Sober and Socially Responsible: Treating Federal Offenders

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THIS ARTICLE PROPOSES the integration of characterological therapy with substance abuse treatment. The integration of these two models addresses most fully the clinical challenges presented by the federal offender population. The ideas presented here are an outgrowth of observation and experience working in contract agencies with this population, first as a clinician in an outpatient substance abuse agency and currently as the Clinical Supervisor at the Salvation Army Corrections Center in Chicago. The Salvation Army (which is the largest federal community corrections facility in the country) is working to integrate these two models in individual and group treatment as well as in the milieu.

Clients arrive at our offices because they have broken the law. Embedded in the lawbreaking behavior we often see longstanding maladaptive personality patterns. In general, substance abuse treatment offered by community agencies to the offender/clients focuses primarily on addiction issues and does not address criminal thinking or other personality problems. Clients mandated for mental health treatment generally receive substance abuse treatment and whatever mental health services the individual clinician decides to deliver. While some mental health clinicians may choose to address personality disorders, others may not, focusing on acute (Axis 1) conditions such as depression and anxiety disorders. Although mental health clients are distinguished from the general population by the presence of Axis 1 disorders, and these do need to be addressed, there is a high co-morbidity and often personality disorders underlie the Axis 1 problems. The work of characterological therapy is to modify dysfunctional, maladaptive personality patterns. Characterological therapy can support and enhance substance abuse and mental health treatment currently offered.

This article describes the maladaptive personality patterns clients present, discusses the theory behind characterological therapy, and notes major limitations in most current outpatient treatment in addressing the client's presenting problems. The article suggests ways that outpatient substance abuse treatment can be strengthened by adding characterological therapy. It describes the main features of characterological therapy and looks at ways that counselors and therapists can be selected, trained, and supervised to provide United States Probation and Bureau of Prisons clients with the highest quality and most comprehensive services.

Maladaptive Personality Patterns Clients Present

Embedded in lawbreaking behavior we often see longstanding, maladaptive personality patterns. In the community corrections setting, four distinct patterns are seen repeatedly. Some clients are antisocial. Their primary issues are a victim stance with a concomitant projection of blame onto the system, rejection of the legitimacy of rules and law, and rejection of authority. Their motto might be "Nobody is going to tell me what to do." Their stance is defiant.

Other clients are schizoid, the loners. Their core issue is trying to take care of themselves in a world they regard as totally hostile. Other people are seen as obstacles to get over, around, and through with as little contact as possible. When they commit a crime, it is generally in the wake of severed relationships in work and personal life: they have run out of conventional resources and commit crimes in desperation. The majority of our clients with bank robbery convictions fall into this category. Their motto might be "Leave me alone." Their stance is vague, evasive, and secretive.

We encounter a third personality disorder in our borderline clients. They move from one crisis to the next. Their crimes are committed in a crisis context, usually accompanied by drug and or alcohol abuse. Their core issue is abandonment and their crimes are almost always committed in the context of relationship failures; when excessive demands they place on relationships cause others to retreat, they act out and commit crimes in anger. Their motto might be "Nobody cares about me." Their stance is "If you meet all my needs, I'll be very good, but if you don't, I'll be horrid." These clients are easily identified by their histories of suicide attempts, overdoses, and self-mutilation and by their tendency to "split"—that is, to shift their characterizations of important others between all good and all bad. They share with their cousins the dependent personalities a complete lack of boundaries.

Dependent clients constitute another group whose personality disorder we encounter. Our dependent clients commit crimes in the context of relationships also. However, their goal is to prevent abandonment. While the borderline commits crimes because a relationship has failed, the dependent commits crimes to keep a relationship. It is common

for dependent clients, especially but not exclusively the women, to report that they participated in criminal activity to "hold" a partner without whom they feel they could not survive. They are really the "nicest" and most pleasant clients to work with. Their motto might be, "I'll do anything for you dear, anything!" and their stance towards the therapist is, "I'll throw myself on your mercy."

Commonly, the clients' substance abuse and personality disorders have a reciprocal relationship, continually reinforcing each other in a circle of escalating dysfunction. For example, the "borderline" substance abuser medicates intense and unstable emotional states with drugs which have the effect of intensifying the instability. The antisocial personality increases drug use or relapses when s/he doesn't get his/her way or when s/he perceives others trying to control him/her.

Some counselors argue that the criminal behavior we see is secondary to drug abuse—i.e., clients steal, lie and manipulate because they are addicts—and that the antisocial behavior will disappear when the addiction is treated. These clinicians would see no need for additional "characterological" work. However, increasing research indicates that the characterological problems clients present often precede their drug use (Doweiko, p. 455; Fishben and Pease, p. 384). My experience taking federal probation client histories indicates that half of the clients were diagnosed as having "conduct disorders" (the diagnosis for childhood antisocial conduct) prior to taking their first drink or drug. However, even without the documented diagnosis of a preexisting personality disorder, substance abuse and criminal activity normalize antisocial thinking that needs to be addressed in treatment.

The Theory Behind Characterological Therapy/ Counseling

In characterological work, personality disorders are conceptualized as long-term consequences of developmental deficits (also called developmental arrest). Deficits occur in the individual's ability to attach to others (bonding) or in the individual's ability to individuate (poor boundaries between self and others). Traditional psychoanalytic theory posits that the different points of development at which the arrest occurs accounts for the structure of the disorder--whether it is anti-social, schizoid or dependent, for example, may depend on the point in early development where the individual's environment failed to deliver the basic conditions for continued emotional growth. (Note: Though there may be disagreement about how and when these disorders arise, it is clear that they exist and are harmful to the individual and to society.) Usually on the "disorder continuum" we think of schizoid and antisocial personalities as having the earliest disruption of growth conditions, with failure of attachment occurring during the first months of life. Thus, according to this theoretical model, many of the most schizoid and antisocial clients are akin to "orphanage babies" or "failure to thrive" babies who missed out on life's earliest socialization and bonding experiences. Although the schizoid client is more isolated and the antisocial client more aggressive, both disorders are associated with lack of empathy for others and lack of remorse for harm caused. Moving along the disorder continuum, borderline and dependent personalities are seen as the result of disruptions of growth conditions at later stages, and are more associated with failures of the environment to nurture towards individuation. Dependent structures are thought to be the result of the environment requiring more independence than the child is developmentally capable of and borderline structure is the result of punishment of early attempts at separation.

Personality disorders need to be understood as existing on a continuum—the "pure" borderline or antisocial disorder does not exist—these are generalizations only. Real clients may show a combination of deficits associated with different disorders. For example, it is common to see clients with both borderline and antisocial features.

It is important to recognize that while deficits are experienced within individual families, the conditions that produce a childhood lacking the basic requirements for development are often rooted in the ills of our society, including poverty, racism, drug abuse by caretakers, and lack of opportunity. Our clients are all too well aware of these injustices. We can and should empathize and acknowledge them at the same time that we insist that the client's deviant response is self-destructive and also especially destructive to those in his/her immediate family and community who may have suffered the same inequities.

Limitations That Have Existed in Programming

Programming Has Not Traditionally Addressed Characterological Issues

When awarded contracts for treatment services, community substance abuse agencies are often unprepared to deal with the more serious and chronic offender population. Substance abuse treatment services have too often been the same services offered to the agency's non-offender population. This treatment, whether it is individual, outpatient, or intensive outpatient, features goals that are behaviorally oriented—abstinence, avoidance of persons, places, and things associated with use, meeting attendance, etc. These behavioral prescriptions have offered the clients a needed structure for sobriety. The limitation of this model when applied to the U. S. Probation and Bureau of Prisons population is that the "core" thinking or "script" of the personality disorder can stand in the way of accepting a behavioral structure for sobriety. Characterological therapy addresses these core issues, enabling the client to make better use of behavioral prescriptions. For example, an offender whose core issue is his victim stance will feel that the requirement to attend intensive outpatient therapy is unfair. His energy will be directed to resisting the program and its goals as a way to "stand up to the system." He may complete the program but obtain few benefits.

There has too often been a Poor Understanding and Response to the Mandate

Another major problem is that outpatient substance abuse agencies, with their mix of mandated and voluntary clients, have special problems defining their relationships with mandated clients. In practice, most counselors experience discomfort regarding their relationship to the mandate. An example of this attitude is reflected in the primary substance abuse treatment text used in one agency where I worked. It advises the drug abuse counselor to "…initially disassociate himself from the coercion process" because "the coercion process hangs like a cloud over the counseling process" (Miller and Rollnick, p. 129). While such disassociation may be appropriate with other populations (for example, employees required by their employers to seek counseling), for our clients it

dooms the therapy or counseling to be ineffective. Therapists or counselors who become defensive or apologetic about being involved in the mandate or try to disassociate from the mandate contribute to the client's loss of confidence that help is available within this structure. In addition, antisocial clients may be tempted to test the clinician by engaging in manipulation and collusion against the probation officer, and borderline clients may use the counselors' discomfort with the mandate to "split"— i.e., characterize the probation officer as all bad.

Counselor Selection Has Often Been Inappropriate for the Population

Counselors who have passive styles tend to emphasize empathy and support without providing needed direction for change. They may maintain a veneer of professionalism, but underneath they really don't know what to do with the client. The result is a mutual "going through the motions" without change. These counselors, though well-meaning, over time become little more than a source of social support for the clients and can tend to form inappropriate alliances which sabotage the probation officer. Counselors who have their own issues with authority are less likely to model respect for the law and the rights of others. Attitudes toward authority are conveyed to the clients both verbally and nonverbally and are reflected in the counselor's lack of boundaries and discomfort with his/her own leadership role in relation to the client.

Supervision Has Not Been Required by the Contract

Supervision is a key element of successful programming. It sets a baseline for worker performance. Even workers who have good generic skills need to develop and refine their skills in terms of specific populations. Agencies have multiple contracts from various funding sources, each with its own regulations and requirements. In this atmosphere the specific kinds of supervision required for U.S. Probation clients is unlikely to take place unless it is clearly required.

Characterological Treatment Has the Following Characteristics

Responsibility for Characterological Change is Placed on the Client

Current substance abuse treatment calls for client acceptance of responsibility for behavioral change. The characterological model adds a critical dimension of responsibility for underlying personality traits. While deficits are not labeled the client's fault and while real empathy can be expressed for the painful losses implicit in current deficits, these are viewed as the client's starting point, with the treatment plan being something of a road map as to where the client needs to go. Simple analogies help the client to understand the task at hand—for example, if your car is damaged, even through no fault of your own, you still have the responsibility to fix it to make it driveable. This position enables the therapist or counselor to avoid using the client's history of "developmental disasters" to reinforce the client's victim stance or blame others for his/her mistakes. It also avoids an overly rigid "Yochelson and Samenow" position that the offenders are "just bad apples." In this therapy, the degree of change is the yardstick by which the client's success or failure is measured. Clients are directly told that this work is about change, that they are responsible for working on the change process, and that they can learn to live more effectively.

The Therapist Functions as a Benevolent Authority/Directs the Treatment

In current substance abuse treatment literature, as mentioned above, there are few clear guidelines for therapists to establish relationships with clients. In numbers of substance abuse treatment texts that were reviewed in preparation for writing this article, counselors were advised to be warm, trustworthy, and nonjudgmental, and to treat the client as an equal, but they were also given caveats such as "these characteristics do not mean that the chemical dependency counselor should be permissive" (Doweiko, p. 375). This lack of clarity leaves substance abuse counselors to their own devices, so that the mix of the counselor's and the client's personalities dictates the counselor/client relationship.

In characterological therapy, the therapist takes a relational stance as a benevolent authority. Clients can be directly told: I am going to be a kind of coach to help you live your life so that you are not in trouble with the law and are sober. With the U S. Probation population, the authority of the therapist or counselor is different from that of the probation officer. It is less legally and more clinically based. Clients need the legal authority of the probation officer. Care must be taken by the therapist or counselor to support the legal structure that is (and it is) preventive to recidivism, while helping the client to internalize values such as respect for the law and the rights of others. The clinically based authority of the therapist/counselor is a new experience for many of our clients—it is an authority based on the therapist's knowledge and experience. For some clients, the acceptance of this kind of authority is a first step in connecting or reconnecting with society. We could call this "soft" authority; most of the authority that we experience in the course of normal life is "soft"—the teacher, the clergyman, etc. Paradoxically, it is the client who has little or no "soft" authority in his/her life or who rejects all soft authority who comes to the attention of the legal structure. This is true of the vast majority of our population when they enter treatment. So it is of great importance that the counselor or therapist support the probation officer and be clearly in charge and directing treatment.

In Treatment, Deficits (Points of Developmental Arrest) and Strengths are Identified

In substance abuse treatment as it is now practiced, change is measured in terms of behavioral goals met; it does not include needed changes in personality traits. In Alcoholics Anonymous, change is measured in terms of a spiritual awakening that results from acknowledging one's own powerlessness and turning one's life over to one's higher power. The AA process of change includes making a moral inventory, making amends and carrying the message to other addicts/alcoholics.

The self-examination of the twelve steps, especially when mentored by a knowledgeable and supportive sponsor, can yield good results in terms of a direction for characterological change. But this is a haphazard process for many clients, as finding a good sponsor can be hit or miss. An obvious problem is that severely character-disordered clients do not engage in the process because their ability to connect, accept soft authority, and examine themselves is so limited. Even those who sincerely participate in moral inventory work may lack a baseline from which to proceed. Their characterological deficits are obscured from their own view by long-held defensive postures. Thus, their moral inventories can end up being "laundry lists" of misdeeds without the unifying perspective of the core issues. In the characterological approach, clients get a clear perspective on their under-

lying problems and a clear statement on what their role in treatment will be.

We start with our theoretical concepts: The problems the client has are the consequence of developmental arrest. Each client receives an individual assessment which is primarily a tool for identifying developmental deficits. As deficits are identified, strengths are also identified and care is taken to balance the identification of deficits with the identification of strengths. It needs to be said, also, that a good therapist does not throw all the client's deficits at the client at once. As mentioned above, most clients have built elaborate defenses to obscure their view of their own deficits. Clients with multiple deficits are often best served by working on one deficit at a time—the therapist will try to choose a deficit that, if corrected, will most improve the quality of the client's life.

Change is Presented as a Decision to Mature

An important part of characterological work is to have each client confront ways in which he/she has not matured. This is another important element of the change process not touched by traditional programming. In identifying deficits, the therapist might say to the client, "There are some ways in which you haven't finished growing up." Here a wonderful quote from Steve Johnson, a leading authority on personality disorders, is applicable (Johnson 1987, p. 76):

> All characterological healing involves, at core a decision to grow up—a decision to mature with respect to those infantile issues at which one is quite literally arrested. The decision to grow up is a decision to finally give up those…hopes of magical fulfillment—fulfillment without effort, without compromise, without limitation—without a rapprochement with reality.

In a sense, the characterological therapist rewrites this statement for each client. For some, it's the magical dream of a life without rules or consequences, for others it's a life without demands, for many it's a life without pain or hard choices.

Clients may be helped to decide to work on maturation issues by the therapist's real empathy for the pain their unconscious script decisions have caused them. Much of the work of therapy consists of identifying self-destructive patterns and outcomes, and helping the client to learn and practice new patterns. Clients have often developed complex defenses to obscure their script decisions, and these defenses need to be dealt with, so that the core characterological issues can be addressed.

In general, clients bring their own personal circumstances to the choice to mature. Clients who are relapsing don't consider the possibility. Con artists who are experiencing rewards from antisocial behavior simply don't see the benefits of change. Favoring the decision to mature, for example, are the following influences—a child or a relationship demands better functioning, the client is tired of being in and out of prison, incarceration has caused pain for the families, etc. The emotional climate in which each client confronts these issues is a powerful factor outside of the therapy room. The probation officer is an important part of that climate, as well. Probation officers who consistently monitor the offender's progress and apply appropriate consequences contribute to a climate in which the client is more likely to choose to mature.

The Therapeutic Relationship Is a Laboratory for Change; Script Decisions Are Identified, Processed and Rewritten

Perhaps the most important factor in the successful outcome of treatment is for the counselor/therapist to avoid playing his/her role in the client's script. Script decisions are the core thinking of the personality disorder. They are the reason for things always turning out the same for the client. The client will bring his thinking and behavior into the treatment room. The therapist or counselor will be subject to the same maneuvers that the client makes use of in other situations. Instead of reacting by "playing his/her role in the client's script," the therapists and counselors identify the script and make a decision not to participate. For example, schizoid clients will look for reasons to cut off the therapeutic relationship, either by attacking the therapist for some perceived imperfection or by wearing the therapist out with negative behavior. The therapist must avoid falling for that effort, and must help the client stay connected. Instead of reacting to the client's negative behavior, the therapist examines it as an in vitro expression of the script, helping the client to understand and examine his/her own behavior. Antisocial clients enter treatment with a "script" in which the therapist (who represents the hated society) is "bad" rather than the client. Accordingly, they may attack the therapist's competence and integrity, labeling the therapist as an oppressor and taking the victim role. It is very important not to play one's role in the client's script, in this case the "heavy" or "enforcer." Instead of being reactive to these early maneuvers, therapists should examine them to learn more about the client. Having refused to play the assigned role, the therapist is able to define his/her role in relationship to the antisocial client.

Borderline clients may also try to rework the relationship for their own ends--their needs for friendship and their dependence issues. They will bring in a script that calls for the therapist to provide all manner of inappropriate services to them, then state "You don't care about me" when the therapist puts appropriate limits. The therapist avoids falling for the client's script by neither rejecting the angry client nor succumbing to his or her demands, but staying centered and refusing to participate in the destabilization of the therapeutic relationship. In all cases, it is important not to humiliate the client when these maneuvers are exposed--they are labeled as outside of conscious awareness, automatic. As obvious as it may be to others, clients do not see their own role in their problems.

Clear Treatment Goals are Identified

In current chemical dependency treatment, goals are behavioral—for example, the avoidance of persons, places, and things associated with substance use. Characterological therapy adds goals that are cognitive and affective. Clients know their goals and are given regular reviews on how they are meeting them. This is the more concrete part of the therapy. Some of the more typical goals are listed below to give the reader a sense of what clients themselves may say they are working on. However, this is by no means a comprehensive list of treatment plan goals.

- Eliminating all or nothing thinking.
- Eliminating false norming (inappropriate comparison—e.g., citing an accomplice who went unpunished rather than looking at the criminal act or the victim).
- Eliminating the victim stance.
- Developing patience and working for things/avoiding the "quick fix."
- Choosing non-destructive relationships.
- Developing boundaries.

- Pacing and prioritizing (learning not to be overwhelmed).
- Avoiding abandonment crisis.
- Developing executive skills such as planning, decision making.
- Acknowledging and experiencing interdependence with others.
- Recognizing when thinking is becoming grandiose/ recognizing limitations.
- Learning to compromise.

The Selection, Training, and Supervision of Counselors and Therapists for Characterological Work

Therapists and counselors need to be selected carefully for work with this population. Several factors are especially important in staff selection. The first is the clinician's own attitude towards authority. Staff who either resist appropriate authority or who tend to take authority inappropriately are not suited to work with the U. S. Probation/Bureau of Prisons population. The counselors need to function as a "soft authority." A second important criteria for staff selection is the workers' ability to process their own reactions as a means of understanding the client, rather than reacting with behavior that reinforces the client's script. Additional factors important in staff selection are counselor standards and willingness to grow. In general, therapists and counselors do not receive training in graduate school that helps them deal with the offender population, and so these clinicians must be willing to acquire new skills.

Basic training in the contextual issues (e.g., the mandate, relationship with the probation officer, soft authority with clients) and basic characterological theory can be covered in a workshop format followed by regular supervision, both group and individual. Such supervision is essential for effective characterological counseling and therapy to take place. Group supervision and individual supervision provide the opportunity for treatment staff to review cases, receive feedback from the characterological perspective, and make appropriate revisions in treatment. Live supervision, where the trainer/consultant serves as a supervising co-therapist, provides the opportunity for modeling appropriate characterological treatment.

Conclusion: Characterological Work in the Milieu

The community corrections setting offers a unique opportunity for the treatment staff to work with the milieu staff—both Resident Advisors and Security staff—to create an environment where the milieu and the treatment deliver a consistent message. When training in this model crosses the traditional lines between treatment and milieu, much of the "splitting" and chaos that the difficult clients effect upon the facility can be reduced and staff can work together with a common understanding of their respective roles in the change process. Characterological training gives staff at various levels a common language and common concepts with which to communicate.

Resident advisors and security staff receive training in the characterological treatment model that takes into account their specific functions. Resident advisors are the case managers who monitor movement and progress through a system of levels of increasing freedom and responsibility. They receive training on the types of personality disorders and goal setting within the milieu. For example, the resident advisor and the counselor might be working with a client who has a poor sense of his/her own limitations (grandiosity). Although the goal of helping the client to accept his/her limitations and be more realistic is shared by both, the resident advisor's work may take the concrete form of helping the client to accept the employment that is available at his/her skill level. The drug treatment specialist would focus on the client's overall feeling that life is not offering what it should, thus dealing with the grandiosity on a more general cognitive and affective level, and connecting the client's feeling to his/her criminal behavior and/or substance abuse. Consulting with each other, these two professionals can stay "on the same page" regarding treatment goals, although their tasks may be different.

Similarly, security staff receive appropriate training that is consistent with this model. They learn to recognize basic behavior patterns that clients present and how to avoid responses that escalate into power struggles. A major issue with security staff is to avoid interactions in which clients can successfully label themselves as victims. These interactions tend to occur when security staff lose "emotional neutrality" and, confronted by the client's challenge, feel a need to demonstrate personal authority. Staff at all levels can reduce their reactivity to the anti-social script.

It is when staff at all levels can communicate a message of personal responsibility and choices that the environment becomes an agent of resocialization and rehabilitation for our federal offenders. When treatment supports the milieu and the milieu supports treatment, the environment becomes a corrective social experience.

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