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This Issue in Brief

It's O.K. Supervision Enthusiasts: You Can Come Home Now!—Author Harold B. Wooten asserts that probation systems have lost interest in supervision of offenders; instead, trendy practices which are best described as elaborate monitoring mechanisms have taken the day. But, the author contends, before we rally the supervision loyalists, we should first admit that changing self-defeating behavior of offenders has never been significantly reinforced as a value in probation. The author cites historical reasons for this failure, identifies current barriers to effective supervision of offenders, and offers recommendations to various participants in the process to address effective supervision of offenders.

A Challenge Answered: Changes in the Perception of the Probation Task.—Author Richard Gray responds to the point of view expressed in this issue's article by Harold B. Wooten. Do probation officers actually help probationers or are they primarily paper pushers or law enforcers? According to the author, past experience and current job orientation have caused a change in probation officers' perspective of their job. The author discusses the sociology of knowledge in addressing shifts in task-related perspectives.

Private Enterprise and Institutional Corrections: A Call for Caution.—The current crisis of overcrowding in American prisons and jails, coupled with reduced resources available for corrections, has led to the development of innovative responses to the problems of institutional corrections. One such innovation which has been proposed and is receiving increasing support is the idea of "privatizing" institutional corrections. Authors Lawrence F. Travis III, Edward J. Latessa, Jr., and Gennaro F. Vito examine the movement to contract with private firms for the construction and operation of prisons and jails. Focusing on legal, cost, and accountability issues in such contracting,the authors conclude with a call for caution in the movement to employ private companies for the provision of this governmental service.

Impact of a Job Training Program on CETA-Qualified Offenders.—In this article, author Dennis B. Anderson reports on research—conducted in an industrial midwestern city during 1984—of a job training program for CETA-qualified probationers. Controlling for self-selection and risk factors, the study compared these pro-

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Short-Term System-Therapy With Adult Probation Clients and Their Families

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Theory

DESPITE obvious differences in outlook, the various approaches used in criminal justice over the past decade appear to have a common goal of *deterring* the offender from engaging in criminal behavior. It is clear, however, that neither incarceration, probation, nor parole are uniformly successful in stopping all clients from resuming illicit behavior. Wilson (1983) has recently reviewed the field of research on deterrence and found growing evidence for the influence of developmental and familial factors on criminal behavior. These findings should offer increased incentive for probation personnel to refer problem clients to psychotherapy services which focus on personal and family developmental issues that can be linked with recidivist behavior.

Wilson's findings are also supported by recent studies within the field of psychotherapy, which document the influence of *system factors* in sustaining high levels of recidivism and drug use among many offenders. The picture that is emerging shows that repeated episodes of criminal behavior resulting in arrest, trial, and incarceration can be triggered by acute or chronic difficulties within the offender's intimate social system. These often take the form of a dysfunctional pattern involving the offender, family of origin, and/or family of procreation (or a surrogate system). The pattern typically commences with the first sign of delinquency, most often in adolescence. Thereafter, any move by the offender back toward a normal course of maturation (individuation) and away from problem behavior is met by resistance from the family. The "resistances" are rarely explicit or conscious, but more likely manifested as physical, psychological, or socioeconomic crises. Any such crisis may reactivate the client; and his or her commission of delinquent acts can in turn serve to deflect the attention of the family away from other crises. Reincarceraton may thus (ironically) have the net effect of "rescuing" and stabilizing the family unit, albeit at the sacrifice of the offender member's personal autonomy.

In our experience with probation clients, this pattern has been observed to continue (with increasing rigidity) over the course of 20 years or more, well into some clients' forties and fifties! The dysfunction may eventually spill over to affect other systems as well, including the family of procreation, workplace, correctional system, and other institutions.

The strong influence these system-factors can have on the interaction between professionals and clients is often neglected in program planning, policy, and practice. This helps to explain the low effectiveness evinced by a broad variety of legal sanctions and rehabilitative approaches used by criminal justice agencies in recent years. Any efforts which place primary focus on the offender as an individual are prone to undervalue the ongoing influence of contextual factors on his or her behavior, hence, to underutilize system-interventions. In contrast, a system-oriented approach seeks to identify and work directly with the crucial source of influence, toward the goal of,

> . . .creat(ing) a context in which the problem/dysfunctional behavior is neither adaptive nor necessary. (Haley, 1976)

A systems-orientation also crosscuts (and can incorporate) many of the specific techniques of individual, family, and group therapy in vogue.

Practice

In our own work with probation clients we have found it productive to use a systems conceptualization to assess the potential relevance of physical, psychological, social, and cultural factors in treatment. Ideally, this assessment commences at the outset of treatment, since the utility of various therapeutic approaches is strongly linked with the specific array of problems (and resources) presented by each client. One client may benefit from individual counseling, where another may require the increased structure of family or group modalities.

The general intent of any model of psychotherapy is to elucidate and change life-patterns which interfere with the client's sense of well-being, autonomy, and growth. Approaches vary with regard to how much attention is paid to past vs. present experience, conscious vs. unconscious states, and intrapersonal vs. interpersonal processes. In selecting an appropriate approach, a clincian must consider not only what difficulties in living are being presented, but also assess how current interests and capabilities may affect progress in treatment. For exam-

ple, a client who does not consciously desire or realistically conceive of accepting responsibility over his or her own thoughts, feelings, and behavior is not likely to engage readily in an insight-oriented, psychodynamic mode of therapy requiring extensive personal commitment.

Fortunately, other approaches may be usefully implemented with the less autonomous client. These typically aim to address more obvious problems in a manner that is acceptable to the client, while opening the way to greater personal autonomy in the future. These approaches generally gain leverage toward change by taking an authoritative stance where the client is unwilling or unable to do so. The authority may or may not be reinforced with sanctions, depending upon the voluntary or involuntary status of the client's participation in treatment.

Two means by which the more directive approaches gain most leverage toward change are to (1) *restrict the focus of therapy to a single problem area,* and (2) *broaden the impact upon the client's situation.* A restriction of focus permits the problem to be defined more concretely, usually with quicker affirmation by the client, and thus sets the stage for a highly structured, time-limited treatment plan. The impact of the therapy may be enhanced by increasing the frequency of sessions, including significant others (such as family members) as direct participants, and/or working directly or indirectly (through tasks) in the home environment.

The degree of structure and directiveness required in treatment is gauged to maintain a strategic balance between the level of personal responsibility that can be elicited from the client with reasonable effort at each stage and the legal sanctions that can be brought to bear by the court (e.g., length of probation, frequency of reporting, grounds for revocation, etc.). This balance is constructed at the outset of treatment through specific discussions between therapist, probation officer, client (and significant others). It is reviewed at regular intervals through further discussion, optimally formalized via the probation officer's participation in group supervision.

(1) Family Therapy

Our *family practice model* draws strongly on the earlier work of two related schools of psychotherapy, the structural (Minuchin, 1974) and strategic (Haley, 1980). As reported by Stanton, Todd and Associates (1982), a hybrid, structural/strategic approach has also been successfully used with chronic heroin addicts in Philadelphia, many of whom were current or ex-offenders.

The first goal of therapy in the most severely distressed family systems is to work with the entire family or an essential subunit of offender, parents, and/or others he or she is living with. The aim is to prevent the family from falling into a tendency to detour conflict, while helping members to learn to work through their problems more responsibly—i.e., without scapegoating certain members or inappropriately involving outside agencies, such as the courts.

The client's family in most instances *can* be mobilized to collaborate in problem-solving; indeed, when they are directly involved in the problem their involvement in treatment is necessary for change. This is an extremely powerful tool in preventing reinstitutionalization of the client in a hospital, halfway house, or correctional facility. With this in mind we will work to get the family involved in treatment as early as possible.

(2) Individual Therapy

Our practice with individual clients employs either a psychodynamic (Sifneos, 1972) or a strategic (Haley, 1976; Rabkin, 1983) approach, depending on the client's psychosocial status at the time of intake. We recommend, with rare exception, that clients who manifest direct dependency in relation to parents, e.g., by living at home, *not* be referred to individual therapy before an attempt to intervene directly with the entire family is made. The individual mode is thus used primarily with clients who have made a true *separation,* in both the economic and psychological sense, from the family-of-origin. It is, of course, also used as a later phase of treatment, following attainment of family-related therapeutic goals.

There is often a definite advantage to conducting individual therapy in a *psychodynamic* mode in situations where it is evident that the client has attained some kind of physical separation from the family at the time of intake, yet carries specific problems indicative of an incomplete emotional individuation over into his dealings with other persons in current living activities. It may also be a necessary mode of treatment in cases where no other family members are available to participate, due to geographic distance, refusal, illness, death, etc. The therapist in effect utilizes the transference relationship to help the client to strengthen his or her ego-functioning to a level where insight and working through are feasible. The time required for this process to take hold will vary with the level of emotional development actually achieved by the client prior to "arrest."

Strategic therapy is symptom-focused and utilizes behavioral tasks to "direct" the client into a more functional condition. This approach should be used in cases where the problem is clearly of a reactive nature, affecting the current functioning of a client who has in the past demonstrated an ability to understand and cope successfully with the normal stresses of daily life. The reaction can be related either to a recent stress (e.g., death of a family member) or a traumatic past experience (e.g., combat duty in Vietnam).

Stylistically, these directive approaches call for active *encounter* with the client's defenses and behavior, as this has proven to be more effective than passive modes. We intend to reinforce what is said to the client in a consistent and constructive manner and call on the probation officer to reinforce the responsibilities and limits necessary when working in this manner.

Some examples of the kinds of problem situations in which this system-based approach has proven useful with probation/parole clients are:

- *Recurring problems with compliance* — minor infractions which aren't strong enough reason to revoke probation in each instance but cumulatively take a lot of time to deal with. Also, repeated instances of more serious infractions such a dirty urines.

- *Unstable living situation* — A client who is continually moving about, perhaps between his parents' home and a friend's apartment or from one apartment to another.

- *Camouflage* — Where a client readily presents a minor problem that he or she wants help with which might be covering over more serious difficulties.

- *"Graduation" difficulties* — After an uneventful term of probation, a client who is nearing termination suddenly begins experiencing problems that interfere with compliance.

Problems are not always presented directly by the client however. Here are some other situations where system-therapy may be indicated:

- *Helpful information* — Volunteered by another family member or neighbor to tell the probation officer of things the client is doing that may violate probation. Example: a girlfriend who calls to say that the client is abusing her or has neglected to pay support.

- *Family crises* — Emergencies surfacing somewhere else in the family but affecting the client's ability (and interest) in compliance with probation. The client may tend to them first and tell the probation officer only afterward. Example: a brother has a mental breakdown and is hospitalized and the client is forced to take care of other siblings while the parents deal with this.

Symptomatic behavior exhibited by the offender can be a primary or secondary focus in therapy, depending on the client and family's level of psychosocial functioning and ability to mobilize material resources. As noted earlier, family systems exhibiting a low level of functioning may required a highly specific, structured treatment plan in order to comply with the aim of changing even a single, focused symptom. When it is evident that the primary symptom is under control, the goals of therapy may then shift to support for more generalized growth, as indicated by independent living, employment, marriage, and other normal life experiences for the client.

Progress in therapy is gauged mutually through an integration of reports from the probation officer, therapist, offender, and significant others. This will combine subjective reports and concrete indexes such as consistency of attendance, clean urines, etc. Successful intervention requires active collaboration between the professionals involved with the case, chiefly the probation officer and primary therapist; attainment of effective clarity of hierarchies and boundaries among all parties; and continued monitoring of the process by an objective observer, in the person of the clinical supervisor.

Case Example #1

Jane (fictitious name) is a young woman who was referred to us as a result of repeated minor infractions of her probation. She is the second youngest in a family consisting of the natural father and five children. All of the children had been previously involved in drug use and drug treatment at the time of referral. The family had also exprienced chronic neglect and abuse with one of the children legally removed from the home. The natural mother had committed suicide and the father had a criminal record for bank robbery.

Several family members, including Jane, her father, and two sisters were seen in the initial interview. They agreed with the therapist on a plan of family therapy to include work on the following areas:

(1) Avoidance of unplanned separations (elopement, incarceration, etc.);

(2) Support of current needs to maintain a drug- and alcohol-free home environment; and

(3) Eventual, planned separation from the home by family members who desired to leave the nest.

The first stage of treatment, in which all members were seen conjointly, focused upon the clarification of "boundaries" needed for family members to become aware of appropriate vs. inappropriate demands upon each other, and thus reduce the extreme interdependence (and threat of violence) between the father and the children. Approximately 1 month after the initial session,

the family was able to support Jane's move to quarters shared with her boyfriend, Tom. The treatment soon shifted from family to individual sessions as, one at a time, siblings began to disengage from the father's home. For the next 4 months Jane was seen weekly with the focus of therapy balanced equally between ways to retain the improved quality of relations with other family members and moving ahead to work on personal career and family goals. The frequency of sessions was reduced to every other week during the final 6 months of probation, anticipating a termination of treatment concurrently with probation.

During the 16-month period of treatment, Jane accomplished the following improvements: a consistent record of clean urines; an amicable separation from the parental household; a new job with increased pay and responsibilities; an increased capacity to clarify needs and goals; and a mastery of intimate relations with others. Other family members benefited similarly, weathering several significant shifts in living arrangements and love interests. Jane's boyfriend Tom participated actively in the final stage of therapy as the couple worked to expand their capacities to live with each other and develop plans for marriage.

Case Example #2

A more rapid and crisis-prone course of family treatment is shown in the case of Ed, a man in his mid-thirties, who was referred to us during his eighth year of supervision, just 4 months prior to the scheduled termination of parole. At this time Ed had suddenly resumed illicit drug use, began missing appointments with his parole officer, and was requesting immediate hospitalization for a nervous condition. When his request was denied, the client panicked, began making urgent telephone calls to the therapist; in these calls, Ed expressed a great fear of losing control over his behavior and in one, threatened to abuse his wife. This prompted an immediate interview with the parents and parole officer attending.

The client did not show for the initial interview, and it was agreed by the parents that they would take on the responsibility of bringing Ed to the next session. This was accomplished, and it was agreed that Ed could seek hospitalization on his own if he so desired but that the therapy would focus on issues of how he could improve his management of personal and family responsibilities once he left the hospital. Ed did enter the hospital for a brief period but then decided that he was ready to begin work on the family issues. As this shift occurred, other family members began to manifest problems: His mother remarked that her involvement in therapy was giving her hypertension, and his wife began to drink heavily. Ed shifted between his own home, his parents', and a third, private apartment during this time, depending on which family member needed the most immediate attention. It emerged that this kind of cycling was responsible for Ed's chronic feelings of stress and exhaustion (which had led to both the resumption of drug use and the request for hospitalization).

As the therapist worked intensively to aid Ed in clarifying the various areas of difficulty, the feelings of stress and hopelessness were reduced. Throughout this period other family members continued to experience crises. He did not reengage in conflict with his parents but turned his attention to improving his relationship with his wife and child. The parents dropped out of treatment at this time, and Ed was seen conjointly with his wife. His wife's mother then began to engage in efforts to keep the marriage from pulling together and asked the therapist to help her move Ed's wife and child back to her home. This was resisted by the wife, and her mother then attempted to obtain legal custody of the grandson who she believed was being neglected. Working together in therapy, the client and his wife were able to resist this attempt. The therapy terminated concurrently with the probation, with Ed having accomplished significant gains in his feelings about himself and his role as a husband and father. The couple requested and was referred to a private therapist for additional sessions on parenting issues.

Case Example #3

George is a single white male in his early thirties. At the time of referral, he was on Federal probation for stealing mail and state probation for drunken driving. The mail theft was undertaken to support an extensive heroin habit. As a result of his arrest and conviction he lost his driver's license. He was required by the court to live in his parents' home and enter family therapy.

The initial treatment approach used with George and his parents was strategic, the goal being to prepare George for a resumption of independent living in a more functional lifestyle. The goal was to be attained through the following objectives for George: (1) securing employment, (2) reinstating his license and buying a car, (3) moving into his own apartment.

At first, both parents demonstrated a high (yet understandable in the circumstances) degree of resistance to the idea of George's leaving home. This was manifested by statements which devalued George's self-esteem and sense of mastery. Behavioral tasks were prescribed, which redirected the parents' attention to issues of the father's approaching retirement, and the approaching empty nest—reframed by the therapist with a sense of expectation and excitement about the reduced responsibility and increased opportunity to pursue personal hobbies. This strategic shift to a focus on the parents' life cycle tasks not only got George out of the hot seat, but also interested

George in helping the therapist focus his parents' attention away from him.

In less than a year of counseling, George's parents made a successful adjustment to retirement. They sold their home and moved back to their hometown, some 300 miles away. George successfully resisted moving with them, stretching (although not entirely breaking) the longstanding bond of loyalty and helplessness.

George continued in individual therapy for several months more, with the explicit goal of completing the process of psychological separation from his family of origin and establishing himself as a competent male. The therapist also wanted to be sure that George could resist any pull to reunite with the parents. As the therapist worked weekly with George, he did not reengage in helpless behavior vis-a-vis his parents. Rather, he secured a part-time job and pursued a relationship with a girlfriend, despite objections from the parents. With the help of his probation officer, George was able to locate a full-time job in another part of the country. The final phase of treatment focused on plans for this move, and therapy ended when George started the job.

In this case, George's symptomatic behavior of helplessness and inability to function autonomously were tolerated by his parents. His problems were timely in distracting his parents from attending to important developmental tasks of their own. By enlisting George's assistance to help his parents overcome their resistance to retirement and emptiness of the nest, he was able to give up his symptoms and begin to think of himself as a competent adult. Only when his parents could sufficiently loosen their hold on George could he begin the process of living a life on his own.

Evaluation

In an informal, internal assessment, several indices of participation and progress in therapy were tabulated for 46 cases referred to individual and family therapy between October 1981 and May 1983. Because assignment to therapy was not random and because comparison group data were not available, no tests of statistical significance were performed. However, the results do provide general guidance on the quantity and quality of services delivered.

(1) *Attendance/Use*—Thirteen hundred and eight sessions were scheduled in this interval, and 1042 were actually held, for an average of 23 sessions per client and a "no-show" rate of 20 percent for the group. Actual duration of treatment at the time of study ranged between 3 and 103 sessions, or 1 and 17 months per client.

(2) *Current Status*—At the time of study, 24 clients (52 percent) were active in treatment. Eleven (24 percent) had completed therapy and/or probation successfully, and 11 (24 percent had been terminated prematurely from treatment due to violation of probation or refusal to continue (although 1 of these dropouts had since reentered treatment).

(3) *Change*—Improvement/deterioration was assessed via therapist ratings on several scales.

(a) *Drug Use/Abstinence*—Seventeen clients (39.5 percent) had become abstinent since entering treatment, and another 10 clients (23 percent) remained abstinent throughout treatment. Twelve (28 percent) did not sustain abstinence throughout treatment, while only 3 (7 percent) deteriorated on this variable since entering treatment (i.e., entered "clean" and subsequently showed evidence of drug use).

(b) *Employment*—Six clients (14 percent) sustained part- or full-time jobs throughout treatment, and another 18 (42 percent) acquired part- or full-time jobs during treatment. Eighteen clients (42 percent) did not enter employment, and only 1 (2.3 percent) actually lost employment while in treatment.

(c) *Residency*—Seventeen clients (39.5 percent) sustained interdependent living while in treatment, and another 4 (9.3 percent) acquired this status during treatment. Seventeen clients (39 percent) did not attain independent living (but remained dependent on parents or institutions), and 4 (9.3 percent) lost independence during treatment.

(d) *Clinical*—Therapists felt that 9 clients (21 percent) had made significant psychosocial gains since entering treatment, and another 17 (39.5 percent) had made some gains. Ten clients (23 percent) were judged to have made no real change; 6 (14 percent) to have experienced some regression; and only 1 (2.3 percent) to have had significant setbacks since entering treatment. In interpreting these data readers should keep in mind the variations in length of treatment, hence, progress in treatment evidenced by clients at the time of study.

While it is difficult to interpret the data presented above in the absence of comparative data for a similar group of persons who did not receive treatment, it is possible to offer some general comments. First, the retention of clients in therapy is remarkably high for this kind of population. This may be in large part due to the mandatory nature of the treatment and sanctions available to the probation officer for noncompliance. We suggest that another factor is the systematic manner in which the intake and treatment process is conducted. Including the probation officer and (in family therapy) significant others helps to reduce the possibility of resistance through triangulation and conflict. Another factor is the here-and-now focus upon current status of the client's relations with the probation officer and family members.

A majority of clients appear to have made some general gains in psychosocial functioning while in treatment, and this progress is reflected more concretely in similar rates of improvement/success in abstaining from drug use and sustaining employment. Somewhat fewer clients attained independent living status; this may be due to the reduced focus and leverage toward this goal, possible in individual therapy (vs. family therapy), or it may indicate that a longer term of treatment is needed. Independent living may not be a priority in all cases, however, particularly where the client plays a beneficial role in supporting parents and/or siblings or is him or herself assisted by these others in the care of his or her own children (single parent).

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