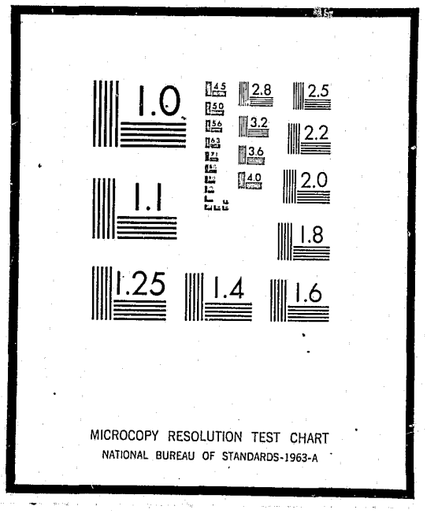

Behavioral Techniques for Sociopathic Clients

By Richard R. Parlour, M.D.*

Community mental health services are increasingly confronted with sociopathic clients and consequently forced to develop techniques that will be effective in such cases. Our Day Treatment Program regularly includes probationers and parolees on an involuntary basis because of our experience that people who break the law usually need to be coerced into treatment initially if meaningful involvement is to be achieved. Close cooperation with the judiciary is necessary because brief return to jail is frequently necessary to motivate sociopathic clients in the early months of treatment. The mixing of court referred cases with the usual psychiatric caseload has not been difficult in our program, contrary to previous reports in the literature. The behavioral orientation of our program may explain its success with sociopathy. This article will describe concepts and specific techniques we find useful in rehabilitation; they should be applicable in correctional institutions as well as community programs.

Definition of Behaviorism

Behaviorism, developed primarily by students of learning, has been applied in large diverse populations of patients, such as in state hospitals, for less than 10 years. There is confusion about what behaviorism actually is at the level of practice. On the one hand much of existing counseling procedures follows behavioral principles; these inadvertent practices could be more effective through conscious application of behaviorism without necessarily conflicting with other aspects of the treatment. On the other hand, many counselors who like behavioral concepts find it difficult to translate into everyday practice the often esoteric reports from the behavioral laboratory, or to extend to other disorders the clinical behavioral techniques developed for rather specialized situations such as phobias, sexual disorders, etc.

This confusion has been partially dispelled by recent papers showing the similarities of actual clinical work by behaviorists and psychoanalysts (2, 5, 7, 8, 9, 10). Behavioral and psychodynamic principles can be seen operating in all human fields of action. Also helpful are papers describing behavioral therapy in familiar outpatient situations such as marriage and family counseling (1, 4, 6, 14, 22, 23).

Because there is no generally accepted definition of behaviorism, even among behaviorists, it will be necessary to propose one for purposes of discussion. Its essential principles are:

(1) Definition of situations in observable behavioral terms.

(2) Structuring correctional programs directly around behavioral objectives.

(3) Utilizing reinforcement techniques imaginatively.

(4) Measuring baselines and results.

(5) Emphasis on the responsibility of the client and his significant others for cure by establishing corrective contracts with them.

The simplest and best known concepts of behaviorism are operant (reinforcement) and classical conditioning techniques in which pleasant and unpleasant stimuli are presented to subjects in association with target behaviors to be modified. This aspect of behaviorism has been well enough described in the literature to warrant no further explication here except for a comment about punishment.

It is generally held by behaviorists that punishment has very little value in training because its effect is merely suppressant; the punished organism is only inhibited from action when the real need is to substitute constructive behaviors that will be simultaneously rewarding enough to the trainee to ensure future repetition. In a limited sense this concept of punishment is undoubtedly true. However, neat laboratory concepts often break down in the face of complicating uncontrollable variables in clincal situations. Unsophisticated observers may see little difference between the application of aversive techniques in the clinic and punishment procedures as they have been traditionally used. For example, because of assaultive incidents, the offender may be excluded from a counseling group for a prescribed time period or may be given an electric shock or may

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lose tokens or other privileges. Perhaps not so obvious is the absence of a vindictive spirit in skilled aversive treatment, the elaborate structure of opportunities provided for the client to achieve rewards and the careful selection of a procedure that is aversive to the individual client in an *optimal* degree of painfulness. Although the behaviorist usually prefers to work completely without aversive techniques, even the withholding of rewards is aversive. In certain refractory cases, deliberate painful applications are an absolutely necessary part of the treatment plan to initiate positive results; in many others aversive techniques speed the process to the point that efficiency demands their use. The concept of punishment is largely a semantic, philosophical problem (20-21) which may be avoided in practice by substituting new phrases such as "aversive conditioning" or "negative consequences."

In reality reinforcement concepts in behaviorism are only the tip of the iceberg. Knowingly or not, reinforcement is universally though often not skillfully practiced, so the uniqueness of behaviorism lies mostly in the context of the reinforcement, not the reinforcement itself. This special structuring of the treatment should be discussed more than the reinforcement itself.

Behaviorism defines clinical problems in terms of client behavior. Radical behaviorists claim to ignore clients' thoughts, feelings, heredity, environment, and other factors, but this is patently impossible to do and probably erroneous to attempt. Observations of reputable behaviorists in action reveal that they deal with the whole person and relate to clients in a warm personable manner (10), but the focus of treatment is to define the client's difficulty in terms of what he and others do and what kinds of action would be better. Thus a depression is partially described in terms of withdrawal from customary wholesome activity, and the treatment in terms of reestablishing previous levels of performance or even surpassing them to prevent future depressions (14). Whereas some therapies assume people will act better when they feel better and therefore focus on relief of dysphoria, behaviorism assumes people will feel better if they first act better. Thus behaviorism is strongly related to the treatment philosophy of Alcoholics Anonymous and to its many offspring, a very substantial field of correctional endeavor in its own right (11, 17, 18).

This focus on behavior lends objectivity to therapy with interesting ramifications. Behavior can be measured unlike most other mental phenomena and so there is the possibility of making corrections even more scientific. Goal Attainment Scaling is a familiar system for recording treatment outcomes useful for this purpose (24). Measurement of results is even more important now that government funding is increasingly subject to cost/benefit analysis (26). Moreover, the untutored clients, their families and the taxpayers at large can understand changes in behavior more readily than more abstract psychological concepts commonly employed. They can cooperate more intelligently in the treatment and more willingly support it financially when they can measure the results for themselves. Furthermore, the emphasis on changed behavior creates an expectation of cooperation from clients. Those not really interested in self-improvement are less likely to waste the counselor's time by continuing a procedure that makes demands on the client himself.

Behavioral treament is a discipline for the counselor also. Initially it is difficult for counselors to translate their usual diagnostic and treatment processes into behavioral terms. However, adding the behavioral dimension to other clinical skills can be intriguing and refreshingly creative. The mere exercise of making this translation will usually turn up some new diagnostic data or some treatment resources previously overlooked. If the behavioral analysis of the case is a required part of treatment records, counselors become comfortable with it in a few weeks.

The eclectic behaviorist, in contrast to the pure one, sees behaviorism as a complement to existing valued techniques, not a substitute. It is an additional point of view in case and program management which stimulates greater inventiveness. The risk of diffuseness is not an absolute contradiction to eclecticism; on the other hand purer behaviorists have an important role to play in our scientific growth as well.

Behavior-Oriented Techniques

In *Responsibility Therapy* (17) I attempted to extract and expand upon the principles of A.A. in order to make the A.A. treatment philosophy more generally applicable to various personality problems. A.A. principles are already widely used for drug addiction (Synanon, Day Top Village), criminosis, (7 Steps Foundation), gambling compulsions, divorce, and others. Very similar is Recovery, Inc. (11) for ex-mental hospital patients, founded by an Adlerian, Dr. Abraham Lowe.

Aside from recognition of a "higher power," not a principle of behaviorism, A.A.'s methodology is essentially behavioral; identifying erroneous behavior, making restitution, and developing improved habits, sharing these plans with significant others and A.A. members for guidance and encouragement (18). Aversive methods in A.A. have been subtle compared to the frank procedures of Synanon such as "haircuts," games, extra duty, and wearing signs proclaiming one's infractions. As mental health professionals are forced to grapple with these sociopathic problems in community mental health centers, more and more of these techniques from A.A. and Synanon are being incorporated although frequently their sources are not recognized, nor is their kinship to behaviorism. A.A. procedures might be improved by applying other features of behaviorism after deliberate study.

Implicit in behaviorism is an approach to counseling elsewhere called "contract psychology" (3, 17). Client and counselor first negotiate to define what are the problem behaviors, and then what each of the parties involved is committed to do to change these behaviors for the better. Relatives, friends and other agencies can also be enlisted in the counseling on a committed basis (15). Corrective contracts are of course subject to renegotiation at all times as the nature of the problem is better understood, but insight is the product of planned action, not the reverse. Contract counseling did not originate in the learning theory laboratory nor is it exclusively applicable to behavior therapy. Yet one cannot really make contracts about anything except behavior, and rewards and punishments based on contract performance are clearly implied. So contract counseling must be included in a comprehensive description of behavior therapy, especially when the reinforcement techniques are explicitly included in the contracts.

A very natural corollary of contract counseling for clients is Personal Development Contracts for staff (26). In effect these are personalized job descriptions negotiated between staff supervisors and their subordinates, reviewed, and if need be revised, every month or two. They take the place of the more customary, awkward, and sterile annual reviews for employees. They provide relevant, vital and documented communication as to what each staff member can be expected to do. These contracts should be written in communication with all levels of staff; reviews are generally most effective in the staff persons' peer group but in some cases reviews should be done privately with the supervisor. The director's contract should be reviewed by staff and by those in the community to whom he must answer. Aside from its value as a widely recognized modern management technique, management by objectives, this procedure gives the staff firsthand experience in contract psychology that will enhance their counseling skills.

Similar to contract counseling is the technique of graded privilege and responsibility (G.P.R.) based on the client's success in meeting treatment commitments. Perhaps the best known example of this technique is the Ward 206 experience described by Glasser (19). Ward 206 was populated by chronic veterans who had failed to respond to other active treatment programs for years. Levels of privilege and concomitant responsibility were established on Ward 206; previously unmotivated patients began to try earning higher ward status which ultimately led to trial visits and even lasting discharges for a substantial proportion of these otherwise hopeless cases. The G.P.R. techniques obviously include positive and negative reinforcement and punishment so it clearly belongs in the sphere of behaviorism. Token economy programs are a variation of this that fits the laboratory model even closer because tokens can generally be given to clients more immediately than can new privileges; the promptness of rewards and punishments is a major consideration in effective behavioral therapy.

As clients achieve higher G.P.R. status they should usually be given more responsibility for the total treatment program. They can assist new or less capable clients as sponsors in the program, help the illiterate prepare their budgets (see below) and treatment contracts, serve as assistants to staff in ancillary therapy activities and counseling groups, and, perhaps, most important, participate in staff meetings where training and decision-making occur. Many people, the poor especially, have little experience in leadership and decision-making. Like everyone they have had opportunities for leadership but did not recognize or for other reasons failed to capitalize these opportunities with resulting ego impoverishments. Day treatment and residential programs particularly lend themselves to G.P.R. techniques although with suitable modifications these techniques are equally effective in family life and other natural or therapy group processes (3, 5, 22, 23).

Money budgets and time budgets are detailed,

written plans of how money and time are to be spent. Disorganized people may not be able to plan more than a day or an hour ahead, but with improvement, plans can extend a week to years in the future. Such planning strengthens self-improvement programs, especially if reinforced by positive and aversive consequences. Budgeting structures and reinforces behavior. It encourages personal responsibility for self-improvement because these are the clients' own plans. It helps others in the family or other functioning groups to integrate their behavior, encouraging them also to structure their behavior more responsibly. Time budgets, especially, provide therapists with valuable information about clients at a glance, often suggesting beneficial changes of the daily program which might otherwise be easily overlooked. It is a simple device with much therapeutic potential for clients of all degrees of wealth and education, particularly valuable in medication clinics for chronic cases with whom one cannot spend much time.

A constant challenge in counseling is to discover more precisely the sources of the problems that clients bring. This is no less true in behavior-oriented counseling, although this might not be apparent in the familiar stereotypes of behaviorism. From the beginning one structures the therapy in terms of the data at hand; active treatment is not delayed because the case is not fully understood. The necessary additional data most reliably emerge from the process of defining problem behaviors, establishing corrective action contracts with as many as possible of those involved in the case (the treament team includes staff and significant others), observing results and appropriately revising the treatment program. This process is usually self-propelling as the various persons involved contribute interest, motivation, and contract proposals, but at times there may be lulls in the proceedings or premature termination may be considered. A stimulant to counseling at such times is the Responsibility Inventory, (17) an exhaustive list of possible responsibilities. Clients review the list, decide which responsibilities are presently fulfilled and what behaviors need to be added to achieve acceptable performance. These new behavior commitments should be incorporated in the time and money budgets to strengthen their implementation. In fact, the Responsibility Inventory is very useful for determining when termination should occur. It leaves the client with a good assessment of his needs for future growth, encourages him to implement this on his own initiative, and provides a way for him to assess his future treatment needs. Sometimes a Termination Contract can be written with clients, based on data from the Responsibility Inventory.

Homework assignments for each participant in the counseling should be agreed upon at each meeting. This procedure puts responsibility for cure clearly on the side of the client and his significant others in concrete, readily verifiable ways. Counseling staff acts mostly as consultants, eagerly available to clients who want to work in self-improvement, spending minimal time with those who do not. This stance by treatment staff responsibly befits its duty to the taxpayers, to deliver the best possible results per dollar spent. Constructively motivated clients are given enthusiastic attention; the unmotivated are ignored as much as possible.

It is commonly thought that involuntary treatment cannot succeed, raising an issue that is philosophical rather than scientific because the facts do not support that contention (12, 13, 16, 20, 21). Even without the evidence of effective involuntary treatment in detention and the enforced indoctrination of prisoners of war, we can say that hardly anyone comes to counseling simply because he wants to be more responsible. Almost all clients are driven to counseling by a combination of dysphoric internal coercion and environmental pressure. Rarely does treatment begin voluntarily, but frequently involuntary treatment becomes a solid cooperative enterprise when clients see clearly what changes are needed and have a workable plan to achieve these changes. As good results emerge in the counseling positive motivation multiplies, and, after a successful termination, continues to reinforce the new behaviors developed.

I will assert from clinical experience that unemployment is a major cause of personality problems in poverty areas just as it is with the affluent and retired populations in general. Providing useful work for clients is powerful treatment that is best not solely left in the hands of private or public employment agencies. This is not to say that full employment efforts should be duplicated by correctional facilities however. Everywhere there are things that need to be done, abundantly so in poverty areas. Lack of money to pay for needed services should not prevent the doing, especially by clients who have the time and need the experience for purposes of growth. This is a way clients

can repay the community for clinic services and build the clinic's image as a constructive force in the community. Clients will receive important exercise of mind and body and a sense of usefulness so essential to mental health, developing good employment habits for later paying jobs and establishing a work record and work references for future employment applications. Therapists can insist that clients be employed for pay or as volunteers as part of the corrective contracts if the clinic develops voluntary job opportunities with local employers who agree to train and supervise the workers in cooperation with the clinic. Is this behavioral counseling or social work? Community facilities should be ready to fill in the gaps of needed services if the corrective potential is substantial. When one sees firsthand the remarkable personality improvements frequently resulting from this procedure, it has to rate high as therapy. A behavioral orientation in counseling leads quickly to invention of such programs because unemployment is sick behavior.

Certainly family counseling is not a behaviorist invention, yet involvement of family or significant persons in the client's life is especially important in the behavioral orientation because these significant others are likely more aware of the client's problem behaviors than is the client himself. Failure to involve these persons can easily lead to their unwitting sabotage of the counseling, while gaining their intelligent participation strengthens it 24 hours per day (15). By now it is axiomatic that significant others also have problem behaviors of much significance to the identified client and the community, so family counseling is particularly valuable because it reaches so many people at one time. Clients who do not have participating family members can be provided "community sponsors" from among responsible clients, former clients, or other volunteers who are willing to attend counseling meetings and look in on the client's life away from the clinic. In short the behaviorist focus forces us to look for objective data on client behavior where it can be found and to develop a reinforcement network, a treatment team in the community. Requiring clients to participate in organized community groups (churches, clubs, etc.) will help to expand the treatment team, to decrease the expenditure of treatment resources by the clinic and strengthen the clinic's ties with the community.

Behavioral therapy is like good child-rearing procedure in most respects. Clients can apply their counseling experiences at home with the children. Sound structuring of family life, by itself, relieves many ills (25).

Confrontation of Passivity

Like family counseling confrontation techniques are not original with behaviorism and yet are essential to it because of the objective behavioral focus. A most constant challenge is the pervasive passivity of some clients, especially those from lower socioeconomic levels. This is not to say that most are passive people because impulsive and destructive action is common enough among our clients, but when it comes to looking at problems, discussing them, and seeking constructive alternatives, massive passivity is the classic dynamic to be found, sometimes embellished with various physical or mental symptoms, but often quite starkly plain. The causes of this syndrome are probably multiple and as yet obscure to scientific explication, but treatment cannot wait for the ultimate etiological answers.

Undoubtedly lack of verbal facility is part of the problem, but we know too well that our more facile (intellectual) clients may resist responsible insight very effectively. Fortunately actions speak louder than words, so behavior therapy is often the best communication procedure. Techniques like time budgets, contracts, and responsibility inventories make illiteracy an additional handicap but not an insurmountable one because significant others can be enlisted to help, thus building the client's level of involvement with others. The stimulus of these exercises can actually raise the literacy level of clients in a few weeks; some eventually go back to school with a positive attitude. Skilled teachers, paid or volunteer, can be great assets to the clinic staff; learning to read and write is very gratifying to illiterate clients.

Another possible reason for passivity is a sense of impotence in life, the habitual expectation of failure, a chronic hopelessness prevalent among disillusioned people. Careful structuring of treatment, utilizing the behavioral principles of successive approximation (dividing the training goals into small steps) can practically guarantee the experience of success by clients, if they can be persuaded to try. It is the initial resistance to effort that is such a serious obstacle of counseling. Some will respond to displays of kindness and sincere interest by staff; some will be inspired by reasonable discussions of their problems, including good advice and specific instructions; some will catch

the spirit of self-improvement in a program that utilizes G.P.R. techniques; but many will need aversive experiences in counseling before serious engagement occurs.

Allowing clients to be unproductive in counseling is bad for the morale of the client himself, the other clients, staff and the community at large. Ordinarily productive treatment contracts can be worked out with clients and their significant others without special demandingness from the counselor. However, at times the counselor will need to remind the client of unhappy consequences that will follow from unproductive counseling. Sometimes the counselor must mobilize pressure from the spouse, employer, parole officer, conservator, or guardian to motivate the treatment. The client's consent for consultation with these significant others should be obtained as early as possible in the treatment. Therapeutic effort depends on emotional involvement in the treatment; negative emotions of clients are not as gratifying to the narcissism of the counselor as positive ones, but they can be even more instrumental for cure and frequently are a necessary thing in counseling as psychoanalytic experience has shown. The client is expected to make at least a minimal commitment for corrective action for each identified problem behavior. Complementary commitments from significant others should be obtained as much as possible because concerted action strengthens the training in geometric proportions.

With the establishment of a sound training contract the counseling task becomes wise administration and revision of the contract. Individualized positive and aversive reinforcements are included in the contract; they also need regular review to assure effectiveness because what may be motivating to clients one week may not be motivating the next. The evaluation of results at each counseling session provides the new data which clarifies the true nature of the problem and indicates contract modifications, a psychodynamic process familiar to experienced counselors of all theoretical persuasions (2). This explicit structuring of the treatment readily exposes pathological passivity which will require a better definition of the problem, better corrective commitments and better reinforcement procedures.

There are some reinforcement procedures that are particularly useful in group therapy, including family and therapeutic community meetings, when clients refuse to acknowledge problem behaviors or to negotiate corrective contracts. Before taking special aversive action in such cases, one should confront the client calmly and accurately to avoid unnecessary escalation. It might be a natural impulse to exclude the uncooperative client from the group at such times, but usually such exclusion will not be aversive and will in fact reward the client for his intransigence; hence, the need for other tactics. Sometimes assignment of uninspiring extra duties can be made until the impasse is breached. Temporary demotion to a lower G.P.R. level may also be used, cautiously because some clients will like the idea of lesser expectations. In both of these cases, care must be taken to avoid interrupting other therapeutically potent activities because of the added aversive assignments. At times this issue must be compromised, however rationing smokes and giving meals a bite at a time for good performance have also been effectively done. When clients go to sleep during meetings or do not listen or respond appropriately, they may be required to stand up for a suitable time. When this minor discomfort and embarrassment do not suffice, corner-standing may be considered. The client is instructed to stand facing a corner of the room, to cool off, and to think about a corrective plan of action, and to return to his place in the group when he is ready to make corrective commitments acceptable to the group. The client may need to be forcibly placed in the corner by members of the group who have been trained to do this safely and therapeutically under direct supervision of staff; these members remain with the client to see that he stands correctly, to see that he understands correctly the problem to be confronted, and to assure him of his ability to solve the problem if he will try. Those physically unable to stand in the corner may be seated there. This procedure gives physical contact and extra attention to the client that may make it more pleasant than aversive to some; therefore it will not be effective in all cases but has proved to be the turning point in counseling for many. It is especially valuable to the morale of the group to see that resistance is not tolerated indefinitely and can usually be dealt with firmly in the situation.

Although aversive reinforcement can be effective and is frequently necessary, positive reinforcement is preferable for several reasons. Laboratory evidence strongly favors positive reinforcement and training. Unnecessary coercion is repugnant to staff, clients, and the taxpaying

community. A positive, friendly atmosphere in treatment programs is unquestionably desirable. Curiously, even benevolent people tend to take for granted the good things they experience day after day. The use of firm measures against irresponsible behavior demands in fairness that responsible behavior be acknowledged with at least equal vigor. Sound behavior training (for pathological passivity most particularly) includes systems for ensuring that clients are praised and rewarded for good performance. This principle can be established with staff if program supervisors practice it with subordinate staff and require them in turn to include appropriate praise of clients in therapy procedures. Behaviorally structured counseling lends itself nicely to this because individual and group counseling meetings are in large part reviews of existing training contracts. Each item well-performed can be positively noticed by the counselor with little effort. Further reinforcement for this would be counting and charting positive and negative confrontations in each meeting so the counselor and clients are constantly aware of this otherwise elusive, critical factor. Frequent appropriate praise and other rewards for good performance will substantially reduce the amount of aversive activity necessary to keep training productive.

Thus while the versatile community psychiatrist must be adept in structuring positive reinforcement into his programs, he is willing and able to be aversive in the pursuit of therapeutic progress.

Case Report I

This 20-year-old divorced male was referred by the Probation Department after he was revoked for escaping from the county jail. He has been stealing since age 5, including robbery; other convictions include incorrigibility, drunk driving, battery, for a total of 11 convictions. He has never sustained legitimate employment. He has broken his hands from hitting walls when angry and made several suicide attempts while separated from his wife.

Before accepting this client, we had a special conference with the judge to be certain that he would support the therapeutic needs of the client for return to jail when the client might stop working in the Program. The court order was tailored to the procedures of our Program. Meanwhile the client was not accepted in the program until he was using time budgets in jail and completed Part I of the Responsibility Inventory. As expected, he tested our limits at every point. When accepted in the program, he continued living in the jail, coming to the Program from the jail each day. His first contracts were to correct his habit of "conning" people into sympathy for him daily and his temper outbursts whenever frustrated, a behavior occurring twice a day. In a month he had stopped trying to get sympathy and his temper flared only once a week; at this time he was transferred from jail to the convalescent hospital where our clients live when they have no home of their own. Because of an incident in which he smoked marihuana and cut his wrist in anger at his ex-wife and repeated lies, he was required to spend the entire Christmas holidays at the convalescent hospital; at that point his option was return to jail after any more infractions or to put himself in good standing in the Program by helping the hospital staff to provide a cheery Christmas to the elderly patients at the hospital who had no place to go. He passed this critical test superbly and began to be a leader in the Program. The next month he was beaten up by his ex-wife's boy friend who was laying in wait for him on a pass. Although his pride was hurt and he was shocked at his ex-wife's vindictiveness, he calmly reported the incident to authorities and continued his responsibilities in the Program. The next month his girl friend had a miscarriage and he telephoned his counselor in a panic; by the time the counselor could call him back, he had planned what to do and was implementing his plan. The next month he forced one of the nurses to kiss him; we learned that the nurses had been flirting with him for weeks and he expected approval for his actions, but he accepted with grace a serious reprimand for his actions.

This man is now working on a contract about his pouting and sulking when things don't go his way. He writes his own contracts and time budgets with minimal assistance from his counselor and is the most dependable client leader at the hospital. He appears capable of completing the Program successfully in a total of 9 months.

Case II

This 20-year-old single male was referred to our Program after five violations of his current probation. At age 14 he was first put on probation because of repeated runaways, school problems, stealing. After a hit and run at age 17 he was put on probation again. The next year he was convicted of possession of marihuana, and at age 19 for possession of "whites." Later that year he was arrested for disturbing the peace while intoxicated. His third "dirty" urine test precipitated his referral to Day Treatment where his mother hoped he would learn to accept rules.

His father died when he was 6 years old. At age 7 he was unconscious for a week after being hit by a car. He began disruptive behavior in school in the 7th grade and has not been steadily employed. He takes drugs when he feels lonely or rejected.

At the time of admission this man was living with a lady 8 years older who refused to cooperate in the Program. We therefore required him to live at our convalescent hospital. It is important that the Program is carried out evenings and weekends through the support of significant others. Frequent family counseling is required; if a client has no available significant others, we find volunteers who will work with him at home.

His passive-aggressive character structure required treatment contracts on several matters: discontinuation of resort to illicit drugs, of destructive and/or abusive temper outbursts, of passive resistence to the Program, and of lying; correcting his alienation through responsible involvement with others.

After 2 months in the Program it was apparent that the client was involved only superficially, constantly in minor trouble and never assuming responsible leadership. A surprise urine test proved what we had suspected, continued illicit drug use, whereupon we applied to the probation officer for a week's confinement in the county jail. Curiously, therapeutic detention is against the policy of the Probation Department, but the officer agreed to help us file the necessary papers. So the client's counselor took him to court. The judge not only ordered the jailing but also specifically modified the probation to fit the needs of the Program. (It is preferable that a specific court order be obtained before admission to the Program.)

Following his return from jail, the client's attitude has been much more positive. The frequency and severity of his offenses in the Program are much reduced, but, more important, he now cheerfully volunteers to help less capable clients and ably fulfills leadership

roles. This therapeutic detention was especially effective because he had spent enough time in the Program to appreciate its attractive qualities, the fun and the possibility of learning to live more meaningfully. His time in jail also helped to motivate other clients in the Program, not just those on probation, but other clients and staff; it underlined the seriousness of life and the need to make good use of our freedom and resources.

We are now hopeful that this client can successfully complete the Program. Graduation requires that a client be living in the community, handling his responsibilities well and employed full time as a volunteer or in a remunerative job.

Discussion

In past years close cooperation between county mental health programs and their respective probation departments has been limited by a number of rather basic problems. Among these are:

(1) The issue of involuntary treatment.

(2) Problems of confidentiality.

(3) Poor communication by mental health services with other agencies aside from the confidentiality issue.

(4) Esoteric treatment approaches not readily understandable and of doubtful relevance to the issues faced by courts of law.

We submit that none of these issues is insurmountable, granted a mental health service that recognizes a responsibility to serve the sociopathic half of the psychopathologic population. Unfortunately the vast majority of mental health professionals have never worked in corrections; this glaring gap in mental health training programs needs to be closed if the professions continue to claim expertise in the understanding of human nature and human problems. Also the vast majority are deeply imbued with philosophic biases about the proper place of authority in life generally and treatment particularly; these anti-authoritarian biases have no scientific basis whatsoever and in fact much elaborate theorizing is required to explain away the substantial contrary evidence. Hopefully in time these defects can be overcome, especially now that the mental health enterprise is highly committed to community mental health, a challenge that will surely purge many unrealistic attitudes.

Rare indeed is the person who comes to treatment simply because he wants to be a better person. Almost all are driven into treatment by painful feelings, by concerns about loss of relatives, or friends, or employment, or freedom. We are not impressed by the superficial difference between clients coerced into treatment by law enforcement and those coerced by other threats of loss. We depend upon the probation office to arrange a few day's therapeutic detention for probation clients whose motivation is flagging; so far this procedure has been consistently therapeutic.

Almost all nonorganic pathology begins with and perpetrates a lie, hence the emphasis on openness in RDTP. Clients first show their willingness to give up mendacity by officially authorizing staff to communicate with significant others (including the court and other involved agencies). Probation officers, welfare workers, conservators and others are regular participants in our therapy groups. Contrary to some expectations this participation enhances rather than inhibiting therapeutic communication. Sullen withdrawn clients are the exception here.

Those persons and agencies for whom we have authorization for consultation (usually all significant ones) receive written progress reports at least monthly, listing the problem behaviors identified in each case and numerical measurements of progress on each behavior. Ninety-nine percent of authorized inquiries are answered within 2 days, most within 2 hours. A responsible treatment program is responsive.

Although all known theories and modalities of treatment are utilized in RDTP, one way or another, the definition of client problems in measurable behavioral terms translates our activity into an understandable language that transcends cultural boundaries. Perhaps more important, this procedure puts us on a scientific footing which the mental health professions have always endorsed but implemented much less often. A scientific basis should resolve many of the troublesome controversies in our field, ere long.

The Riverside Day Treatment Program is far from perfect; its results seldom approach the miraculous. The wonder is that clients can achieve solid personality growth in a program that some would call moralistic, coercive, unprotective and simplistic. Yet, they are.

Conclusion

Behaviorism broadly defined has substantial potential as a supplement to usual correctional counseling procedures. A variety of specific techniques have been described and two cases managed in our Day Treatment Program presented. Hopefully, application of behavioral principles can make the necessary punitive aspects of corrections a truly beneficial training experience for correctional clients. Punishment does not have to be negative or destructive!

APPENDIX

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