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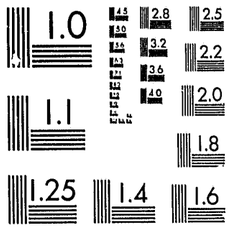

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Federal Probation

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JUNE 1984

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ACQUISITIONS

This Issue in Brief

The Evolution of Probation: The Historical Contributions of the Volunteer.—In the second of a series of four articles on the evolution of probation, Lindner and Savarese trace the volunteer/professional conflict which emerged shortly after the birth of probation. The authors reveal that volunteers provided the courts with probation-like services even before the existence of statutory probation. Volunteers were also primarily responsible for the enactment of early probation laws. With the appointment of salaried officers, however, a movement towards professionalism emerged, signaling the end of volunteerism as a significant force in probation.

Don't throw the Parole Baby Out With the Justice Bath Water.—Allen Breed, former director of the National Institute of Corrections, reviews the question of parole abolition in light of the experience with determinate sentencing legislation in California, the current crisis of prison overcrowding, and the improvements that have been made in parole procedures in recent years. He concludes that the parole board—while it may currently not be politically fashionable—serves important "safety net" functions and retention of parole provides the fairest, most humane, and most cost-effective way of managing the convicted offender that is protective of public safety.

LEAA's Impact on a Nonurban County.—LEAA provided funds for the purpose of improving the justice system for 15 years. To date, relatively little effort has been made to evaluate the impact of LEAA on the delivery of justice. In this article, Professor Robert Sigler and Police Officer Rick Singleton evaluate the impact of LEAA funds on one nonurban county in Northwestern Alabama. Distribution of funds, retention and impact are assessed. While no attempt has been made to assess the dollar value of the change, the data indicate that the more than one million dollars spent in Lauderdale County did change the system.

Developments in Shock Probation.—Focusing on a widely used and frequently researched probation program, this paper by Professor Gennaro Vito examines research findings in an attempt to clearly identify the policy implications surrounding its continued use.

Family Therapy and the Drug-Using Offender: The Organization of Disability and Treatment in

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a Criminal Justice Context.—The paper describes offenders' behaviors which exacerbate conflict between probation professionals to protect a fragile interpersonal situation within the offender's family. The mirroring of familial conflict by professionals leads to high rates of recidivism whereas the professional's ability to work collaboratively with the offender's family frequently enhances autonomy and more responsible behavior, assert the authors, David T. Mowatt, John M. VanDeusen, and David Wilson. Three modes of interaction characterizing the interface between probation professionals and the offenders' families are described.

Toward an Alternate Direction in Correctional Counseling.—While examining some of the problems in correctional counseling, e.g., authority, resistence to change, etc., this article calls for an alternative to traditional therapies. Dr. Ronald Holmes recognizes the need to move toward a model of counseling which reduces the importance of traditional therapeutic values and stresses the need for humane relationships. This model encourages an equal relationship between the counselor and the client, an examination of conscious determinants of behavior, and a belief in the client's ability to change.

Victim Services on a Shoestring.—The criminal justice system is currently demonstrating more concern about the victims of crime. Robert M. Smith, probation and parole officer for the State of Vermont, writes that although we in corrections oftentimes do not become involved with offenders until long after some crimes were committed, we still can play a significant role with regard to victims. Furthermore, some of these interventions do not require additional resources; rather, it is a matter of rethinking our own attitudes.

Medical Services in the Prisons: A Discriminatory Practice.—This article by Professor James T. Ziegenfuss reviews the provision of medical services in prisons and the growing involvement of the courts. Studies reported in the literature raise serious questions as to the quality and quantity of such care. Traditional approaches would suggest amelioration of the situation by providing more and better care. However, the consideration of alternatives to the present delivery system is examined in this article, as exemplified by the developing drug and alcohol treatment system. Importantly, the resolution of the problem is defined in terms of service system design and redesign. Additional needed research and analytical studies are identified.

Legal Assistance to Federal Prisoners.—Legal Aid Attorney Arthur R. Goussy describes the duties of the visiting attorney to the Federal Correctional Institution, Milan, Michigan from February through October 1981. Commencing in April, a total of 136 interviews were conducted with 126 inmates during visits taking a total of 71 hours. Prison authorities felt this service would assist inmates in: (1) pursuing their criminal cases; (2) coping with prison grievances; and (3) resolving private legal matters. This paper addresses, experientally, these problems and the merits of legal consultation.

Love Canal Six Years Later: The Legal Legacy.—It was August 1978 when the New York State Health Commissioner declared a health emergency at the Love Canal site on the outskirts of Niagara Falls, which ultimately led to the evacuation of nearly 1,000 families. For 5 years, Hooker Chemical and Plastics Corporation had used the 15-acre site to dump 21,800 tons of toxic chemicals until it sold the property to the Niagara School Board in 1953. Since 1978 the Justice Department has initiated a $124.5 million lawsuit against Hooker and New York State has filed suits totalling $835 million, charging Hooker with responsibility for the Love Canal disaster and other illegal dumping in the area. Issues remain, however, in the assessment of legal responsibility in this case. In this paper by Professor Jay Albanese questions of causation, prosecution, sentencing, and prevention are examined to illustrate the difficulty in doing justice in cases involving the scientific and legal issues raised by exposure to hazardous waste.

All the articles appearing in this magazine are regarded as appropriate expressions of ideas worthy of thought but their publication is not to be taken as an endorsement by the editors or the Federal probation office of the views set forth. The editors may or may not agree with the articles appearing in the magazine, but believe them in any case to be deserving of consideration.

95613

The Evolution of Probation

*The Historical Contributions of the Volunteer**

BY CHARLES LINDNER AND MARGARET R. SAVARESE**

AS MOST of us already know, probation was brought into existence in this country by a relatively small number of dedicated individuals, most of whom were volunteers. Of course, the very first name that comes to mind is that of John Augustus whose pioneering work in and around Boston during the mid-1800's earned for him the title, "father of probation." But there were other volunteers, both in Massachusetts and other jurisdictions such as New York and Chicago, who followed Augustus and who continued his work, still on a voluntary basis, winning acceptance for probation, in the process and, thus, laying the groundwork for passage of the first official probation laws.

Whereas volunteers had been the undisputed leaders and pioneers during the early stages of the evolution of probation, their role changed radically very shortly after the enactment of probation legislation. Almost inevitably, the advent of publicly paid professional probation officers led to an eventual diminution of both the volunteers' functions and status within the system. In most jurisdictions, a consistent pattern emerged following the creation of a formal, official probation system; as paid probation officers were hired, increased in numbers, and became professionalized, they often concentrated their organizational efforts on the removal of volunteers from the system or, at the very least, on severely limiting the role and functions of volunteers.

In New York State, for example, the trend toward professionalism was evident during the first decade of statutory probation services and, in many instances, publicly paid probation officers were simply substituted for volunteers. Elsewhere, volunteers were subjected to supervision by professional, salaried probation officers, limited in the scope of their duties and responsibilities, and assigned reduced caseloads. Most importantly, a number of attacks on the quality of volunteer work served as a stigma and tarnished the credibility of volunteers as a whole. So strong was the anti-volunteer feeling, as a result, that it would not be until the 1960's that a revival of volunteer services in probation would occur.

Whereas the contributions made by the early volunteers to the development of probation have received considerable attention, the later struggle between volunteers and professionals has been overlooked for the most part. This article is an attempt to explore the various roles played by volunteers at different stages in the evolution of probation culminating in the volunteer/professional conflict and the eventual outcome of that struggle.

THE ROLE OF VOLUNTEERS PRIOR TO THE PASSAGE OF PROBATION LEGISLATION

The years prior to the passage of the statutes legally authorizing probation and the appointment of probation officers could very well be called the "golden years" of voluntary probation services for it was during this period of time that volunteers played their most prominent, fruitful role in both initiating and then developing probation until it became an accepted, well-established practice. Indeed, in many jurisdictions, long before probation received the official sanction of law, volunteers were active in the courts where they provided, on a strictly informal, unofficial basis, a type of assistance which would, much later, be recognized and accepted as the essential core of professional probation practice. The services provided by these early volunteers included both investigations of defendants and informal supervision, for although the courts lacked the ability, at this time, to place an offender under formal probation supervision, the combination of a suspended sentence plus informal supervision was often used as an alternative and served essentially the same purpose.

The Premier Volunteer

Of course, the first and foremost volunteer was John Augustus and his accomplishments in launching probation in this country overshadow the efforts of all other volunteers who labored during this period prior to the existence of a formal probation system. Appropriately credited with being the "father of probation," Augustus was the "first to invent a system, which he termed probation, of selection and supervi-

*This is the second in a series of four articles on the evolution of probation.

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Family Therapy and the Drug Using Offender

The Organization of Disability and Treatment in a Criminal Justice Context*

BY DAVID T. MOWATT, JOHN M. VANDEUSEN, AND DAVID WILSON

THERE HAS BEEN a sharp growth of conjecture and inquiry concerning the cost and quality of services provided by public institutions, in recent years. Illich (1976) has ventured to say that the current organization of health care in the United States and other developed countries actively precipitates and sustains illness. This article addresses the general question of how an institution mandated to serve the public good might come to develop modes of operating that are contrary to its own professed mission. We shall attempt to shed light on this matter by describing several modes of interaction observed among identified clients, their families, and professional helpers in one institutional setting—the criminal justice system. Our primary concern is the impact of the relational structures on the organization of disability and treatment in this context.

Background

A number of authors have discussed the notion of symptomatic behavior as a regulator which serves to detour and dampen stresses that would otherwise threaten the integrity of a nuclear family unit (Bateson, Jackson, Haley, and Weakland, 1956; Ackerman, 1958; Bowen, 1960; Laing, 1969; Davis, Berenson, Steinglass, and Davis, 1974; Kantor and Lehr, 1975). Among professional helpers, there is growing acceptance of the general idea that families can reinforce the disabled status of one member through expectations and behaviors that might appear quite normal to the outsider. The *homeostatic* quality of this process is to be stressed: *all members,* including the symptom-bearer, come to accept the disability as a *compromise* which stabilizes relationships and thus allays the threat of severance of parental, marital, or filial bonds. Symptomatic behaviors wax and wane in relation to the degree of stress experienced (or anticipated) by the family system (Haley, 1967). Since most symptoms are in themselves stressful or untenable, the system acquires a dynamic, rather than a static, equilibrium over the course of time. It would thus appear that the *structural dimensions,* rather than the *content* of interactions, serve to differentiate such families from others (Aponte and VanDeusen, 1981).

More recently, clinical understanding has expanded to include *institutional correlates* of dysfunctional processes in families containing a seriously disabled member. In working with schizophrenic young adults at the time of first hospitalization, Haley and colleagues (including Mowatt), noted that the psychotic break occurred at a time when the young person was expected to separate from his or her family of origin and function as an autonomous adult. A critical life event was usually impending, such as: graduation from college or professional school; marriage; advancement in a career; etc. A family approach to psychotherapy was developed by Haley, which consisted of placing the parents in charge of the young person upon discharge from the hospital. This was seen as a way of attaining a stabilization of hierarchies within the family, conducive to therapeutic resolution of the turmoil associated with the young person's separation from the family. Haley (1981) has since provided data which substantiate the effectiveness of this approach in reducing the frequency of rehospitalization over a 4-year follow-up period.

Similar patterns linking identified patient, his/her family, and the hospital or other health care provider have been described by Minuchin, Rosman, and Baker (1978), with families containing children with anorexia nervosa, labile diabetes, and ulcerative colitis. These investigators found that inclusion of the pediatrician or other primary care provider in the family therapy program significantly reduced the need for hospitalization.

*This article was prepared for presentation in a session on *Applied Mental Health Research: Transformations of Disability Within Formal Care Systems,* at the 81st Annual Meeting, American Anthropological Association, December 3-7, 1982, Washington, D.C. Copyright is reserved by the authors. The article should not be copied, distributed or cited without permission from the authors, who can be contacted at: Resources for Human Development, Inc., 120 West Lancaster Avenue, Ardmore, Pennsylvania 19003; (215) 649-6400.

In their work with chronic heroin addicts, Stanton, Todd, the present authors, and other colleagues have built on the treatment approaches of both Haley and Minuchin. Addiction is viewed as bound-up with an effort on the part of the family of origin to maintain a dysfunctional homeostasis (Stanton, Todd and Associates, 1982). Here, turmoil within the family is detoured by a refocusing of attention on a series of mini-crises provoked by the addict and his habit. Those who have worked with heroin addicts may be familiar with this phenomenon, marked by continual shifting in and out of drug treatment and other service institutions. The phrase "pseudo-individuation" is used by Stanton, Todd, Heard, Kirchner, Kleiman, Mowatt, Riley, Scott, and VanDeusen (1978), to describe the addict's untenable involvement in the family of origin, in which he/she neither clearly "inside" nor "outside." Developmental and social factors pressing for a separation are apparently countered by conditions within such families, which prevent a complete transition from taking place. Haley (1981), Stanton, et al. (1982), Minuchin, et al. (1978), all describe the onset of the disability as functioning to allay or dampen stresses at other loci in the family. These stresses most often would involve the parents, or the parents and an extended family member (e.g., grandmother). Once instituted, the symptomatic adaptation can become increasingly central to family functioning, as members come to pattern their expectations and behaviors around it. Mowatt, Heard, Steier, Stanton and Todd (1982) demonstrated that when the crises occurring in addicts' families are contained and resolved within treatment, the dysfunctional sequences maintaining the symptom are dissolved. The outcome of treatment is positive when compared with families in which a crises did not occur during treatment.

The subject of this article is a further development of this conceptual framework, based on our recent work with criminal offenders assigned to family therapy for drug problems as a condition of probation/parole. We have found that structural characteristics manifested by families in this population are remarkably similar to those described in earlier family studies. When the arena of institutionalization is expanded to encompass the legal and judicial system, however, the possibilities for dysfunctional enmeshments between family and formal care systems are greatly multiplied (figure 1). Accordingly,

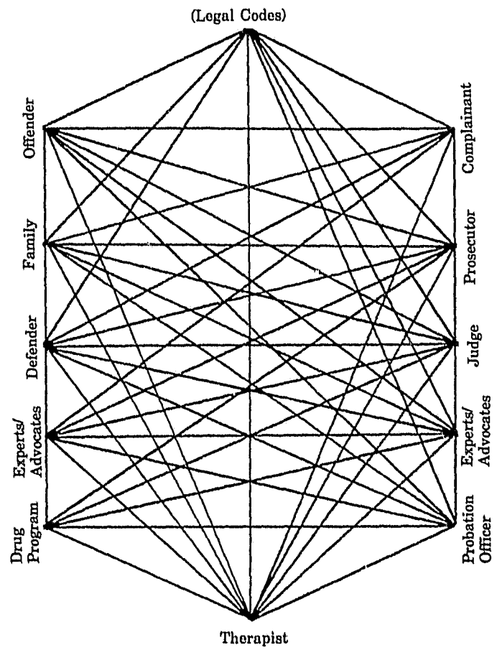

Figure 1. Opportunities for Entanglement of Participants at Various Loci in the Criminal Justice System

we will here describe characteristics of familial and institutional relations which serve to impede treatment at the criminal justice interface.

Aspects of Disability in Offenders' Families

The population in focus consists of probation and parole clients who have been engaged in outpatient family therapy. All of these clients have a history of drug problems, and the therapy is viewed by the institution (probation office) as a useful means of diminishing/preventing drug usage.[1] The "disability" at hand is thus compounded of a *legal conviction for criminal behavior* and a *proclivity for drug abuse,* although no formal diagnostic classification (such as DSM III) is applied. This leaves considerable latitude for the definition of the problem and goals for treatment. The situation can pose numerous difficulties for all involved, particularly if expectations vary.

A key difference between this population and those described in earlier studies is that families containing a convicted member have often accepted an

[1]Current conditions in the justice system favor the assignment and acceptance of this disability as an alternative to harsh, costly confinement in prison. The process of negotiation leading to this outcome may even begin at the time of arrest and continue throughout adjudication (cf. Scheff, 1968; Rothman, 1980).

untenable compromise for a *much longer period of time.* Several of the clients we have seen in treatment have been in their forties and still maintained an adolescent-like dependency on their parents. Here, the marginality of the offender's status in the family and in society has induced a balance that is at the same time *rigid* and *fragile.*

> Once the young person and parents fail to disengage, the triangular stability can continue for many years, independent of the offspring's age, though the onset of the problem began at the age of leaving home. The "child" can be forty years old and the parents in their seventies, still taking their crazy son or daughter from hospital to hospital, and doctor to doctor. (Haley, 1981: 31)

We would add, from lawyer, judge to judge, and probation officer to probation officer.

> This is illustrated in the case of a 45 year old man who had been a major cocaine dealer, and, yet, behaved like a 17 year old when interviewed with his mother. The mother still faithfully did the son's laundry, and threatened "heart failure" whenever the client/son stopped taking drugs, applied for a straight job, or mentioned his girlfriend during a therapy session.

One might wonder why the pull of the family against the "outsiders" who are attempting to help is so strong?[2] In their work with addicts' families, Mowatt, et al. (1982) found that long periods of drug-free status were frequently followed by the emergence of serious difficulties in one or both parents, including psychosis, alcoholism , heart conditions and death.[3] These patterns occurred among families in treatment and also among comparable families who were not involved in family therapy, suggesting that the observed patterns of crisis were not an effect of treatment.[4] These findings lend support to our view that the compromises adopted by families containing a disabled member are organized in a dysfunctional manner and frequently headed for disaster.

Aspects of Treatment

As the reader may have guessed, there is an inherent dilemma in conducting therapy along conventional lines with families of this kind. A majority of professional care-givers enter, knowingly or unwittingly, into a collusion with the family's efforts to maintain a homeostasis in which neither change nor stabilization of the current situation are tenable.

> If one thinks in organizational terms a therapist cannot avoid being part of the family organization. As a therapist talks to a young person about his thought processes he is an outsider dealing with a family member and the organization has rules for dealing with outsiders. If he clarifies family communication, by the act he has become an authority in the family heirarchy. To overlook the organizational situation can lead to naive interventions which prevent change or even make matters worse. In fact, families will make use of a naive clinician to stabilize and avoid change. (Haley, 1981: 29)

Should a professional be successful in creating change in the presenting symptoms, his/her good efforts might bring about a more unmanageable crisis elsewhere in the family system.

> This is illustrated by the case of a client referred to family therapy after eight years of a relatively stable parole. Previously, he had given consistently clean urines and established a positive relationship with his parole officer. The referral was made just four months before the scheduled termination of the parole. At the time, the client had resumed illicit drug use, began missing appointments with the parole officer, and was requesting immediate hospitalization for a nervous condition. When the request for hospitalization was denied, the client, in a panic, asked to be re-incarcerated. The therapist received a number of urgent telephone calls, at odd hours, in which the client expressed fear at what he might "do with himself." The client was then seen with his parents and the parole officer and the immediate crisis was alleviated.
>
> As the client improved in therapy, his mother began to complain of hypertension and his wife began drinking heavily, with periodic blackouts. The client shifted between his own house and his parents' home during this time, depending on which of the women in his life was in trouble. This situation was resolved when the client's father threatened him in an indirect manner, during a treatment session, by expressing his own need to constantly carry a gun to feel safe. After this, the client did not return to the parents' house, and the parents left treatment.
>
> Subsequently, the therapist worked with the client and his own wife toward improvement of their marriage. The wife expressed interference from *her* mother as a source of marital discord. The therapist received a telephone call from the mother-in-law which confirmed this, as the mother-in-law requested assistance in her efforts to "rescue" the daughter from the marriage, and return to live in her home. In a subsequent meeting with the mother-in-law it became clear that her efforts to win her daughter away from the client had failed, and her strategy has already shifted to that of attaining legal custory of the grandson, who she believed was being neglected. The client and his wife were able to resist the mother-in-law and the parole was terminated successfully.

Needless to say, the engagement of this family system with the criminal justice system was intensive and the impending release from parole served to trigger crises at several loci within the extended family. The "solutions" sought by family members at these junctures involved reaching out to new institutions, including the hospital, child welfare, and police department. Schwartzman and Bokos (1979) have described the occurrence of a similar phenomenon among addicts engaged in methadone maintenance programs:

> ...At all clinics, different beliefs about treatment (and ability of staff to tolerate clients' frustration) led to wide differences in constraints on clients, so that the treatment ideology at the level of the methadone treatment system was characterized by dissonances between staff members and clinic treatment ideologies. Such dissonances are almost inevitably amplified and create a social system that is analogous to the addict's natal family, characterized by communicated expectations that the addict be out of control and his own messages that he is out of control and covertly demanding contraints. (Schwartzman and Bokos, 1979: 348)

[2]The pull from the parents often increases with *advancing age,* and is particularly strong on the youngest child, who is the last to leave home (VanDeusen and Urquhart, 1982).
[3]The nature of processes linking psychological stress and sudden and rapid death are discussed by Engel (1971).
[4]Family therapy was in fact correlated with *fewer* critical life events among parents during and after treatment.

A general question raised by such cases is: What constitutes an *appropriate interface* between helpers in the justice system and the complicated interpersonal systems amongst the offender's intimates? We shall address this question by describing several general *modes of involvement* that we have observed in treating over 30 offenders and their families at various stages of probation and parole. It is most useful to view these modes as representing regions along a continuum of *dysfunctional structural arrangements* linking offender, family and institution (Aponte and VanDeusen, 1981). At the most intense extreme are interactions in an "enmeshed-inactive mode," which perpetuate or worsen an already tenuous interpersonal situation. The "separate-active mode," at the other end of the continuum, is characterized by concerned collaboration between professionals and family members, allowing for an effective resolution of developmental issues and change. Between these poles lies a middle-ground comprising an "introspective-reactive mode." These modes are described, respectively, in the following sections.

The Enmeshed-Inactive Mode

In this mode, difficulties emerge from the absence of a capacity on the part of the helper or helping system to maintain a sense of distance and separateness from the troubled client and family. Rather than resolving problems, the helper's actions embed, sustain or exacerbate them. A relevant concept from the family literature in Bowen's (1966) notion of "fusion," which refers to a lack of psychological differentiation among members of a group, demonstrated by continual confusion of roles and responsibilities, lack of autonomy, etc.

> To illustrate this kind of configuration we offer the case of a client with a fifteen year history of psychiatric difficulty. He had initially broken down one semester short of graduation from school, and was arrested for petty theft. Although the family did not seek professional help, the client appeared to recover; he married, and obtained full-time employment. Ten years later, the client was referred to us after a series of involvements with the justice system. In constructing the family history during therapy, it became clear that the initial break had been a response on the part of the threat of a marital separation between his parents, in turn precipitated by infidelity on the part of the client's mother. During the intervening years, the client's own marriage deteriorated, also marked by infidelity on the part of the wife, and was dissolved when the client become re-involved in petty theft, and incarcerated.
>
> Upon his release from prison, the client was assigned to a parole officer, began full-time employment, and re-married, this time to a woman ten years younger than himself. He was committed to "doing it right this time." The parole officer began to stop by the client's home periodically to check on his progress. Since the client was employed, the parole officer usually saw the client's wife in these visits. He described her as "a woman with a heart of gold who did not know what she was getting into" in this marriage. The wife became the parole officer's confidant, as he felt she provided the most reliable information concerning the client's activities. The parole officer benevolently instructed the wife to call him whenever she experienced tension in the marriage, as the officer flet protective toward the young woman.
>
> Several months into his parole, the offender was arrested for acting inappropriately, after breaking into a complete stranger's house. There was no discernible motive for the break-in and, with the parole officer's recommendation, the client was re-incarcerated for a minimal period. We might best comment on this episode by citing Haley:
>
> > Every deviant act is also a message to the member of the group and to outsiders. The act can be seen as a metaphor, often a parody of a theme important to the group. (Haley, 1981:41)
>
> The metaphorical message to the outsider in this offender's behavior is, quite obviously one of acting out the intrusiveness in the system, which could not be resolved via direct communication.
>
> The high level of enmeshment exhibited in relationships of this kind makes it difficult to assess who is actually at fault: the client, for re-enacting his parents' difficulties in his own marriage(s)? The parole officer, for dividing over-protective concern between the client and his wife? Or the wife, for accepting the role of the surrogate monitor, which complemented her husband's abdication of responsibility for direct contact with the parole officer? The problem cannot be reduced to any simple sequence of cause and effect among members of a system operating in an enmeshed-inactive mode, since there is an absence of clear, consistent hierarchies and responsibilities. Constructive action becomes impossible in a system where the boundaries are so unclear, and the first task of treatment is thus to help the helpers escape the fusion via the establishment of rules, roles, and limits.

The Introspective-Reactive Mode

What distinguished the mid-range from the enmeshed-inactive extreme, is a capacity on the part of the helpers to introspect and thereby remain separate from the familial chaos. Where more than one helper is involved, however, there is still a tendency for *fragmentation* between professional helpers, in which each looks to the others as the source of blame for a case not going well. This frequently takes the form of the probation officer blaming the therapist for using the wrong treatment approach with the client; the probation officer or therapist not being sufficiently sensitive to ethnic or social issues affecting the client's adjustment; the professional not having been an addict or an offender and thereby being unable to empathize with the client's condition; or the helper adopting too soft or too firm a stand in relation to the client.

Interactions of this sort frequently become institutionalized as "scapegoat planning," a condition in which each agent expects interference or at least lack of cooperation from the others, and sets its own strategy unilaterally (Breyer and Malafronte, 1982: 655). This climate tends to propagate a *triangulation of conflict* among the professional staff, so intense or extensive that all treatment efforts come to a halt. Examples include: (1) therapist-therapist's supervisor-probation officer; (2) former probation officer-therapist-current probation officer; (3) probation officer-probation supervisor-therapist; (4) local/branch

probation office-central office-therapist; etc. In retrospect, it can usually be shown that these triadic situations among professionals branch off from a primary triangulation involving probation officer-therapist-client. This core triad is similar to the dysfunctional coalition around the "special case," described by Stanton and Schwartz (1954) in their classic study of behavior in the mental hospital. It has been observed by Haley (1967), among others, that this core triangle frequently mirrors the triadic situation existing in the identified patient's family of origin (figure 2).[5]

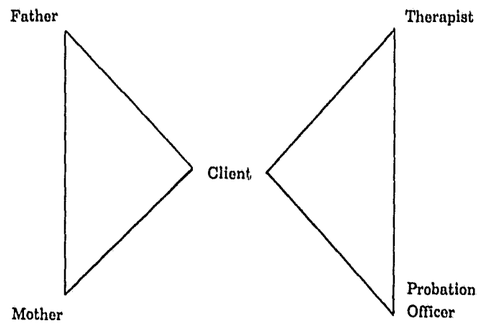

Figure 2. The Core Family Triad and Its Mirror in Therapy

We wish to emphasize that the fragmentation of helpers exhibited in the introspective-reactive mode is not indicative of true separation, but more appropriately viewed as a variant form of *overinvolvement* in the problem; one which can be susceptible to the formation of a dysfunctional homeostasis among institutional systems (cf. Schwartzman and Bokos, 1979). The only therapeutic resolution we have found to be effective in situations where these unfortunate entrapments occur, involves helping the helpers to meta-communicate about the dysfunctional aspects of their interactions with one another, while joining in a united effort a contain and resolve them. The primary focus returns to the client and his/her disability as, by stages, the institutional and familial coalitions are dissolved. This approach is illustrated in the following case:

The client had a fourteen-year history of drug offenses which had led to long periods in institutionalization via probation, halfway houses, outpatient methadone programs, and residential treatment facilities. At the time of referral, this client was in his fifth year of probation, during which time he had been transferred through three probation officers, had periodically resumed illicit drug use, and was unemployed. At referral, it was learned that his term of supervised residence in a halfway house was nearing an end. The therapist, overwhelmed by what she perceived as the probation officer's overinvolvement with the case, suggested that the probation officer become the primary therapist. This was complemented by a genuine interest on the part of the probation officer, in becoming more adept in the practice of psychotherapy. A triadic struggle was thus instituted between the therapist, her supervisor, and the probation officer. This was followed by the therapist's resignation. The supervisor was then left with the case and began seeing the client jointly with the probation officer. After each session, the therapist/supervisor and probation officer would discuss their countertransference interactions, as a way of assessing how the client might be re-enacting the triadic conflicts within his family of origin (keeping in mind, that the client was anticipating reunification with his parents). For example, the therapist noted that the probation officer's efforts to help the client were frequently met with provocation from the client. The probation officer would then vacillate between overprotectiveness and vindictiveness, as the client tried to back out of the confrontation.[6] The therapist, on the other hand, tended to remain aloof and confused.

The therapist and probation officer then began discussing these issues in the presence of the client, and the client's functioning within the halfway house improved somewhat. Substantial change occurred only after the client was discharged to his parents' house, and the same kinds of interactions were confronted directly in the family during conjoint therapy sessions. This involved *disengaging* the client from a hostile, dependent relationship with his mother; confronting father's aloofness during disputes between his wife and son; and getting the parents to work together on the matter of their son's assuming a more responsible and independent place in the community.

The Separate-Active Mode

This least dysfunctional mode of family-institutional involvement is characterized by clear boundaries between professional agents and family members; clear assignment of responsibilities; and a collaborative effort between all parties toward the goal of increased autonomy and responsibility on the part of the offender. The responsibility for the difficulty/disability and for change are initially placed with the offender. Although the client is required to attend treatment as a part of the probation/parole, it is pointed out that he placed himself in the present situation and it is only through his efforts *at this time* that treatment will be effective.

Family therapy is sometimes offered to the parents as a final alternative to incarceration of the son or daughter. Frequently, the therapist allies with the parents (and probation officer, in his/her "rehabilitation" role) in a strategy of the family's demonstrating to the judge or parole board that they can be responsible (effective) around significant parameters of change, such as drug abuse, thereby obviating the need for incarceration.[7] We have found that the effectiveness of this intervention is largely determined

[5]In our view, this process of triangulation recurring across contexts may be equated with the phenomena of *countertransference*, described in the psychoanalytic literature (cf. Grindberg, 1979).

[6]This mixing of contrary roles is inherent in the probation officer's job, as the agent designated by the justice system to both *assure compliance* with the sentence (punishment), and *cultivate reform* (rehabilitation).

[7]It is interesting to note that the device of inducting the family as an agency of diversion and rehabilitation is entirely absent in the criminological literature. Trends in rehabilitation programs have oscillated between individual and group modes of therapy and counseling, without any recognition or use of "natural resources" in the client's social system.

by the ability of the therapist to contain and resolve within the family, the turmoil that can be expected to ensue after any noticeable improvement on the part of the offender. Such progress generally indicates that increased movement toward separation will follow, perturbing the family homeostasis and thereby increasing uncertainty and stress among the other family members.

Treatment of families operating in this mode achieves success when the detouring of family conflict through engagement of the justice system is blocked, and developmental issues within the family (frequently "frozen" since the time of the client's initial difficulty) are resolved. The following case illustrates effective intervention with a system functioning in a separate-active mode.

The client is a 28-year-old male, who was first arrested while a senior in high school. His father had died when the client was 14, and before that time the client had done well in school and was relatively happy with his family life. Following the father's death, the client's mother became involved in a series of bitter arguments with her own mother, who had insisted that the family move into the grandmother's residence. As is typical of many families with an addicted member, issues of separation and individuation had not been resolved between the parents and extended family members (Bowen, 1974; Carter, 1977).

The client's mother's amplifying struggle for her own autonomy was stabilized when the client attracted the attention of school officials for his truant behavior and suspected drug abuse. His behavior improved for a short period of time following the mother's re-marriage. However, the client soon found himself in the position of being mother's confidant, and his drug abuse seemed to oscillate in step with her discord either with the stepfather, or her mother (figure 3).

This tenuous situation amplified to the point of the client's incarceration. This served to stabilize the whole family situation, as any disagreement within the family became secondary to the rather disastrous predicament of the young man in relation to the justice system.

Following the client's release from prison, the family attempted to get him back onto his feet without professional help. The client began working with the stepfather and was soon married to a recent divorcee who had two children from her first marriage. Although the family's efforts were genuine, untenable coalitions remained in force, which were only resolvable with outside, professional intervention. Specifically, the client failed to perform on the job, partially as an expression of his own vengeance toward the stepfather, but also in response to the mother's undercutting of the stepfather's efforts. Her own ambivalence in the marriage took the form of soliciting rescue, then sabotaging it, a pattern to which both the client and stepfather fell victim. Secondly, the client's marriage became the container of the family's unresolved grief over the death of the father. The mother saw in the client's wife aspects of herself that she had not grieved since her first husband's death. The couple were thus placed in the untenable position of having to keep alive the idealized memory of the mother's first marriage. Thus, the client found himself at times, as he described it, "acting like his father and his stepfather." He also remained in the position of rescuing, through his own failure, three unhappy women: grandmother, mother, and his own wife.

The therapy followed two stages: resolution of the dysfunctional coalitions in the family system which maintained the client's failure; and individual work with the client to resolve issues of grief and intimacy. The parents, the client and his wife were initially seen jointly with the probation officer, who clarified for the family the requirements of the client's parole: that he maintain full-time employment, drug-free status and attend weekly therapy sessions. The client's history of entanglements in the parents' problems was quickly identified, and it was agreed that the parents would continue in therapy until this was resolved. The client began full-time employment and the family situation appeared to stabilize although at this point the client began missing sessions.

The parents were then excused from treatment, and the client was seen with his wife and the probation officer. The wife then alleged that the treatment was pulling the marriage apart. The probation officer's insistence that the client remain in therapy was met with resistance, although the client continued to attend sessions individually. What emerged at this stage was the client's regression within therapy to a point in development preceding his father's death. This was accompanied by a desire to move back into his mother's house. The futility of this isomorphic rescue operation was explored with the client, the therapy at this

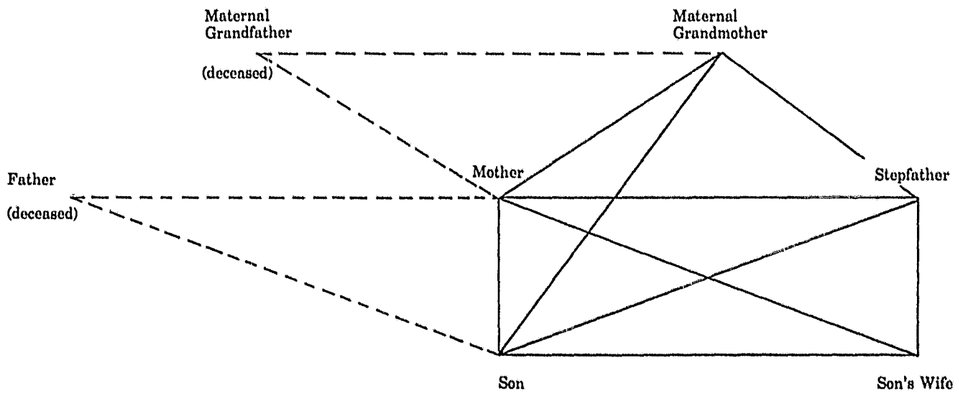

Figure 3. The Dysfunctional Sequences Linking Client, His Wife, Stepfather, Mother, and Grandmother.

point providing a *holding environment* which protected the client from the homeostatic pull of the family of origin (Winicott, 1965). This facilitated the client's grieving his own father's death and, consequently, the grieving of an isomorphic structure which had been kept alive in the family of origin since the father's death (Boszormenyi-Nagy and Spark, 1973). The grandmother experienced a brief psychotic episode at this time, and was hospitalized. The unfortunate occurrence provided an opportunity for mother and grandmother to resolve their own issues of separation and individuation, promulgating in the mother the capacity to be more committed to her marriage. The client began to empathize with the stepfather's plight, and was in some ways able to achieve a reparation with him through his experience as a stepfather in his own marriage. Resolution of the client's grief over his own father's death was followed by an increased awareness of his own need to be a father, and a capacity for more commitment in his marriage.

In this case, it may be seen that what had been a homeostatic family structure in which the client had assumed an *institutional identity*, evolved into a growing interpersonal system, consummated by the client himself becoming a father. This process exemplifies a condition of systemic, "second-order" change, to be distinguished from localized, "first-order" cessation of symptomatic behaviors (Watzlawick, Weakland and Fisch, 1974). We hope that the case illustrations offered here have shown how interventions aimed at the latter, which do not take into account the interpersonal context in which a disability has become seated, can be insufficient or even counterproductive.

Conclusion

In closing, we would caution that the aim of the present report has been to provide the reader with a sense of the plausibility of our conceptualization of certain modes in which disability and treatment can be organized in an institutional context. We recognize a need for further development and substantiation through formal research, and hope to report on the results of such studies in the future.

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Toward an Alternate Direction in Correctional Counseling

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Counseling in a correctional setting is a most difficult task. Usually the correctional facility is not especially conducive to voluntary cooperation or as an inducement for personal change in the direction of prosocial values. The correctional client often sees no difficulty in his life other than his present incarceration. In addition, the problem of authority inherent in the role of the correctional counselor has never been truly resolved (Hamilton, Smith and Berlin). Delving into the realm of the underlying factors which have resulted in his criminality is largely ignored because of practical considerations of the time and the place in addition to the lack of professional training of many correctional therapists. Too often the counseling session takes the form of asking predictable questions which elicit predictable answers. When the counselor hears from his client, "I am beginning to cope with my problems," he can be assured that the latter is apeing key words to impress the therapist. Such "in" words are often used by correctional clients, and the counselor is trapped into believing that rehabilitation is not only taking place but a great deal of credit must go to him because of his expertise as a therapist. As can be seen, games are played, and both are losers in the exchange.

Historically, correctional counseling has been mired in the medical model no doubt in part because of its close affiliation with the social work profession. Because of the philosophy of the medical model concerning rehabilitation, the correctional client is termed "sick." He is sick because he has violated society's norms and values as evident in the criminal act. After all, it is assumed that no "well" person will commit a crime.

> The most fundamental requirement for further research on the effectiveness of prison and parole programs would seem to us to be a frank recognition that psychological treatment programs involve assumptions about the causes of crime, the informal and formal organization of the prison and parole, and the nature of the post-release experience, all of which may b quite unrealistic when applied to actual existing conditions. (Kassenbaum, Ward, and Wilner)

Valuable time has been spent in therapy attempting to come to grips with extant problems because of past familial situations, unresolved complexes, or sibling rivalries. The unconscious has traditionally played an important role in the understanding of the problems of the criminal, and following this approach through catharsis he will be rehabilitated and returned to society as a contributing member of the community.

Regardless of the claims made the psychiatrists, psychotherapists, or other adherents of the psychodynamic model, it can be safely stated that the success rate predicated upon treatment has not been overly successful. Martinson stated:

> With few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effects on recividism. (Martinson)

Vocational and Academic Counseling

Not all counseling takes the form of a psychological/psychiatric inventory. Vocational education can be successfully argued as a form of counseling. It lacks in essence the traditional structure of a counseling session, and the focus of its interest in obviously practical and job-related. However, there are many vocational programs which are so poorly instructed, the materials sorely antiquated and consequently useless, or ideas and techniques equally antiquated and useless, that the training does not adequately prepare one for a job outside the prison walls. For example, auto mechanic classes in prisons are too often taught with instructional materials which resemble little the modern equipment in a sophisticated garage or the maze of gears, pumps, or wiring of a high-powered automobile. Of course, making license plates, leather wallets or purses can pass the time inside the walls, but it does little to prepare the person for a life-surviving job on the outside. But the values regarding the work ethic and ideals connecting work and reward are manifestly instructed.

Academic education inside the prison can also be seen as a form of counseling. Because many academic programs are for the most part remedial and geared to residents with limited formal education, it can do little to prepare a person for accepting a fulfilling position in society (Evans). Too many immates are years behind in their education, possess few skills necessary for learning, and are poorly motivated to advance in their educational career. Some residents attend school only because it may impress the parole board. However, it is within this setting that acceptable

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