Psychiatric Treatment of the California Felon Using Transactional Analysis

by

Franklin H. Ernst, Jr., M.D.

History [1,2,8]

From the late 1940's and into the 1960's penology in the United States gradually shifted away from its traditionally punitive role towards 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[6]. 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 re-organization 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 1,000 consecutive admissions at California Medical Facility in the early 1960's yielded very nearly the same results[7].) 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; however, 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 were concerned not with 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."[1] 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[9]. Thus as time has gone on Adult Corrections came to have an increasingly larger proportion of severely disturbed in its population. To reverse this trend the department about 1950 began 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 Medical 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 Medical Facility in 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 (2005) close to 200,000 people at a cost of $35,000 per inmate per year are incarcerated in the State prison system alone, not counting county and federal facilities[10].

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; 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. Men were seen individually by the therapist as indicated. Groups met twice weekly for one hour. Theses group therapy cases 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 symptomology, etc. was preferably heterogeneous. On average, patients were in groups 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. In his group sometime after the end of his first year therapist began to hear complaints again: e.g. he is not moving ahead, nothing new, he should be allowed to try his new gains outside. These are usually 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 continued to progress he also began to exert increasing efforts to manipulate his treatment and institutional situation. I heard them say 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 are 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, and 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 prison; 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 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 being that the "natural" evolution of the group itself will have a healing effect on the individual.

In the prison groups personally conducted (by Dr. Ernst), 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 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 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 for or--"), run a "protection racket" with fellow members' confidences ("and you better not (both) talk about this to the therapist or I'll pull the covers off you"), embezzle the therapy to the wing (where their cell was), ("Ah, Doc, We, ah, already covered all that last night in the wing, Doc"), "til-tap" the conversation (steal the conversational ball by distracting or provoking the observing members, then during the distraction change the subject of conversation), and kidnap and hold for ransom the treatment hour ("help" a key man in the last discussion to "forget" the next meeting).

Accordingly having been robbed, embezzled from, conned, having 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: 1) the rules of group therapy, or 2) whether treatment was compulsory or voluntary. It had more to do with more efficient use of the patient's conversational exchanges, the psychotherapist's knowledge of behavioral dynamics, and more efficient use of the time spent in the psychiatric operating room.

It turns out that being “obliged or compelled” by another person is a significant part of an inmate's former way of life (throughout). So their complaints about authority actually developed into discussions of how they arrange to get authorities to try to control their activities.

Two aspects of group treatment of inmates are mentioned here: 1) the treatment contract between patient and doctor, that is, the presenting complaint of a patient to the doctor, and 2) the study of the conversation stimulus-response patterns of the patient as they unfold in his group.

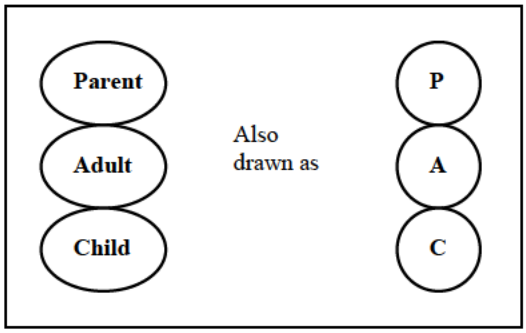
The presenting symptom or complaint is what the man hopefully comes to the doctor to have treated. In prison this frequently means for the uninitiated inmate a statement like: "Doc, I want to get out of here." Later he learns that many therapists "go for ‘problems." So he modifies his therapy objective to say: "I want to get over my problems" (whatever that may mean). With the objective of the treatment of the person stated, the exploitative maneuvers are more readily dealt with in the treatment situation. In the groups of Dr. Ernst it became almost routine for the therapist and patient to have a clear idea of what the patient came to treatment for by the end of the first group session. This immediate professional approach to a patient resulted in very considerable 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 fairly rapidly began centering on the fact that an individual member of the group show major changes in his behavior 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 included the changes in tone of voice, cadence of speech, accent, quality of facial mimicry, respiration, body postures, visible blushing, sweating, and reddening of eyes. When the inmates began noting these observable changes in each other, the therapist proceeded to talk with the

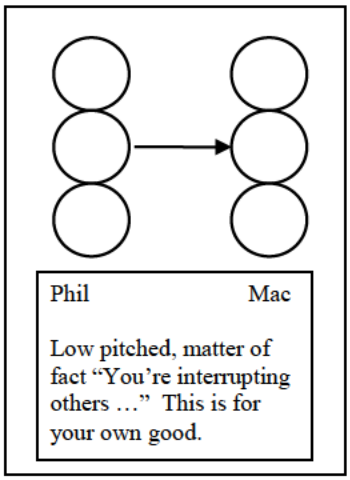
patients about what conversational stimulus of one member produced the particular verbal and behavioral response of the second person, i.e., it became possible to study the units of their social action "one conversational stimulus — one conversational response" of the second person to what the first person had said.

In short, the author changed his approach to his group and their members. Groups were given a chalk talk about each person having three sides to himself, i.e. a **Parent**, and **Adult**, and a **Child**self [1]. These could be represented by three circles stacked on each other and enclosed in a larger envelope as follows:



The Parent self comes from the person's own parent (or parent surrogate). The Child comes from the person's own memories and behaviors that begin in his childhood. The Adult is the thinking, data processing self inside the person.

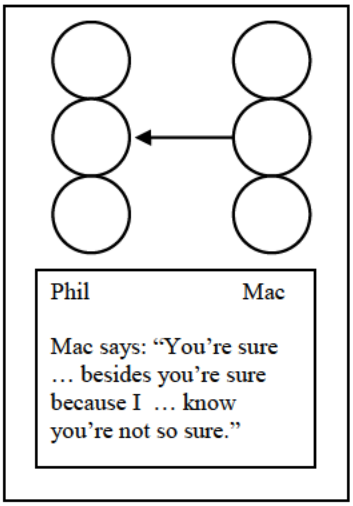
Inmates of the writer's groups assimilated and accepted this diagram for themselves. Author drew these diagrams on a chalkboard in his group treatment office.



The following is an example of such a (stimulus/response) transactional conversational exchange that occurred in a group session.

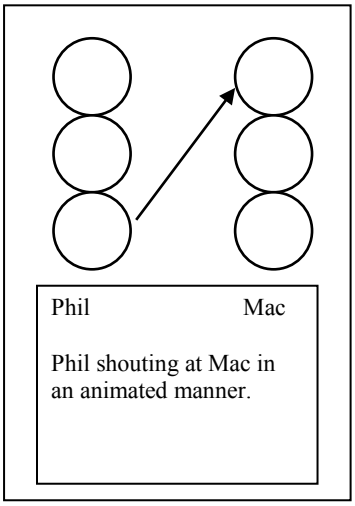
Phil, in a matter-of-fact low-pitched, clear, and confidential manner said to Mac: "Say, Mac, I want to tell you something for your own good. You talk about good manners but you interrupt other people while they are talking. Now, I know you might not like this, but I'm doing this for your own good."

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 just trying to impress the doctor."

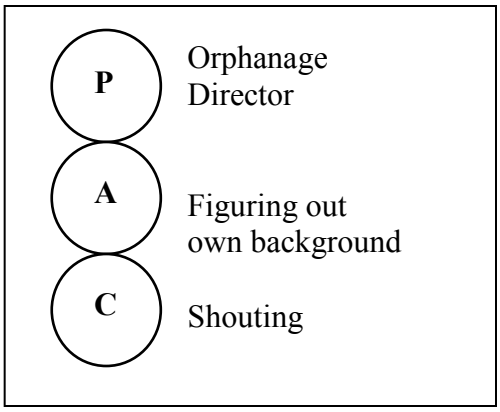


Directly following this, Phil was shouting and threatening, while the group snickered at Phil's loss of temper.

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. Phil's first remark, Mac's response acting as a stimulus back to Phil and thirdly Phil's response to Mac (Mac's response) which operated as a stimulus for Phil's second remarks, included a gross behavioral change in Phil's appearance.

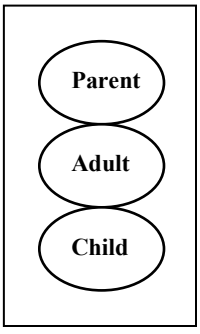


On inquiry by therapist the significance of the change for Phil was that he clearly recalled the historical background of these two personality qualities in himself. The person with the confidential, low-pitched voice he identified as being copied as his own Parent from the highly respected director of the orphanage where he lived until 16. Secondly, Phil gave historical verification of his second behavior as coming directly in unchanged form from his childhood temper tantrums. In this act of reasoning and giving credit to each of these two aspects of himself, 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 Phil, Mac, and the rest of the group 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 by an individual of having experiential options within himself and having a choice in the uses of these in itself resulted in very significant improvement in Phil's behavior; in the quality of stimuli which he offered people, and in the quality of responses which he returns to those who want to start something with him.

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 relies from his disturbed childhood to his overbearing parental techniques. Later this same procedure of analyzing his transactions was carried out also with Mac.



These functional distinct qualities of self were schematically diagrammed on a black-board during the group session as Parent, Adult and Child.

The fact that inmates in these groups have both an operational and a functional grasp of these three real qualities within themselves and inside others was attested to by members having a reduced frequency of involvement in "jailhouse incidents" and an increase in non-exploitative interpersonal skills. The therapist remembering the inmate's reasoned objective in the group "to get out of prison and stay out" present frequent opportunities in group to contrast this goal of the particular inmate with discrepant, contradictory behavior and demonstrate to the patient the presence within himself of his own rebellious child.

Since the intent of the Department of Corrections in 1964 and the legislative acts which governed this department were to secure the correction of an inmate's social behavior, this above noted ability of Phil now to modify his quality of social initiative and responsiveness was his cure. If you will, he learned to differentiate straight forwardness in others from "I'm only 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 reduced the number of pastime conversations on baseball, injustices, courtroom evidence, medical waiting room items such as "my ulcer diet," headaches and "what was your hemorrhoidectomy like?"

At the Vacaville prison a written psychiatric report was made annually to the releasing agency on the inmate's performance. The patients in therapy knew this. In fact they were aware that it is often the key item determining their release or retention for another year[2]. For some therapists this reporting was objectionable because "it interferes with psychotherapy" but for those who kept their job it is inescapable[3].

It became clinically advantageous to take the position that everything the patient said and did with the group therapy could be looked at from the viewpoint of the patient's childhood self attempting to influence this reporting. Historically, the act of making records and the filing of descriptive and identifying information about the inmate has been going on for several years before he came to a therapy group. He has been fingerprinted and "mugged" repeatedly; individual detailed crime reports by several persons and agencies have been done each time he has been apprehended, convicted; a chronologic cataloguing of his criminal record or "rap sheet" has been reproduced in multiple copy; judicial, sociological and psychological reports are duly filed on each man.

The study of this phenomenon and its possible gratifications to the inmate were incorporated by this writer into composing the annual psychiatric evaluations in the therapy group member during the preceding year. One of the results of this approach was a decrease in the time spent "buttering up" the therapist and later when not released exclaiming "foul" to the therapist about treatment not doing anything for him. Removing the secrecy cloak from this writer’s report has reduced the counter-secrecy intrigues by group members around the therapists.

Soon after joining a group most of my patients came to see that being in jail resulted from playing a game called "cops and robbers"[4], i.e., professional “robbers” are very rarely caught. Being captured was often experienced and reported to writer to inmates as a "relief." Being caught was the expected outcome of his "game[1]."

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 the hider will stay quiet and if not found he begins to give increasingly loud hints to the seeker. Upon being found the squeals and giggles of delight of the 3-year-old 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 would-be hider.

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

In the old time "tough" prisons the structuring of time was rather complete. The rules (of the game) of the “keepers” and the “kept” 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 penology is generally rather more 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 this uniqueness.

The institutional design has become less directed toward rewarding contra-social behavior. This has decreased the social advantages (gains) which come to one who “can take the physical punishment and prolonged isolation and segregation.” In this way it is hoped there is less opportunity for a case-hardening situation to develop; there is a reduced amount of training time spent by inmates in a post-graduate school of criminology, convict style.

This article is aimed to identify that the therapist of an inmate therapy group can direct his energies and work toward correcting the behavior of the offending inmates by attending to the repetitively carried out conversational transactions which lead to loss of behavioral options. Recognition of alternative behavioral choices provides the inmate with a markedly improved measure of control over his day to day situations. For example, the euphemistic stimulus, "Why, my goodness! 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 above response, a second, such as: "I can if I want to," or a sophisticated group member may reply: "Haven't you got something else to do besides offering to hold my coat?"

Summary

The objective in the psychiatric **treatment** of the incarcerated felon can become the correction and “care” of his psychological and social tactics that eventuate in loss of his “freedom” and behavioral options and then loss of control over his social stimuli and responses. Inmates often have not “relearned” how to use previously unpracticed social options for initialing or responding in conversations. The inmate with a measure of improved social control previously not available to him is on the road to staying out of jail.

Two of the major advantages the so-called anti-social person gives up on are:
1) Playing "cops and robbers" with its attendant gratifications, and
2) The use of "go-directly-to-jail" to solve external or internal life stresses and problems.

Bibliography

1. Berne, E.: Transactional Analysis in Psychotherapy. New York: Grove Press, 1961. The word "game" is used with a very precise definition including the elements of repetitively carried out serial transactions involving maneuvering another person and having a unique "payoff" for the individual.
2. Proceedings of Scientific Meetings: Group Treatment in Prison. Transactional Analysis Bulletin, 2: 5, 1963.
3. McCormick, P.: Ibid., 2 : 57, 1963.
4. Ernst, F.: Journal of Social Therapy and Correctional Psychiatry, 8: 3, 1962.
5. Proceedings of Scientific Meetings: Transactional Analysis Bulletin, 2: 72, 1963.
6. Chapter 1, paragraph 5000 (Establishment of Department); added by Statutes. 3d Ex Sess., ch. 2, par. 1. California Penal Code, 1944.
7. Rouse, Winslow: The Problem of Adult Corrections: A case study of State Penal Administration in California. Presented to the Graduate Faculty of the Claremont Graduate School, June 1961.
8. This article is adapted from a paper first read by Dr. Ernst at the Western Regional Meeting of the American Psychiatric Association, San Francisco, California, September, 26-28, 1963. At the time this was written in 1963 Dr. Ernst was a consultant/staff member, and Mr. Keating was the Superintendent of California Medical Facility, Vacaville, California. Mr. Keating was listed as a co-author in the paper that appeared in the American Journal of Psychiatry. The paper was published in The American Journal of Psychiatry, Vol.120, No.10, April 1964.
9. In 1976 the California Legislature passed into law determinate sentencing rules thereby abandoning indeterminate sentencing standards.