vast majority of our inmates, crime is best understood as a lifestyle choice made by the offender.
- This choice is influenced by certain conditions in the offender's life. These conditions include a variety of biological, developmental, and environmental factors.
- While certain negative conditions may influence choice and limit options, they do not determine behavioral decisions. Choices are also clearly influenced by the values and beliefs which the offender has adopted.
- Values that are reflective of lifestyle criminality include dishonesty, disrespect, intolerance, and irresponsibility.
- Unless an inmate's values and supporting belief systems are modified, lasting behavioral change is not likely.
- An individual is capable of modifying his/her thinking, values, and choices. Especially as adults, we need to accept responsibility for our actions.

It should be emphasized that this 18 - 20 hour program is not intended to undue a lifelong pattern of criminality. The objective is to begin the process through self-assessment, examination of life options, and the development of a specific plan for change. The program is designed to involve the participant at the cognitive, emotive, and behavioral levels. Group exercises, discussions, homework assignments, handouts, presentations, and videotapes have been selected because of their anticipated impact. Five of the seven group topics use segments from a video program entitled "The Price of Freedom is Living Free" (Kindred Publishing, 1993) to initiate discussion and facilitate interaction. These tapes, which feature former and currently incarcerated individuals, focus on the values of honesty, tolerance, respect, and responsibility. [During the symposium participants will sample the materials, exercises, and tapes utilized in the program.]

The initial response of the inmates to the pilot program material has been quite positive. The program is generally viewed as challenging and practical. Most of the inmates comment that there is a great need for follow-up that will allow continued practice of the values presented within the program. The workgroup will develop options for such follow-up.

Summary

The best solution to the problem of eroding values within our country probably begins with interventions that directly strengthen the family, schools, and community. Positively impacting on adult offenders within the federal system, especially the career criminals who account for a disproportionate number of offenses, is also an important aspect of influencing society, however. These offenders, the overwhelming majority of whom return to the street, each influences scores of others in the community. This influence is ultimately felt in all of our families, schools, and communities.

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USING LOGOTHERAPY WITH DRUG ABUSING AND/OR
"LIFER" INMATES

BY

WILLIAM K. MAREK, Ph.D.

FEDERAL BUREAU OF PRISONS

Using logotherapy with drug abusing and/or "lifer" inmates

by: William K. Marek, Ph.D.

One feature of this country's "War on Drugs" has meant that criminals are being given longer sentences. This has increased the desperation, hopelessness, and melancholy of many inmates. They see no reason (and can find no method) to live their lives with purpose, meaning, conviction, and direction, believing only that it is inevitable that their lives be filled with anger, self-pity, and empty despair...until they once again "hit the streets."

Part One of this paper will present an exegesis of Albert Ellis' Rational Emotive Therapy (RET). Part Two will summarize Viktor E. Frankl's *Psychotherapy and existentialism: Selected papers on logotherapy*. Frankl was a psychiatrist, survivor of a WWII concentration camp, and originator of logotherapy. Part Three will present Frankl's two logotherapeutic techniques of Dereflexion and Paradoxical Intention. These two techniques will be augmented by a compilation of paradoxical techniques found in Weeks & L'Abate's *Paradoxical Psychotherapy*. The paper will be freely notated with Ellis' A-B-C-D system.

In Frankl's logotherapy, choice is of paramount importance in living a happy, fulfilled life with purpose and meaning. External factors such as wealth or poverty, prison or beach, concentration camp or mountain top play a substantially less important role. RET and logotherapy are fully compatible because they both stress choice, personal responsibility, overcoming adversity, and the primacy of belief and thought.

Part One

Ellis posits an A-B-C-D theory of psychotherapy that emphasizes the preeminence of Belief (or thought) over an Activating Event (a situation that triggers the A-B-C-D process). C stands for Consequences (short- and/or long-term, good or bad, emotional or corporeal) that are engendered almost exclusively by the Beliefs the person has acquired about the Activating Event. D is an attempt to Dispute the professed Beliefs, if the Beliefs have been leading the person to some bad Consequence.

Activating Events

Activating Events are usually thought of as situations that have just occurred. Pretend a magic video camera exists that captures all events on camera. Play and replay this videotape of any given event. Do the same things happen over and over? Does some fact that occurs on the tape ever change? Do the words spoken by two individuals in an argument ever change? Does a person's sweater ever change color from blue to red? Does the location of the rooms in a house where an argument occurs ever change? NO. All of the facts, all of the small realities that the videotape

shows, are forever unchanging and unchangeable. A person may be aware of only a small portion of the surrounding events but they exist nonetheless. How many realities, then, are there to this videotape? One. By analogy, then, how many realities are there in a videotape of what occurs in a small town? One. A videotape of what occurs in the world? One. As proof, "watching" the videotape clearly demonstrated that nothing on it changed.

The critical points about Activating Events are that **there exists one...and only one...reality to the world and that Activating Events can rarely be changed.** Activating Events may be on-going (being halfway through a prison sentence) but they usually lie in the past. If the Activating Event is old enough, it cannot be changed.

The genes children receive from their parents are a reality. Each child is clearly genetically different. In addition, there is one reality to the physical, social, and familial environment for one person for any given second of time. What the particular physical, social, and familial events experienced by this individual consist of for a given period of time constitute part of that individual's reality and are a part of their personal life history. Whatever events have already occurred are a reality, and cannot be changed.

Another example of an Activating Event is the death of another. The Consequence experienced primarily depends **not** on the Activating Event (the death) but the Belief about the person who died. The emotional Consequence will be vastly different if the person who died is a treasured loved one as opposed to some unknown person who died thirty years previously.

Other Activating Events include having one person end a relationship with another. The other person *may* be coaxed into returning to the relationship but if the other person is gone, that is a plain fact, a reality. If the person returns, there is a new reality to the relationship. There is an Activating Event, a reality, to the color of skin. There is a reality to getting cut off on the road by another driver. There is a reality to the number of individuals (1,800,000, state and federal) in America who are in prison, in jail, on parole and probation, etc. There was a reality to the crime rate in America during the Depression in the 1930's. There is a reality to the number of Americans living in poverty (34,000,000 Americans earned less than \$10,600 for a family of four, according to the 1990 census).

There is one reality to the sound of a ringing telephone, whether or not it rings at 4 a.m. or 1 p.m. There is a reality, an Activating Event, to consuming a specified amount of alcohol. This amount can easily be measured. There is a reality to the amount of nicotine (or any other drug) consumed after a period of abstinence. There is a reality to a three-year-old who falls down and skins her knee. There is a reality to the length of the workday. There is a reality to the pieces of metal or paper that are commonly labeled

"money." The Activating Event of money, the reality, is that they are just bits of metal and paper. There is an Activating Event, a reality, to a signature. Although different individuals have different signatures, a signature is only a signature.

Finally...Karen Carpenter had an Activating Event, a reality of being very thin.

Beliefs

Beliefs constitute the heart of Rational Emotive Therapy. Beliefs can reasonably be monitored, enriched, and improved. What a person Believes about an Activating Event will, in almost all cases, determine the Consequence. Individuals who exhibit irrational thinking (criminals, depressives, addicts) generally over utilize the following words: *shouldn't, can't, never, always, must, have to, and need.*

For example, a sentence (A) one person interprets (B1) as "fightin' words" (and ends up throwing a punch) (C1), may be interpreted by another person as humorous (B2), and the second person will laugh (C2). Good marital therapy mainly involves getting the couple to share the same Belief about the one reality in which they live (A)...or to determine that the couple's Beliefs are so far apart as to what constitutes appropriate behavior for a spouse that a divorce (C) is best.

If a person holds Catholic Beliefs, the Consequence will consist of going to Mass on Sunday. If the person changes religions, the Beliefs change first, followed by the new Consequence (going to Temple on Saturday).

Children in a family may experience somewhat the same reality although the specific realities (genes and environment) for each child are different. Even though one of the realities of a household (A) may be to try and influence the children to acquire law-abiding Beliefs, some children choose (B) to go their own way (C). Although environment and genes are important, what the person chooses (B) to do (C) with their genes and environment is immeasurably more important.

It is the Belief about the color of the skin (A) that is critical, not the skin color itself. Certain Beliefs about skin color may manifest themselves as racist activities (C). The actions taken by a driver (C) in response to being cut off by another driver (A) will depend on the Beliefs of the first driver. Since there are so few incarcerated individuals (A) compared to those defined as poor (A), it seems logical that crime (C) has less to do with the actual amount of money present in a household than with the antisocial Beliefs of those who actively choose such a lifestyle (C). The crime rate went down in the 1930's (C), presumably due to a national malaise (B) of "everyone being in the same boat."

It is the learned Belief about the telephone ringing at 4 a.m. (A) that causes the emotional Consequence. This is an example of automatic thinking, thinking that occurs so quickly it seems like the Activating Event itself (the telephone ringing) is the cause of the fear (C).

Contrary to the disease model approach (A) it is the Belief about the drug consumed (A) that is most critical in an addict's recovery (C). Biology (A) is not behavior (C). Even though the addict may have consumed only one beer (A), the Beliefs of "I'm one drink away from a drunk, it just goes to show you I'm an alcoholic, I've fallen off the wagon" and, "Oh, no, I've failed again!!" are far more likely to contribute to relapse (C) than the reality of one beer (A).

After falling down and skinning her knee (A), a three-year-old often looks to her parents to see if she should acquire the Belief she is actually hurt (C). Even though there are typically eight hours in a workday (A), the Beliefs of perfectionists commonly push them to overwork (C). There is a common societal Belief that those round pieces of metal and green rectangular pieces of paper (A) are worth something. There is nothing inherent in money that makes it valuable.

The Activating Event of a signature is that it is only a signature. However, the primary reason a private citizen cannot sign a bill into law, for example, is the Belief individuals hold about the person doing the signing. Witness the chaos that occurs in some countries during a change in power (when a government attempts to introduce a new reality, a new Activating Event). Fledgling governments (or political parties) attempt to establish their legitimacy by Disputing the Beliefs the citizenry holds about the legitimacy of the old government. If a citizen does not Believe, this citizen may experience a bad Consequence.

To conclude Beliefs...Karen Carpenter's Belief was that she was very thin.

Consequences

Consequences are the feelings experienced by a person (sadness because of the Belief about the death (A) of a certain person). Consequences may also be viewed as acted-upon Beliefs (a behavior). If a person holds Beliefs that society deems as moral and upright, this person's Consequence will be to engage in moral and upright behaviors (C). The converse is also true: criminogenic, antisocial Beliefs lead to criminal activity (C).

Racism (C) is a function of the Beliefs held by racists. If the Beliefs are strongly held, the racist activities (C) are more pronounced. Due to strongly held Beliefs by some drivers about the activities of other drivers (A), gunplay on our roadways (C) has

become more frequent. Due to the learned Belief that "the telephone ringing at 4 a.m. means trouble," most people experience fear (C) when the telephone rings at that time. The Beliefs held by an addict about using a proscribed substance after a period of abstinence will be of fundamental importance in determining whether the addict experiences a lapse (C1) or a relapse (C2).

If a three-year-old falls and skins her knee (A), her Consequence may be influenced by the message her parents send her about how to react. If it was the exigencies of the eight-hour workday (A) that caused perfectionism (C), then everyone would exhibit these behaviors (C). Because the Beliefs of perfectionists drive them beyond what can reasonably be expected (B) in one day (A), their Consequences often include ulcers, headaches, and stress.

Were it not for the societal Belief about money being valuable, money would be only what it really is - bits of metal and paper (A). Due to the Belief, however, these bits of metal and paper (A) can actually be used to obtain goods and services. A country at war with another often floods the second country with counterfeit money so that the citizens' confidence level (B) in the value of their money decreases.

To finish this section...Karen Carpenter's Consequence was to die. Which was most important, her Belief about her weight or the reality (A) of her weight? At first glance, it seems like her A because she died due to being so thin. However, what powered this reality? What caused her to take the laxatives and emetics? Obviously, it was her Belief about being thin.

Disputation

Maultsby (1980) has formulated five rules that are to be used when investigating the validity, efficacy, rationality, and reasonableness of a Belief. These rules are as follows:

- 1.) The belief is based on fact. (Is it a fact (A) that she **SHOULDN'T** have done what she did? Probably not. You cannot control **ANY** other person, even if you have done nothing to bring about the activity.)
- 2.) The belief is most likely to preserve your health and life. (If not, the belief should be modified or discarded.)
- 3.) The belief enables you to achieve your immediate and long-range goals most quickly. (If not, the belief should be modified or discarded.)
- 4.) The belief helps you avoid significant conflict with others.
- 5.) The belief helps you feel the way you want to feel.

If the Belief fails these rules, the words used to replace it are *prefer* and *rather*. For example, "I would prefer that he not have cut me off on the road but I cannot change another person. I will exhibit internal control (B) and not chase him with my own car

(C)." Or, a grieving person will eventually come to hold these kinds of beliefs (although they may not be formulated so explicitly): "I would have preferred (B) that my husband not have died (A). Unfortunately, he did. I will grieve appropriately (C) for as long as it takes...but I will (painful sigh) eventually move on."

In Karen Carpenter's case, the power of Beliefs over reality (A) cannot be denied. Even though many attempts undoubtedly were made to Dispute her Beliefs, her beliefs proved too strong.

Part Two

The following material has been summarized by this author from Frankl's *Psychotherapy and existentialism: Selected papers on logotherapy*. Page numbers are included in order to facilitate finding the reference.

Only two classes of people maintain that their will is manipulated (A) and their thoughts (B) controlled by others (A): Schizophrenics and deterministic philosophers. (p. 2)

Man is not free from conditions (A), be they biological, psychological or sociological in nature. But he is, and always remains, free to take a stand (B) toward these conditions (A); he always retains the freedom to choose his attitude (B) towards them. Man is free to rise above (B) the plane of somatic and psychic determinants of his existence (A). Man can reflect on himself from a distance. (p. 3) [Paradoxical intention.]

The Will to Meaning

...pleasure is a by-product (C), or side effect, of the fulfillment of our strivings...but is destroyed and spoiled to the extent to which it is made a goal or target (C). The more a man aims (B) at pleasure by way of a direct intention, the more he misses his aim (C). (p. 5) [Examples include erections and orgasms: a conscious struggle (B) produces poor results (C).]

Self actualization (C), like power and pleasure, also belongs to the class of phenomena which can only be obtained as a side effect and are thwarted precisely to the degree to which they are made a matter of direct intention (C). (p. 8)

...it is my conviction that man should not, indeed cannot, struggle for identity (C) in a direct way; he rather finds identity to the extent to which he commits himself (B) to something beyond himself, to a course greater than himself (C). (p. 9)

If a person is taught that his concern (B) about an ultimate meaning to his life (C) is no more than, say, a way of coming to terms with his early Oedipal situation (A) [then much opportunity and effort will have been misplaced and misdirected. The

difference between logotherapy and psychotherapy is as follows:] During psychoanalysis, the patient must lie down on the couch and tell you things that sometimes are very disagreeable to tell. In logotherapy, the patient may sit erect, but he must hear things (D) that sometimes are very disagreeable to hear. (p. 11)

Existence falters (C) unless it is lived in terms of (B) transcendence toward something beyond itself (C)...Man is responsible (B) for the fulfillment of the specific meaning of his personal life (C). But he is also responsible before something, or to something, be it society, or humanity, or mankind, or his own conscience. (p. 12)

The Meaning of Life

While no logotherapist prescribes a meaning, he may describe it. (p. 14)

But even in a situation (A) in which man is deprived of both creativity and receptivity, he can still fulfill a meaning in his life (C). It is precisely when facing such a fate (A), when being confronted with a hopeless situation (A), that man is given a last opportunity (B) to fulfill a meaning - to realize even the highest value, to fulfill even the deepest meaning - and that is the meaning of suffering (C). (p. 14)

Life can be made meaningful (C) in a threefold way: first, through what we give to life (C) (in terms of our creative works); second, by what we take from the world (in terms of our experiencing values); and third, through the stand we take (B & C) toward a fate we no longer can change (A) (an incurable disease, an inoperable cancer, or the like.) (p. 15)

[Frankl gives an example of a man who experienced severe depression (C1) caused by (his belief about) the death of his wife (A1). Frankl asked him what would have happened if he had died first (A2). The man realized how painful (C2) this would have been for his wife. Frankl then said] such a suffering has been spared her...but now you have to pay for it by surviving and mourning her (C1)....We have to try (B) to reach the absolute best (C) - otherwise we shall not even reach the relatively good. (p. 17)

Freud was enough of a genius to be aware of the limitations of his system, such as when he confessed to Ludwig Binswanger that he had "always confined" himself "to the ground floor and basement of the edifice." [Frankl says we need "height psychologists," individuals who would] do justice to man's higher aspects and aspirations, including their frustrations (C). John Glenn wrote that what is needed is a "basis of convictions and beliefs so strong (B) that they lifted individuals clear out of themselves and caused them to live, and die, for some aim (C) nobler and better than themselves," and that one should teach students that "ideals are the very stuff of survival." (p. 18)

...ultimate meaning (C) is no longer a matter of intellectual cognition but of existential commitment (B & C). (p. 34)

...but man is ultimately self-determining. What he becomes (C) - within the limits of endowment and environment (A) - he has made himself. In the living laboratories of the concentration camps (A) we watched comrades behaving like swine (C) while others behaved like saints (C). Man has both these potentialities (B) within himself. Which one he actualizes (C) depends on decision (B), not on conditions (A). It is time that this decision quality (B) of human existence be included in our definition of man. Our generation has come to know man as he really is: the being that has invented (B) the gas chambers of Auschwitz (C), and also the being who entered (B) those gas chambers upright (C), the Lord's Prayer or the *Shema Yisrael* on his lips (C). (p. 35)

...pleasure (C) is primarily and normally not an aim but an effect, let us say a side effect, of the achievement of a task (C). In other words, pleasure establishes itself automatically as soon as one has fulfilled a meaning or realized a value (C). (p. 40)

It seems to me that the present increasing tendency to become addicted to tranquilizing drugs (C) is a sign that contemporary man has been more and more seduced to a belief in the illusion that he can strive for happiness, or for peace of mind (C). (p. 41)

...whether any circumstances (A), be they inner or outer ones, have an influence on a given individual or not, and in which direction this influence takes its way (C) - all that depends on the individual's free choice (B). The conditions (A) do not determine me, but I determine whether I yield to them or brave them (B). There is nothing conceivable (A) that would condition a man wholly (C), i.e., without leaving to him the slightest freedom. Man is never fully conditioned (C) in the sense of being determined by any facts or forces (A). Rather, man is ultimately self-determining. He determines (B) not only his fate (C) but also his own self (C), for man is not only forming and shaping the course of his life (C) but also his very self (C). (p. 60)

At one time, people turned to rabbis, pastors, and priests [during times of trouble (A).] Psychiatrists now find themselves in an embarrassing situation; he now is confronted with human problems (A) rather than with specific clinical symptoms. Man's search (B) for a meaning (C) is not pathological, but rather the surest sign of being truly human (A). How do (B) clinicians respond (C)? By viewing it as sick, a defense mechanism like reaction formation or rationalization. (p. 72)

Rudolf Dreikurs: "...the assumption of transference as the basic therapeutic agent puts the therapist in a superior position, manipulating the patient according to his training (B) and therapeutic schemes (C)." [Frankl adds] "his psyche considered merely as a set of mechanisms." (p. 80)

...people today are less endangered and threatened by too many demands than by too few....What man really needs is a sound amount of tension aroused by the challenge of a meaning he has to fulfill....A mind is healthy when it has achieved a sufficient share of meaning (C). (p. 83)

Oscar Wilde, in *The Ballad of Reading Gaol*, wrote that "Nothing in the whole world is meaningless, suffering (C) least of all." (p. 87)

But even in the United States - where society is so permeated by the belief that sooner or later science...will do away with man's predicament - there are rumors to the effect (D) that man is after all a finite and mortal being who inevitably has to face dying, and even before this, suffering. The essential transitoriness of human existence (A) adds (B) to life's meaningfulness (C). [Once it is in your past] it is irrevocably stored rather than irrevocably lost. (p. 88)

Through the right attitude (B1) unchangeable suffering (C1) is transmuted (B2) into a heroic and victorious achievement (C2). (p. 90)

[A life can be led meaningfully. Even suffering may not have been in vain. Your life can] be a monument....No one can remove it from the world....[You die] full of faith and pride. (p. 94)

[Even though a person may be in a concentration camp (A),] by virtue of that...called the "defiant power of the human spirit (B)," he had the possibility of holding himself above the influence of his environment (A). [Concentration camp inmates] experienced a moral progression (B & C) - moral, and religious. (p. 99)

Part Three

The material below has been summarized by this author from Frankl's (1969) *The will to meaning*. Frankl's two clinical logotherapeutic techniques of Paradoxical Intention and Dereflection

rely on two essential qualities and capabilities of human existence, self-transcendence and self-detachment. People are often haunted by a fatalistic expectation (B) of the crippling effects of their pasts (A) so they actually become crippled (C). [Psychology often explicitly encourages such thinking]. People suffer (C) more from the thought "I should (B) have complexes (C)" [from the bad things that have happened to me in the past (A)] than from actually having complexes.

1.) **Dereflection:** The harder you try for it, the farther away from it you get (C). This technique is especially good with sexual problems.

2.) **Paradoxical Intention:** Do, or wish for, the very thing you fear. Fear (B) tends to make happen (C) precisely what one fears. The more patients fight, the stronger their symptoms become. [If it's a heart attack you fear,] plan for it...schedule it...go try and have a heart attack. Suffer from anxiety only, not anxiety about anxiety.

Paradoxical intention should always be formulated in as humorous a manner as possible. The patient should detach himself from himself and thereby attain the fullest possible control over himself. Paradoxical intention is not good for psychotic depressions.

In psychodynamic terms, the patient is told to discharge the forbidden impulse. He is given permission to have a more permissive conscience.

The following compilation of paradoxical techniques is taken from Weeks & L'Abate's *Paradoxical Psychotherapy*. It is not an exhaustive list and does not address the machinations of full-blown paradoxical therapy. Paradoxical therapy should generally be used with a fuller understanding of the process than has been presented in this paper. When clinically appropriate, one or more of these classical extinction techniques may carefully be used in conjunction with certain other treatment modalities. Paradoxical interventions are contraindicated for psychotically depressed clients, crisis intervention, homicide, suicide, chaotic and impulsive families, situations where the client has been a victim of some trauma, certain disorders (e.g., pedophilia) and for addicts who might experience severe harm returning to the addiction.

Reframing: The therapist assists the client in changing (Disputing) the client's Beliefs about the Activating Event. The facts of the situation never change, but the client is assisted in seeing the reality in a different light. Example: "It's true that you got fired from your job (A), but you now can go back to school like you always had planned."

Relabeling: The client is taught to change (D) a specific meaning or connotation attached to a person or problem (A). Example: "This cancer (A) is a blessing (D) because it brought my family back together (C)." (Jill Ireland)

Prescriptions: There are many variations to this intervention but they all mean to "prescribe the symptom." A client could be instructed to experience the symptomatology, for example, as frequently and as strongly as possible (C). A client could be instructed to schedule a maladaptive symptom at a certain time of the day. The client will eventually recognize (D) the absurdity of the symptom and learn to laugh at it (C).

Restraining: Therapists expend much effort in trying to get the client to respond, think, or behave as the therapist wishes. The therapist is expected to always be supportive, helpful, and optimistic. When therapy does not proceed smoothly, the therapist works harder. A dangerous dependency relationship may soon be established where the therapist "saves" the client whenever therapy bogs down. The therapeutic process may stall so badly that the therapist believes it best to confront the client or make a referral.

"Restraining" is best summarized as "in order to change, stay the same or give up." Phrase the intervention with a positive connotation, give a prescription, and "restrain" the behavior. Therapist: "Well, it's really a good thing for you to be crying so much because of your grandfather's death. You'll probably want to keep track of how long you cry each day. However, you probably don't want to get better overnight."

Negative Consequences of Change: This is a useful technique for highly resistant or clients with problems of long duration. Have the client make a list of all the possible negative consequences if he or she actually were to improve. Try and foresee the responses of the client and be prepared to assist the client view the responses in a negative light. Client: "Leaving my house (which I haven't done in three years) would force me to meet other people (C)." Therapist: "Are you sure you want to meet other people so quickly after leaving your house? I think you should think about the possible negative ramifications (C) of such a decision." Client: "Well, if I leave the house, maybe I'll finally be able to get a date (C)." The goal is to compel the client into giving the therapist reasons why a consequence once perceived as "bad" is now good.

Inhibiting and Forbidding Change: Inhibiting Change forces clients to go slower than they think they should (B). The obvious benefit is that clients will press for quicker change. There are two methods of Forbidding Change. The first advocates allowing the client to "give in" to the problem. Therapist: "I want you to give in to the desire (B) to wash your hands (C). Let yourself go. Report back to me next week how many times you give in."

The second method of Forbidding Change is to tell the client NOT to engage in the behavior. The therapist later allows the behavior to occur in specified ways (prescription). This technique tends to reduce performance anxiety (B), which is often the root problem. This is often the technique of choice in sex therapy.

Declaring Hopelessness: In this technique, the therapist declares change to be impossible. This is a last-ditch technique to be used with a stubborn "yes, but..." client who has not responded to other interventions. The goal is for the therapist to gain control of the client's professed inability or refusal to change (B).

Predicting a Relapse: In general, a paradoxical prescription is followed by predicting a relapse. The prescription is successful if the symptomatology disappears. If the symptom does reappear, the client is placed in a "therapeutic double bind:" If the symptom reappears it is under the therapist's control, since she predicted it. If it does not reappear, it is under the client's control. The symptom has been defined in such a way that it can no longer be perceived as uncontrollable or spontaneous.

If the symptom reappears, begin additional prescriptions on a behavior that is now probably less severe. Since the symptom has been defined as being under someone's control, it is much less anxiety provoking. Other clients may attempt to prove the therapist wrong by not having a relapse. To help secure changes in thought and behavior made by paradoxical interventions, the therapist should continue to respond pessimistically: "Well, I know you two are fighting much less now, but aren't we moving a little too fast? You'll probably fight much more next week."

This paper was written under the auspices of the Federal Bureau of Prisons. It does not necessarily represent the official policy or opinions of the Federal Bureau of Prisons.

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**Identification Of Unresolved Issues With The Early Memory Procedure:
Assessing Violence Potential**

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IDENTIFICATION OF UNRESOLVED ISSUES WITH THE EARLY MEMORY PROCEDURE: ASSESSING VIOLENCE POTENTIAL

Many of us performing mental health evaluations are asked to help determine our client's potential for aggressive/violent behavior. The results of our evaluations are often given a lot of weight by our referral sources, as they make decisions which impact on the lives of many people. For example, State Boards of Pardon and Parole tend to place a lot of weight on our evaluations before they deny or grant someone parole. Likewise, State Classification Committees use our evaluations to place inmates at certain prisons and the Classification Committee within those prisons use our evaluations to place inmates within a specific dormitory. Our assessment of aggressive/violence potential is also used by the Local, State, and Federal Courts and by the Department of Family and Children Services to place people in specific treatment programs, to place conditions on parental custody of their children, to place children in foster care while allowing supervised visitation, and to terminate parental rights. These are "heavy" decisions, which is why we are asked to assist in the decision making process. The importance of these decisions becomes painfully clear when an inmate who has been paroled commits a violent crime often we gave him a mental health clearance. All at once, our psychological report reaches rational significance as it appears on the Evening News or 60 Minutes with the relevant sentences highlighted.

Since our psychological evaluations of aggressive/violence potential are often the cornerstones to legal decisions which affect many people, we must use the most reliable and valid measures of personality. The traditional objective and projective personality tests, namely the MMPI and Rorschach, have been proven over time to be excellent psychological tests, evaluating one's reality contact, logical thinking, perceptual accuracy, stress tolerance, mood, psychological resources, controls, defenses, needs, sense of self, and interpersonal style. In the hands of a good diagnostician, these tests are very sophisticated instruments which allow one to describe an individual's personality structure and thus make fairly accurate predictions and appropriate recommendations. Unfortunately, research has shown that our ability to predict dangerousness with psychological tests is a little better than chance (Monahan, 1981; Steadman, 1980).

An alternative to using traditional psychological tests to predict aggressive/violent behavior is the use of actuarial equations (Klassen and O'Conner, 1988a; 1988b; Norton, 1988; Selby 1984; Wenk, Robinson, and Smith, 1972). At first glance these equations appear to yield a higher degree of accuracy than psychological tests (Monahan, 1981) but closer examination reveals a significant number of false-positive and false-negative rates (Klassen and O'Conner, 1988a) and an absence of replication studies.

Given these limitations, Tobey and Bruhn (in press) note that a need

exists for assessment techniques which accurately identify individuals at risk for dangerous "acting-out" behavior. An instrument which is showing a lot of promise is the Early Memory Procedure (EMP) (Bruhn, 1989). The EMP is a projective technique which explores personality organization, especially current life concerns/unresolved issues. Additionally, the EMP helps us formulate a picture of the client's needs, interests, major attitudes and beliefs, and his/her perception of self, others, and the world (Bruhn, 1989).

Bruhn (1984) discussed some of the potential applications of Early Memories (EMs) in personality testing. One of these applications is the identification of individuals who are at risk for aggressive/violent behavior. Adler, founder of the School of Individual Psychology, was a strong advocate of using EMs for diagnostic purposes. He also noted the wealth of clinical information in the EMs of a criminal population (Ansbacher and Ansbacher, 1956). Unfortunately, very few clinicians and researchers have investigated the merits of such a procedure. A handful of studies have been performed with criminal populations but the samples were very small, the studies were poorly designed, and the instruments varied across studies (Opedal 1935; Thatcher, 1979; Wolman, 1970; Quinn, 1973; Reinaies, 1974; Plottke, 1949).

In the early 1980's, Bruhn developed a Cognitive-Perceptual Model (Bruhn & Last 1982a; Bruhn and Schiffman, 1982; Bruhn and Bellow, 1984, 1987; Bruhn, 1984, 1985) which allowed us to do therotically oriented research with EMs without a rigorous grounding in psychocanalytic or Adlerian theory, both of which require several layers of inference before one can proceed from the data in the memory to the interpretations (Bruhn and Last, 1982; Davidow and Bruhn, 1990). This model was used by Bruhn and Davidow (1983) to isolate several key elements in delinquent protocols that differentiated them from a matched sample of non-delinquent EMs. Bruhn and Toby (1991) noted that a total of 80% of the delinquents were accurately identified in this post-dictive study as were 100% of the non-delinquents. Davidson and Bruhn (1990) reported in a replication study, with a matched sample of 71 delinquent and non-delinquent boys, that 81.7% of the delinquents and 95.8% of the non-delinquents were correctly identified. Another significant finding was a false positive rate of only 4.9%.

The EMP's ability to discriminate a criminal from a non-criminal population has been impressive. In order to investigate the EMP's sensitivity, we decided to perform a pilot study testing its ability to discriminate between types of crimes. We assumed that the type of crime committed by an individual was not a random event. The reasons for an individual becoming a thief vs an arsonist vs a child molester vs a murder vs all of the above, may very well be tied to unresolved issues of abuse which can be identified by the EMP.

We must remember that recollection of the past is not a random or haphazard process. Bruhn's cognitive-perceptual model states that EMs are those recollections which have the most significance for us at this

time in our life. We remember useful information, not useless information. Consistent with this principle of utility, Bruhn (1989) proposes that EMs have the greatest ability to help us understand our major unresolved issues. When these early recollections cease to have utility, they fade in clarity and recede from consciousness.

Based on these assumptions, and previous research, we developed the following hypothesis.

1. The number of inmates with abusive themes will vary as a function of their crime. More specifically, we expect to see more violent inmates with abusive themes in their EMs than non-violent inmates.
2. The average number of abusive themes per inmate will vary as a function of their crime. We expect to see more abusive themes per violent inmate than per non-violent inmate.
3. The percentage of all EMs with abusive themes will vary as a function of the inmate's crime. We expect to see a greater percentage of EMs with abusive themes from violent inmate's EMs than from non-violent inmate's EMs.

METHOD

Subjects

The sample consisted of 32 maximum security male inmates, incarcerated at Georgia State Prison. Sixteen of these inmates were charged with robbery and 16 were charged with murder. Out of the 16 inmates charged with murder, 6 were also charged with rape. The mean age was 33 years old with a range of 24 to 47 years of age. Nineteen inmates were white and 13 were black, (10 white and 6 black inmates charged with murder, and 9 white and 7 black inmates charged with robbery). The mean Culture Fair IQ was 97 with a range of 89 to 114. These 32 protocols were randomly picked from 100 protocols which were categorized by crime.

Instrument

The follow explanation of the EMP has been quoted from Bruhn's EMP Manual (1989). (Note, only the first part of the EMP was administered).

The EMP consists of a self-administered, 32 page booklet that is divided into two parts. In Part I, the individual is asked to produce his earliest memory and the four memories that come to mind next --- five spontaneous EMs in all --- as well as one particularly clear or important memory (lifetime) and any additional memories that are noteworthy. These memories are then rated by the individual

for quality of affect (on a seven-point scale) and clarity (on a five-point scale). The client is also asked to rank order his three most important memories in the section and to explain the basis for their importance.

Scoring

Each inmate wrote 6 EMs which were scored by a modified version of the Early Memory Aggressiveness Potential Scoring System (EMAPSS). The presence or absence of the following themes were rated for each EM: 5 types of physical abuse, 3 types of animal abuse, and 4 types of psychological abuse. If any of these themes were present, their severity was ranked on a 3 point scale, (Table 1).

TABLE 1

Early Memory Scoring Sheet

		Absent		Present	
I.	Physical Abuse				
	A. Pt. assaults/hurts someone	0	1	2	3
	B. Someone assaults/hurts pt.	0	1	2	3
	C. Pt. observes assaultive behavior	0	1	2	3
	D. Someone is physically threatened	0	1	2	3
	E. Physical abuse heard about or read	0	1	2	3
II.	Animal Abuse				
	A. Someone intentionally hurts an animal	0	1	2	3
	B. Someone is hurt by an animal	0	1	2	3
	C. Someone is threatened by an animal	0	1	2	3
III.	Psychological Abuse				
	A. Pt. psychologically abuses someone	0	1	2	3
	B. Someone psychologically abuses pt.	0	1	2	3
	C. Pt. observes psychological abuse	0	1	2	3
	D. Psychological abuse heard about or read	0	1	2	3

RESULTS

The data was analyzed by collapsing the inmates charged with murder and both murder and rape and by keeping them separate. The three types of abusive themes were collapsed because there were very few themes of animal or psychological abuse. There was also very little difference in the severity ratings of the abusive themes between violent and non-violent inmates; therefore, these results will not be discussed.

Does the number of violent inmates with abusive themes in their EMs differ from the number of non-violent inmates with abusive themes? Out of 16 violent inmates, 13 had abusive themes in their EMs while 8 out of 16 non-violent inmates had abusive themes in their EMs. This difference

almost attained significance, ($\chi^2 = 3.50$, $df=1$, $P \leq .06$). A comparison of the inmates charged with murder to the inmates charged with both murder and rape revealed that 80% or 8 out of the 10 inmates charged with murder had abusive themes in their EMs and 83%, or 5 out of the 6 inmates charged with murder and rape had abusive themes in their EMs. These results suggested that more inmates convicted of violent crimes have abusive themes in their EMs than inmates convicted of non-violent crimes. There was no significant difference in the number of inmates convicted of murder who had themes of abuse in their EMs from the number of inmates convicted of murder and rape.

Does the number of abusive themes found in violent inmate's EMs differ from the number of abusive themes found in non-violent inmate's EMs? A total of 43 abusive themes were found in 16 violent inmate's EMs while 16 abusive themes were found in 16 non-violent inmate's EMs. The average number of abusive themes per violent inmate was 2.7 and it was 1.0 per non-violent inmate. This difference did not attain statistical significance; however, it showed a trend with violent inmates recalling more abusive themes than non-violent inmates. The average number of abusive themes per inmate charged with murder was 2.4 in comparison to 3.2 per inmate charged with murder and rape. Once again, there's a trend indicating that the more violent inmates have more abusive themes in their EMs than inmates convicted of non-violent crimes.

Does the percentage of EMs with abusive themes in comparison to the percentage of EMs without abusive themes differ among violent and non-violent inmates? Each inmate produced 6 EMs; thus, there was a total of 96 EMs produced by the violent inmates and 96 EMs produced by the non-violent inmates. Out of these 96 EMs from the violent inmates, 43 of them or 45% contained abusive themes, in contrast to 16 EMs with abusive themes out of 96 EMs from non-violent inmates. The number of EMs containing abusive themes differs significantly between the violent and non-violent inmates ($\chi^2=7.84$, $df=1$, $P \leq .001$). In other words, almost half of the violent inmate's EMs contained abusive themes while only one-fifth of the non-violent inmate's EMs contained abusive themes. Once again the difference between the inmates charged with murder and inmates charged with murder and rape was not significant; however, there was a trend suggesting that inmates convicted of murder and rape had more EMs with abusive themes (53%) than inmates only convicted of murder (40%). These results indicate that themes of abuse are more pervasive in the EMs of violent individuals than non-violent individuals.

DISCUSSION

The question which generated this study was whether the EMP could discriminate between violent and non-violent inmates. Bruhn and Toby (In Press) and Davidow and Bruhn (1990) reported that the EMP could discriminate a delinquent population from a non-delinquent population with a very low false positive rate. The data from the present study suggested that the EMP can also discriminate inmates charged with violent crimes from inmates charged with non-violent crimes. The data

revealed the following three trends. First, there were significantly more violent inmates who had themes of abuse in their EMs than there were non-violent inmates who had abusive themes. Second, the EMs of violent inmates contained more abusive themes than the EMs of non-violent inmates. And third, abusive themes were significantly more pervasive in violent inmate's EMs than in the EMs of non-violent inmates. In other words, the percentage of violent inmates EMs containing abusive themes was significantly greater than the percentage of non-violent inmate's EMs which contained abusive themes, (2.6 :1).

These results support the assumptions generated by the cognitive-perceptual model; namely that the type of crime committed by inmates is related to unresolved issues which can be identified with the EMP. Unresolved issues dealing with abuse appear to be related to aggressive/violent behavior; whereas, unresolved issues dealing with injuries, victimization, rule breaking behavior, illness, fire setting, abandonment, and mastery appear to be related to non-violent crimes. Bruhn and Davidow (1983) isolated these key elements in delinquent protocols, and were thus able to discriminate a delinquent population from a matched non-delinquent population. The present study leads us to speculate that with the identification of unresolved issues via the EMP, we are able to identify who is at risk for committing a non-violent or a violent crime. (Note, just because violent inmate's EMs contain more abusive themes than the EMs of non-violent inmates, we cannot say that they were abused more than non-violent inmates or a non-criminal population. Conversely, when someone has a history of being abused, we cannot say that they will be violent. We suspect that many people who have been abused would not produce any abusive themes in their EMs, primarily because they have resolved the issues surrounding their abuse).

Needless to say, this study needs to be replicated with a larger sample and a control group. Another question awaiting investigation is: How much unique variance does the EMP explain vs other psychological tests (e.g., MMPI and Rorschach)? The ecological validity of this research is high given: (1) the increase in both violent and non-violent crime, and (2) the questions we are asked by the courts and other government and service agencies. The outcome of such research has tremendous implications, both for diagnostic procedures and clinical interventions.

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DETECTION OF MALINGERED COGNITIVE IMPAIRMENT

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Detection of Malingered Cognitive Impairment

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Psychological evaluations of intellectual functioning are sometimes necessary in the correctional setting. Unfortunately, characteristics of inmates often interfere with a precise measurement of cognitive ability. These characteristics include lack of motivation or cooperation, lack of sufficient rapport, distrust, noisy testing conditions, interruptions for routine inmate management, and, particularly in forensic evaluations, the presence of considerable secondary gain. These interferences to accurate testing are referred to as "response bias." A particular form of response bias (referred to as "malingering") occurs when ability is intentionally suppressed for secondary gain.

In studies of clinical detection of malingering in the general population, patients are able to produce realistic findings of impairment on neuropsychological tests (Mensch & Woods, 1986), whereas clinicians are generally unable to detect malingered performance at better than chance levels (Heaton, Smith, Lehman, & Vogt, 1978; Faust, Hart, & Guilmette, 1988), even when forewarned that examinees might be faking impairment (Faust, Hart, Guilmette, & Arkes, 1988). Nevertheless, several measures of malingering are currently available to clinicians for use in a psychological evaluation. The purpose of this paper is to briefly review such measures and report on a new methodology to identify response bias.

Currently Available Tests

1. Rey Memory Test (Bernard & Fowler, 1990; Goldberg & Miller, 1986; Lezak, 1983; and Schretlen, Brandt, Krafft, & Van Gorp, 1991). Five rows of three related items are presented visually: two variations of "1 2 3" and "A B C" each, and a circle, square, and triangle. Although only two truly distinct concepts exist (sequence and category), subjects are told to remember and reproduce "all 15 (emphasized) items." Even most cognitively impaired individuals reproduce at least 9 items and 3 rows after a brief exposure (Goldberg & Miller, but cf. Schretlen, et al.). Performances below that are generally considered biased.

2. Dot Counting Test (Lezak, 1983; Paul, Franzen, Cohen, & Fremouw, in press). Twelve cards with dots arranged in either organized or random patterns ($n = 6$ for each type of card) are presented individually to

subjects who are instructed to count the dots as quickly as possible without making mistakes. The total counting time for organized patterns is expected to be far less than that for the random patterns in compliant individuals.

3. Comparison of word recognition vs. word recall (Lezak). A list of 15 words are presented to subjects from the Word Recognition Test (WRT; Lezak) which comprises 15 stimulus words followed by 30 recognition word choices and the first trial of 15 words from the Auditory Verbal Learning Test (AVLT; Lezak). Response bias is suspected in individuals who recalled more words than they recognized.

A more promising approach to detect response bias has been to objectively analyze response patterns. For example, a forced-choice response format facilitates the development of several strategies for detecting non-compliance through the analysis of response patterns. Pankratz, Fausti, and Peed (1975) used a two-alternative forced-choice method to investigate suspicious deafness. They presented 100 tonal-discrimination tasks of equivalent difficulty and concluded that malingering was present when significant variations from chance occurred (i.e., at the .05 level, less than 42 correct discriminations). They argued that the technique has value for the assessment of any sensory loss. In fact, this technique, now termed Symptom Validity Testing (SVT; Pankratz, 1979), has been effective in demonstrating true ability in patients who presented with such various symptoms as deafness, anesthesia, and memory deficits (Pankratz, 1979, 1983; Haughton, Lewsley, Wilson, & Williams, 1979; Binder & Pankratz, 1987; Hiscock & Hiscock, 1989; Bickart, Meyer, and Connell, 1990; and Binder, 1990). In particular, at least one test which depends on an evaluation of test score has been developed out of the forced-choice format:

4. Portland Digit Recognition Test (PDRT; Binder, 1990, in press; Binder & Willis, 1991). This test is essentially based on SVT and modeled after a task described by Hiscock and Hiscock (1989). Subjects are verbally presented a 5-digit number and then asked to count backward aloud until interrupted after 5 seconds. They are then presented a card showing the target number and a distractor and asked to identify the number to be remembered. After the first 18 trials the

response delay increases to 15 seconds; after the next 18 trials, the response delay increases to 30 seconds for the last 36 trials. A score of less than 27 correct (at $p < .05$, one-tailed) indicates persons who have intentionally suppressed their memory ability.

A New Methodology for Detecting Response Bias

The central test described in this paper depends on the two-alternative forced-choice format, but use measures other than the score to identify malingering:

5. The Forced-Choice Test of Nonverbal Ability (FCTNV; Frederick and Foster, 1991). The FCTNV is a modification of the Test of Nonverbal Intelligence (TONI; Brown, Sherbenou, & Johnsen, 1982). The TONI is a picture matrix test which comprises two equivalent forms of fifty items each. For each picture puzzle, four or six answer choices are available. In the TONI, either form is presented in order of difficulty until the evaluatee's ceiling is reached. In the FCTNV, all 100 items were presented, but in a random order of difficulty. Only the correct choice (target) and one distractor were presented for each of the 100 TONI picture puzzles. This resulted in 100 trials of a 2-alternative forced-choice task. As in SVT, the number of items answered correctly served as a measure of response bias. At $\alpha = .05$ the range of random responding for 100 items is 42-58. Because random responding characterizes the performance of individuals with no ability at all, scores below 42 indicate that true ability has been suppressed and that responding is biased toward incorrect answers. Frederick and Foster identified several other measures (in the form of decision rules) which can be generated by the 2-alternative forced-choice response format:

A. Slope of performance curve and correlation of test performance to item difficulty. A curve describing test performance from the least to most difficult test item was plotted for each subject. (In Frederick and Foster, item difficulty was determined post-hoc.) An improvement in performance as the test items increase in difficulty, which is completely unexpected for compliant performances, results in a positively-sloped performance curve. But, a better measure of biased responding is the correlation of test performance to item difficulty (CORR). As compared to

a decision rule for positive slope alone, the use of CORR increases the range of sensitivity for cases of random or irrelevant responding. That is, some performance curves which result from random responding have a negative, but not significantly negative, slope. In order to use CORR as a detector, the confidence interval for random responding when $\alpha = .01$ was computed. The negative boundary of this confidence interval is -0.275 , which resulted in this decision rule: "If $CORR > -0.275$, then suspect biased responding."

B. Consistency ratio. Fifty pairs of picture puzzles of equivalent difficulty ("equivalent item pairs", EIPs) were created and a measure of consistency was thereby derived. The consistency ratio (CR) was defined as the ratio of the number of EIPs in which both items were answered correctly to the maximum possible number of EIPs in which both items could be answered correctly (which is the total test score divided by 2). If a is the test score and b represents the number of equivalent item pairs in which both items are answered correctly, the equation to compute CR is:

$$CR = b/(a/2), \text{ or } CR = 2b/a.$$

In this manner, a test score of 50 can generate a ratio from 0.0 to 1.0, depending on the response style (see Table 1). For scores from 42 to 50 (the lower range of random responding), the mean consistency ratio is 0.50, and that value was chosen as a cutting point: "If $CR < 0.50$, then suspect biased responding."

C. Slope*Consistency ratio. In the first study of Frederick and Foster, a significant interaction effect existed between slope and CR. Consequently, a decision rule incorporating the product of the previous two measures (slope*CR) was generated based on post-hoc analysis: "If score is below average and slope*CR > -0.0041 , then suspect biased responding." The new decision rule was highly specific (a 97.1% correct rejection rate for normal controls) and highly sensitive (94.2% correct detection) to simulating malingerers who scored below average for an initial sample of 86 compliers and 84 malingerers. This decision rule maintained its rate of detection in the 2 subsequent analog studies described in Frederick and Foster. In a follow-up study in which college students were given financial incentives to successfully

malingering, the rate of detection was slightly (but statistically significantly) compromised.

Summary of Studies to Date

Table 1 summarizes four studies which have included college students. Students were divided into three groups: normal controls, naive simulating malingerers, and informed simulating malingerers. Normal controls ($n = 267$) were asked to give their best effort on the test. Naive simulating malingerers ($n = 266$) were asked to fake brain impairment when they took the test, but to do so without being obvious. Informed simulating malingerers ($n = 139$) were also asked to fake believable cognitive impairment, but they were

Table 1
Percentage of College Students by Group Identified as Biased Responders by Measures on the FCTNV

Group	n	Score	Measure		
			CR	CORR	Slope*CR
Normal control	267	0	0	0	3.4
Naive simulating malingerer	266	10.9	26.7	39.1	90.2
Informed simulating malingerer	139	0.7	4.3	6.5	61.1

given information about how to successfully mangle without detection. As Table 1 demonstrates, score, CR, and CORR were all specific detectors of response bias. That is, they identified only those people who could properly be classified as malingerers. However, they were not fully sensitive measures of malingering: Many of the malingerers evaded detection on these measures. In particular, their sensitivity to response bias was significantly compromised when information about them was given to subjects. The slope*CR decision rule was both specific and sensitive as a detector of response bias, and remained specific even when students received information about the mechanics of the test.

Table 2
Percentage of Forensic Evaluatees or NGRI Acquittees
Identified as Biased Responders by Measures on the
FCTNV

Group	n	Score	Measure		Slope*CR
			CR	CORR	
Forensic evaluatees	18	5.6	33.3	50.0	77.8
NGRI acquittees (normal)	18	0	5.6	0	22.2
NGRI acquittees (cognitively impaired)	14	0	0	0	0

Table 2 summarizes data from two studies in which forensic evaluatees and forensic patients were administered the test. The forensic patients (all acquitted Not Guilty by Reason of Insanity, NGRI) were divided into two groups: those that had a history of cognitive impairment on prior psychological testing (cognitively impaired; $n = 14$) and those for whom no cognitive impairment was noted (normal, $n = 18$). The forensic evaluatees included 16 competency evaluatees, one pre-sentence evaluatee, and one pre-release evaluatee. As Table 2 demonstrates, there was a high rate of biased responding among forensic evaluatees, but the committed patients had a low rate of biased responding. In particular, the FCTNV did not detect biased responding among those acquittees with a recorded history of cognitive impairment, which suggests that the FCTNV is not simply sensitive to poor performance on the test.

Discussion

The data in Table 2 indicate that clinicians should be particularly cautious when interpreting psychological tests completed by forensic evaluatees. Although the FCTNV is not available for commercial use, clinicians should at least include some of those

measures mentioned earlier when conducting intellectual assessments. SVT, and the PDRT in particular, is especially helpful when evaluating suspicious complaints of memory loss. Furthermore, clinicians should be aware that biased responding does not necessarily indicate that malingering is present. Evidence of biased responding should be evaluated in the context of the assessment and referral question and clinicians should attend to factors such as fatigue and poor testing conditions before assuming that biased responding is willful or intended for some secondary gain.

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Malingering Detection

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COMMUNITY MENTAL HEALTH AND THE FEDERAL BUREAU OF PRISONS:

OLD WINE IN NEW BOTTLES?

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COMMUNITY MENTAL HEALTH AND THE FEDERAL BUREAU OF PRISONS: OLD
WINE IN NEW BOTTLES?

For many years, the Federal Bureau of Prisons has offered programs for the diagnosis and treatment of seriously mentally ill inmates in addition to, or perhaps more precisely, separate from and in parallel with, an impressive array of other quality programs that are conducted by psychology services, the chaplaincy and social work. This afternoon, I would like to challenge your thinking and engage your interest in looking at some issues related to mental health to which I have given a good deal of thought during the past six years in which I've been associated in one way or another with the Bureau. Actually, the thrust of these remarks has changed several times since I first contacted Dr. Denny with a proposal for a presentation on community mental health. The final shape of this presentation coalesced around a few special themes which were relevant for this Symposium, but which also gave me an opportunity to engage you in a process of considering the business of how we provide mental health services, and utilize our professional resources, for whose benefit and in what manner. I'd also like to share with you my vision of mental health programming in BOP which may go a bit beyond the structures with which many of you are already quite familiar. And lastly, I will comment on this "separatism" or "parallelism" which I mentioned a moment ago and how I think it influences our activities, our professional image and our interprofessional relations.

Let us begin with a brief proposition that follows from an overview of mental health programming in the FBOP. As you know, the major mental health programs and resources for the diagnosis and treatment of seriously mentally ill inmates are located primarily at four inpatient referral centers although other evaluative, treatment and special services are offered throughout the rest of the system. What has seemed missing to me, however, is an overarching, shared sense of mission in mental health that acknowledges the legitimate interests of all "stakeholders" yet balances the imperative of institutional security, the volume of patients and quality of professional care while preserving disciplinary identity. My proposition is that neither the needs of correctional security and stability nor those of quality mental health care are being fully served by the present system. Let us examine why this may be so.

There seem to me to be at least seven factors that suggest the usefulness of, indeed necessity for, BOP to reconsider the way in which mental health services are provided and mental health resources are utilized:

- An explosive increase in the number of inmates entering the system over the past decade; a portion of these, perhaps 3-4%, will be severely "troubled"; many more will be "troubling" and some will be a combination of both; mental health expertise will be needed to sort out and manage these three groups.
- A corresponding insufficiency of inpatient beds for acutely mentally ill patients.
- A chronic shortfall in expert treatment resources.
- A steady accumulation of long-term patients for whom acute hospitalization is no longer needed but who are unsuitable for general population and still require a therapeutic environment.
- The prospect of constraints on the building of new facilities in the current era of federal fiscal belt-tightening.
- A new sense of commitment for programming for "special needs offenders" e.g. the handicapped, elderly; retarded; women; HIV positives; etc.
- The desirability, indeed necessity, for BOP to examine all of its operations and programs for purposes of evaluating their efficiency, effectiveness, productivity and quality, all often accreditation-related, i.e. is BOP as an organization getting the optimum return from the resources which it has made available? Are these resources utilized and configured in the way that makes most sense from the viewpoint of quality of care and fiscal responsibility? Simply put, are we doing the right things and are we doing things right?

Large organizations (or families for that matter) are staggeringly resistant to change and changes in such systems have to be made thoughtfully, carefully, usually incrementally and with a realistic sense of what is and is not possible. The traditional emphasis by BOP upon long-term inpatient care for severely troubled inmates in special referral centers represents, in my view, an old paradigm which is no longer as feasible as it once was - because of the seven factors just described. It has therefore seemed to me that a more contemporary paradigm is

needed, one that capitalizes upon existing strengths but also recognizes new realities.

Notwithstanding the impressive array of programs already offered by psychology, psychiatry and other services what is missing, or so it seems to me, is a higher level conceptualization which offers a vision of what a comprehensive mental health system would look like when it is fully assembled (a kind of philosophical "glue" if you will) that binds the system together, provides its values, its energizing principles and serves as a "grand design". Such a conceptualization should be strategic in scope, but also frame the key issues in correctional mental health for the 1990's and encompass specific tactical objectives which serve as the master "blue print" for entire system. What characteristics should we look for in such a conceptualization? It has seemed to me that whatever concept we come up with needs to encompass 6 principal considerations:

- It should make full use of existing BOP mental health assets, human and otherwise.
- It should be consistent with the nature, traditions values, character, image and reputation of the present system.
- It should strive to continuously seek common elements and find common ground among competing and occasionally conflictual inter-professional and correctional interests and priorities.
- It should not be naive about the existing system's constraints, its vulnerabilities, priorities, and alliances as well as the rationale (historic) for the organizational separation of its two largest mental health disciplines.
- It should take into consideration the system's readiness for, and receptivity to, change in the way it thinks about, and provides mental health care and utilizes its trained mental health-related expertise.
- Lastly, while respecting the system's traditions, arrangements, values and accustomed ways of doing things in the mental health area, it should not be so timid as to refrain from encouraging people to take a fresh look at the totality of the mental health/mental illness picture and all the tasks involved.

With these parameters in mind and drawing upon the correctional and psychiatric literature as well as my own experience with community mental health principles and practice, it has seemed to me that BOP might well present an ideal

opportunity for a version of the community mental health approach insofar as the planning, organizing and providing services suited for the BOP are concerned. Discussions with senior staff both at mental health and administrative levels suggested the feasibility and the desirability of such an approach. This has since come to be referred to in BOP as the "community mental health model". For purposes of clarity let me spend a few minutes on the basic model and what I mean when I use the term "community mental health" (CMH).

According to Richard Lamb, the history of the CMH movement (often called the Third Psychiatric Revolution) can be traced: 1) in the 18th century to the French psychiatrist, and superintendent, Phillipe Pinel and his assistant, Pussin, who struck the chains from patients in the Bicetre in 1797 and the Salpetriere in Paris in 1800; 2) in the 19th century, when the school of moral treatment in the U.S., led by Benjamin Rush, stressed a humane and rehabilitative approach to the mentally ill including the efforts of the crusading Dorothea Lynde Dix; 3) and in the 20th century with the experience of psychodynamically-oriented psychiatrists and psychologists in World Wars I & II, biopsychoculturalists like Adolf Meyer and public minded citizens like Clifford Beers. From all these influences four key principles were elucidated that became emblematic of the CMH movement. These are: 1) proximate; 2) immediate; 3) simple and 4) expectant Rx (it was found that this approach was far more effective than the evacuation of stigmatized psychiatric casualties to far-away hospitals with few returning to duty). Thus the notion of timely treatment close to home while minimizing long-term morbidity (and greatly facilitated by normalizing psychotropic agents) became a defining mark of the community mental health movement. We need to keep this in mind when we momentarily consider how we can improve our own system.

The nascent CMH movement was further energized and crystallized by Federal legislation in the second half of the current century - in large part because of deplorable abuses of asylumization, in part because of the availability of antipsychotic medication and the zealous pursuit of civil liberties and least restrictive environments for chronic mental patients by courts, advocacy and civil rights groups. The stage was set for deinstitutionalization which was then precipitated by two pieces of legislation in 1963 - the "Aid to the Disabled Act" (financial support for the mentally ill living in its community) and the "Mental Retardation Facilities and CMH Centers Construction Act" - which required 5 basic services (inpatient Rx, emergency services, partial hospitalization, outpatient services and consultation/education). Added by statute in 1975 were 7 more requirements for: services for children, the aged, screening, alcoholism and drug abuse services, follow-up and transitional housing.

Thus the original CMH Model had 8 main elements or characteristics: responsibility for a defined population (catchment area); treatment close to home; comprehensive services; a multi-disciplinary team approach; continuity of care; consumer participation; program evaluation and research; and prevention.

This brief historical overview concludes by noting that there were a number of areas in which the original model subsequently disappointed many of its most ardent proponents. These included a lack of data to support the notion of preventing mental illness; a lack of focus on the chronically mentally ill with severe disorders (in favor of what were called the "walking wounded"); all the problems we have come to subsume under the more pejorative characterizations of "deinstitutionalization" (e.g. homeless); problems with professional role blurring; and problems involved with consumer participation. Today's CMH movement however is leaner, more realistic, more modest in aim and more problem-oriented; it retains its laudable traditional emphasis on early case identification and prompt intervention; treatment close to home; expectancy of return to function; the notion of dysfunction precipitated by environmental stressors; of defined catchment areas, and continuity of care; of program evaluation; efficient use of resources; comprehensive services; and, importantly, a focus on major mental illness.

I hope these principles of the CMH movement strike you as being as relevant to the BOP as I believe they are. We have 80,000 inmates spread across the country, but tightly organized in 6 regional areas with 4 major psychiatric facilities, a great diversity of psychiatry, psychology, nursing, social work, chaplaincy, activities therapists and related disciplines who daily serve the mentally ill as well as other staff and inmate needs with their expertise, a strong tradition of professional commitment to quality services despite resource shortfalls, and a sense of pride about the system and prospects for the future. I believe the ingredients are all there for a wonderful mental health program recipe which is multifaceted, multipurpose and multitalented.

Let us concede that there is, however, another set of undercurrents in this otherwise rosy picture. I anticipated that there would be resistance to asking that a fresh look be taken at the BOP mental health system. Nor was I a stranger to the long-standing 'turf' struggles and conflicts between psychiatry and psychology, as well as those between these disciplines and others as well. Early on I received and still receive veiled and not-so-veiled comments (all from mental health professionals I might add) about these issues such as those paraphrased as follows:

- Why fix something that isn't broken?

- 90% of what our psychologists do in non-referral centers *has nothing to do with mental health services!*
- Let the psychiatrists get their own act together before they involve themselves in what we do!
- I'm never going to work for a psychiatrist (or a psychologist)!
- This community mental health model thing is a joke and it isn't anything new - we've been *doing this* all along!
- Treatment for mentally ill inpatients is only a very small part of what we psychologists do throughout BOP.
- Nobody respects what we as masters-level social workers can do for patients.
- If we're not careful, CEOs will hire social workers instead of us because of salary savings.
- Psychiatrists are (only) supposed to treat the severely mentally ill.
- Psychiatrists are only really needed (useful?) in prescribing medication; what do they know about group process, witness evaluations, group dynamics, substance abuse, psychometric testing, hostage negotiation, forensic assessments or population management?
- Physicians don't have the rigorous training in the scientific method that we do!
- Psychologists just think that all we're trained to do is to prescribe medication; they think we're nothing more than high-priced "pill-pushers" and barely competent at that; they don't realize the breadth, depth or rigor of our training and how difficult it is to become board-certified!
- There is no "crisis" right now in mental health, so let's not do more than what we're doing.
- What are we doing participating in an (interdisciplinary) Mental Health Advisory Group; *this doesn't have anything to do with us!*
- Why this "remedicalization" of mental health services?
- Nobody asks us Chaplains to participate in team meetings about patients.

- Who is this guy Cowell and what is his agenda? Is he trying to take control over all mental health professionals? He doesn't know how things really work.

I think these examples will give you a pretty good idea as to - let's call it what it is - the suspiciousness on the part of some who perceive a threat in the call for a bit of rethinking about whether we're "doing the right things and whether we're doing these things right". One response on the part of those so threatened is, "of course, we are doing the right things - and we've been doing them long before you got here"!

Another possible response might be, "well we are pretty good at what we do, and our programs and our methods are time - tested, our organizational arrangements are sound and we prefer them the way they are, and no one has as much experience in population management as we. Yet, perhaps there is something to be gained for us and for those we serve by being open to considering whether the current system can be improved - even if it isn't broken."

Moreover, these cross currents are played out in a dynamic field of forces in which psychiatrists and other mental health professionals are sometimes seen, in the words of Frank James, as "a soft touch in a hard setting", a setting where fine distinctions may not always be made between inmates who are troubled and those who are troubling. Even among the field at large, (if not in BOP), the disciplines themselves reflect a diversity of views (read: ambivalence) including: mental health treatment should be made more available in correctional facilities; can rehabilitation even take place within the walls of a prison? why work toward pouring more psychiatric and psychological help into prisons when most inmates need not, and should not, be there? Some major professional organizations did not even begin to address the problem of mentally ill in correctional facilities until the mid 1970s. Debate continues on the societal level as to whether a greater number of inmates could be handled through alternatives to incarceration and wider use of parole.

The point it seems to me, is that regardless of how this great debate shakes out, we are responsible for providing for the mental health of increasing numbers of inmates whose "homes", ("communities"), are the institutions that comprise the Bureau. In World Wars I and II, the environment was the trenches; in the early days of the community mental health movement it was the civilian community or catchment area; for inmates, it is the facility that is their community.

Let me take a moment at this point to state my view on an issue related to the critical questions and comments I've described for you: we've got much work to do in my own

discipline. I have a lengthy list of initiatives which my office has in progress and that I believe are needed and must be accomplished. To mention only a few of the more important:

- More equitable psychiatrist-patient staffing ratios in referral centers.
- More psychiatrists in key non-referral centers.
- Improved mental health services in USPs.
- At least one consultant psychiatrist in every non-referral center (that doesn't already have a full-time psychiatrist).
- Improved consultation between non-referral and referral centers to assist the former in their local management of mentally ill inmates.
- Uniform mental health records for referral centers.
- An improved referral protocol for admission to referral centers.
- More flexibility in the use of psychotropic medication on an involuntary basis.
- A more sensible distribution of psychiatric resources.
- More incentives for well-trained, board certified psychiatrists to enter and remain with the system.

Having our own disciplinary plate full, however, doesn't mean we should lose sight of our vision of what mental health services can be like for the BOP, for at heart, I think all human relations specialists, whatever their discipline or role, know that patient and staff welfare transcend all other considerations. That's what makes us professionals.

Although the community mental health approach to providing services in correctional facilities is not new, (it has been adopted by some states, for example, Oklahoma). Its application to the BOP will have characteristics which I believe are well-suited both to the Bureau and for inmates for whom the Bureau is responsible. I foresee:

- A shift in emphasis to the building of substantial local capacity for the timely identification, diagnosis and ambulatory treatment of mentally ill offenders (gate keeper function) and away from the disruption and expense of their transfer to scarce, costly, long term mental health inpatient care.

- Partial hospitalization services (including day/night care).
- Limited, short-term inpatient stays for selected patients who cannot be managed locally and an eventual resolution of the problem of providing care for chronic patients by a twin strategy of aggressive early intervention to minimize long-term morbidity plus vigorous case management to move patients out of referral centers.
- Aggressive community placement for 4243, 4246 and other groups of offenders requiring continued care but not necessarily - or even desirably, in BOP facilities.
- A spectrum of services tailored to individual patient needs.
- An expansion of sheltered (intermediate)transitional care units.
- Active early case finding and referral.
- Specialized treatment programs.
- Attention to the needs of special populations.
- Family counseling.
- Program evaluation studies.
- Greatly increased 'networking' among all mental-health related disciplines for purposes of mutual support, problem solving, education and the softening of disciplinary "impermeability".
- Much better data on the incidence and prevalence of mental illness, special needs offenders, available treatment resources, lengths of stay, clinical care indicators and performance measures.
- A decrease in length of stays in our referral centers by at least 20%, saving an average of \$100 per patient-day while freeing up beds for acute patients.
- A larger and stronger social work program, brought fully into the mainstream of planning for mental health programs throughout the BC?
- A "circuit rider" program for the sharing of psychiatrists by clusters of contiguous correctional facilities.

- A cap on the building of more inpatient mental health beds because this kind of expansion only drives the system in the wrong direction, i.e. in a direction of greater expense, more emphasis on costly inpatient rather than outpatient care, and more staff shortfalls.

Can this holistic vision of what is possible for the BOP be achieved without active and willing collaboration of all mental health-related "stakeholders"? My answer is "probably not".

Who are these "stakeholders"? They are psychiatrists and psychologists, nurses, chaplains, pharmacists, social workers, activities therapists, occupational therapists, program administrators and CEOs among others. The "they" are you and I.

As some of you may know, since November 1990 there has been an interdisciplinary working group, the Mental Health Advisory Group, composed of representatives from HSD, CPD, and the OGC. This group has met quarterly and represents the principal forum BOP has for dialogue between mental health-related disciplines. Among other activities, in December 1990, the MHAG produced a list of 34 initiatives for the improvement of mental health services. Those initiatives endorsed by the Executive Staff (many of which are now completed) have served as the working "blueprint" for objectives whose implementation is seen as leading to improved care for inmates. Psychiatry, psychology, the chaplaincy, law, and social work are all participants and other disciplines will be brought in as well.

In my view there is a real need for this kind of forum within BOP - regardless of whether or not a mental health "crisis" is thought to exist. It makes no sense to me that as professionals in one area of human relations (though many - faceted) we content ourselves with occasionally peering over our neighbor's disciplinary fence to see if anything is going on there that may relate to - or disturb, our own activities.

On the contrary, I believe that we have already achieved a certain momentum that will in good time, and given a modicum of good will, patience and commitment by all, yield a consolidated and comprehensive system of mental health care, program development, special programs, consultative and staff services, training, research and humane population management regarding which all stakeholders can take collective pride.

I believe that in time the compartmentalized, "separate but barely equal", paradigm between mental health disciplines that I see existing at present, will in an incremental and evolutionary fashion, give way to a more natural, sensible and perhaps less expensive configuration that recognizes all, respects all and includes all.

In summary, I think the community mental health model, updated and tailored for the BOP and widely networked with all stakeholders will in time amount to more than just old wine in a new bottle. I think we can take the system beyond even the state of current excellence for which it is already justly renown.

I'll close here. Thank you for inviting me to speak to you.

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AN INTEGRATED APPROACH TO MENTAL HEALTH
SERVICE DELIVERY IN CORRECTIONS

BY

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An Integrated Systems Approach to
Mental Health Service Delivery In Corrections

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By taking a systems approach to mental health programs, the United States Disciplinary Barracks (USDB) designed a comprehensive, integrated treatment network. Following Total Quality Management principles, it is a dynamic system, constantly being adjusted, evaluated and improved upon. This commitment to continually improving the system is reflected in the mission statement for the Directorate of Mental Health. "Provide constantly improving mental health services to USDB inmates and related services to our other customers." Annex B describes this mission statement and the leadership style used to implement it. The mental health system is closely linked with other rehabilitative and correctional systems, i.e., academics, vocational training, pastoral care, work details, disciplinary boards, etc. Progress within each system is shared with the Inmate Treatment Plans Office, which maintains progress reports on inmates from throughout the prison. This allows prison staff access to a broad spectrum of data, which is critical for decision making and identifying potential problems.

By clarifying our goals and core beliefs, and by following Total Quality Management principles, systems thinking became the focus. Rather than viewing mental health services as separate programs, a system of services was visualized. The system was woven together by two common goals: (1) foster constructive adaptation to long term confinement, and (2) provide inmates the opportunity to develop and practice cognitive and behavioral skills necessary for successful reintegration into society. Coupled with these goals are four core beliefs on which the system is built: (1) lasting change requires significant practice to ingrain new beliefs and behaviors, (2) responsibility for change (growth) lies with the inmate - not with the staff, (3) group therapy is the most effective and efficient treatment approach, and (4) teamwork and networking programs generates a synergy effect, which improves the effectiveness of the entire system. These goals and beliefs form the foundation of all programs making up the mental health system.

The diagram in Annex A provides a visual overview of the mental health system. Consistent with our core beliefs, an inmate enters treatment upon reception and has the opportunity to continue treatment until release from confinement. Group therapy programs are the heart of the system and the groups are linked with common goals and overlapping material. All groups are structured; have clear measurable standards for evaluating inmate participation; incorporate

homework assignments into the group process; and allow for recycling individuals who warrant additional help. Individual counseling is available and all inmates are assigned to a primary counselor. In addition, an extensive system of inmate facilitated self growth programs are available.

GROUP PROGRAMS

(Reception Phase)

During their two week reception phase, inmates complete a battery of psychological tests, individual assessment interviews, are assigned a primary mental health counselor, and are exposed to their first therapy group - Stress in Confinement. The purpose of the group is twofold: (1) provide an orientation to the Directorate of Mental Health, and (2) address adjustment issues to confinement. Early group involvement helps to set the expectation they will participate and disclose in group settings, before they are heavily immersed in the prison culture. By incorporating inmate facilitators in the group, added credibility is given to the information provided.

All inmates will attend the Initial Treatment Group within three months of arrival. This group is designed with three goals in

mind: (1) teach each inmate how to function in a group setting, (2) provide anger and stress management tools, and (3) discuss the impact of chemical abuse on the inmates life-adjustment areas. By funneling all inmates through this group, we insure inmates possess basic group skills necessary for participation in the treatment system. It also provides basic adjustment skills for confinement, and begins the process of assessing chemical abuse and addictions. It should be noted, inmates sign a contract that outlines group standards, expectations, and explains how they will be formally evaluated. Inmates who fail to meet group expectations will not be allowed to advance to other groups, until they demonstrate their willingness to participate. This reinforces our core belief that inmates are responsible for their own rehabilitation, and there are consequences for one's behavior. Change requires work and practice, and all elements of our system reinforce this belief.

By the time an inmate completes Initial Treatment, a formal mental health treatment plan has been developed and agreed upon. The Inmate Treatment Plans Office takes the Mental Health Treatment Plan and combines it with academic and vocational plans to form a rehabilitation road map. Through this process, each inmate gains a clear picture of his responsibilities, and a time-frame for advancement in the system.

(NON-CRIME SPECIFIC PROGRAMS)

Upon completion of Initial Treatment, a variety of non-crime specific groups are available to the inmate. These groups include: (1) Anger Management, (2) Dealing with Criminal Behavior, (3) Sex Education, Awareness and Stereotypes, (4) Beginners Moving Meditation, (5) Advanced Moving Meditation, (6) Smoking Cessation, and (7) Chemical Abuse and Addictions Program. These groups help inmates adjust to confinement, develop new skills, and prepare for their crime specific treatment groups. Depending on their treatment plan, an inmate may be referred to one or all these programs. Effort is made to minimize the number of groups an inmate concurrently participates in. We believe learning and long term growth are enhanced by concentration and practice on one group at a time. However, inmates probably will be involved in adjunct groups (Alcoholics Anonymous, Sexual Offenders Support Group, etc.), in addition to formal treatment programs.

I will now provide a brief description and purpose of the non-crime specific groups. Anger Management presents basic anger control skills and the opportunity to practice these skills. We view these skills as critical to survival both in confinement and

society. Our Discipline and Adjustment Board uses this group as a resource in working with violent inmates, and may offer an inmate referral to the group instead of other disciplinary action. Dealing with Criminal Behavior is based on the work of Samuel Yachelson, Ph.D., and Stanton E. Samenow, Ph.D. concerning criminal thought patterns. The group confronts thinking errors characteristic of criminals and acceptance of responsibility for one's behavior. Sex Education, Awareness and Stereotypes provides fundamental sex education and confronts sexual stereotypes. This information provides a sound foundation for sexual offenders, before they enter their crime specific groups. Moving Meditation highlights discipline, concentration and stress management through body movements and individual meditation techniques. The movements are based on Tai-Chi principles, but there are no combative movements. Moving Meditation has a broad appeal to inmates and has proven very helpful in working with inmates with a history of disciplinary problems. Smoking Cessation was developed to assist inmates who are working to eliminate cigarette smoking. Interest in this program was generated out of a change in the smoking policy for the prison. This program may be short lived, depending on the needs of the inmates. Our Chemical Abuse and Addictions Program is both a crime specific and non-crime specific program. It will be discussed in the following section. These groups are bound by their common purpose

and goals, and are linked by overlapping treatment techniques to enhance learning and practice.

(CRIME SPECIFIC PROGRAMS)

Based upon the typology of crimes committed by inmates within our system, four crime specific programs were developed. These programs consist of: (1) Child Sexual Offenders Group, (2) Assaultive Offenders Group, (3) Larceny Group, and (4) Chemical Abuse and Addictions Program. As with the non-crime specific groups, an inmate may be involved in multiple programs, depending on his needs. All these programs utilize a cognitive-behavioral approach with an emphasis on relapse prevention planning. Our goal is to have all inmates through their crime specific programs before their parole eligibility date, but we also emphasize rehabilitation as a long term concept and encourage inmates to plan well beyond the gate leaving prison.

The Child Sexual Offenders Group provides a focused rehabilitation program for inmates willing to accept responsibility for their dysfunctional behavior related to children. It is divided into specific phases with set expectations for each phase. Depending on an inmate's progress and participation, he may complete the

program in six months or be recycled through the program. This allows an inmate experiencing difficulty, the possibility of focusing on specific change issues and extending his opportunity for treatment. The Assaultive Offenders Program is available for anyone who accepts responsibility for their violent behavior with others. In a similar fashion to the Child Sexual Offenders Group, it also allows for recycling an inmate through the program and is six months in duration. The Larceny Group was designed for inmates convicted of a crime related to property, who accept responsibility for their actions. The focus of this group is the criminal thought process and relapse prevention planning. The Chemical Abuse and Addiction Program was designed to provide a multidimensional treatment program for those inmates who have a substance abuse problem. It extends over a minimum of eleven months, but with the potential for recycle, many may be involved in treatment for eighteen months or longer. All these programs take a similar approach and offer extended treatment for those who warrant it. For many inmates, completion of their crime specific program signals their commencement from formal group therapy. However, it is not viewed as "completion" or "recovery". Continued involvement in self growth programs and individual counseling is expected.

SELF GROWTH PROGRAMS

An extensive system of self help programs complement the formal treatment groups. These programs are coordinated by mental health professionals, but are actually managed by inmate committees operating under a constitution and set of bylaws. These programs include: (1) Alcoholics Anonymous, (2) Narcotics Anonymous, (3) Adult Children of Dysfunctional Families, (4) Sexual Offenders Support Group, (5) Latino Studies, and (6) African American Culture Organization. In addition, Self Growth maintains an extensive library of mental health material for bibliotherapy. The library provides a resource for homework assignments for our formal treatment groups, as well as, providing structured workbooks for the programs listed above. The Disciplinary and Adjustment Board has limited access of inmates on recreation restriction to this library as their only source of reading material. I believe this is another indication of the close linkage of rehabilitation efforts within the USDB.

Self Growth programs are closely linked to other elements of the mental health system and provide some unique benefits. The programs often serve as a non-threatening first step in the rehabilitation

process, by allowing inmates the opportunity to challenge themselves to realistically look at their dysfunctional behavior. These programs help train inmates as group facilitators, and give them experience at organizing and managing activities. This often requires developing conflict resolution skills, sound communication skills, and learning how to compromise. In addition, these programs serve as maintenance groups for those who have completed their formal treatment programs, and as transition programs for those about to re-enter society.

CASE MANAGEMENT AND INDIVIDUAL COUNSELING

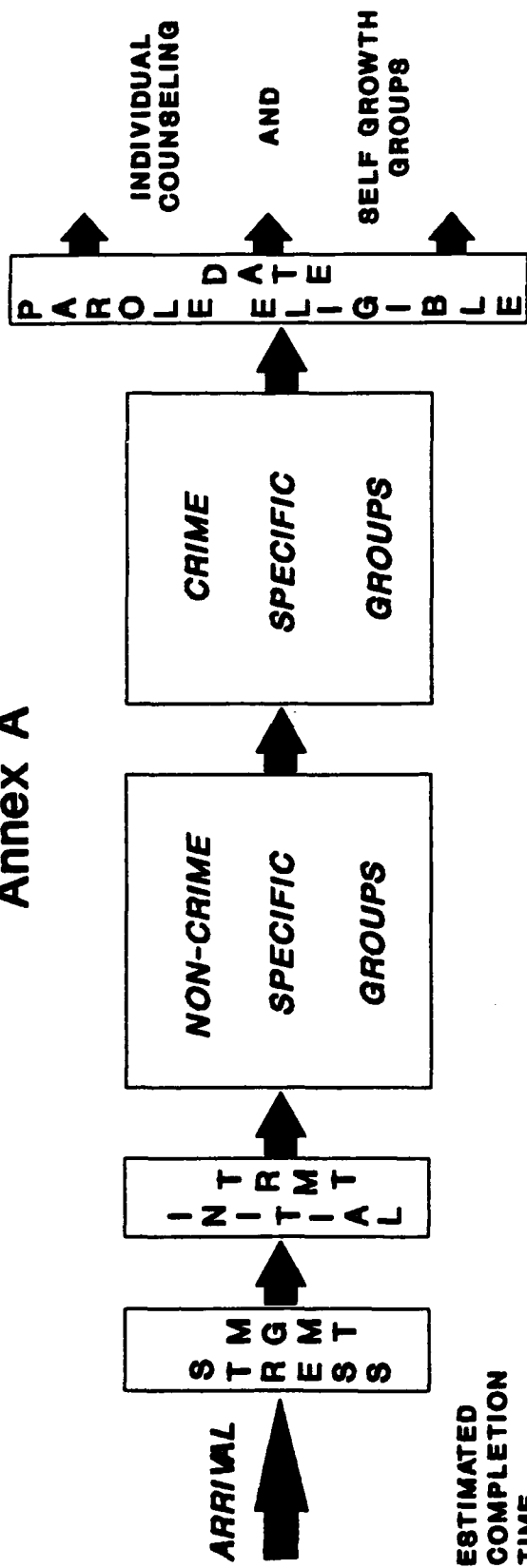
Each inmate is assigned to a mental health counselor for case management and counseling. The counselor coordinates treatment planning, programs enrollment, monitors progress, and provides individual therapy. Information about each inmate is constantly fed to their counselor to insure an accurate mental health picture is maintained. If an inmate is recycled in a program, the case manager is in a position to help the inmate understand what he must work on. Attendance at Self Growth programs is monitored, and a computer list documenting attendance is regularly provided to the case manager. Although individual contact is maintained a minimum of once every 90 days, it will vary according to the needs of the inmate.

DISCUSSION

Implementing an integrated system of mental health services requires significant planning, clarification of goals and objectives, assessment of needs, creativity, flexibility, and teamwork. Any one of these processes may appear overwhelming when confronted with the daily alligators and brush fires of a prison environment. However, when approached in incremental steps, with a clear vision of where you want to go, the process is extremely rewarding. A systems approach improves the effectiveness and efficiency of all elements of the system; minimizes staff manipulation by inmates; empowers the inmate by giving him a clear idea of what is expected and how to get there; and improves staff morale and job satisfaction. I view it as an exciting process because it encourages creativity and innovation. Consistent with Total Quality Management principles, we view our job as constantly working to improve and tailor our services to the needs of our customers. If you want more detailed information on any of our programs, please contact LTC Thomas J. Schmitt, Directorate of Mental Health, United States Disciplinary Barracks, Fort Leavenworth, Kansas 66027.

MENTAL HEALTH SYSTEM

Annex A



ESTIMATED
COMPLETION
TIME

(4 MONTHS)	 (VARIABLE TIMEFRAME)	COMPLETION BY 88% OF SENTENCE	PARTICIPATION UNTIL RELEASE		
INDIVIDUAL COUNSELING SESSIONS (MINIMUM OF ONCE EVERY 90 DAYS)					
SELF GROWTH PROGRAMS (AVAILABLE THROUGHOUT CONFINEMENT)					
ALCOHOLICS ANONYMOUS	NARCOTICS ANONYMOUS	LATINO STUDIES	AFRICAN AMERICAN CULTURE ORGANIZATION	SEX OFFENDERS SUPPORT GROUP	ADULT CHILD OF DYSFUNCTIONAL FAMILIES

ANNEX B

ATZL-DBM

MEMORANDUM FOR Directorate of Mental Health Staff

SUBJECT: Director's Philosophy and Guidance

1. This Memorandum is a guide to my leadership philosophy and style, and to the direction I will lead the Directorate of Mental Health. My intent is to encourage innovation, creativity, and flexibility, while maintaining a shared vision of where we are headed. I plan to establish broad guidelines for services, while concentrating most of my efforts on the process through which we deliver services. As long as we have a shared vision of where we are headed, you are in the best position to make it happen. In the following sections, I will provide my perceptions concerning our mission and the process of service delivery.

DIRECTORATE OF MENTAL HEALTH MISSION

Provide constantly improving mental health services to USDB inmates and related services to our other customers.

Constantly: We must continually work to improve and tailor our services to the needs of our customers. In order to accomplish this, we must continue to acquire new knowledge and skills to meet the changing needs of our customers. It also requires cooperation, flexibility, and teamwork to link all our services into a systematic treatment approach. Complacency, fear of change, and failure to listen to other points of view are roadblocks to meeting our mission. The statement, "If it ain't broke, don't fix it" is contrary to how high quality, leading edge organizations operate - it is contrary to how we operate.

Services: We will visualize our services from a very broad perspective. Our services include, but are not limited to: (1) Inmate Assessments, (2) Treatment Planning, (3) Counseling Services, (4) Consultation, (5) Research, (6) Training and Coaching, and (7) Coordinating. Mental Health is an expansive concept and so must our perception of our services. It rarely should be said "It isn't my job." I want to emphasize our efforts to train, coach, and coordinate with others. The synergy of working together increases the effectiveness of the entire system.

Customers: As with services, it is important we take a broad view of who our customers are. Our customers are anyone with whom we interact. They include: (1) Inmates, (2) Inmate families, (3) All USDB personnel, (4) Other agencies, i.e., parole and clemency boards, social service agencies, judicial systems, etc., and (5) EACH OTHER. We will treat all our customers with respect and in a professional manner. This does not mean our customers are always right, it simply speaks to how they will be treated. I capitalized EACH OTHER because it is the easiest to overlook. We can learn from each other, and we need to remember to train, coach, and coordinate with the person in the next office and down the hallway.

PROCESS OF PROVIDING SERVICES

I strongly believe the process and manner through which we deliver our services are as critical as the quality of the service. Without effective customer relations, our services lose impact and value. With this in mind, I want to emphasize two major components of service delivery: (1) Teamwork, and (2) Communication.

Teamwork

Teamwork is an essential ingredient in the process of quality improvement and in the process of service delivery. Teamwork generates new alternatives, builds on individual strengths, minimizes vulnerability to manipulation, and increases effectiveness and efficiency of the service provided. It requires: (1) A willingness to focus on team goals, rather than individual pursuits, (2) Sharing knowledge and skills, and being open to new ideas, and (3) Developing close, professional relationships with all members of the team. Team players train and coach each other, and seek input from one another.

I will place a major emphasis on team building within DMH, and will all USDB personnel. I will use process action teams as a means to minimize turfism and encourage teaming. I want us to develop a broad view of who is on "our" team. We can not afford to sit back and let team members fumble about because "it isn't my job." I value the input and contributions of all our staff and each of you deserve to feel pride in our accomplishments.

Communication

Information is wealth to a team and an organization. Unlike money, however, wealth of information only grows by sharing it. The services we provide, the challenges we focus on, and the solutions we develop will depend on the breath of knowledge, skills, and information we share. It is imperative in developing quality

services, and in delivering those services, that information flow freely throughout our organization. In order for this to occur, we must work on eliminating the roadblocks which stifle open communication. Everyone is responsible for sharing information and confronting those issues which hamper good communication.

I challenge all of you to help us develop an environment in which everyone feels secure enough to express ideas, ask questions, and challenge our procedures. I believe we all have valuable input to contribute, and that everyone can gain from the ideas expressed. I am committed to open communication and I will demonstrate this commitment through my actions. I strongly believe making mistakes is an important part of growth, the key is what we learn from them. I will share my mistakes and hope you do the same - that way we all gain from the experience. We will not always agree, but I will respect and listen to your opinions, ideas, and beliefs. I ask for you to do the same.

CONCLUSION

I have worked hard to clarify my own leadership beliefs, and I hope I have presented a picture of where DMH is heading. This is not a one time drawing I will tuck away, but rather a start from which to build on. Teamwork and open communication are the building blocks for quality services. Please don't let them become stumbling blocks. I am strongly committed to providing the highest quality service possible, and I believe teamwork is the most effective and efficient way to do so. I also believe teaming is a fun, rewarding way to work.

THOMAS J. SCHMITT
LTC, MS
Director, Mental Health