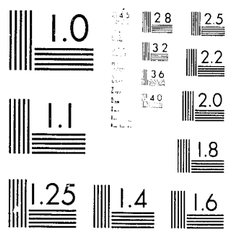




# Federal Probation



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JUNE 1981

Federal Probation is published by the Administrative Office of the United States Courts and is edited by the Probation Division of the Administrative Office.

All issues of rehabilitative and correctional activities in delinquency and crime come within the fields of interest of FEDERAL PROBATION. The Quarterly wishes to share with its readers all constructively worthwhile points of view and welcomes the contributions of those engaged in the study of juvenile and adult offenders, Federal, state, and local organizations, institutions, and agencies—both public and private—are invited to submit any significant experience and findings related to the prevention and control of delinquency and crime.

Manuscripts (in duplicate), editorial matters, books, and communications should be addressed to: FEDERAL PROBATION, Administrative Office of the United States Courts, Washington, D.C. 20544.

Subscriptions may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, at an annual rate of $8.00 (domestic) and $10.00 (foreign). Single copies are available at $3.00 (domestic) and $3.75 (foreign).

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FEDERAL PROBATION QUARTERLY

Administrative Office of the United States Courts, Washington, D.C. 20544

# Federal Probation

A JOURNAL OF CORRECTIONAL PHILOSOPHY AND PRACTICE

*Published by the Administrative Office of the United States Courts*

VOLUME XXXXV JUNE 1981 NUMBER 2

## This Issue in Brief

***A Revisionist View of Prison Reform.***—According to Professor Hans Toch, the assumption that prisons are here to stay suggests new directions for prison reform. Among these is the amelioration of stress for those inmates who because of special susceptibilities and/or placements in prison are disproportionately punished. A classification process that is attuned to inmate coping problems can make a considerable difference, he asserts. In addition, the constructive critic of prison life (as opposed to the nihilistic one) can help prison staff and their administrators run more humane institutions.

***A Positive Self-Image for Corrections.***—The tendency of corrections workers to be apologetic about their work has been a self-defeating characteristic for many years, writes Claude T. Mangrum of the San Bernardino County Probation Department. This tendency, he says, is the result of a poor self-image and it is high time corrections professionals acted to improve this image. The importance of a positive self-concept is discussed in his article.

***Changes in Prison and Parole Policies: How Should the Judge Respond?***—Anthony Partridge of the Federal Judicial Center reminds us that, although sentencing marks the end of a criminal proceeding in the trial court, a sentence of imprisonment is also the beginning of a process presided over by prison and parole authorities. To a substantial extent, the meaning of such a sentence is determined by these authorities. Their policies, therefore, have implications for the performance of the judicial role—both for the duty to select an appropriate sentence and for the duty to ensure procedural fairness.

***Federal Court Intervention in Pretrial Release: The Case for Nontraditional Administration.***—One of the most unique and comprehensive class action suits involving a major jurisdiction in the United States (Houston, Texas) is the case of *Alberti* v. *Sheriff*. In December 1975 U. S. District Judge Carl Bue, Jr., issued a sweeping order directed at improving the operation of the pretrial release programs and streamlining other criminal justice procedures to relieve overcrowding and improve conditions of the county jail. This article, by Gerald R. Wheeler, director of Harris County Pretrial Services, describes the pretrial

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# Restraints: Therapeutic Transition Following Application

BY SHELLE G. DIETRICH, PSY.D.
*Clinical Psychologist, Federal Correctional Institution, Lexington, Ky.*

CULTURALLY, the penal institution serves as a repository for people sentenced by the court to serve a period of confinement. Offenders are sentenced by the court for several reasons: "(1) as punishment for their crimes, (2) to incapacitate them from committing further criminal acts, (3) to deter both themselves and others, (4) to provide them opportunities to change their lifestyles."[1] For these diverse reasons, a rich variety of personality styles is assembled within each institution. One subset of the institutional population is the group of people who have a ready tendency for emotional outbursts. These outbursts may stem from a variety of psychological origins which vary from psychotic delusions of persecution, to the antisocial person's propensity to feel unjustly wronged, to the neurotic person's displacement of long-standing anger from a past source to a present recipient. For whatever reason, in penal institutions, incidents occasionally occur in which an inmate becomes extremely angry and threatens the welfare of others, self, or proceeds to destroy property. On these occasions, the issue of restraining the inmate arises.

The Federal Prison System has a long, established history of attempting to create as humane an institutional environment as possible. With the issue of restraining an inmate, the Federal System's policy is that restraints may be applied in cases "when an inmate presents himself as a danger by assaulting staff, destroying government property, attempting suicide, or inflicting wounds upon himself, or displays signs of this imminent violence."[2] The term "restraints" usually means metal cuffs or leather bands which are secured to the inmate's wrists and ankles and attached to a hospital bed. At no time are inmates restrained to fixed objects such as cell doors. The policy states further that medical and mental health personnel be contacted and assume responsibility for the inmate. It is stated that, "The use of restraints should be viewed as a last resort and where other means of effective control have failed or are impractical."[3] Normally, the use of restraints does not exceed 8 hours. If restraints are needed beyond 8 hours, the inmate is placed under the supervision of the Medical personnel and the Regional Director is telephonically notified, followed by proper documentation. Guidelines concerning rotation of the inmate's position and examinations every 30 minutes are established.

Such guidelines to promote the minimal use of restraints and the maximal insurance of avoidance of abuse promotes humanitarian management and insurance of inmates' rights to humane treatment. As directed by policy, Federal correctional professionals use the method of restraints only as a last resort, after other methods to subdue the inmate have failed. It is the purpose of the present article to describe a recent case in which the use of restraints was indicated. The case history will be presented to demonstrate the enormous rehabilitative challenges presented to penal institutions. The progress of the beginning phases of treatment and the methods of management of the inmate's increasing degrees of rage will be described to demonstrate how each crisis intervention occurred with incremental increases in environmental security. Finally, the therapeutic transition following the application of restraints will be fully described as this step formed a basis for positive therapeutic interaction in later treatment stages.

### CASE HISTORY

The inmate is a 34-year-old Black female who was originally committed to a Federal facility for a sentence of 1-9 years 4205(b)(1) for Assault on a Federal Officer. She had previously been ordered to be evaluated at a local psychiatric hospital where she was found to be competent to stand trial after a 1-month evaluation. The inmate had reportedly been previously hospitalized at the local hospital on numerous occasions, but would be discharged, discontinue psychiatric medication, and not pursue outpatient care.

After 6 months at the Federal facility, the inmate was diagnosed as paranoid schizophrenic

[1]Norman A. Carlson, "Presidential Address." Paper presented at the annual meeting of the American Correctional Association. Philadelphia, 1979.
[2]Bureau of Prisons, U.S. Department of Justice. FPS 5566.1 "Use of Force and Application of Restraints on Inmates."
[3]*Ibid.*, p. 3.

TABLE 1

| | | |
|---|---|---|
| AGE: 7 | Habitually so deports herself | No petition |
| 9 | Petit larceny | No petition |
| 9 | Without adequate parental care | Commit to Dept. of Public Welfare |
| 9 | Petit larceny | No petition |
| 9 | Without adequate parental care | Commit to Dept. of Public Welfare |
| 11 | Petit larceny | Indeterminate commitment to Dept. of Public Welfare |
| 13 | Housebreaking | No petition |
| 15 | Disorderly Conduct | No petition |
| 16 | Disorderly Conduct | No petition |
| 16 | Petit larceny | Indeterminate probation |
| 17 | Unauthorized use of auto | No disposition known |
| 17 | Destroying DC property | Petition filed |
| 18 | Dismissed from probation | |
| 20 | Petit larcency (shoplifting); | Not guilty |
| | Robbery (force and violence); | Nolle prossed |
| | Simple assault; | 120 days |
| | Simple assault; | Not guilty |
| | Petit larceny | 120 days |
| 24 | Petit larceny | $25/10 days; ESS—1 yr. probation |
| 24 | Burglary III; | Nolle prossed |
| | Unlawful Entry; | 1 year probation |
| | Attempted Burglary II | 1 year probation (concurrent) |
| * She successfully completed the probation even though while under supervision she was unemployed and was rearrested on the charges below: | | |
| 25 | Attempted Robbery | Dismissed |
| 25 | Bench warrant—Bail Reform Act | 9 mos.-3 mos.; work release |
| | (failed to appear in court) | 6 mos.; suspended 1 yr. probation |
| * She failed to participate in drug treatment as ordered and was generally uncooperative with the probation office. | | |
| 28 | Bench warrant—Bail Reform Act | Probation revoked |
| * She did not appear in court for revocation of probation and was arrested at her home. | | |
| 28 | Assault with dangerous weapon (razor) | No papered |
| 28 | Bench warrant—Bail Reform Act | No papered |
| 29 | Assault with dangerous weapon (rod) | 1SS; 2 years probation |
| * Probation expired even though two rearrests occurred while under supervision and she did not participate satisfactorily in a narcotics treatment adm. program and psychiatric treatment. | | |
| 30 | Assault with dangerous weapon (knife) | 5 years probation |
| * Special probationary conditions included (a) out-patient treatment at St. Elizabeths Hospital; (b) reside with father; (c) curfew set at sundown unless with father; and (d) use medication prescribed by doctor. | | |
| * She violated all probationary conditions except the one requiring that she live with her father. She was rearrested four times yet no action for revocation was taken pending disposition of the new charges. | | |
| 31 | Simple assault | 1 year; ESS—2 years |
| | Possession of prohibited weapon | Nolle prossed |
| | Assault with a dangerous weapon (knife) | Nolle prossed |
| | Carrying a dangerous weapon | Nolle prossed |
| * The execution of sentence was suspended and she was placed on probation for 2 years with special condition of outpatient treatment at St. Elizabeths Hospital with participation in a narcotics treatment adm. program. | | |
| 32 | Unauthorized use of vehicle | Dismissed |
| 33 | Disorderly conduct | Nolle prossed |
| 33 | Assault on Federal officer; | Instant offense |
| | Assault with dangerous weapon; | Instant offense |
| | Mayhem | Instant offense |
| * She was being held in jail for disorderly conduct and stabbed a Federal officer in the eye with a pencil. One month later, she was found to be competent and sentenced to 1-9 years at a Federal institution. | | |

and transferred to another Federal institution for psychiatric evaluation. The referral summary stated that she had attacked a guard, displayed flat affect, alternated between intense and avoidant eye contact, and was noncooperative most of the time. After transfer, she was placed on Haldol 30 mg., q.i.d., and after 1 month, was transferred to the Female Psychiatric Unit, Lexington, Kentucky, for long-term intensive psychotherapeutic care. In the presentence investigation report for the instant offense, the inmate was described as "a threat to society who will continue inflicting her violent behavior upon others as long as she wishes." A summary of her ineractions with the judicial system is presented in table 1.

Sometimes, a historical review of the judicial system's attempts to deal with public offenders can prove to be an embarrassment as evidenced in the judicial history of the present case. Frequently, "more of the same" sort of solution is attempted even after repetitive failures. Sometimes, the reason for failure is placed on the offender who is viewed as "unmotivated," "uncooperative," or "resistive," yet the actual

burden of responsibility must always remain with the professional person whose task it is to discover what might be rehabilitative. In the present case, the inmate had endured many therapeutic efforts and was once again referred for intensive psychotherapeutic intervention.

When the inmate arrived at the Female Psychiatric Unit, she appeared to be in contact with reality in all perceptual spheres. That is, she knew where she was, what date it was, and what time it was. She did not appear to be assaultive and was placed on a closed ward with other inmates. The psychotropic medication was discontinued in order to evaluate her psychological status without the influence of psychotropic medications. She communicated some inappropriate statements such as calling the staff by titles of relatives (Mom, sister, aunt) and seemed confused at times as to whether the person was actually her relative or only physically resembling her relation. Although this behavior indicated psychotic confusion and thought disorder, it also was viewed as a way of attempting to establish interpersonal contact which was a good prognostic sign. She was very cooperative in dealing with staff and taking psychological examinations. However, the inmate took the psychological tests as a child plays as if they are at school. She sat at a desk, worked very diligently, was absolutely serious in her endeavors, and seemed to enjoy the aura of "hard work." However, her marking of responses regressed at times to marking circles (true or false) as if she were coloring and not reading each item. She would then read a few questions and revert back to coloring. Nothing was said to her concerning her testing behavior since she seemed to be genuinely working and any mention of her behavior was thought to have been taken as a narcissistic injury. That is, she would have felt abused, berated, and the relationship with the examiner would have been damaged.[4]

She initially tried to identify, or associate herself, with "goodness." She wanted to attend religious services which she attended with staff escort, she wanted to drink sugar water (incorporation of sweet, good items), and requested enemas (getting rid of "bad stuff"). She tried to believe that she was a good person and was normal. She was appropriate in interpersonal interactions with staff, on her escorted trips in the main institution, and in the ward community meetings. She was able to discuss fairly complex interpersonal interactions and seemed to be adapting to the unit very well.

One month after her arrival, however, an outburst occurred. The inmate had been required to deal with many institutional limitations. During this period of evaluation, she was required to wait for increased institutional privileges such as eating in the main institutional dining room and movement without staff escort, the beginning of employment, and the interviewing by legal counsel. Although some delays were minimal, such as two days, the waiting seemed enormous to the inmate. When the unit manager notified her that the legal counsel would be breaking his appointment and would see her the next day, the inmate became irate, threw a milk pitcher on the floor, and began to throw objects at the television set and around the room. Additional staff were summoned, the inmate retreated to her room, and was eventually talked into moving to the second floor of the unit where more secure individual rooms are available. No force was needed to make the move, and her outburst was viewed as a psychotically based incapacity to wait rather than a break of contact with reality.

The inmate remained on the second floor for 6 days and seemed to function acceptably until she was denied cigarettes. She had chosen to spend her commissary monies for food and cosmetic items rather than for cigarettes. The unit staff attempted to discuss the possibility that if she did not purchase the cigarettes, she would feel deprived and angry but she stated that she was giving up smoking. When she ran out of cigarettes, and the unit staff refused to supply them for her, she became enraged, demolished her cell, broke cosmetic items against the wall, and then set fire to her mattress. She was immediately removed from her cell and quickly taken across the hall to a clean cell without undue struggle. She then proceeded to tear up the clean cell, destroy the mattress, and dent the furniture. After her rage had subsided, the damaged items were removed from her cell, and she was left with a pallet of torn up mattress padding and a sheet which she preferred to a new mattress and with which she seemed quite content. Clinical staff would periodically join her in the cell on her pallet and discuss the state of affairs with her.

At this point, the inmate was viewed as a person in the progress of regression and the staff made interpersonal contact with her at each stage of disintegration.[5] As clearly supported in the professional literature, many patients must become more ill before they can get better.[6] The inmate's desire for the soft, ambiguously formed pallet versus the new mattress was meaningful therapeutically and her process of regression may have stopped at that point. However, the next day, she once again became agitated when the unit staff would not allow her to go to work. She paced the floor, and began to throw water out the window of the cell door. The water was shut off, and the psychiatrist joined her in the cell to discuss the administration of medication. Additional staff were summoned in case of assault, yet she agreed to go with the psychiatrist back across the hall to a new clean cell. However, when she learned that she would receive antipsychotic medication, she became assaultive and had to be placed in restraints. She was restrained to the bed by her gauze-wrapped ankles and wrists and Prolixin Enanthate, 2 cc, IM, was administered.

Such a case history demonstrates only one example of the many clinical challenges which are presented to penal institutions. The provision of graduated levels of environmental control exemplifies the correctional system's efforts to humanely deal with individuals who for pathological reasons become agitated when faced with environmental frustrations such as limitations which more healthy individuals would be able to sustain, understand, and tolerate. In such an example as described in the above case history, once the environment is maximally secure, that is, after the application of restraints, the therapeutic efforts continue. It is in this transition from maximal safety that the present case example is most instructive.

After the restraints were secured, the mental health professionals then remained with the inmate for the next 5 hours. It is this phase which seems to have been vital to the following positive therapeutic improvements. When the inmate was first restrained, she was completely and ruthlessly rageful, screamed obscenities, and spit at all available human targets. Two of the mental health professionals remained with her and attempted to maintain a distance out of spitting range but within interpersonal contact. She initially espoused murderous intentions which gradually subsided after an hour and a half. During this time, she was intermittently only told that she would not be abandoned. She became fatigued and gradually her anger began to subside. The mental health professionals kept fairly silent with an atmosphere of stability and nonintrusiveness. The atmosphere of a "holding environment" was created along the lines described throughout the writings of D. W. Winnicott.[7] The "holding environment" is described as one in which there is a provision of a stable though personal environment which is interpersonally warm with protection from the unexpected and unpredictable. The environment is reliable and good things (e.g., food, therapeutic interpretations) are provided according to the patient's felt need and ability to use them. There is a deep, accurate, and timely understanding and conveying of knowledge about the patient's deepest anxiety that is experienced, or that is waiting to be experienced. Such an environment protects the patient against feelings of abandonment, provides solidarity and safety for the patient to endure intense hatred and rage, and helps the patient to build up a belief in a benign environment. As the day progressed, the inmate was willing to eat dinner and was fed by the professional person.

The next day, the restraints were lengthened to allow for greater movement yet the inmate continued to be fed by the therapist even though, practically, she could have fed herself. She seemed to enjoy the nurturance and the restraining factor became an enjoyed reason for her to be waited on. She seemed to be playing "sick patient" and enjoyed the special attention and care. Shortly thereafter, she was released from restraints with continued close interpersonal contact with her primary therapist. The inmate states that the foundation of the therapeutic relationship lies in the therapist's living through her most rageful period. The lack of the therapist's being able to be "scared off" and the refusal of abandonment has established a solid beginning to long-term treatment. There are certainly many additional therapeutic stages through which the therapist-patient dyad will proceed. Such major therapeutic landmarks for this particular patient include the merger of "good" and "bad" people in order to establish and be able to bear ambivalence towards others, progression through the stages of depression, and the establishment of solid, realistic interpersonal relationships.[8] Yet these later stages of development could not be solidified without the establishment of the basic trust

[4]Of course, the initial test results were invalid. Subsequent psychological testing was conducted 3 months later when the inmate was better able to maintain reality contact and valid results were obtained.

[5]J. LaPlanche and J. B. Pontalis, *The Language of Psychoanalysis* (New York: W. W. Norton & Co., Inc., 1973). Regression is defined as "a reversion to earlier forms in the development of thought of object-relationships or of the structure of behavior." In the present case, "regression" is used in a formal sense to describe a transition to modes of expression and thought that are on a more primitive level than normal functioning.

[6]D. W. Winnicott, *Through Paediatrics to Psychoanalysis* (New York: Basic Books, Inc., 1975).

[7]*Ibid.*, p. 174.

[8]These major therapeutic landmarks are based on object-relational models as described in the following references: H. Guntrip, *Personality Structure and Human Interaction* (New York: International Universities Press, Inc., 1961). O. Kernberg, *Object-Relations Theory and Clinical Psychoanalysis* (New York: Jason Aronson, Inc., 1976). H. Kohut, *The Analysis of the Self* (New York: International Universities Press, 1971). D. W. Winnicott, *The Maturational Processes and the Facilitating Environment* (New York: International Universities Press, 1961).

achieved by withstanding the inmate's most intense rage and hatred.

Many contributions have been offered concerning infantile and psychotic anger.[9] All are in agreement, however, that in such states a person is in a state of infantile helplessness. Isolation at these times only promotes the pathology which is derived from infantile reactions to abandonment. The presence of another, however, must be of a special type. The person must provide a "holding environment" while protecting the safety of the patient and others. The rage must be lived through with the primary therapist until reparation begins.[10] At that time, the patient is ready for re-establishment of positive relationships whereupon the staff person may once again become the provider of good things.

[9] H. Guntrip, *Schizoid Phenomena, Object Relations and the Self* (New York: International Universities Press, 1969). M. Klein and J. Riviere, *Love, Hate and Reparation* (New York: W. W. Norton & Co., Inc., 1964). H. Spotnitz, *Modern Psychoanalysis of the Schizophrenic Patient* (New York: Grune & Stratton, 1969).

[10] The term "reparation" was originally used by Melanie Klein to describe the mechanism whereby the patient seeks to repair the effects his destructive phantasies have had on his love-object. For further explanation of the term, see J. LaPlanche and J. B. Pontalis, *op. cit.*, note 5.

### *Summary*

A case is presented of a 34-year-old Black female who was admitted to the Female Psychiatric Unit with a diagnosis of paranoid schizophrenia. After 1 month, she became assaultive and gradually deteriorated to a state in which restraints were needed. The process of her rage, the descriptions of her anger, and the method of staff intervention are discussed. The crucial part of the therapeutic endeavors has derived from the staff's unwillingness to desert her during the height of her rage. Such interaction formed the basis for future therapeutic stages which are summarized.

# The Juvenile Court Needs a New Turn

BY SOL RUBIN

*Counsel Emeritus, National Council on Crime and Delinquency*

THE BY NOW "old" juvenile court system has in its history been subject to considerable criticism and attack. The criticism, not much noticed when an occasional article or state court decision complained that neither the child nor the parent received even a semblance of due process before the court or other elements of the juvenile justice system,[1] startled the juvenile court judges when the Supreme Court of the United States rendered decisions in the same vein. The first decision, in 1962, condemned confessions obtained by "secret inquisitorial processes" as suspect, especially so when applied to a 14-year-old boy.[2] This did not touch the juvenile court directly, but presently others did.

In 1966, in *Kent* v. *United States*,[3] the Court reversed a conviction in a case transferred from juvenile to criminal court in accordance with the statute. It held that required elements of due process and fairness had not been met; it required a hearing, effective assistance of counsel, and a statement of reasons. The storm came over the following language in the decision: "There is much evidence that some juvenile courts, including that of the District of Columbia, lack the personnel, facilities, and techniques to perform adequately as representatives of the State in a *parens patriae* capacity, at least with respect to children charged with law violation. There is evidence, in fact, that there may be grounds for concern that the child received the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children." The next case, *In re Gault*,[4] generated even more excitement, yet its holding broke no new ground, and any other decision—once the Supreme Court took the case for review—could hardly have been expected.

The case is really of significance for its bringing to attention the still prevalent paternalistic (autocratic) pattern of the juvenile courts, what Roscoe Pound called "star chamber." The Arizona Supreme Court upheld a commitment, to age 21, of a 15-year-old boy who was alleged to have made a lewd telephone call to a neighbor. The complainant was not present at the meeting; the adjudication was based on the judge's statement that the boy had admitted making some of the

[1] H. N. Lou, *Juvenile Court Laws in the United States (1927).*
[2] Gallegos v. Colorado, (370 U.S. 49 (1962).
[3] Kent v. United States, 383 U.S. 541 (1966).
[4] In re Gault, 387 U.S. 1 (1967).

END