SUPPORTIVE PSYCHOTHERAPY FOR INCARCERATED INDIVIDUALS

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Learning Objectives

- Review the main types of psychotherapy used when working with incarcerated individuals
- Define and describe supportive psychotherapy*: The techniques of supportive psychotherapy were used well before the invention of psychotherapy itself. Supportive psychotherapy is especially suited for individuals with limited capabilities or education, in threatening or hostile circumstances, and in crisis situations. So it is an excellent choice of psychotherapy in correctional settings.*
- Distinguish the adaptations of supportive psychotherapy to special populations found in correctional settings

A Quick Start

- Some types of psychotherapy best studied in correctional settings include cognitive-behavioral (CBT), supportive, dialectical behavioral therapy (DBT), mentalization, mindfulness, motivational interviewing (often used for substance use issues), relapse prevention and similar therapies for substance use, and interpersonal psychotherapies
- Correctional settings present an opportunity to combine individual psychotherapy with group programs targeting the problems experienced by residents of those facilities
- Therapists should be aware of the many developments in programming for residents of correctional facilities as well develop a greater awareness of the role of social injustice in leading to incarceration of individuals

Some controversies or at least “informed disagreements”

- Suicidal behaviors—controversy over dealing with repetitive suicidal behaviors and the meaning of so-called “suicidal gestures” or “manipulative” behaviors
- Retraumatization—assessment of it and controversies over the use of seclusion and restraint
- Serious mental illness: controversy of criminalization of mental illness, true or not or maybe partially true?
- Personality disorder: controversy of the treatability (if any!) of antisocial personality disorder (or is the diagnosis itself questionable)

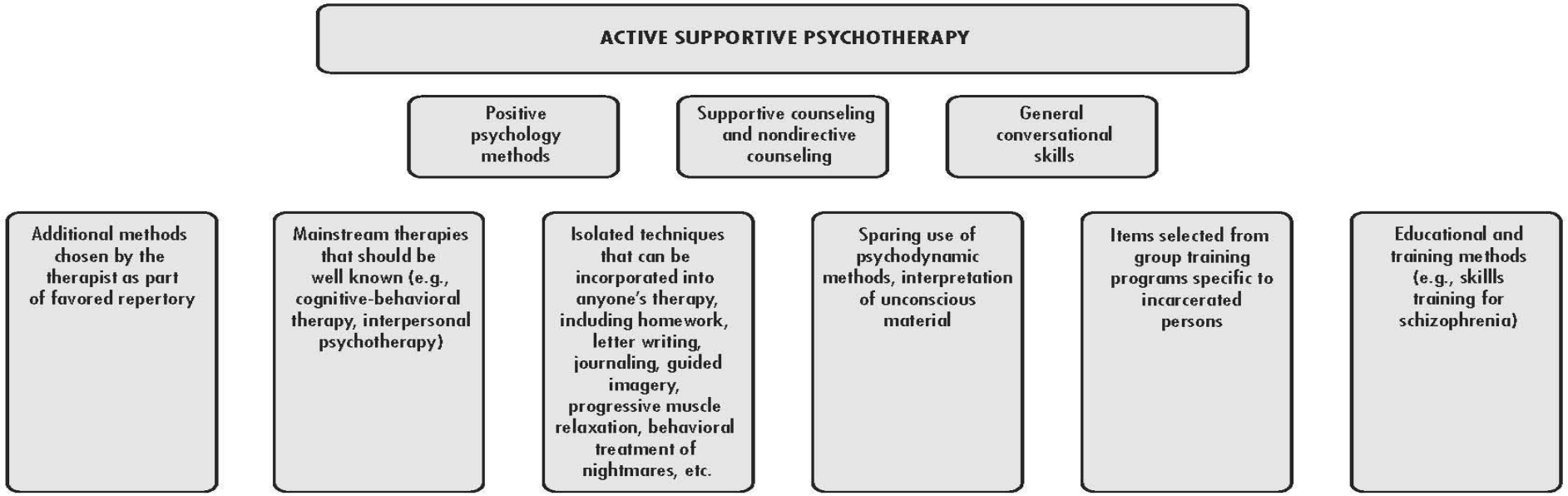
What issues do newly incarcerated individuals have to deal with and how do YOU deal with them (the person and the issues!)
Here are just a few…

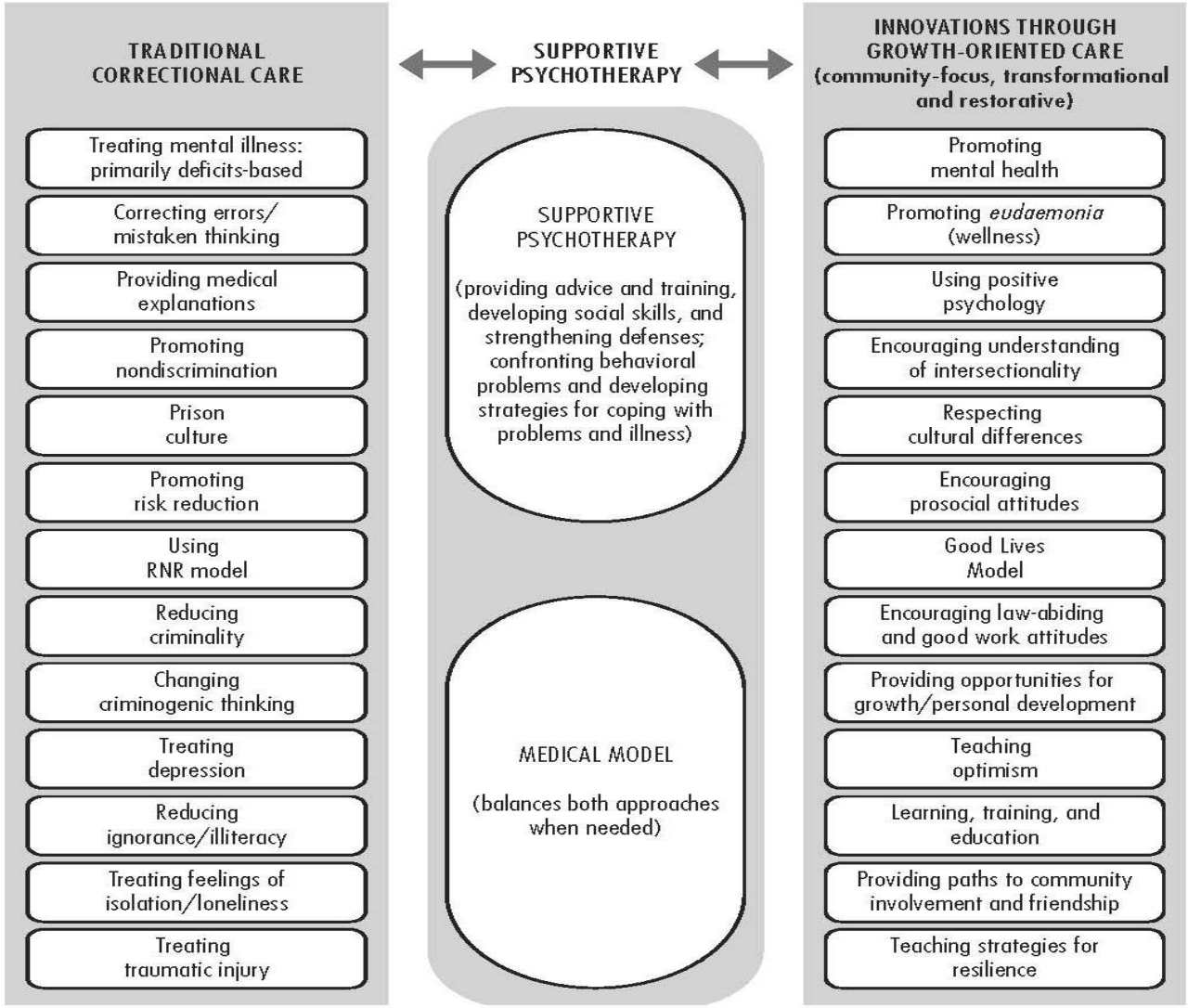
- Disenfranchised grief is grief at the loss of things other than the usual death or sickness issues such as loss of home, job, and opportunity experienced by persons entering the criminal justice system, especially locked settings
- Adjustment disorders with mood changes and/or disturbance of conduct
- Retraumatization reactions in a situation in which one is unable to leave
- Sense of injustice related to social injustice issues
- A particular experience of persons with personality disorders called “narcissistic wounding” (“…I was stupid…” or “they caught me”) both of which relate to criminal thinking and behavior issues but can also create risk of suicide

Supportive Psychotherapy

- A form of psychotherapy which often serves as a basis (like trunk of a tree!) for more complex psychotherapies
- Cultivates a so-called positive transference and does not use typical “deep” psychodynamic or psychoanalytic interpretations
- Not necessarily simplistic, but relatively straightforward and can certainly be practiced by a wide range of therapists as long as they stay within the limits of their licensure (e.g., don’t diagnose if you are not allowed to)
- Typical uses self-esteem enhancing interventions but in the correctional setting needs to be modified for individuals with criminal thinking and personality disorders related to it
- Doesn’t seem to acquire the extensive research of the other therapies but does actually have a strong research and outcome basis even if not as well known

Supportive Psychotherapy Overview of Techniques



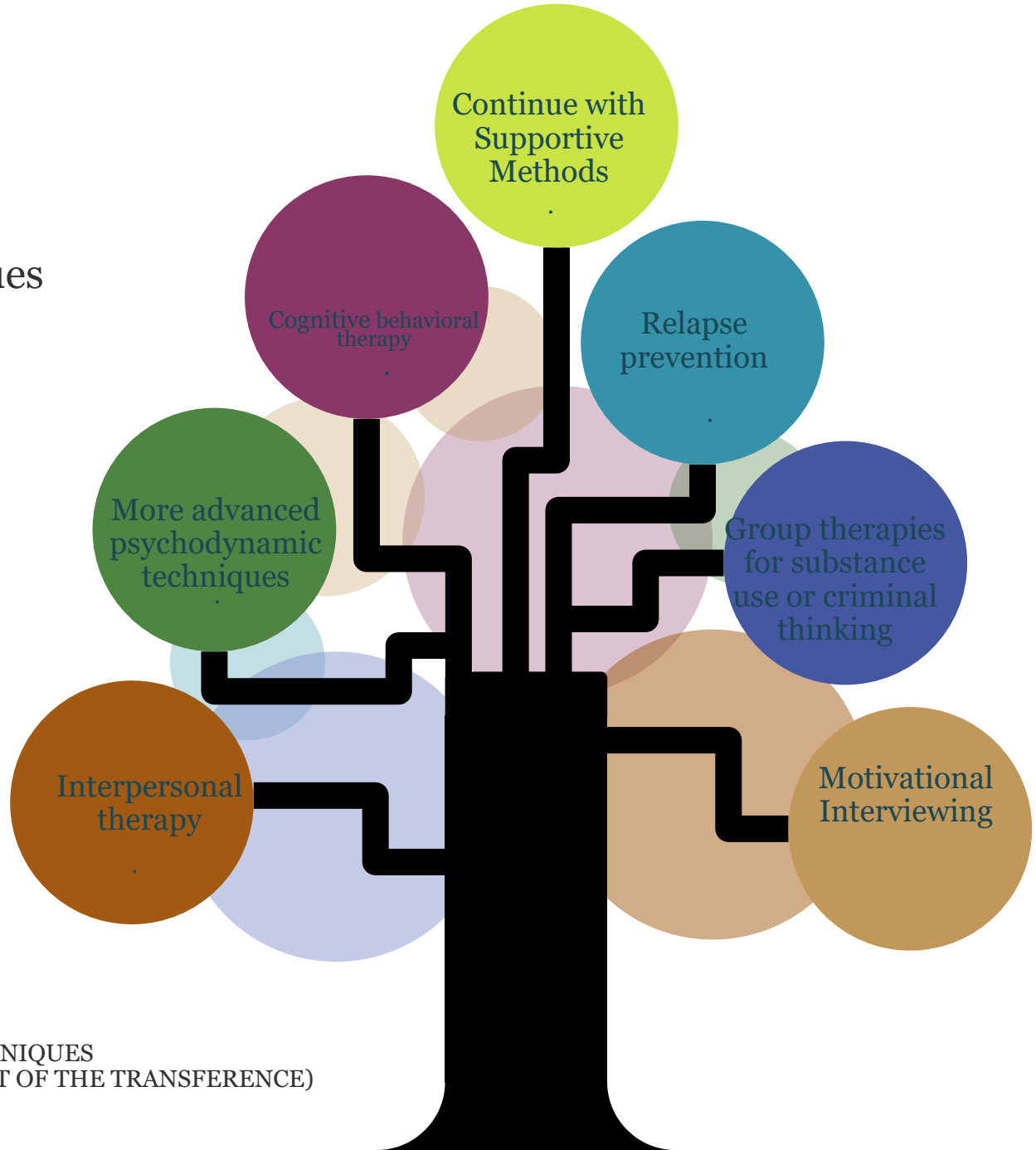


Supportive Psychotherapy

Relationship to Traditional Correctional Care and Innovative Growth-Oriented Care

Therapy Tree

Supportive relationship and techniques are a basis for many other therapies



SUPPORTIVE RELATIONSHIP AND TECHNIQUES
(INTERPRETATIONS AND MANAGEMENT OF THE TRANSFERENCE)

Supportive Psychotherapy: Techniques

- Listening
  - Active, personal, and professional listening
  - Questioning
  - Expressing interest and empathy
  - Echoing, tracking and commenting
- Confronting
  - Looking at issues together as well as noting inconsistencies among different behaviors, beliefs and purported values
- Giving Explanations (which at times may be called interventions, clarifications, or interpretations)
- Advising or even Directing (carefully managed depending on the patient)

Advice and Direction

Do not give any advice that is out of your expertise.

You can use the two column method (pros and cons) but leave the final decision up to them.

For litigious or paranoid patients severely qualify advice to avoid complaints or even lawsuits. Example: “You can sign up for that program if you think you can handle it but that’s going to be up to you. You have to be able to control your own behavior.”

Possible goals of individual therapy

- Deal with crisis in getting arrested, sentenced, or entering prison, separation from family, etc.
- Develop healthy (non-violent and as healthy as possible) compensations for isolation, rage at injustice and imbalance of power and institutional and personal oppression and dominance (from staff and/or other persons)
- Develop a healthy lifestyle including healthy non-victim relationships and physical health
- Prevent relapses and recidivism
- Avoid fighting, avoid discipline and rule violations, avoid conflict with correctional officers,
- Improve socialization, lessen isolation in prison
- Faith-based coping
- Offense-related types of proposed insight or awareness, e.g., lessen criminogenic thinking

Treatment Planning

1. Collaborative effort among staff and with patient to understand problems, find approaches to solutions, and measure progress.
2. Essential to the patient's records and may be formally a part of patient's program in the institution's policies
3. Provides a starting point for discussion with the patient on the plan of treatment.
4. Provides a basis for tracking progress, problems and issues
5. Provides continuity of care from one person to another and in case of transfer or turnover.

Goals for Treatment Planning

- Provide emotional support from a caring provider
- Enhance functional recovery and achieve maximum potential despite problems caused by illness
- Minimize suicidal and self-harm actions and potential
- Deal with crises (e.g., grief and disenfranchised grief, entry into jail or prison)
- Treat disease processes (e.g., lessen positive symptoms, compensate for negative symptoms)
- If possible and as appropriate engage family in treatment and resolve family conflicts
- Provide education and “psychoeducation” about mental illnesses, their manifestations and course
- Address issues related to acceptance or rejection of medications
- Provide coping mechanisms for hallucinations, delusions, manic states, urges to hurt self or others
- Link to adjunctive treatments such as groups and transition to community
- Address co-occurring problems (other mental health and medical diagnoses, substance use, criminal behavior, intellectual/educational challenges, personality disorder)
- As appropriate to the individual assign homework
- (And for the therapist) participate in coordinated treatment planning with other disciplines

Sample Treatment Plan (Slide 1 of 4)

- Mr. Jones is a 35-year-old single man who has been struggling with a psychotic mental illness for 15 years. Now he is in prison for the third time for possession with intent to sell of methamphetamine. He has had 3 previous inpatient psychiatric hospitalizations, the latest in 2019 which lasted for 2 weeks. He has previous convictions for assault with a deadly weapon and a DUI. He has two sons by his previous marriage. He has never gotten his G.E.D. He has been in the county mental health clinics, but he never seems to stick with his medicines. We've got a lot of issues to tackle with this man, but no one seems to be able to turn around his mental health condition or his criminal behaviors. He could probably be a better father, too.
- DSM-5 TR Diagnoses
- Methamphetamine use disorder, severe; alcohol use disorder, severe
- Schizophrenia
- Adult antisocial behavior (but we do not think he is a lifestyle criminal)

Sample Treatment Plan (Slide 2 of 4)

- **Problem list**
- Patient has a history of suicide attempts (a priority safety issue)
- He gets into fights frequently (and he does that when he is in jail or prison) (interpersonal issue)
- He was using methamphetamine (substance issues) and alcohol
- He hears voices (mental health issue); we may not be able to fit every single problem on the treatment plan but these might be the ones to target in the initial plan
- **Long Term Goals** Target date (6 months)
- Finally get his G.E.D.
- No suicide attempts in 6 months or tells therapist prior to considering an attempt
- No institutional discipline for at least 6 months
- Complete his co-occurring disorders classes

Sample Treatment Plan (Slide 3 of 4)

- **Current Objectives** (Short Term Goals) Target Date (90 days)
- States he is hearing hallucinations less than one day a week
- Attend all his group meetings
- Attends 90% of his medical management and adheres to his mutually agreed treatment plan
- Attends 90% of his psychotherapy sessions
- Makes at least a monthly contact with his two sons
- **Interventions**
- Psychotherapy every 2 weeks by Dr. Able
- Medication management monthly by Dr. Baker
- Exercise in the yard (daily, self-directed); Diet for Health
- Written assignment at every therapist meeting
- Coping skills review and repetition at every therapist meeting
- Controlled breathing and mindfulness taught once and reviewed in 2 months
- Co-occurring disorders group twice a week
- Attend his substance user group
- G.E.D. classes

Sample Treatment Plan (Slide 4 of 4)

- **Follow-up and Review Date(s)**
- 3 months
- 6 months
- Signatures and Dates
- Therapist/Case Manager _____Date_____
- Prescribing Provider_____Date_____
- Social Worker_____Date_____

- Patient (I agree with this treatment plan)
- _____Date_____
- Patient (I DO NOT AGREE with this treatment plan)
- _____Date_____
- Reasons_____

Crisis Response Safety Card

- Therapists are generally familiar with crisis response safety cards. These are prepared by the patient with your help and include:
- **CRISIS Response Safety Card**
- Triggers and stressors
- Coping strategies
- Resources such as people to contact, phone numbers and information sources
- Reasons for living (suicide) and goals for improving mental health and social success
- Inspirational quotes , music, or art.

- **SAFETY/INFORMATION CARD FOR THOSE ABOUT TO LEAVE**
- We have recommended that this approach be expanded to consolidate information for those who are about to leave the institution for jobs, health, family, and other information needed on the outside

Crisis Safety Response Plan (Blank)

- **SIDE 1**
- **WARNING SIGNS I AM GETTING SUICIDAL OR GOING TO HURT MYSELF**
-
-
-
- **HOW CAN I COPE BY MYSELF WHEN I START GETTING INTO TROUBLE?**
-
-
-
- **WHO CAN I CONTACT?**
- Call the National Suicide Prevention lifeline 988
-
- **SIDE 2**
- **HERE ARE MY REASONS FOR LIVING**

Crisis Response Safety Plan (filled in page 1 of 2)

•WARNING SIGNS I AM GETTING SUICIDAL OR GOING TO HURT MYSELF

•When I'm sleeping less or sleeping poorly

•When I stop going to the yard

•When I stay in my cell

•When I stop eating

•When I start to hear voices again

•When I think of cutting my arm

•When I think I should be dead

•When I start to feel guilty about being in prison

•When I think about what my father did to me and I am so mad

•When I pick up the razor and start playing with it

•HOW CAN I COPE BY MYSELF WHEN I START GETTING INTO TROUBLE?

•Read a book

•Wrap the razor up in a towel and put it away or give to cellie or CO to hold

•Do some of my drawings

•Read the Bible with the passages I marked and mark some new passages

•Go to the yard and exercise or exercise in the cell

•Just go to sleep

•Do my deep breath

•My progressive relaxation that they taught me

•My mindfulness exercises

Crisis Response Safety Plan (filled in page 2 of 2)

•**WHO CAN I CONTACT?**

- My mother 202-555-1212
- My brother 202-555-1313

•Tell my CO now that it is an emergency

•Tell the nurse who brings me my medicines

•Send in a mental health request

•Talk to my cellie

•Call the National Suicide Prevention lifeline 988

-
- **SIDE 2**
-
- **HERE ARE MY REASONS FOR LIVING**
- My family
- My children
- Suicide is a sin and I don't want to do that
- I like most of the things in life, just not the prison
- I can get out in a year
- I like watching television

Therapy Response Card

THERAPY RESPONSE CARDS FOR THOSE BEING TREATED

- Throughout therapy we recommend adapting this tool to help the patient:
- Summarize feelings from each session
- Help the patient keep a focus on therapeutic progress
- Understand and follow treatment plan and progress
- Understand homework

Therapy Response Card (blank)

Notes on Therapy	
What I Learned	
What I am Feeling	
What I want to learn	
Homework	
What do I want to talk about the next time?	

It’s Reigning Men (Toxic Masculinity)

- Men’s prisons express toxic masculinity, a cultural phenomenon of exaggerated attitudes with hostility towards women and hypocritical attitudes towards homosexual behavior which is nevertheless predominant despite being officially despised (this concept may be called by similar names such as “hegemonic masculinity”)
- This toxicity results in behaviors of dominance, violence, cruelty, and sadism as men try to “prove” their worth within the value system expressed by this cultural phenomenon
- There are more positive role models for men such as responsible roles as father and husband and occupational and social responsibility. Prison programs have been developed to foster this.
- Gangs are also a component of prison culture that are related to toxic masculinity. Attempts can be made to assist patients with gang exit strategies both within the prison and when they are released (Note: It is actually easier than it appears to gradually wean oneself from gang involvement.)

Recommendations for therapy with men

- Give patients adequate time to develop trust,
- Structure therapy (rules create less anxiety than open-ended activities),
- Use metaphors and stories (get familiar withs sports quotes and recent games)
- Let them draw their own conclusions from the lessons of therapy rather than give them the whole answer (which can be embarrassing to them),
- Help them work through their parenting issues of their mother and possibly absent or abusive fathers (whom they may have modeled themselves after),
- Help them to undo their inappropriate conceptions of relationships to women, and
- Work through their false assumptions of the relationship between masculinity, criminality, and violence.
- Based on Glicken MD: *Working with Troubled Men: A Contemporary Practitioner's Guide*. Mahwah, NJ, Lawrence Erlbaum Associates, Publishers, 2005

But what causes criminal behavior?
No single answer--there are many theories!
This is a VERY brief review (Slide 1 of 3)

- Classical and rational choice and deterrence—dates back to Locke and Hobbes
- Routine activity—Cohen and Felson—plays a role in some behavior
- Neoclassical positivism, hard determinism--Newman, Wilson, Martinson—probably incorrect and led to claims that “nothing works”
- Conflict, Marxist, radical, convict criminology, “green” criminology—numerous proponents going back to Marx believe that the criminal justice system reflects the interest of powerful groups
- Feminist and feminist pathways—Adler, Simon, Campbell, Daly, Chesney-Lind, Pasko—recognize women’s historical position as dominated and suppressed and women’s pathways follow trajectories of escape from abuse and victimization
- Power and Control Theory—Messerschmidt, Hagan

Theories of Criminal Behavior (Slide 2)

- Biological, Developmental—Gall, Kretschmer, Agnew, Lombroso, Eyesenck, Ferrero, Goring Hooten, Sheldon, Pollak, Mednick, Moffitt—many adherents but state that biological and developmental factors determine criminality and limits the role of treatment—today seems to be what most people think of psychopaths (determined by biology and untreatable)

- Psychological—Freud, Friedander, Cleckley, Hare—role of mental conflicts and personality defects—applies to some criminals but limited

- Social Process, Social Learning, Differential Association—Akers, Bandura, Burgess, Elliott, Sutherland, Glaser, Goffman—People learn from their environments and crime is a social illness—this theory is widely accepted and also implies that people can learn to be prosocial; consider the life of Abel Magwitch in Dickens' *Great Expectations (*he becomes a benefactor to the young boy Pip*)*

- Social bonding and control, containment—Gottfredson, Hirschi, Matza, Nye, Reckless—shows that low self-control is a remediable factor in crime

Theories of Criminal Behavior—Slide 3

- Labeling, Reintegrative Shaming, Restorative Justice—Becker, Braithwaite, Cooley, Lemert, Tannenbaum—believe that labeling and stigmatization worsen criminal behavior
- Social Disorganization—Ohlin, Park, Shaw—Explains the development of crime in disadvantaged areas
- Anomie and Strain—Durkheim, Agnew, Burgess, Cloward, McKay, Merton, Messner, Miller, Rosenfeld—Absence of social norms and blocked opportunities create crime—an attractive theory
- Integrative and Pathways—Akers, Bernard, Sampson, Laub—Among many offering integrated theories combining the social learning, social bonding, and strain theories
- General Personality and Cognitive and Social Learning—Andrews and Bonta—Integrates role of biological, psychological and family, social and environmental factors and is the basis of the dominant paradigm of treatment—RNR or Risk-Needs-Responsivity

Eight criminal thinking styles and how to counter them (slide 1 of 2)

- Mollification—blaming on others, minimizing the importance or damage of an action. "She asked for it." "Nobody got hurt." "What's the big deal, they're not going to miss a few bucks." "Everybody does it." "Everyone else I know is worse." "If you were me, you'd do the same thing." COUNTER BY pointing out factual inaccuracies and moral inconsistencies in what they state, i.e., people were really hurt by what they did, and it is certainly not true that "everybody" does that etc.

- Entitlement-they are special and deserve this; they confuse a want with a need. "I deserve to be rich." "Nobody can prevent me from getting this." COUNTER BY pointing out that in all societies people need to earn their place by work and respect for others.

- Power orientation. The world consists of people who have power and those who don't. Without power they feel like they are in a "zero" state and worthless. "You'd better do this or else." "Submit to me, you f—head." COUNTER BY helping them to understand their poor self-esteem and compensation for it but the unrealistic grandiosity needs to be rejected.

- Cutoff. They stop thinking of alternatives but cutting off debate, acting impulsively, lacking reflection and self-control. They will use drugs to dull their decision-making. "What the hell…I'll just do this!" COUNTER BY pointing out the mental tricks and substance use that they employ to avoid thinking through alternatives and teaching self-control.

Eight Criminal Thinking Styles (Slide 2 of 2)

- Sentimentality—a soft spot for little contributions to charities or being kind which is meant to compensate for the hugely thoughtless and dangerous behaviors they engage in. "I'm a good person. I take in lost dogs. I donate to Save the Whales. I am a gang leader but I contribute to the community center." COUNTER BY pointing out that isolated instances don't fool anybody about them being charitable and do not make up for the central aspects of their lifestyle which damages others.

- Superoptimism—they have unrealistic expectations about what they can get without being qualified or working for it. "They'll never catch me for these burglaries…I'm too smart for them." "I know a lot about drugs…I can teach your relapse prevention course." COUNTER BY showing them prison is full of people with similar thinking which is immature and will deprive them of a normal life.

- Cognitive indolence. They do not put in the work to think things out, do not put in the work or logic that other people need to put in. "I already know everything I need to know to pass this course. I don't need to do the homework or even attend the class." COUNTER BY gently yet increasingly showing them that they need to put in the work just like anybody else.

- Discontinuity. They fail to see the conflicts between their criminality and the need to obey the law. They don't have the unified, consistent personality that non-criminals strive for. "I'm a good person, I don't know why you always call me a criminal…my rap sheet is only 5 pages." They may glory in their impulsiveness as "I'm the kind of guy who if I just think of something I do it." COUNTER BY pointing out the Jekyll and Hyde nature of their behavior which makes others see them as dangerous and makes them dangerous to their own future.

Based on Walters GD: Overcoming offender resistance to abandoning a criminal lifestyle, in Tough Customers: Counseling Unwilling Clients. Edited by Welo BK. Lanham, MD, American Correctional Association, 2nd ed., 2001, pp. 77-97

What else can I do about my patients with criminal thinking?

- Work with group programs that target criminal thinking, e.g., Thinking for a Change (https://nicic.gov/projects/thinking-for-a-change) or Collaboration of Chemical Dependency Professionals from the Minnesota Department of Corrections and the Hazelden Foundation: Criminal and Addictive Thinking Workbook: Mapping a Life of Recovery and Freedom for Chemically Dependent Criminal Offenders. Center City, MN, Hazelden Foundation, 2002
- Follow individual techniques from criminologists such as Walters (see references, much of this is available on-line)
- For substance use disorders use all the free resources from SAMHSA
- Become familiar with the traditional psychodynamic forms of defensive thinking which underly criminal thinking such as rationalization and denial and notice the defensive style of your patient
- Identify and deal with resistance

Resistance is futile (if you know to counter it)

Resistance consists of factors which slow down, defeat, distract, divert, or terminate the therapy because your patient does not want to learn or gain insight in the direction that helps his or her progress towards the treatment goals. Resistance can be obvious, as in "I don't want to see you anymore. Goodbye." It can show itself in prolonged silences. Note that motivational interviewers have switched to a new terminology called "sustain talk."

To forestall resistance, avoid confrontational "Why" questions such as "Why do you keep using drugs when it gets you arrested?" "Why do you keep hitting people?" Etc. (Persons in criminal justice systems often associate such questions with the interrogations of law enforcement. Instead ask these questions and tell these things:

- What were your thoughts in coming here?
- In the past did you ever find it helpful to talk to a teacher, counselor, clergyman?
- If you weren't angry about coming here, what would you want to talk about?
- When people make you do things, what negative feelings do you have?
- When you are forced to do something, do you think you are more resentful or less resentful than other people?
- Create some kind of early success for your patients, such as in an easy but gratifying homework assignment
- Ask the patient what he perceives as the roadblocks to the therapy
- Get buy-in on a problem they want to work on
- Rather than disagree with their beliefs, ask them to tell you the evidence for their beliefs
- Source: Harris GA: Overcoming Resistance: Success in Counseling Men. Lanham, Md., American Correctional Association, 1995

And some other ways to increase cooperation

- Avoid extended debates because persons with criminal histories need to save face and will switch to a strategy of "win at all costs"
- When using confrontations, make them appear as constructive criticism
- Redirect the disruptive patient back to the issue and away from their distraction—"Let's talk about what's going on with you now, not what happened in the past"
- Reverse their attribution of responsibility when they blame someone else for their situation. For example:
  - So you're saying you have such little self-control that you blame other people for your lack of self control?
  - So you're saying that you're incapable of self-reliance?
  - So you say that one good deed makes up for all the pain and suffering you have caused other people?
  - So you're saying that this counseling is not worth it? Does that mean that everything about you has been fixed?
  - You keep saying that respect is very important to you. How much respect are you giving (me, your family, your cellmates) now?
  - Based on Elliott WN: Managing offender resistance to counseling—The"3R's". Federal Probation 66(3):43-49, December 2002.

Trauma (Slide 1 of 4)

- Trauma plays a role in criminal behavior via violence and substance abuse
- It impairs institutional adjustment, e.g., via numbing and dissociative features of traumatic reactions, and creates additional risks for institutional discipline and violence via anger, hostility, and hyper-response to threats
- It impairs the ability of an incarcerated person to benefit from the various therapies
- A single therapeutic alliance (e.g., with you) can make a profound difference to a traumatized person, e.g., a person with a history of abandonment

Trauma (Slide 2 of 4)

- **Kintsukuroi** is the Japanese art of putting broken pottery together with precious materials, making the repaired pottery more beautiful than in was before.
- In the same way, psychotherapy can help people with a history of trauma process their experiences in a way that makes them stronger and better able to cope with stressors and to improve their mental health

Trauma (Slide 3 of 4)

SHARE: Safety Hope Autonomy Respect Empathy is one of several acronyms to remind us of the components of trauma-informed care

Levenson JS, Willis GM: Implementing trauma-informed care in correctional treatment and supervision. Journal of Aggression, Maltreatment & Trauma 28(4):481-501, 2019

- Trauma history among prison populations is much more prevalent than the general population. Trauma informed care should begin with the introduction of individuals into the justice system, and is especially important to understand in beginning in any therapy.
- Safety: provide a safe place to discuss, but realize that the full story is a work in progress and may avoiding the topic altogether is common for both patient and therapist
- Hope: provide reasons to work on the issues and stressor
- Autonomy: provide strategies for managing stressors and learning to recognize their own importance
- Respect: provide reassurance that reactions are justified, but that the patient can learn to deal
- Empathy: The fundamental attitude of the provider employing the best practices (know the difference between sympathy and empathy)

Trauma (Slide 4 of 4)

Some quick pointers on trauma-informed care

- Provide a safe place to discuss
- Clarify the nature of the trauma
- Reframe the narrative of the trauma…for example, if someone abused you it is their fault, not anything you did
- Avoidance of the topic is common on both sides, and is part of the work in progress
- The patient may need protection and strategies for dealing with or avoiding persons who harmed them
- Relaxation, coping strategies such as creativity, physical activity, listening to music or reading inspirational information such as the Bible or poetry
- Other coping strategies
- Gaining perspective

Serious Mental Illness

- Schizophrenia
- Major depression but not all depression
- Bipolar disorder
- In some systems, severe PTSD
- Typically does not include adjustment disorders and personality disorders (although these can be quite severe at times)

Treating Serious Mental Illness

- Follow recovery concepts and model
- Avoid special housing units (needs creative solutions)
- Also avoid use of special housing and mental illness programs by persons who DO NOT have serious mental illness
- Most persons do better with medications, but therapists need to accept rejection of medications and continue to work with such persons
- Due to suicidal risk: Do a suicidality assessment on all visits; consider a standard scale such as the Columbia Suicide Assessment Scale
- As allowed, plan to vary frequency and duration of sessions (avoid “therapeutic overload”)
- Address negative transference issues; cultivate a generally positive transference

The “Lose-Lose” dilemma in delusional patients

- “Don’t you believe me when I tell you that the CIA is going to kill me in the prison?”
- If you say you agree with them (and in general if you side with delusions) they will respond with “You are just humoring me. I know you don’t believe me.” Also, this position gets into conflicts later on when they are no longer delusional.
- If you say you disagree with them, you also lose because they say “You don’t believe me so why am I wasting my time talking to you?
- The best response is to say “I just met you. I need to get to know you. I don’t know what to believe about you until you tell me about yourself so let’s spend a few sessions doing that. But meanwhile, if you are feeling threatened, let’s do what we can to get you feeling safe so you don’t think someone is going to shoot you tonight!”
- Show understanding of their feeling but not necessarily agreement with their belief. Also, they may accept a referral for medication for their anxiety rather than for their delusions (and that is okay).

Dealing with hallucinations

- Teach distraction strategies such as listening to music, exercising, writing in diary (see the many handouts from the Best Practices in Schizophrenia Treatment Center)
- Learn to accept them (acceptance and commitment)
- Argue against (and disconnect) the delusions which follow (cognitive therapy)
- Be reassured, comfortable, and less frightened by them (supportive)
- Understand them as a response to stress (reattribution theory)
- Experience them without judgment (mindfulness)
- Connect them to past experiences such as trauma and attacks on self-esteem (psychodynamic)

Kreider V, Sivec H: Cognitive Behavioral Therapy for Psychosis Handouts: Best Practices in Schizophrenia Treatment.

Available at https://www.neomed.edu/wp-content/uploads/Cognitive-Behavioral-Therapy-for-Psychosis-Intensive-Training-Handouts-Fall-2021-1.pdf

Dealing with delusions

- As with hallucinations, delusions can be normalized to an extent while not totally buying into the patient's delusional system, e.g., related the delusions to "prison paranoia"
- Look for "genetic" sources in personal history of deprivation, abuse, or trauma
- When the patient is ready, you can express mild questioning or skepticism
- If the patient has any doubts whatsoever, begin to confront the delusion and to explore its formation
- If patient becomes non-delusional, explore the process of delusional formation and possibly interpret the content
- Offer consensual validation for elements of reality in the delusion
- Interpret the delusion as "poetic truth"

Helping the depressed person

Know your patient's history and risk factors for suicide (What suicide attempts did your patient have in the past?)

Reiterate your ongoing advice about suicide prevention: Tell your therapist or another medical worker or the CO

Despite the potential for malingering, at the start, take the patient's distress at face value

Educate about the biological aspects of illness (i.e., "It's a chemical imbalance"); provide educational materials or journals

Instill hope that the depression will get better rather than last forever. "There is light at the end of tunnel"

Divide and conquer (address multiple "sub-complaints" separately)

Deal with bereavement not just for death, but talk about losses from the transition to prison

Discuss medication issues, efficacy, and side effects (as you see fit and are qualified if you are not the prescriber: You may actually be more credible because you are not the prescriber)

Counter feelings of self-blame and responsibility for the depression.

Counsel patient not to make major decisions while depressed

Prevent blaming and "bridge burning" with family and other inmates (e.g., accusing them of putting them in prison, displacing anger by "telling off" other persons in prison)

Cautiously and judiciously improve social support from family, other prisoners, and staff (asking patient who they think can help and discuss when and how to ask others for help)

Tell them not to be so hard on themselves (counter temporary reductions in self-esteem associated with the depression)

While enhancing self-esteem, temporarily put on hold your anti-criminogenic talk and agendas ("Now is not a good time to deal with those issues, but we will get to them later")

The manic patient

Be firm, caring, and supportively emotionally restraining and explain to them that you are doing just that

Send to infirmary or hospital if necessary and explain why

Limit the damage they do to their relationships within and outside of prison

Do not buy into the manic person's point of view (e.g., jump up and accuse the CO of harassing them because the patient says so)

Support the use of medications unless you have serious reservations about what and how much is being used (if so, discuss with prescriber)

Develop a consistent therapeutic and staff approach that counteracts the manic patient's tactics, utilizing the patient's own beliefs about self.

Use many frequent and short interventions when they work

Ask patient for immediate feedback to determine if he heard you (e.g., "I promise not to go up on the second tier and bang on my enemy's door") to see if your interventions are remembered and accepted

Set limits within therapy

.....Avoid fruitless interactions so as to reinforce fruitful ones

.....Don't continue talking when you realize it is ineffective in that particular session

.....Don't be a hero by continuing sessions when there is risk of violence

Set protective limits outside of therapy (including interactions with staff and other residents of the unit)

Assist the family if they get involved your patient's treatment

Suicidal thoughts and suicidal behavior

CDC recommends you try to be more specific than using the term “suicidality” but we do find that difficult at times (Crosby AE, Ortega L, Melanson C: Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011)

- Not a diagnosis, although for a time DSM considered making it one
- Rates higher in jails and prisons despite lack of firearms and restricted availability of pills for overdoses (but patients can and do hoard pills for possible suicide)
- Per CDC you should try to avoid talking about “completed” or “successful” suicide which gives the wrong impression; also should not speak of “manipulative” suicide attempts since they are frequently serious attempts and tend to lead to neglect of serious attempts
- Rather you should be specific when describing a person’s behavior
- Proper management requires creative solutions such as making it possible to have a suicide watch on an administrative segregation unit rather than in the infirmary, etc.
- After all attempts you should institute a Crisis Response Safety Card

Some brief advice on chronically suicidal behavior

First and foremost, follow your institution's policies!

- Learn to "listen with the third ear," a term made famous by psychoanalyst Theodor Reik--Don't wait for them to raise an issue, locate the elephants in the room.
- Determine the actual motivations and prior thoughts behind actual suicide attempts, including cultural beliefs, e.g., motives of revenge or self-punishment
- Identify coping strategies and defenses to suicide (typical strategies of supportive psychotherapy); pay attention to failed defenses leading to suicidal actions; this includes examining the role of trauma
- Help patients manage emotions better and tolerate psychic pain
- Useful in prison: Examine the effects of taunts or encouragements by patient's peers to self-harm for the enjoyment of the others
- Explore patient's fantasies (sadistic or otherwise) of how others will react to her death and encourage discussion of their unrealistic nature (e.g., visiting their own funeral as Tom Sawyer did) and support that the friends and family will need to get over the patient's death
- Develop religious (e.g., faith-based) supports or existential issues that oppose suicide
- Determine the right balance of exploration and support (our preference is the latter)
- Of course, all this is part of a multi-disciplinary therapy including the use of a CRSP, involvement (to the extent possible) of outside family and friends.
- Manage your countertransference reactions and your own stress.
- Based on Yager J, Feinstein RE: A common factors approach to psychotherapy with chronically suicidal patients: Wrestling with the angel of death. Psychiatry 80(3):207-220, 2017 (Note that common factors approaches to therapy are similar to supportive psychotherapy methods.)

Insomnia

- Medical directors and prescribers are reluctant to treat due to potential for widespread abuse of sedating medications
- Develop a good working relationship and protocol for referrals of insomnia to prescribing providers
- Suggest you require two weeks at least of filling out a sleep log to justify referral
- Teach CBT for insomnia (can be delivered individually or in group in a single 90 minute session or 10-12 sessions) obviously there is a lot to learn which we cannot detail here but which you can teach
- Provide education and handouts for so-called sleep hygiene (not really about physical items but habits
  - Don’t take naps or caffeine late in the day
  - Options may be limited but get out of bed or sit up and do something quite for 10-20 minutes and then try again to sleep
  - Have a bedtime and waking up routine
  - Learn that it is normal for adults to wake up several times at night; what’s abnormal is to sleep solidly without awakening for 8 hours

Personality disorders

- Formerly had their own Axis in DSM but no longer
- Are they no longer thought to be permanent? It depends!
- Major ones that cause problems in jails and prisons: antisocial, narcissistic, borderline, paranoid

Treatment goals especially relevant to persons with severe personality disorders

- Learn not to use lying as a lifestyle
- Learn feelings/empathy for others
- Learn not to disrupt the treatment of others (“treatment interfering behaviors”)
- Compensate for narcissistic injury leading to suicidality (while therapist attempts to treat the narcissism)
- Learn non-criminal lifestyles
- Learn that antisocial behavior has negative consequences to their narcissism (e.g., that one of their malignant personality characteristics conflicts with one of their other malignant personality characteristics)
- Understand how their genetics and childhood experiences shaped the person they are today
- Explore their interpersonal experiences
- Explore inner experiences which lead to anger and rage and other behaviors

Borderline Personality Disorder

- Persons with a pattern of unstable relationships
- Often engage in “splitting”--seeing others as “all-good” or “all-bad”
- Often suicidal or self-injurious
- Often “the bane of my existence” and “all it takes is one of them and I hate going to work”
- And yet: there is considerable change in diagnoses over time suggesting that they can be treated successfully
- The best program we have found is called “Good Psychiatric Management” a simple set of rules for educating them about their illness and giving them tools to management their own emotions
- Also best to treat in a group setting using Dialectical Behavior Therapy, Seeking Safety or Stepps (Systems Training for Emotional Predictability and Problem Solving)

Narcissistic Personality Disorder

- Not necessarily criminals, but classically “selfish” people who only think of themselves
- Typically grandiose and egotistical
- “No one else matters but me”
- Can use others as objects for their ends
- But typically have fragile self-esteem which can lead to suicidality when caught by law enforcement (“I thought I was too smart to be caught”)
- The fragile self-esteem and resulting depression in prison can motivate them to engage them in treatment

Antisocial Personality Disorder

- Persons who routinely neglect the rights of others
- Persons who do not have empathy for the feelings of others
- Highly represented in both men and women in corrections, but do not assume that antisocial acts prove a diagnosis of antisocial personality disorder
- Antisocial behaviors typically start in early teen years and can include “classic” behaviors such as fire-setting and cruelty to animals
- Can be charming and manipulative of therapists and create effectively therapist collusion with their behaviors
- Not always treatable (and do not always want treatment) but if there is something that creates distress it can be made an object of treatment

Intellectual disability, educational deficits and brain injury (Slide 1 of 2)

Defects of cognition are prevalent in prison populations

- 20% may have cognitive impairments
- As many as 40-50% may have experienced brain injury
- More than 35% have less than a high school education

Problems include

- Reading difficulties
- Critical thinking
- Concreteness of thought
- Problems understanding social clues
- Problems understanding consequences and in fact right from wrong
- Interpersonal problems including aggression, being bullied, violence, rule-breaking

Reactions include

- Anger
- Confusion
- Disinterest/attention to new information
- Memory

Source: Magaletta PR, Diamond PM, McLearen AM, Denney RL: Traumatic brain injuries in correctional populations—understanding and responding to an important need, in Managing Special Populations in Jails and Prisons. Edited by Stojkovic J. Kingston, NJ, Civic Research Institute, Inc. 2010

Intellectual disability, educational deficits and brain injury (Slide 2 of 2)

Working with these individuals

- Repetition
- Careful explanations
- Education
- Memory aids
- Patience
- Careful approach to correcting misunderstanding
- Repetition (oh, we are repeating ourselves!)
- Use of written materials, pictures, stories that illustrate and explain

- **Source: Novalis 2023 (see references)**

Some additional problems (as if you didn't have enough already!)

- Attention deficit disorder
  - Highly prevalent in correctional facilities
  - Predisposes to poor academic performance and involvement with criminal justice
  - Prescribers are reluctant to give addictive medications for treatment but there are still several FDA approved non-addictive medications
  - Management includes education about compensatory methods (many manuals available) to control one's time and activities
- Intimate partner violence
  - Enroll them in a program!
- Anger management
  - Enroll them in a program!

Warning: Don't OD on Diagnoses! (That is: Don't overdiagnose!)

- Trauma is highly prevalent in the histories of incarcerated persons but not everyone has PTSD; also it is not necessarily true that entering and living in prison causes a new diagnosis of PTSD
- Not every depressed person has or gets Major Depression
- Not every moody person has Bipolar Disorder or Borderline Personality Disorder
- Not every nervous person has Generalized Anxiety Disorder
- Not every person reporting hallucinations has schizophrenia
- Not every depressed person with schizophrenia has schizoaffective disorder
- Not every person who commits crimes has antisocial personality disorder (and that means you can dispense with your therapeutic nihilism for many such persons)
- Not every person who cannot sleep his first few nights in prison has chronic insomnia
- Not every person with unusual symptoms is a malingerer

A Little Knowledge Can Be a Dangerous Thing

- You can learn a lot from a brief presentation but you should not stop there
- You need to commit to lifelong learning about your profession and your patients
- Your presence here at NCCHC obviously speaks to your commitment to learning how to be a better psychotherapist
- Fortunately, many resources are available if you look for them (e.g., SAMHSA manuals for substance use disorders)
- But improving the conditions and outcomes for incarcerated persons may take courage to create institutional change and overcome the existing correctional culture; there is a lot of help to avoid "burnout" but what occurs in many facilities is "moral injury"—being involved, failing to prevent, or even just witnessing acts which offend your moral beliefs and expectations. There are numerous articles about this but try Thomas T: When burnout is moral injury. Clinical Psychiatry News June 2022 and you should be able to see it at https://www.mdedge.com/psychiatry/article/254760/ptsd/when-burnout-moral-injury

Time to Say Goodbye (slide 1 of 4)
(we mean, when persons leave the institution)

How to prepare:

- Can there be coordination with outside agencies?
- Are there arrangements for housing, jobs, family support, health care?
- Type of discharge: expiration halfway hose, probation, community supervison, etc.
- Is person living in pre-release unit and getting pre-release counseling?
- Review medications and plans for mental health follow-up
- Review substance use history and plans for coping with this on the outside
- Explore feelings and attitudes, expectations and plans and help shape them into realistic plans
- Warn about post-release risk of suicide, substance use and depression as well as interpersonal difficulties that may occur

- Develop a plan for last session and if allowed plan for getting feedback after release

Time to Say Goodbye (slide 2 of 4)

Decision-making

- Guidance and advice on these issues

Document

- Ideas and phone numbers
- To do list for the individual
- To do list for prison staff
- Resources: people, places

Training: How to…

- Use Phones and computers
- Find help
- Apply for a job
- Get health insurance, driver's license, etc.

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Time to Say Goodbye (slide 3 of 4)

Ideas for the Crisis Response Safety Card for leaving

- Triggers and warning signs about suicide, decompensating
- Warning signs that the reentry plan has encountered roadblocks
- Personal contacts
- Professional contacts
- My goals and reasons for succeeding (and living)
- My resilience strategies
- My medications
- My inspirations

Time to Say Goodbye (slide 4 of 4)

In addition to the formal card (or notebook):

- Emergency summary to keep in shoe (in case phone/notebook are lost}
- Copy for a trusted person such as family or counselor
- Email a copy to self: if needed, help with setting up and knowing how to use a library for access
- Help with strategies for updating as things change

THE END

thank you

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