PSYCHIATRIC TREATMENT OF THE CALIFORNIA FELON

Franklin H. Ernst, M.D. * & William C. Keating, Jr., M.D.**

HISTORY

During the past thirty years penology in the United States has gradually been shifting from its traditionally punative role towards rehabilitation of the 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; psychiatrists and statisticians have become part of 20th century penology. Today's presentation is limited to the place of psychiatry in California's Department of Corrections.

This department as it exists today developed from the California Prison Reform Act of 1944. The first Director of Corrections (under this act) Richard McGee, had as his initial task, the development of goal oriented policies and procedures to implement them. These policies were to relate the current professional concepts in order to establish a logical rationale for the corrective process. Among the numerous initial studies undertaken in this reorganization 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 requires a degree of conformity. This 10% of the commitments can be attributed to the application of the McNaughten-Rule-of-responsibility-for-an-act as defined in the California Statutes. This McNaughten Rule has

*Consultant and staff member California Medical Facility, Vacaville, California
**Superintendent California Medical Facility, Vacaville, California

proven effective as an exclusionary device; however, many mentally ill are not excluded on the basis of this concept of right and wrong for the given act.

The law is concerned not with presence or absence of illness but with the intent of the person. Except in capitol offenses, and in the absence of obviously inappropriate behavior in the courtroom, the question of illness is infrequently raised. Additionally, the individual himself often prefers to be known as bad rather than mad; as a man in a therapy group recently said - "I didn't like the nickname Sick Sam: but Slick Sam was OK." Thus many a person in prison has consciously not only accepted but even sought the anti-social position rather than explore the sources of his anxiety and maladaptive social techniques.

Because of the nature of the indeterminate sentence law in California such individuals when they are later considered for release, appear less ready, compared to the not so disturbed man. Thus as time has gone on Corrections has come to have an increasingly larger proportion of severely disturbed in its population. To reverse this trend the department began, about 15 years ago, 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 consultations was carried out the magnitude and multitude of psychiatric problems began to be uncovered. A psychiatric inpatient facility was decided upon; where a program could be unique and directed toward the treatment of the mentally ill.

To this end the Federal Government Facility at Terminal Island was leased in 1951 by the State until the California Medical Facility at Vacaville

was completed in 1955. When this Facility was planned, 6000 men were confined. It was anticipated that 10,000 would be confined when the Medical Facility was completed so a 1,000 unit mental hospital was built inside a fence. With the population explosion in California, the numbers in prison have also mushroomed to the point now that Corrections is responsible for 25,000 confined persons, plus another 10,000 on parole. As a result, the Medical Facility now can serve only 4% of the commitments contrasted to the planned 10%. Therefore, only the most acutely disturbed can now be admitted. Until additional facilities or treatment procedures are available many cases must now be denied treatment at the Medical Facility despite a potentially favorable prognosis. There are two out-patient clinics in Los Angeles and San Francisco but these provide treatment for only a fraction of the parolees.

PROCEDURE

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

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

Today there are about 600 men in some 55 therapy groups at Vacaville.

These groups are led by psychiatrists, psychologists and psychiatric social workers. Group composition remains essentially stable until individuals are terminated by parole or administrative transfer. There are usually twelve members in a group and as openings in groups occur new members are added. Groups meet twice weekly for one hour. Men are seen individually by the therapist as indicated. Therapy cases are reviewed periodically by a psychiatric screening committee. Patients as a rule do not change therapists and therapists are urged not to change patients. Group composition relative to crime, psychiatric symptomotology, etc., is preferably heterogenous. On an average patients are in groups about 18 months. Once in a group, a man (generally by two months) becomes (a) verbal, (b) interested in learning and tolerant of criticism, and (c) has improved social control. Sometime after the end of the first year complaints begin to pick up again; he's not moving ahead, there's nothing new, he should be allowed to try his new gains outside. This is probably related to his not having been paroled after his first one or two visits to the releasing agency. This will be discussed in more detail later. Although the second year man continues to progress he also begins to exert usually increasing efforts to manipulate the treatment and institutional situation so as to be terminated - "Doctor, isn't there such a thing as too much treatment", and "coming here ain't getting me out, Doc". The implicitly contradictory element of this is that efforts to manipulate begin to occur while at the same time he is also in the group for the first time actively considering changing some of the basic tenets of his way of life.

While attendance in therapy groups is "voluntary" in one sense, in

that patients are not hunted out by a policeman if they do not attend, in another sense it is obligatory inasmuch as they are explicitly expected to attend, and absence becomes a subject of group investigation and administratively non-participation in the group entitles a man to "a free one-way ride" to another prison because of the limited number of group psychotherapy "chairs". Among inmates Vacaville enjoys a reputation of being one of the better correctional retreats.

While voluntary versus obligatory attendance and its effect on the individual psyche may well be central to later discussion here, 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 societal blackball, lasting up to one life time.

CLINICAL FINDINGS

Attempts to use what is sometimes referred to as psychoanalytic type group psychotherapy were not particularly successful in the hands of this author. Classically the manner of the therapist is 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 being that the "natural" evolution of the group itself will have a healing effect on the individual.

In the prison groups personally observed, it early became evident that prisoners took advantage of such conceptual orientations as "voluntary", group cohesion, and group support. For example, statements of therapists 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 the "rules" of group therapy; the inmates had learned these rules from the books on 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 others, - many inmate-patients figured out how to exploit the situation. Some of the maneuvers observed have been 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 for or --"), run a "protection racket" with fellow members' confidences ("and you better not talk about this to the therapist or I'll pull the covers off you"), embezzle the therapy to the wing ("we already covered all that last night in the wing, Doc"), "til-tap" the conversation (steal the conversational ball by distracting and provoking the observing members then making them feel guilty for their anger at him, while also changing the subject of conversation), and kidnap and hold for ransom the treatment hour. Accordingly having been robbed, embezzled from, conned, watched group members made to buy protection, witnessed rat-packing and having had my mental til tapped, I decided that treating a person for an illness had less to do with (a) the rules of group therapy, or, (b) whether treatment was compulsory or voluntary; it had more to do with more efficient utilization of (a) the patient's conversational exchanges, (b) the psychotherapist's knowledge of behavioral dynamics, and (c) more efficient use of the time spent in the psychiatric operating room.

It has turned out, as I will show later, that being obliged or compelled

by another person has been a significant part of the inmate's way of life throughout, so that their complaints about authority actually develop into a discussion of how they arrange to get authorities to control their activities.

Two aspects of group treatment of inmates are mentioned here: (a) the contract between patient and doctor, that is, the presenting complaint of a patient to the doctor, and (b) the study of stimulus-response patterns as they unfold in the group.

The presenting symptom or complaint is what the man hopefully comes to the doctor to have treated. In prison this frequently means for the uninitiated inmate a statement like, "Doc, I want to get out of here". Later he learns that many therapists "go for 'problems'" so he modifies his therapy objective to say, "I want to get over my problems" (whatever that may mean). With the objective of treatment stated the exploitative manuevers are more readily dealt with in the treatment situation. In my groups it has become almost routine for the therapist and patient to have a clear idea of what the patient comes to treatment for by the end of the first group session. This immediate professional approach to a patient seems to result in very considerable reduction of time consumed by the classic "first phase of group therapy".

My patients very infrequently now go through the initial maneuvering to find out "how do you please the doctor" or "bug him".

The group work then fairly rapidly begins centering on the fact that the members of the group change grossly from time to time and that these changes are more profound than might at first appear. With the

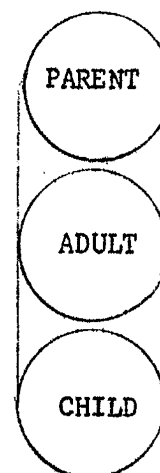
orientation of attention toward these gross behavioral alterations of each other in the group, inmates quickly grasp the advantages to themselves of studying these personality changes witnessed among each other. The changes referred to here include the changes in tone of voice, cadence of speech, accent, quality of facial mimicry, respiration, body postures, visible blushing, sweating, and reddening of eyes[1]. When the inmates have begun noting these observable changes in each other, the therapist proceeds to talk with the patients about what conversational stimulus of one member produced the particular verbal and behavioral response of the second, i.e., it has become possible to study the units of their social action - one conversational stimulus - one conversational response.

The following is an example of a conversational - transactional unit from a recent group session.

Phil, in a low-pitched, clear confidential manner says to Mac, "Say, Mac, I want to tell you something for your own good. You talk about good manners but you interrupt other people while they are talking. Now I know you might not like this but I'm doing this for your own good." Mac's conversational response had a bouncy quality as he told Phil, "You're sore because I know that you aren't so pure, besides you're trying to impress the doctor". Directly following this, Phil was shouting and threatening, while the group snickered at Phil's loss of temper. The change in Phil from the low voiced, confidential talking person apparently trying to help, into a person with a high-pitched voice, talking in machine-gun fire bursts of words calling Mac names, were evident and clear for all group members to see.

The significance of the change for Phil was that he clearly recalled the historical background of these two personality qualities in himself. The person with the confidential, low-pitched voice he identified as being copied from the highly respected director of the orphanage where he lived until 16. Secondly, Phil gives historial verification of the second as coming directly in unchanged form from his childhood temper tantrums. In this act of reasoning these two aspects of himself out, Phil demonstrated in the group an objective quality of himself, a data processor sensitive to psychological information. These three qualities were schematized in a blackboard diagram for both Phil and Mac to see and labeled Parent, Adult and Child - each quality doing something unique. In group work this finding of at least two differently organized, operationally distinct qualities of personality has been the single most characteristic finding of seeing people in groups. The discovery of having personality options within himself and utilizing a choice of these, in itself has resulted in very significant improvement in Phil's behavior, (a) in the quality of stimuli which he offers people, and (b) in the quality of responses which he returns to those who want to start something. As a result of operationally locating these choices within himself he is more frequently using Adult data - processing to determine his social procedures as contrasted to the diseased childhood and overbearing parental techniques.

These functional and operational qualities of self are schematically diagrammed on a blackboard during the group session as Parent, Adult and Child. The fact that inmates have both an operational and a functional grasp of these qualities in themselves and others is attested by their



reduced frequency of involvement in "incidents". The therapist who remembers the inmate's reasoned objective is "to get out of here and stay out" has frequent opportunities to contrast this goal with his behavior and then demonstrate the presence within the man of an operationally rebellious child.

Since the intent of the Department of Corrections and the Legislative Acts which govern it, is to secure the correction of an inmate's social behavior, this ability of Phil to modify his quality of social initiative and responsiveness, is cure. If you will, he has learned to differentiate straightforwardness in others from "I'm trying to help you" as a maneuver to tease his childhood self into a volcanic display. Additionally, he now knows what to expect in response to his own efforts to exploit someone else.

Therapeutic reference to the contractual arrangement markedly reduces the number of pastime conversations on baseball, injustices, courtroom evidence, medical waiting room items like my ulcer diet, headaches and "what was your hemorrhoidectomy like".

At the Vacaville prison an annually written psychiatric report is made to the releasing agency on the inmate's performance. The patients in therapy know this, in fact they are aware that it is often the key item determining their release or retention. For some therapists this reporting may be objectionable because "it interferes with psychotherapy" but for those who keep their job it is inescapable[3].

It has been clinically advantageous to take the position that everything the patient says and does with the group therapy can be looked at from the viewpoint of the patient's Childhood self influencing this report. Historically the act of making records and filing descriptive and identifying

information on the inmate usually has been going on for many years before he came to a therapy group. He's been fingerprinted and mugged repeatedly; individual detailed crime reports by several persons and agencies have been done each time he's been apprehended and convicted and a chronologic cataloguing of his criminal record or "rap sheet" has been reproduced in multiple copy; judicial, sociological and psychological reports are duly filed for each.

To study this phenomenon and its possible gratifications to the inmate I have been composing these psychiatric evaluations in the therapy group during the past year. One of the results has been a decrease in the time spent "buttering up" the doctor and later when not released exclaiming "foul" to the therapist about treatment not doing anything for him. Removing the secrecy cloak from this has reduced the counter-secrecy intrigues in the group.

Soon after joining a group most of my patients see that being in jail has resulted from playing a game of "cops and robbers"[4]; that is professionals very rarely are caught; that being captured is the expected outcome and often is experienced as a relief.

The psychogenesis of "cops and robbers" is seen in the normal two to four year old game of hide and seek; where (contrary to popular opinion) and as any parent can tell you, the objective is to be "found and caught". In childhood "hide and seek" there is a specified time the hider will stay quiet, if not found he begins to give increasingly loud hints to the hunter. Upon being found the squeals and giggles of delight of the three year old found, attest to the joy of the game and the gratification of being caught.

When roles are reversed three year olds are so honest they even squeal when they are the finder.

The joy, pleasure, and excitement of the very recently "recaptured" recidivist upon interview by a member of either the clinical or custodial staff is available for observation and often apparent in the staff member.

In the old time "tough" prisons the structuring of time was rather complete. The rules (of the game) were stricter and more definitely laid out with larger stakes available including many more occasions to put one's time and life on the "I dare you" line. Present day California penology is directed toward diminishing the uniqueness of being a "bad guy". In old time prisons prestige was available for being hardened, for example, "nobody ever broke him", "that guy could really take it"[5]. Intrigues and special language enhanced uniqueness.

The institutional design now is to reward contra-social behavior less and deprive the person of those advantages which come to one who can take physical punishment and prolonged segregation. In this way there is less opportunity for a case-hardening situation to develop; there is reduced amount of training time spent by inmates in a post graduate school of criminology, convict style.

The design of the therapist is to cure the offender of his repetitively carried out conversational transactions which lead to loss of behavioral options. Recognition of choices in behavior which previously had been thought unalterable, provide the inmate with a markedly improved measure of control over his day to day situations. For example, the stimulus, "why, you can't let somebody run over you like that", previously would unfailingly

have evoked the response of "Of course not, I know it"; but with treatment can result in the optional choice of either the original response of a second, such as, "I can if I want,", or, a sophisticate may reply, "haven't you got something else to do besides offering to hold my coat?"

In summary the medical objective in the psychiatric treatment of the incarcerated California felon is to cure him of his psychological and social tactics that eventuate in loss of his behavioral options and then loss of control over his responses; of, if you will, the relearning of how to use previously unpracticed social options for initiating or responding to conversations, provides the inmate with a measure of social control previously not available to him. The renunciation(a) of playing "cops and robbers" with its attendant gratifications, and (b) the use of "go-directly-to-jail" to solve external or internal life stresses are two of the major advantages the so-called, anti-social person, gives up on cure.

Bibliography

1. Berne, E., Transactional Analysis in Psychotherapy. Grove Press, Inc., N.Y., 1961

2. Proceedings of Scientific Meetings. "Group Treatment in a Prison". Transactional Analysis Bulletin, 1963, 2: pg. 52-3; No. 6

3. McCormick, P., Proceedings of Scientific Meetings. "Preparing for Group Work with Adolescent Offenders". Transactional Analysis Bulletin, 1963, 2: pg. 57, No. 6.

4. Ernst, F., Use of Transactional Analysis in Prison Therapy Groups. J. of Social Therapy and Corrective Psychiatry, 1962, 8: No. 3.

5. Proceedings of Scientific Meetings. "Dynamics of a Navy Prison". Transactional Analysis Bulletin, 1963, 2: pg. 72, No. 7.

408 Tennessee, Vallejo