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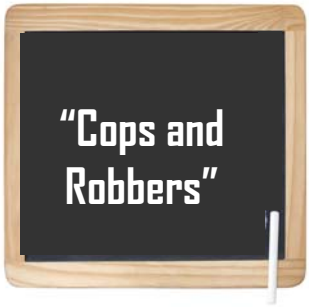
Game Codes – Newsletter of Games People Play

Addresso'Set Publications

Special points of interest:

"Three aspects of group treatment of inmates were altered by the therapist. (1) The writer/therapist changed his treatment method from the "psychoanalytic group therapy" process to that of analyzing transactions, transactional analysis. (2) A treatment contract between patient and doctor was initiated. That is, the presenting reason of a contract between the patient and the doctor remained paramount. (3) The study of the conversation stimulus-response patterns of the patient as they unfold in his group became a focus of group "study."



Inside this issue:

"Cops and Robbers"

"The psychogenesis of 'cops and robbers' is seen in the normal 2 to 4-year-old game of 'hide-and-seek.' In this latter game, contrary to popular opinion and as any parent can tell you, the objective is to be 'found and caught.' In the childhood 'hide-and-seek' there is a specified time during which the hider will stay quiet, but if not found at its end he begins to give hints to the seeker. Upon being found the squeals and giggles of delight of the 3-year-old who has been found attest to the joy of the game and the gratification of being caught. When roles are reversed 3-year-olds as a rule also squeal at the successful conclusion of seeking the sibling or parent acting as the would-be hider."

F.H. Ernst Jr., M.D.

"Psychiatric Treatment of the California Felon"

The following is an unpublished paper written by F.H. Ernst Jr., M.D.: "Psychiatric Treatment of Prisoners Using Transactional Analysis." Dad based this 2007 writing on his 1964 paper titled "Psychiatric Treatment of the California Felon," published in the American Journal of Psychiatry, Vol.120, No.10, 1964.

Eric Berne, M.D. referenced the original in his book "Games People Play" on page 140: "For further information about 'Cops and Robbers' and games played by prison inmates, see Ernst, F.H. and Keating, W.C., 'Psychiatric Treatment of the California Felon.' American Journal of Psychiatry. 120:974-979, 1964."

Psychiatric Treatment of Prisoners Using Transactional Analysis
by Franklin H. Ernst Jr., M.D., 2007.

From the late 1940's and into the 1960's penology in the United States gradually shifted away from its traditionally punitive role toward that of rehabilitating (correcting) the incarcerated person. As this goal of correction has been accepted, prison systems have struggled to incorporate and adapt the tools and techniques of the treatment professions to this end. The skills of educators and social scientists, psychologists, psychiatrists and statisticians became part of 20th century penology. This presentation is limited to the place of psychiatry in California's Department of Corrections during the middle of the 1900's.

The California Department of Corrections program of rehabilitation developed from the California Prison Reform Act of 1944. The first Director of the California Department of Corrections was Richard A. McGee. He had as his initial task, the development of goal oriented policies and procedures to implement them. These policies were to relate then current professional concepts in order to establish a logical rationale for the corrective process. Among the numerous initial studies undertaken in this reorganization of California Department of Corrections was the definition of problem areas as they existed at that time. Careful analysis was begun of men being received into the department. Intake statistics showed approximately 10% were suffering from emotional illness of such degree as to preclude their adequately adapting to a normal institutional routine, a routine which required a degree of conformity. (A study of one thousand [1000] consecutive admissions at California Medical Facility in the early 1960's yielded very nearly the same results.) This 10% of the felony commitments can be attributed to the application of the M'Naghten Rule of responsibility-for-an-act as defined in the California Statutes. This M'Naghten Rule proved effective as an exclusionary device; how-

ever, many mentally ill were not excluded on the basis of this concept of right and wrong for the given act.

California law (not necessarily the lawyers or judges) at the time of this writing was concerned not with the presence or absence of illness, but with the **intent** of the person. Except in capital offenses, and in the absence of obviously inappropriate behavior in the courtroom, the question of illness then was infrequently raised. The individual himself often prefers to be known as "bad" rather than "mad." As a man in a therapy group said: "I didn't like the nickname sick Sam, but slick Sam was OK." Thus many a person in prison consciously not only accepted but even sought out the anti-social life position rather than explore the sources of his anxiety and his maladaptive social techniques.

Because of the nature of the indeterminate sentence law in California in 1964 the more disturbed individuals, when they were considered for release, appeared less ready, compared to the not so disturbed man. As time has passed Adult Corrections came to have an increasingly larger proportion of severely disturbed in its population. To reverse this trend the department began in about 1950 to staff most prisons with a psychiatrist who functioned in a consultative capacity to the institutional staff and the releasing agency. As this program of consultation was carried out the magnitude and multitude of psychiatric problems began to be uncovered. A psychiatric inpatient facility was decided upon whereby a program could be unique and directed toward the treatment of the mentally ill.

To this end the Federal Government Facility at Terminal Island near San Pedro, California was leased in 1951 by the state until the construction of the California Medical Facility at Vacaville was completed in 1955. This facility was originally planned to hold 6000 men. It was anticipated that 10,000 would be confined when the facility was completed. Later a 1,000-unit mental hospital was built inside a fence.

With the population explosion in California, the numbers in prison also mushroomed to the point that by the end of the 1950's California Corrections was responsible for 25,000 confined persons, plus another 10,000 on parole. As a result, the California Medical Facility in Vacaville by 1964 served only 4% of the commitments contrasted to the planned 10%. Therefore, only the most acutely disturbed could be admitted to CMF then. Until additional facilities or treatment procedures were available, many cases were denied treatment at the new Medical Facility despite a potentially favorable prognosis. Today (in 2007) close to 200,000 people at a cost of $40,000 per inmate per year are incarcerated in the State prison system alone, not counting county and federal facilities.

In 1964 there were two outpatient clinics: one in Los Angeles and the other in San Francisco. These provided treatment for a fraction of the parolees.

Procedures

Upon arrival at the receiving facility, a 90-day period was used to establish a diagnostic formulation, assess the new inmate's ability to adapt to routine, and determine what programming was most likely to result in a corrective experience during the incarceration. During this period significant positive neurologic findings were studied in detail; and some acute emotional symptomatology was treated with ataractic medication.

When the initial physical, sociologic and psychiatric work-ups had been completed those inmates selected were entered into the Medical Facility's group psychotherapy program. Although treatment consisted of all the adjunctive components usually found in a mental hospital, the principle forte at the Medical Facility was group psychotherapy, as it had been since 1951.

About 600 men were in some 55 therapy groups at Vacaville in 1964. These groups were led by psychiatrists, psychologists and psychiatric social workers. Group composition remained essentially stable until individuals left the group because of parole or administrative transfer. There were usually 12 members in a group. As openings in groups occurred new members were added. Groups met twice weekly for one hour. Men were seen individually by the therapist as indicated. The individuals in therapy groups were reviewed periodically by a psychiatric screening committee. Patients as a rule did not change therapists and therapists were urged not to change patients. Group composition relative to crime, psychiatric symptomotology, etc. was preferably heterogeneous. On average, patients were in groups for about 18 months.

Clinical Findings

Once in a group, a man (generally by two months) had become:
1) verbal,
2) apparently interested in learning and tolerant of criticism, and
3) had improved his social control.

Sometime after the end of his first year the therapist began to hear complaints from his patient again: e.g. he is not moving ahead, he is not learning anything new, he should be allowed to try his new gains outside prison. These were usually related to his not having been paroled after the first or second

"In the prison groups personally conducted by the writer it clearly became evident that prisoners took advantage of such conceptual orientations as voluntary group cohesion and group support. For example, statements of the therapist like "attendance at group meetings is voluntary," "this is your group," "talk about whatever you want," were racketeered with. Attempts to steer talk onto presumably more worthwhile subjects were frequently countered by inmates who would cite the "rules" of group therapy back to this writer. Inmates had learned these rules from books about group therapy which they purloined from the staff medical library. In other words, discovering that therapists were enjoined to follow certain directions and advised against other procedures; many inmate-patients figured out how to exploit the situation. Some of the maneuvers observed were used to "rat pack" a member (the "hot seat" technique), "pull a stick up job" with the therapy time ("You better give me what I'm asking

interview by the releasing agency. This will be discussed in more detail later. Although the second-year man continued to progress he also began to exert increasing efforts to manipulate his treatment and institutional situation. For example they were heard saying things like: "Doctor, isn't there such a thing as too much treatment" and "Coming here to group ain't getting me out, Doc." The implicitly contradictory element of this was that very frequently these efforts to manipulate began to occur at the same time he was for the first time actively considering changing some of the basic tenets of his way of life (as expressed in group therapy).

While attendance in therapy groups was "voluntary" in one sense, in that patients were not hunted out by a policeman if they do not attend, in another sense it was obligatory inasmuch as they were explicitly expected to attend. Absence became a subject of group investigation and administratively non-participation in the group entitled a man to a "free one-way ride" to another "harder" prison; this because of the limited number of group psychotherapy "chairs." Among inmates Vacaville enjoyed a reputation of being one of the better correctional retreats.

While voluntary versus obligatory attendance and its effect on the individual psyche may well have been central to later discussion, the point of this paper is to describe the psychotherapeutic treatment of patients with, if you will, functional social diseases, which "net" them each one a societal black-ball, lasting up to one lifetime.

Initial attempts by the writer (F.H. Ernst Jr., M.D.) to use psychoanalytic type group psychotherapy were not particularly successful. In classical psychoanalytic group therapy the therapist's manner is seen as a benign, perhaps benevolent listener who directs comments toward the group, reflects questions asked of him back to the group, promotes what is called "group support" and "group cohesion", tending to be more an observer and less a participant in the group process. The thesis was that the "natural" evolution of the group itself would have a healing effect on the individual.

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It turned out that being "obliged or compelled" by another person is a significant part of an inmate's way of life (throughout). So complaints about authority actually developed into group discussions of how group members arranged and baited authorities to try to control authority activities.

Three aspects of group treatment of inmates were altered by the therapist. (1) The writer/therapist changed his treatment method from the "psychoanalytic group therapy" process to that of analyzing transactions, transactional analysis. (2) A treatment contract between patient and doctor was initiated. That is, the presenting reason of a contract between the patient and the doctor remained paramount. (3) The study of the conversation stimulus-response patterns of the patient as they unfold in his group became a focus of group "study."

The inmate/patient (presenting) symptom or complaint is what the

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"Game Codes—Newsletter of Games People Play"
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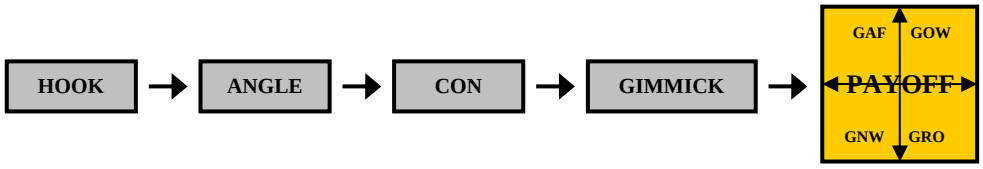
A game is defined as a recurring set of transactions with ulterior transactions, concealed motivation, a gimmick, and a payoff. Eric Berne, M.D. used a particular variation of the duplex transactional diagram to represent the ulterior aspects of a game. Berne added the concept of switch in 1966 and introduced "The Game Formula." Con + Gimmick = Response > Switch > Payoff. The "Ernst Game Diagram" as described by Franklin H. Ernst Jr., M.D. in his paper "The Game Diagram" shows the phenomena of the variableness of a game and number of variations without contradicting "Berne's Game Formula." The Game Diagram" has five moves: Move #1-Hook, Move #2-Angle, Move #3-Con, Move #4-Gimmick, Move #5-Payoff. Diagrammatically it looks like this:



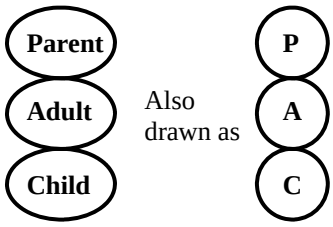
"Mastery of the universe is proportional to the symbols man has by which to represent his universe."

man hopefully comes to the doctor to have treated. In prison this frequently means the uninitiated inmate will make a statement like: "Doc, I want to get out of here." Later he learns that many therapists "go for problems." So he would modify his therapy objective to say: "I want to get over my problems" (whatever that may have meant). With these objectives of treatment of the person so stated, the exploitative maneuvers became more readily dealt with in the treatment situation. In the groups of Dr. Ernst it was routine for the therapist and patient to have a clear idea of what the patient came to treatment for, often by the end of the inmates first group session. This immediate professional approach toward a patient resulted in a reduction of time consumed by the classic "first phase of group therapy."

Patients very infrequently went through the initial maneuvering to find out "how do you please the doctor" or "bug him."

The group work then began centering on the fact that an individual member of the group showed major changes in his behavior in group from time to time and that these changes were more profound than they appeared at first. With the orientation of attention toward these gross behavioral alterations of each other in the group, inmates quickly came to grasp the advantages of studying these personality changes witnessed among each other. The changes referred to here included tone of voice, cadence of speech, accent, quality of facial expression, respiration, body postures, visible blushing, sweating, and reddening of eyes. As the inmates began noting and **reasoning** about these observable changes in each other, the therapist proceeded to talk with the patients about conversational stimulus of one member, producing the particular verbal and behavioral response of the second person being witnessed. It became possible to study the units of their social action "one conversational stimulus — one conversational response."

In short, the author changed his approach in dealing with his group members. As group events proceeded, this therapist gave brief chalk talks about each person having three sides to himself, i.e. a **Parent**, and **Adult**, and a **Child**self. Drawings were drawn showing three circles stacked on each other and enclosed in a larger envelope. The functionally distinct qualities of self were schematically diagrammed on a black-board during the group session as Parent, Adult and Child (Figure No. 1).



to be continued