

PSYCHOSOCIAL ONCOLOGY: MANAGING CANCER-RELATED DISTRESS IN ADULT CORRECTIONAL SETTINGS

Carolyn H. Suppa, Ed.D., Jess Grayson-Luzier, Ph.D., and John C. Linton, Ph.D. —
Contact: carolyn.suppa@camc.org

ABSTRACT

Rates of chronic illness, including cancer, are higher in prison populations than in the general public. Considering the greater incidence of cancer and the recognized burden of cancer-related emotional distress, mental health providers in correctional settings must screen for emotional distress and develop an array of evidence-based interventions and services for inmates with cancer along the cancer trajectory. Distress is considered a normal response to every aspect of the cancer trajectory and generally is used to describe a wide range of unpleasant feelings or emotions. Distress also may affect thoughts and behavior and interfere with coping abilities. The *NCCN Distress Management Guidelines* from the National Comprehensive Cancer Network (NCCN) are presented for their use in correctional settings, and evidence-based therapeutic interventions within the field of psychosocial oncology are discussed.

MANAGING CANCER-RELATED DISTRESS IN ADULT CORRECTIONAL SETTINGS

Treatment of clients with cancer has been a burgeoning area with which clinical psychologists have had to become familiar. More specifically, prison populations are an important focus of intervention because of inmates' increased propensity for and incidence of severe medical problems, including cancer. Individuals in prison often come from disadvantaged backgrounds (Markman, 2007), and living in poverty is accompanied by a myriad of health risk factors. Thus, inmates often have been exposed to a greater quantity and severity of risk factors for cancer, including carcinogen exposure and exposure to viruses (Mathew, Elting, Owen, & Lin, 2002). Because of the substantial stressors and adjustment difficulties associated with cancer, it is important for psychologists working in correctional settings to understand the psychological sequelae of treatment for inmates with cancer. The following article will first provide an overview of

chronic health problems (specifically cancer) and medical treatment in correctional settings. Next, cancer related distress will be discussed, including symptoms, etiology, and evidence-based assessment tools. Finally, psychosocial treatment interventions specific to cancer patients in correctional settings will be reviewed.

RATES OF CANCER IN CORRECTIONAL SETTINGS

Inmates tend to have higher rates of chronic illness, including cancer, than their age-

“Distress is a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional) social, and/or spiritual nature that may interfere with the ability to cope...with cancer, its... symptoms, and its treatment.”

matched non-incarcerated peers (Markman, 2007). A recent survey considered the prevalence of chronic physical and mental illness as well as access to care among U.S. inmates (Wilper, Woolhandler, Boyd, Lasser, McCormick, Bor, et al., 2009). The study used data from the U.S. Bureau of Justice Statistics Surveys: the *2004 Survey of Inmates in State and Federal Correctional Facilities* and the *2002 Survey of Inmates in Local Jails*. Demographic features of the sample indicated that most respondents were male, under 35, of minority racial backgrounds, and parents of minors at the time of incarceration. Results demonstrated that inmates had rates of diabetes, hypertension, heart problems, cancer (including breast, cervical, colon, leukemia, lung, ovarian, prostate, testicular, and uterine), stroke, brain injury, kidney

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problems, liver problems, and asthma at higher rates than age-standardized controls from the general population. Clearly, a broad view of medical issues in inmates demonstrates that this population is at greater risk for the development and maintenance of serious and chronic medical problems than non-incarcerated populations.

Less research has focused specifically on cancer in prison populations, but early epidemiological reports suggest that incidence and mortality from cancer is higher in inmates. Mathew, Elting, Owen, and Lin (2002) reviewed a retrospective cohort of over 1,800 inmates diagnosed with cancer in the Texas Department of Criminal Justice from 1980 to 1999. Results demonstrated that prison populations had a significantly greater risk of being diagnosed with lung cancer, non-Hodgkin's lymphoma, cervical cancer, or oral cavity/pharynx cancer than matched controls. Furthermore, prison populations were more likely to die from lung cancer, non-Hodgkin's lymphoma, liver cancer, oral cavity/pharynx cancer, or Kaposi's Sarcoma than the control group. Another study using information from the Texas Department of Criminal Justice from 1992-2003 demonstrated that liver cancer death rates increased by an average annual 6.1% among male inmates, compared to 2.0% state average and 2.9% U.S. average (Harzke, Baillargeon, Goodman, & Pruitt, 2009). The authors concluded that male inmates in Texas were between 4 and 7.5 times more likely to die of liver cancer compared to their non-incarcerated age-matched peers. As demonstrated by these

initial studies, inmates are certainly not immune to the threat of cancer during their incarceration.

Over 2 million inmates in the U.S. rely on the prison system for their health care (Wilper et al., 2009). Claims have long been made that both quality and access to medical care in prisons may be lacking. For instance, Wilper and colleagues (2009) reported that 13.9% of federal inmates, 20.1% of state inmates and over 68% of local jail inmates had received no medical exam since incarcerated. In terms of medical treatment of patients with cancer, often pain management is a crucial piece of treatment (Lin & Mathew, 2003). Yet, cancer-related pain may be discredited by medical staff as drug-seeking behavior, because drug abuse is a problem for many inmates (Markman, 2007). Furthermore, a bimodal problem occurs in regard to sentencing length. Shorter sentences due to overwhelmed prisons may preclude the patients from getting adequate medical care or treatments for their cancer, such as specific courses of chemotherapy or radiation (Markman, 2007). On the other hand, longer sentences and life-sentences have increased the number of inmates who are diagnosed with cancer while in prison; yet many prisons have yet to implement hospice services in their medical contracts (Hospice Management Advisor, 1999). Clearly, it is important for psychologists in correctional settings to assist an interdisciplinary team in understanding the medical complications and psychosocial nuances of treating patients with cancer.

CANCER-RELATED DISTRESS

The National Comprehensive Cancer Network (NCCN), which

has developed clinical practice guidelines for treatment of many aspects of oncology, has used the same multidisciplinary panel approach applied to their other guidelines to provide for "the care of the psyche" and to "articulate common serious and treatable psychiatric syndromes, offer a differential diagnosis for distress and consider the psychological, social and spiritual component of symptoms like fatigue and pain" (APOS Institute for Research and Education, 2006, p.2). These are known as the *NCCN Distress Management Guidelines* (available at: nccn.org).

The NCCN panel employed the term distress to decrease the stigma of mental health issues and to reflect a degree of expected emotional symptoms. Distress is a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling such as depression, anxiety, panic, social isolation, and existential and spiritual crisis (NCCN, 2010).

One study of outpatient cancer clinics found that approximately one-third of patients with cancer were found to be experiencing significant levels of distress. This figure was greater in patients with tumors having a poorer prognosis. Other research has shown that throughout the trajectory of the illness, the incidence of cancer-

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related distress in North America ranges from 35% to 45%, while end-of-life distress affects 58% of patients with cancer (Zabora, Brintzenhofesoc, Curbow, Hooker, & Piantadosi, 2001). In correctional settings this could mean that many more cancer patients are experiencing significant distress than may be initially identified.

Research also supports that a significant proportion of perceived distress in patients with cancer goes unrecognized by the health care team (Zabora, et al., 2001). In 2007 the Institute of Medicine (IOM) published a report concluding that “today it is not possible to deliver good quality cancer care without using existing approaches, tools, and resources to address patients’ psychosocial health needs” (Adler & Page, 2008, p. 1). That IOM report found, however, that many of these recommendations for addressing the psychosocial needs of patients with cancer and their

families have not been enacted. The IOM report also indicates that both cancer survivors and their caregivers perceived that their health care providers did not comprehend or recognize their depression, increased stress, and psychosocial needs. In addition, there was a perception on the part of survivors and caregivers that their providers did not appear to consider psychosocial support as an integral part of quality care, were not aware of resources and did not offer referrals to support services (Nelson, 2007). This may be an even greater problem in correctional settings, due to the perception of many inmates that their medical care is inadequate.

According to the NCCN, a number of symptoms are considered normal and expected from the time of suspicious finding, diagnosis, treatment, and recovery. These include normal fear and worry of the future and uncertainty; specific concerns about illness; sadness about loss of usual

health; anger; loss of control; poor sleep and appetite; poor concentration; and preoccupation with thoughts of illness and death (NCCN, 2010). The guidelines also provide indicators of patients who are at increased risk for distress (refer to Table 1) and periods of time for increased vulnerability (refer to Table 2). Correctional psychologists should familiarize themselves with these indicators to better screen for those cancer patients who are in need of increased psychosocial services.

EVIDENCE-BASED INTERVENTIONS

In order to adequately address and diagnose these symptoms – as well as to provide a research tool – the *NCCN Distress Management Guidelines* include a simple screening tool for measuring

TABLE 1: Characteristics of Patients at Increased Risk for Cancer-Related Distress

Indicator
- History of psychiatric disorder or substance abuse
- History of depression / suicide attempt
- Cognitive impairment
- Communication barriers
- Severe comorbid illness
- Spiritual / religious concerns
- Social problems:
• Family/caregiver conflicts
• Inadequate social support
• Living alone
• Financial problems
• Limited access to medical care
• Young or dependent children
• Younger age; woman
• History of abuse (physical, sexual)

Note. Derived from the *NCCN Distress Management Guidelines*.

TABLE 2: Time Periods when Patients are at Increased Risk for Cancer-Related Distress

Time Period Indicator
• Finding a suspicious symptom
• During workup
• Finding out the diagnosis
• Awaiting treatment
• Change in treatment modality
• End of treatment
• Discharge from hospital following treatment
• Stresses of survivorship
• Medical follow-up and surveillance
• Treatment failure
• Recurrence/progression
• Advanced cancer
• End of life

Note. Derived from the *NCCN Distress Management Guidelines*.

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distress. The Distress Thermometer (NCCN, 2010, p. DIS-A), which is similar to a 0-10 pain scale, includes a patient's self-report of distress and a problem list which are recommended as part of the initial evaluation and triage process as well as at certain points along the trajectory. Further information on understanding and implementing this and other aspects of distress management is available from the American Psychosocial Oncology Society (available at: apos-society.org/professionals/tools-resources).

Use of the Distress Thermometer assures communication, aids in referrals for increased services, helps ease distress, and has been shown to increase patient satisfaction (Fulcher & Gosselin-Acomb, 2007). The Distress Thermometer's usefulness has been validated against longer instruments as a rough screen for distress and can be administered by verbal or written approach (Zabora et al., 2001). Scores of 5 or more indicate a significant level of distress that should be evaluated further. Scores of <5 indicate normal fears, worries, and uncertainties and usually are evaluated and managed by the primary oncology team. Thus, a score of 5 serves as the NCCN algorithm for referral to a mental health professional. In addition to a score of 5 or greater, there are other reasons for referring to mental health professionals as indicated in Table 3 (Suppa & Linton, 2009).

While the symptoms and issues listed in Table 3 often are considered to be reflective of moderate to severe distress and most frequently treated by mental health professionals, mild forms of distress often may be addressed by the primary oncology

TABLE 3: Reasons for Referring to a Mental Health Professional

- Patients scoring ≥ 5 on the NCCN DIS-A Distress Thermometer
- Patients currently experiencing intense or overwhelming anxiety or any symptoms of:
 - Major denial
 - Psychosis
 - Dissociation
 - Delirium (disorientation, confusion, memory problems)
- Patients with previous history or family history of:
 - Depression
 - Substance abuse
 - Suicide attempt
 - Psychiatric hospitalization
 - Other psychiatric disorder(s)
- Patients displaying hostile or inappropriate behavior towards family or staff
- Patients who, during cancer treatment, require maintenance of:
 - Psychotropic medication
 - Steroids
- Patients experiencing difficulty making treatment decisions or complying with treatment
- Patients considering certain aggressive treatments such as HSCT
- Patients considering end-of-active treatment decisions
- Patients dealing with other concomitant life stressors
- Patients who have special issues with regard to:
 - Age
 - Support
 - Previous experience with cancer
 - Fertility
 - Spirituality/values
 - Irrational beliefs
 - Previous experience with death in family
 - Pain

team, support and advocacy groups, and other community organizations. Basic interventions reflecting good communication and mutual respect for all levels of distress include clarifying the diagnosis and treatment options; discussing possible side effects of treatment; ensuring continuity of care; acknowledging and assessing distress; educating patients regarding vulnerable periods for distress; mobilizing resources; and providing referrals to other services such as complementary

interventions, including exercise, relaxation and creative therapies (NCCN, 2010).

For patients who are experiencing more significant difficulties, the APOS has provided another set of recommended interventions. These evidence-based treatment components include cognitive-behavioral therapy, support and advocacy groups, stress reduction exercises, physical exercise, complimentary therapies

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(journaling, music, dance, art), and the implementation of problem-solving techniques. In particular, the COPE model of problem-solving is a cancer focused motivational approach (Houts, Nezu, Nezu, & Bucher, 1996). The COPE acronym represents the following essential elements of this conceptual model:

- Creativity – to overcome obstacles, manage problems, and to see problems and solutions in a new way.

- Optimism – to face other's expectations and the problem-solving process; need realistic optimism to recognize seriousness of problem yet see that solutions are possible.

- Planning – to implement medical instructions and address the emotional challenges associated with cancer therapies.

- Expert Information – to encourage a sense of control and confidence when managing physical and emotional problems due to cancer and related treatments.

Several trials show that COPE techniques for problem formulation, decision making, and solution implementation can be taught in approximately 90 minutes, although sustained intervention may be recommended. There has been a 10-session program outlined as well (Nezu, Nezu, Friedman, Haddis, & Fouts, 1998). While COPE is being tested with various groups of cancer patients and their families, the body of scientific evidence regarding its use is limited; however, many clinicians are reporting patient success and satisfaction with receiving problem-solving skills for optimism, courage and self-confidence at the beginning of the cancer journey and prior to the

onset of many challenges (Tuma, 2007).

While the NCCN acknowledges that there are no well-defined standards of care for the psychosocial sequelae of cancer, they have provided clinical practice guidelines for the optimal recognition and management of cancer-related distress. All mental health providers should comply with the Institute of Medicine's new recommendations for integrating evidence-based psychosocial services as the standard of care for patients with cancer and their families. Considering the greater incidence of cancer among inmates and the emerging evidence alerting care providers to cancer-related emotional distress, correctional psychologists should screen for emotional distress and utilize available evidence-based interventions and services for inmates with cancer.

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Carolyn H. Suppa, Ed.D. is Senior Psychologist at Charleston Area Medical Center (CAMC), Charleston, West Virginia, and Director of the CAMC Cancer Patient Support Program. Also, Dr. Suppa is an Associate Professor, West Virginia University (WVU) School of Medicine, Department of Behavioral Medicine and Psychiatry in Charleston, West Virginia, and an internship supervisor for the WVU Division of Social Work. Jess Grayson-Luzier, Ph.D., is Assistant Professor, Department of Behavioral Medicine and Psychiatry at the West Virginia University School of Medicine in Charleston, West Virginia. John C. Linton, Ph.D., is Professor and Vice Chair of the Department of Behavioral Medicine and Psychiatry at the West Virginia University School of Medicine in Charleston, West Virginia. He is certified in Clinical and Clinical Health Psychology with the American Board of Professional Psychology.

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RIISING COST OF CORRECTIONAL HEALTHCARE

Ruth A. Naglich, BSN—Contact: ruth.naglich@doc.alabama.gov

The majority of law abiding, taxpaying citizens do not generally think about how healthcare is provided, or who provides and pays for the healthcare needs of the criminals that they so desperately want locked up and off their streets. However, when state correctional facilities receive an individual for their first incarceration; for many of them this is the first time in their life that they have received professional medical or mental health services.

The U.S. Bureau of Justice reported in midyear 2008 that state and federal prison authorities had jurisdiction over 1,610,446 prisoners: 1,409,166 in state jurisdictions, and 201,280 in the federal jurisdictions. In 2008, national healthcare spending was estimated to be \$2.2 trillion (16.3%) of the nation's Gross Domestic Product (GDP). In addition, and as indicated in Figure 1,

the Centers for Medicare and Medicaid Services (2008) indicate that the amount spent on healthcare in the United States is expected to nearly double to \$4.3 trillion (19.5% of GDP) — \$1 of every \$5 spent — by 2017.

The responsibility of providing access to all medical and mental healthcare needs for over 1.6 million individuals is a fiscal and physically daunting task. This is the on-going challenge that correctional administrators and correctional healthcare professionals face every day. Thirty-one of 38 U.S. correctional systems responding to an October 2009 *Corrections Compendium Survey* said that their budgets for providing inmate healthcare had continued an upward trend. Ensuring healthcare for those who are incarcerated is no small task in this time of ever-increasing healthcare costs; however, many correctional officials have found sound solutions.

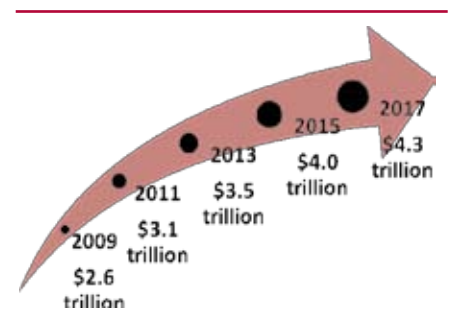


Figure 1: Projected U.S. Healthcare Spending

Through the implementation of continuous inmate healthcare education, chronic-care clinics and a strong practice of preventive medicine, many states are seeing a slower rise in the year-over-year increase in their healthcare cost. In addition, appropriate risk sharing contracts for professional correctional healthcare with the private sector, have assisted many states in minimizing their year-over-year

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cost increases. For example, in 2003, the Alabama Department of Corrections (ADOC) made the decision to invest in an infrastructure to support and monitor inmate healthcare needs. This was after a number of costly lawsuits surrounding healthcare and years of unpredictable budgeting for health cost. A collaborative approach between the state and the private sector resulted in a system to man-

age costs appropriately for the state, while at the same time, improving healthcare services for the ADOC offender population. The breadth of clinical data tracked, analyzed, and reported enables the state to manage care more efficiently, identify potential catastrophic cases early, and predict our costs accurately. Since 2006, the ADOC's year-over-year budget increases have remained at 6% or less, versus 10%-15% that

was experienced in the previous 5 years. The ADOC's commitment to support this pro-active approach has demonstrated that good healthcare is cost effective.

Ruth A. Naglich, BSN, is Associate Commissioner of Health Services, Alabama Department of Corrections, Montgomery, Alabama.

ARTICLE

AGE OF HOMICIDE PERPETRATORS AND PROBABILITY OF A DEATH SENTENCE

Lindsay A. Howard, Keran Zmora, B.A., and Peter J. Donovan, Ph.D. — *Contact: lhoward1@binghamton.edu*

The state of Texas has the largest death row population and executes the highest number of offenders of any state in the nation. Since 1985, approximately 435 people have been put to death in Texas (Texas Department of Criminal Justice, 2010). This is about 2% of the approximately 23,000 known offenders in Texas who committed homicide and who were given the death sentence during that period (National Center for Juvenile Justice, 2006). The purpose of this study was to determine the frequency of a death sentence given to offenders who committed homicide as a function of their age at the time of the offense.

Previous studies (e.g., Bergeron & McKelvie, 2004) found that people over 50 were treated more leniently than younger offenders who were sentenced for homicide. In the current study however, it was hypothesized that the older a homicide offender was, the more time he had to build up a criminal record. Aggravating circumstances (such as an offender's prior criminal record), were presented during the penalty phase of the trial, during which the judge or jurors determined if the case presented before them was worthy

of a death sentence (Michigan State University Comm Tech Lab and Death Penalty Information Center, 2004). Given the fact that a defendant's prior record was taken into consideration when a decision on the death sentence was made, it was assumed that older offenders who had an extensive criminal record would be more likely to receive capital punishment.

METHOD I

The principle source of data on homicide offenders that was used was the *FBI Supplementary Homicide Report* (FBI SHR). The offender's age at the time of the offense was classified by the FBI as: 18-24, 25-49, or 50 and older. A condensed database version of the FBI SHR compiled by the National Center for Juvenile Justice in a report titled: *Easy Access to the FBI's Supplementary Homicide Reports* was used to determine the number of male offenders in each age group who committed homicide in Texas between 1985 and 2005. Similar data extracted from the Texas Department of Criminal Justice (TDCJ) website on death row offenders were put into an SPSS file for analysis. The file contained the ID numbers of all male offenders who committed homicide between 1985

and 2005, the year of offense, age at offense, and a code for whether or not the offender had been executed by the state. In the SPSS file of TDCJ death row offenders, age groups were created analogous to those provided in the FBI SHR. A frequency analysis was performed to determine the number of offenders on death row whose age at the time of the offense corresponded to the aforementioned age groups. The data on Texas death row offenders was further divided into the number who had been put to death and those who had not.

RESULTS I

The total number of male offenders who committed homicide in Texas between 1985 and 2005 was 22,199. Of the 22,199, 562 (2.5%) were sentenced to death and 272 (1.2%) of them were executed. The percentages of individuals sentenced to death who committed homicide between 18-24 and 25-49 were similar. A total of 9,125 individuals committed homicide between the ages of 18-24 and 269 of them received a death sentence; of the 11,395 who

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committed homicide between the ages of 25-49, 285 of them were sentenced to death. This represents 2.9% and 2.5% of homicide offenders respectively. However, offenders who committed homicide at 50 and above ($n=1,679$) were treated differently than younger offenders; only eight (.48%) of them were sentenced to death.

These findings coincide with previous studies (Bergeron & McKelvie, 2004). It is reasonable to assume that the older the offenders are, the more time they have had to accumulate prior offenses. Although previous findings support more lenient treatment of older offenders, it was assumed that this would not be evident in capital cases due to the influence that the offender's prior record might have on the judge and jurors.

METHOD II

Information on each offender's prior prison record was obtained from online sources and entered into SPSS for tabulation. The information provided by the TDCJ was used to determine if each offender who was sentenced to death had a prior prison record, and, if so, had they been convicted of any violent crimes. The researchers classified the following convictions as violent: murder, robbery, sexual abuse, assault of any kind, and kidnapping. Other offenses, such as burglary and drug possession were considered as prior convictions of the non-violent type.

RESULTS II

It was found that 36.2% of offenders who committed homicide between the ages of 18-24 had prior

offenses, and of those with prior offenses 51.0% had been convicted of at least one violent crime; 64.0% of offenders who committed homicide between the ages of 25-49 had prior offenses and of those, 53.6% were violent; lastly, 75.0% of offenders who committed homicide at age 50 or older had prior convictions and of those with prior convictions, 33.0% were violent crimes.

SUMMARY

As hypothesized in this study, the percentage of older homicide offenders had longer prior prison records than younger homicide offenders. It was, therefore, somewhat surprising and a bit of a paradox, to find in the same study that older homicide offenders received fewer death sentences when compared to younger homicide offenders. The results of the study point to a variety of other topics for further research. For example, homicide rates decline steadily with age. What are the characteristics of the offenders, the situations, and the characteristics of the victims that lead to age-related differences? Do calculation and impulsivity interact in the juries' deliberations in a way that make those 50 and older seem less dangerous? Are younger offenders more likely to murder younger, more sympathetic victims? Are older offenders more likely to use a gun rather than pummel or stab their victims in a way that seems particularly violent? Are victims of older offenders more likely to be viewed as acting under duress against family members, rather than impulsively against unknown victims? Although, it was not the intent of this study to answer these types of

questions, we do recommend that others do the homicide-offender research that may help to uncover the variables in our justice system most often leading to the imposition of a death sentence, perhaps for nothing more than monitoring purposes only.

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Lindsay A. Howard is a bachelor's degree (B.S.) student in the Integrated Neuroscience Program at Binghamton University, Binghamton, New York. Keran Zmora, B.A., graduated in May 2010, with a degree in psychology from Binghamton University, Binghamton, New York. Peter J. Donovan, Ph.D., is Professor of Psychology in the Department of Psychology, Binghamton University, Binghamton, New York.



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TALKING TO LIFERS: DILEMMAS AND OPPORTUNITIES

John L. Gannon, Ph.D.—Contact: jg@ia4cfp.org

The following is a slightly-edited version of an article that appeared in the March/April 2010 issue of *The National Psychologist* (TNP). Permission to reprint the piece here was given by TNP.

If we can set aside for our current purposes the obvious fact that there are surprisingly many paths to a life sentence, and a remarkable array of kinds of people who find themselves in that position, that mentally ill lifers have a right to mental health services, and that the more or less standard array of good clinical practices, good listening, humane respect, etc., all apply, there are still occasions during which therapists who encounter lifers may feel a good deal of discomfort. I believe that these feelings arise out of the therapists' projection of their own feelings regarding the terrible fate that the lifer must now work out by virtue of his sentence (regardless or perhaps despite his morally impaired standing in the community of men because of his crime). The existential issues of doing life can sometimes throw therapists off track, creating professional uncertainty and anxiety in the therapeutic environment.

Looking at the lifer across from him, the therapist must believe that when the gavel fell, and a life sentence was pronounced, it surely seemed that all was lost and life hardly worth living. But is this response by the lifer or vicariously by the therapist warranted? If one takes seriously the question, is the lifer's conclusion that all is lost right or nonsense, the answer is clearly the latter.

Emotionally devastating personal

events and reasonable conclusions are not identical. Therapy with lifers includes acknowledging those feelings, which will by necessity arise from the past, but simultaneously being firm in shifting the thinking toward a more realistic understanding of and devising a life plan for the future. All is not lost. In fact, many of the most important aspects of human life, opportunities which should not be underestimated, remain broadly open to the lifer.

What do lifers lose? The principle losses are personal autonomy, geographical restriction, and, typically, absence of access to sexual expression with opposite-sex partners.

Yet, myriad people have not only forgone those very same opportunities, but found their renunciation ennobling and satisfying. Sailors, fishermen, and sea-borne shipping crews are in restricted areas for long periods, subject to dominating authority, and limited in sexual expression. Faithful husbands and loving fathers voluntarily leave their families to serve in remote locations with insects, unbearable heat or cold, and immediate dangers while on military or scientific missions. Even more dramatic renunciation of personal autonomy, geographical expansiveness, and sexual expression can be seen in those monks who spend lives in small and spartan cells with no expectation or practical possibility of opposite-sex sexual expression.

No doubt personal choice about the lives they are living makes the phenomenology of these groups different, but new life choices are made everyday by lots of people, and it is possible to choose even that which is imposed. And, wouldn't it be profoundly ironic should a murderer doing life complain about comparisons

with these groups based on their choices given the deprivation of the choice of life itself they imposed on their victims?

Paradoxically, talking to patients, including lifers begins with listening, first, to understand their own view of their existential condition. Determining the criteria of reference is crucial here. Comparisons of their own expected life sentence with a fantasy life of no work and non-stop sex and drugs and rock and roll they would like to think they are missing will lead only to envy, frustration, and unhappiness. They may have had a good life waiting outside the walls, but in many cases they would not. Comparisons to monks and faithful husbands in remote locations are not inappropriate for generating context. Eventually, the lifer must come to realize the simple point that while things are indeed bad, all is not lost. Furthermore, if other, reasonable human beings actively seek the very conditions the lifer seeks to avoid, it is likely there are opportunities available to him that have not been explored.

What might those opportunities be? First, what I call my "fundamental formula," $QL = QR$, where Q = Quality, L = Live and R = Relationships. Virtually, all the wisdom and religious literatures, whatever its origins, make it clear that pursuit of things is futile, while developing the discipline to become something worthwhile and building good relationships with those loved and those loving is everything. Becoming better lovers in the broad sense of that term, is a life-long and life-worthy task for anyone, in or out of prison. More importantly, a focus on becoming rather than

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getting, and on being better in relationships not only provides deeper life satisfaction, but contributes to the transcendent goal of expressing and nurturing compassion, understanding, and tolerance in oneself and in society at large. Geographical range and sexual expression are frosting, but the cake of life satisfaction is the love we give and receive. For a high QL, the lifer must develop and maintain high QR. In addition, a good lover must learn to control those characteristics of impulsivity, entitlement, narcissism, and irresponsibility often found in lifers, and working on QR can be the guiding star that allows for progress down the path toward the personal fulfillment they fear they've lost.

In addition to the basic formula, consider philosopher Owen Flanagan's observation that human flourishing depends on the ability to participate in the Beautiful, the Good, and the True. Since prisons are not notable for their inclusion of any of the three, the challenge becomes worthwhile and their accomplishment that much more meaningful. Creating and experiencing beauty, growing in goodness within oneself

and supporting it in others, working diligently to avoid delusions of either grandeur or helplessness, and recognizing that deceiving others is only one step on the staircase of self-deception can be a life plan unto itself, regardless of the physical surroundings. So, putting aside the question of whether psychologists or other mental health workers should be spending time with lifers who are not mentally ill, there are important messages to be conveyed to lifers that may help them to avoid the paralyzing despair that might settle in when clarity about their situation comes into focus.

First, all is not lost. Restrictions in a life behind bars are substantial and emotionally devastating but, as can be seen in the lives of those who chose similar restrictions voluntarily in their own lives, the restrictions are manageable. If it is being done, it must be possible.

Second, though the lifer's narcissism and antisocial behavior may belie the truth, we are in fact social animals. The failure to recognize this relationship while he was on the outside is likely to be part of the reason the lifer is on the inside. Improving QR is not only good for the lifer, it is

part of the change that he needs to undergo to become a non-criminal (a prosocial goal worth pursuing regardless of his imprisonment).

Third, The Beautiful, The Good, and The True, are characteristics of the world that integrate immediately, importantly and intensely, with the human psyche. For thousands of years they have been recognized by wise people as foundations of human flourishing. They are subtle and complex by nature, so they are always challenging and can't be boring. Their permutations are infinite, so they cannot be exhausted during any man's lifetime. Their accomplished pursuit demands self-discipline, thoughtfulness, dedication, optimism, honesty, and active engagement with other human beings, all things that help us become worthwhile people. Lifers would do well to pursue the "fundamental formula" and Flanagan's trine, as should we.

John L. Gannon, Ph.D., is IACFP Executive Director/Affiliate Liaison and is a private consultant in Pismo Beach, California.

CONFERENCES

2nd North American Correctional and Criminal Justice Psychology Conference, Toronto, Ontario, An International Meeting of Minds for Correctional Excellence, June 2-4, 2011, Sheraton Centre Toronto Hotel. Co-sponsors are the Criminal Justice Section of American Psychological Association's Division 18 and the Criminal Justice Section of the Canadian Psychological Association. For more information visit the website: tinyurl.com/ddobyv.

18th Annual International Community Corrections Association Research Conference on What Works in Community Corrections, Louisville, Kentucky, October 31-November 3, 2010, The Galt House and Suites, Louisville, Kentucky. Contact: janebrowning@iccaweb.org.

12th Annual International Corrections and Prisons Association Conference, Ghent, Belgium, October 24-29, 2010, Cultural Centre of Ghent University. In collaboration

with Ghent Institute for International Research on Criminal Policy, the Belgium public Federal Service of Justice will host ICPC's 12th Annual General Meeting and Conference. Contact: icpc.ca.

19th Annual International Community Corrections Association Research Conference on What Works in Community Corrections, September 18-21, 2011, John Ascuaga's Nugget Hotel, Reno, Nevada. Contact: jane.browning@iccaweb.org.

ARTICLE

ALTERNATIVES TO VIOLENCE PROJECT

Nancy Shippen, M.Ed. — *Contact: nancyshippen@comcast.net*

The Alternatives to Violence Project (AVP) started in prisons in the U.S. in 1975, and now operates in communities, schools, colleges, and conflict situations worldwide, from Rwanda to Attica. Research has demonstrated a reduction in recidivism and violent attitudes and behavior.

Initially created at the request of lifers who “knew how to solve situations with violence” but needed training on alternatives to violence, AVP is a training program enabling participants to deal with all levels of conflict in new and creative ways. Workshops run by trained facilitators are experiential (not based on lectures). The AVP workshops are an opportunity to experience the first alternative to violence as a community based on respect and caring. This experience of trust and respect is transforming, leading to new neuropathways being established in the brain. This change is not temporary and as it is reinforced, it establishes new habits of thought and new, more healthy, attitudes.

These 2-3 day workshops involve the shared experience of participants, interactive exercises, games, and role-plays to examine the ways in which humans respond to situations where injustice, prejudice, frustration, and anger can lead to aggressive behavior and violence. A Basic AVP workshop explores the five pillars of AVP: affirmation, communication, co-operation, community building, and transforming power. An Advanced AVP workshop builds on the principles of the first workshop, and each group works towards a consensus to choose topics they will explore in more detail. Participants who have experienced our workshops and

want to deepen their involvement can continue the advanced work or train to become facilitators with AVP.

A key element of AVP is pre-emptive conflict resolution by creatively transforming unhealthy relationships and communities through sharing, caring, improved communication skills, and sometimes even surprise and humor all based on the assumption that everyone has some experience with successful conflict resolution. The AVP team brings out the wisdom in the room and provides a framework for exploring and building skills. We visualize Transforming Power with the following visual aid:



During each session, a Light & Lively game lightens the mood after sharing deeply, as well as being crucial in building the nonverbal bonds between participants. The sharing of eye contact, smiles, creativity, and bodily coordination establishes a remarkable degree of trust and connection. Participants in prison workshops report frequently that they become unable to pass each other in the facility without a smile of recognition and warm feeling of connection.

Historically, AVP has placed an emphasis on the fact that all participants are volunteers. The willingness of outside volunteers to bring the program into prisons has been deeply meaningful to the inside participants. However, this has also been the main constraint to building the program. In most facilities with

established programs there is a wait list, often more than a year in length. In states with established programs the parole board has gained respect for the program. Inside participants often report at the beginning of a weekend that they have come for the certificate for their parole folders. They very often report at the end that they received something much more important than the certificate as evidenced by the following testimonial from an AVP workshop participant:

“I grew up in a single parent family in the projects. I learned that violence was an acceptable solution at a young age. My thinking led me to take another man’s life. One would think that incident would open my eyes. It didn’t. I continued to live a life of violence in prison for 12 years. I mistakenly thought that’s what I had to do since I was in prison. I knew that I had to change but I didn’t know how. I took responsibility for the murder I committed but I didn’t know how to take responsibility for my every day actions. When I was introduced to AVP, I was enlightened and interested. I didn’t understand it all but I wanted more. It was life saving. Since then I have become a facilitator. Each time I learn more about myself. I also get a lot of encouraging feedback from inmate participants who I felt were inspired enough to start on that road to change, AVP being the catalyst.”

Recent discoveries in the neuroscience of social intelligence have begun to shed light on why this program has been so successful. Daniel Goleman, in his 2006 book *Social Intelligence*, defines its components as social awareness and social facility. Social awareness (Continued on page 13)

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is further broken down as; primal empathy, attunement, empathetic accuracy, and social cognition. From the very beginning of the Basic AVP workshop, participants explore these components. Often, in the first session, after a brief exploration of the importance of good listening is the exercise Affirmation in Pairs in which partners speak for 3 minutes about what they like about themselves and why. The other partners have a minute to reflect back what they have heard to check for accuracy and completeness. When both have had a chance to talk and reflect back, they then introduce each other to the group. The experience of thinking about positive aspects of your life and then hearing positive things said about you from your peers can be very powerful. This is just one of the exercises which open the group to the power and opportunity for attunement, empathetic accuracy, and primal empathy. Common debriefing comments indicate all three:

- "All my life, negativity has been around me. I am negativity. It has created me. My thoughts were negative. When I dealt with other people, it was in a negative realm, even when I tried to do what I thought was right. The AVP took out the negative and put in positive. It gave me new avenues to view, new alternatives, other ways to see things. Where as before, I saw everyone as a potential enemy.

Like most of us here, we came from a war zone, America is a war zone. You have to look at life as a soldier every day. Now I sit back and look at the world in a different way with a different perspective. I wasn't into male bonding, but now I look at that in a totally different light."

- "I went into the workshop as a pessimist and I came out a changed person. I was alive, I was actually alive. I liked what I saw in myself. It was a real high and I've been doing it for 2 years and I love that feeling; and to see other people awakened in the workshops, to see their lives change."

The AVP workshops are presented by a team which models cooperative, non-hierarchical presentation. These teams often are extremely diverse including outside and inside facilitators representing a wide diversity of age, race, socioeconomic background and experience in facilitating. The mutually supportive team sits within the group, which quickly begins to engage and empower the participants.

Throughout the workshops there are opportunities to exercise social facility. Activities incorporate whole group, small group, dyad and individual exercises aimed at providing a variety of experiences and groupings with as many participants as possible. Even the moving in and out of groups allows for synchrony, self-presentation, influence and

concern.

During each session there is a Light & Lively game. These are non-competitive games which maximize eye contact, creativity, and humor. Some are quite active and physical. Some participants are hesitant at first but almost all become enthusiastic participants by the end of the workshop.

It is our belief in AVP, that it is the sum total of workshop presenters' and participants' life experiences that provide a true source of profound wisdom for each workshop. Participants soon find deep respect for each other's experience and are often surprised at their own wisdom and willingness to share personal situations.

For more information about AVP and the effects of the program on recidivism reduction, go to: avpusa.org or avpinternational.org.

Nancy Shippen, M.Ed., is Founder and the Executive Director of Our Prison Neighbors (AVP), Acton, Massachusetts. She serves in several other roles with AVP Massachusetts, AVP USA, and AVP International. For 30 years, she also taught special education for the learning disabled and emotionally disturbed in public, private, day, and residential schools throughout Massachusetts.

IN BRIEF

Changes in the DSM. The American Psychiatric Association is proposing major changes in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). In a new twist, the Association is seeking feedback via the Internet from mental health workers and the general public about whether the changes

will be helpful. The manual suggests some new diagnoses. Gambling, so far, is the lone-identified behavioral addiction, but in the new category of learning disabilities, there are problems with both reading and math. Also new is binge eating, distinct from bulimics because the binge eaters don't purge. The draft of the new

manual also proposes diagnosing people as being at high risk of developing serious mental disorders, e.g., dementia or schizophrenia, based on early symptoms, even though there's no way to know who will worsen in a full-blown illness.

ITEMS OF INTEREST

THE 12TH UNITED NATIONS CONGRESS

John L. Gannon, Ph.D. — *Contact: jg@ia4cfp.org*

The Government of Brazil hosted the 12th United Nations Congress on Crime Prevention and Criminal Justice in Salvador, Brazil from 12 to 19, April, 2010. Salvador (São Salvador da Bahia de Todos os Santos) was Brazil's first capital, the hub of a thriving slave trade in the 17th century, and occupies a dramatic setting on the Bay of Saints on northeastern coast. The U.N. Crime Congresses have been held every 5 years since 1955 in different parts of the world and have contributed to shaping international and domestic policies and promoting novel thinking and approaches to criminal justice, which is seen by the U.N. as one of the key institutions of the modern state. The conference's theme was: *Comprehensive Strategies for Global Challenges: Crime Prevention and Criminal Justice Systems and Their Development in a Changing World*.

The 12th Crime Congress brought together 4,000 policymakers and practitioners in crime prevention and criminal justice, parliamentarians, individual experts from academia, and representatives of civil society, as well as the media from around the world. The 12th Crime Congress, marking the 55th anniversary of the Congresses, was intended to offer a unique opportunity to stimulate in-depth discussion and proposals for action along three principal avenues:

- Establishing the criminal justice system as a central pillar in the rule-of-law architecture;
- Highlighting the pivotal role of

the criminal justice system in development;

- Emphasizing the need for a holistic approach to criminal justice system reform to strengthen the capacity of criminal justice systems in dealing with crime

Special attention was paid to children, youth and crime; smuggling of migrants; trafficking in persons; money laundering; and cybercrime.

As is the practice, participants in the 12th Congress adopted a declaration containing recommendations based on deliberations held during the high-level segment, the round tables, and the workshops, that is to be submitted to the Commission on Crime Prevention and Criminal Justice at its 19th session, in 2010.

Participation in the Congresses is by invitation from the United Nations only and it was an honor for me to qualify and to represent IACFP at the Congress. In addition to attending meetings and presentations, I was able to promote IACFP with attendees and encourage several to submit material to our newsletter and journal.

After many years of attending and presenting at conferences, I am beginning to call the entire process into question. Conference attendees sit through workshops teaching them how to polish the machinery of corrections while we seem helpless to influence kinds of people sent for processing, and have little in the way of consensus about the ends of the processing itself.

So, while I am less sanguine about the continual rehashing of by now

stale criminal justice topics at conferences in the United States, and the inefficient transmission of information through in-person workshops when we all have the Internet, the extraordinarily primitive conditions in many countries in numerous regions around the world make conferences such as this one sponsored by Brazil and the U.N. not only worthwhile, but extremely valuable.

It may surprise some people to learn that in some respects even marginally developed countries are advanced compared to us. For example, both Tonga and Samoa proffer a much more humanitarian response to wrongdoers, and posters seem to abound throughout Nigeria urging authorities to stop sending the mentally ill to prison. But in many, many other countries, wide scale corruption and rampant crime create intolerable conditions for citizens, and the development of a state sufficient enough to advance the rule of law and to protect the law-abiding will depend on the kinds of improved understanding, exchange of credible information, and mutual, high-level support that can take place at U.N. Congresses. I think that maybe they should have them more often.

John L. Gannon, Ph.D., is IACFP Executive Director/Affiliate Liaison and is a private consultant in Pismo Beach, California.

ITEMS OF INTEREST

ALL-ABOUT-FORENSIC-PSYCHOLOGY NOW ONLINE INFORMATION RESOURCE FOR FORENSIC PSYCHOLOGY

All-About-Forensic-Psychology was launched in October 2005 and

seems to be a good resource for forensic psychology. It is owned and

maintained by David Webb, a Uni-
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FORENSIC PSYCHOLOGY NOW ONLINE (Continued from page 14)

versity lecturer from the U.K. who now lives and works in Spain.

Their website is designed to help anyone looking for informed and detailed information on forensic psychology and related disciplines. Definitions, history, theory and practice, forensic careers and

degree options are just some of the many topics under review. The primary aims of the website are to make the academic study of forensic psychology more accessible and to offer a balanced account of forensic psychology, as opposed to the often distorted, sensationalized, and inac-

curate view promoted in the popular media.

For more information, go to: all-about-forensic-psychology.com. There is also a link to IACFP on the prison psychology page of the website.

ITEMS OF INTEREST

MONOGRAPH NOW AVAILABLE ON THE MMPI®-2 FBS (SYMPTOM VALIDITY) SCALE

A test monograph is now available on the FBS (Symptom Validity) Scale, which was added to the MMPI-2 hand-scoring materials and Extended Score Report in 2006. This monograph provides documentation on the development, validation, interpretation, and application of the FBS Scale, including its use in defending forensic testimony.

Scale composition, T-score conversion tables, and other psychometric properties are also presented in the monograph.

The FBS helps identify non-credible symptom reporting and has been cited as one of the most commonly used symptom validity measures by neuropsychologists. Introduced by Lees-Haley, English, and Glenn

(1991), the FBS is supported by a substantial body of research. An FBS bibliography is provided in Appendix C of the monograph. With the inclusion of this scale, the MMPI-2 provides nine validity indicators. To order the FBS monograph, call 1 (800) 627-7271.

MEMBER ARTICLE

THE BRIEF SYMPTOM INVENTORY AS A POTENTIAL ASSESSMENT FOR VIOLENCE IN COUNTY JAIL INMATES AT INTAKE: AN EXPLORATORY STUDY

Ronald R. Mellen, Ph.D., Jason Guillilan, B.S., and Peggy Sharp, B.S.—*Contact: hobbits6@bellsouth.net*

ABSTRACT

The present exploratory study was motivated by Brief Symptom Inventory (BSI) results from a single-case study of a violent male county jail inmate (DH). Using non-patient norms, all nine of the inmate's clinical scales were exceptionally elevated suggesting faking bad or malingering. His $\bar{x} = 78$ where the normative data placed T-scores at 50 and clinically significant scores ranged from 63 to 80.

The BSI results were then obtained for a group of 10 violent

male inmates in a different county jail. Their mean sub-scale score was 74, very similar to DH's. These findings suggested that DH's BSI results may have been typical for violent male inmates representing significant mental health issues rather than faking bad or malingering.

Finally, mean scores for the violent inmates' BSIs were compared to the BSI scores of a group of 17 non-incarcerated, non-violent males attending a court-ordered, out-patient substance abuse treatment program. When the two groups were,

compared, the variance in mean T-scores for all nine clinical scales was 11 points, violent inmate group $\bar{x} = 74$, substance abuse group $\bar{x} = 63$.

INTRODUCTION

The inmate assessment process is essential to the accurate security level placement of an offender, and the provision of appropriate psychological/medical treatment. Because many institutions are forced to work with limited resources, a preliminary

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screening instrument such as the BSI (Derogatis, 1993) could prove helpful in identifying potentially violent inmates.

RESEARCH DESIGN

The BSI data sources for this article were from two published studies (Mellen, Manners, & Rukers, 2010; Mellen & Pamer-Shedd, 2009) and one unpublished 2009 study by Mellen, Guillilan, and Sharp, completed at a rural Alabama county jail. For the three studies, the treatment was the Alpha-Stim SCS and the BSIs were utilized as one of the pre-treatment dependent variables. The single case study (Mellen, Manners, & Rukers, 2010) utilized a violent jail inmate's BSI results and were noteworthy due to exceptionally elevated clinical scales suggesting either faking or malingering. Confusion resulted when it was noted that the inmate's response patterns on the Behavior Rating Inventory Executive Function-Adult Version (Roth, Isquith, & Gioia, 2005) and the 16 Personality Factors (Cattell, Cattell, & Cattell, 2002) fell within researcher expectations. If the inmate's results could be shown not to be an anomaly but in fact an accurate measure of significant emotional problems, then using the BSI at jail intake may be warranted as part of an initial screening process.

To address this issue the BSIs of 10 violent inmates housed in a jail administrative segregation unit were used for comparative purposes. These inmates were volunteers in a larger 2009 unpublished study by Mellen, Guillilan, and Sharp. Means from the violent inmates were then used for comparison with DH's BSI profile (see Table 2).

In addition, to providing a con-

text for understanding how deviant the violent inmate's profiles were, a comparison was made between their BSI results and scores from subjects attending a court-ordered, outpatient substance abuse treatment program (Mellen & Pamer, 2008). These were also pre-treatment BSIs.

RESEARCH QUESTION

Is there preliminary evidence that the BSI could be used to identify an inmate with a level of psychopathology and violence that he may be a danger to officers and other inmates?

THE BRIEF SYMPTOM INVENTORY

The BSI, a screening instrument for mental disorders, has 53 items. It is composed of nine symptom dimensions and three global scales. The global scales use the nine scales to generate an estimate of a patient's total stress levels. Only the nine symptom scales were utilized in the

present study. These nine scales were: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. In their instructions, test takers are told to go back no more than 7 days when addressing how much a specific problem bothered them. The subjects then mark a Likert scale, where the 5-option range from 0 (not at all) to 5 (extremely).

The clinical scales:

SOM—the shifting of psychological stress to bodily pain.

O/C—unremitting thoughts and/or actions that are unwanted.

IS—a sense of inadequacy with others.

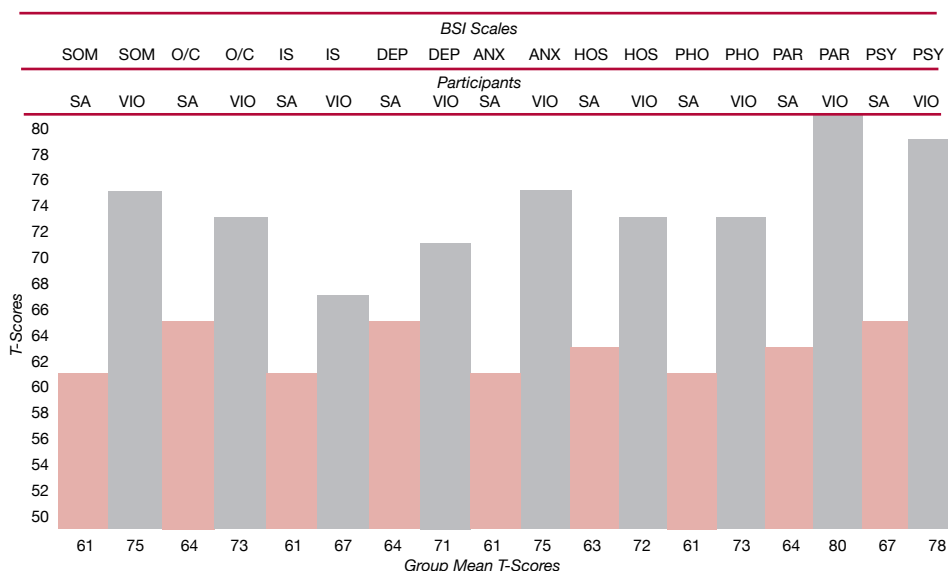
DEP—dysphoric emotions.

ANX—feelings of nervousness, terror, and/or panic attacks.

HOS—feelings and actions associated with anger.

PHO—irrational fear of a person, place or object.

TABLE 1: Comparison of BSI Mean T-Scores for the Substance Abuse Group and the Violent Inmate Group



Note. SA = Substance abuse group; VIO = Violent inmate group.

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BRIEF SYMPTOM INVENTORY (Continued from page 16)**TABLE 2: Comparison of BSI T-Scores for the Single-Case Violent Inmate and Mean T-Scores for the Violent Inmate Group**

Note. DH = Single-case violent inmate; VIO = Violent inmate group.

PAR—irrational suspiciousness and fear of loss of autonomy.

PSY—extreme withdrawal, schizoid lifestyle and/or psychosis.

To establish clinical significance, two or more of the clinical scales must exceed the cut-off score of 63 (Derogatis, 1993).

SUBJECTS

As noted above, three sources of subjects were utilized. The first was the subject in a single-case study of a violent jail inmate. The second set of subjects were 10 violent jail inmates. The third set was composed of 17 subjects (non-violent) attending a court-ordered out-patient substance abuse treatment program. All subjects were male.

Some self-report demographic information was available on the violent group members. Racial distribution: four whites and six blacks. Their average age was 26.7 years with a range from 20 to

42 years. While two inmates, one white, one black, reported having obtained GEDs and none reported having finished high school. The average grade completed was eighth. Two reported having been married. On average the number of jail incarcerations was five. The incidence of the father being absent was one for white inmates and four for black inmates. When asked what changes they would like to bring to their lives the responses were:

- *Increased self-control - 1
- *Learn to think before acting - 3
- *Control anger - 3
- *Develop trust - 1
- *Change habits - 1
- *One stated he didn't need to change anything.

RESULTS

Because the present study was exploratory in nature a statistical analysis was not completed. However, Tables 1 and 2 were included for descriptive purposes. Table 1 shows

important differences between violent inmate group scores on the BSI and those of the substance abuse group. While the nine-scale average T-score for the violent inmate group was 74, the average score for the substance abuse group was 63. The violent inmate group had one score in the 60 range (67) and the remaining scores were above 70, while seven of the nine substance abuse group mean scores were below (marginally) the cutoff score of 63.

Not surprisingly, for the violent inmates the three scales with the most implied psychopathology were hostility, paranoia, and psychoticism. For the substance abuse group, the three highest scales were obsessive-compulsive, depression, and psychoticism, a pattern that fit with their primary disorder. Results in Table 2 demonstrate a strong concordance between the scores (maroon) for the original single-case inmate, DH, (\bar{x} = 78) and scores (gray) for the group of violent jail inmates (\bar{x} = 74).

DISCUSSION

The above data show that DH's results were probably not an anomaly but more likely an indicator of significant psychopathology. In addition, the data reflect that as T-scores increased there was an increase in the degree of psychopathology in these offender populations with the greatest manifestation in the violent inmate group.

Specifically, the T-score mean for the substance abuse group was 63 while the mean score for the violent inmates was 74. Clearly, scores for both offender groups were elevated when compared to the T-score of 50 for the normative non-psychiatric (Continued on page 18)

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atric population. Finally, the three highest scores for the two inmate groups reflected the psychopathology of each group.

LIMITATIONS

As with any exploratory study limitations are significant and it is true for the present effort. The sample sizes were small and the process for selecting subjects was suitable only for an exploratory study. Also, the addition of other offender groups would have been beneficial.

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Ronald R. Mellen, Ph.D., is a correctional psychologist and Professor in the Department of Criminal Justice, Jacksonville State University, Jacksonville, Alabama. Jason Guillilan, B.S. is a master's degree student in the Department of Criminal Justice, Jacksonville State University, Jacksonville, Alabama. Peggy Sharp, B.S. is a master's degree student in the Department of Criminal Justice, Jacksonville State University, Jacksonville, Alabama.

IN BRIEF

Racial Disparity in Sentencing. The U.S. Sentencing Commission has indicated that black and Hispanic men are more likely to receive longer prison sentences than their white counterparts. The commission looked at sentences meted out since the January 2005, U.S. v. Booker decision gave judges sentencing discretion. In 1999, blacks received 14% longer sentences. By 2002, there was no statistical differences. After the Booker decision, black men received sentences 10% longer than whites. Using another method, the commission found that black men were receiving sentences that were 23% longer than whites. Hispanic men received sentences 7% longer than white men. Immigrants also got longer sentences than U.S. citizens. The commission warned that the report needs to be read with caution and may not mean that

race or class is influencing judges when they hand longer sentences. The commission was not privy to all of the information on all offenders' past criminal records.

State Prison Numbers Drop. For the first time since 1972, U.S. prison numbers for state inmates has dropped. According to the Pew Center, 1,403,091 people were under the jurisdiction of state prison authorities on January 1, 2010, down by 5,739 from the year earlier. Pew also reports that there were only 174,000 offenders in U.S. state prisons in 1972.

Uniform Crime Reports. The Uniform Crime Reporting (UCR) Program was conceived in 1929 by the International Association of Chiefs of Police to meet a need for reliable, uniform crime statistics for the nation. In 1930, the FBI was tasked

with collecting, publishing, and archiving those statistics. Today, several annual statistical publications, such as the comprehensive *Crime in the United States*, are produced from data provided by nearly 17,000 law enforcement agencies across the United States. Other annual publications, such as *Hate Crime Statistics* and *Law Enforcement Officers Killed and Assaulted*, address specialized facets of crime such as hate crime or the murder and assaults of law enforcement officers respectively. Special studies, reports, and monographs prepared using data mined from the UCR's large database are published each year, as well. In addition to these reports, information about the *National Incidence-Based Reporting System*, answers to general UCR questions, and answers to specific UCR questions are available at: fbi.gov/ucr/ucr.htm.

ASSOCIATION UPDATES

2010 MHCC CONFERENCE IN CHICAGO HIGHLIGHTS FOCUS ON COMMUNITY ISSUES

Richard Althouse, Ph.D. — Contact: goldmine123.a@gmail.com

This year's Mental Health in Corrections Consortium (MHCC) conference, sponsored by the Forest Institute and the Adler and Chicago Schools of Professional Psychology, was held at the Renaissance Blackstone Hotel in downtown Chicago April 12-14. I was privileged to be the master of ceremonies for the conference, and I can say that Jennifer Baker, and her assistant, Phyllis Beckman, did a great job of organizing everything, including arranging for the plenary and luncheon speakers, workshops, and student poster awards.

Given that a number of states are faced with releasing thousands of prisoners back to their communities to help relieve overcrowding, reintegration challenges are now becoming more prominent in the research and corrections literature. That was no less true for this conference and its plenary speakers. Richard Hart spoke of how staff at the Chicago Salvation Army prepares its staff to work with mentally ill offenders returning to Chicago. David Delmonico and Elizabeth Griffin informed attendees about how to understand sex offenders who use the Internet (an extremely eye-opening and information-packed presentation). Joel Dvoskin, in his provocative



The President of IACFP, Richard Althouse, Ph.D., represents our Association at the 2010 MHCC Conference.

presentation titled: *Psychology, Crime and Punishment: We Couldn't Do It Worse If We Tried*, talked about how psychology has dropped the ball in helping corrections use well-known psychological principles in reshaping offender behaviors.

The majority of workshops focused on sex offender issues or community safety concerns. Some participants were able to take a tour of the nearby Salvation Army facility and learn how this agency helps returning offenders, some of whom are mentally ill, reintegrate into the community. Others

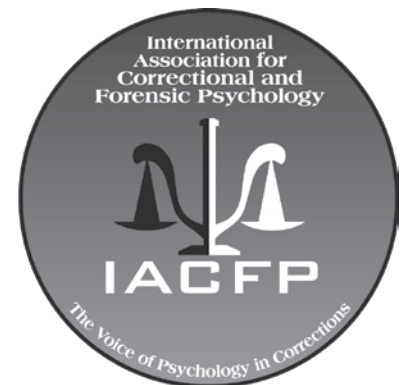
learned of a volunteer mentoring program in Toronto that monitored sex offenders 24/7 in the interests of community safety, or about how communities might use regional assessment centers as alternatives to re-incarceration. Attendees could also learn about a shift in conceptualizing treatment for sex offenders, replacing relapse prevention models with self-regulation combined with good-lives models.

The MHCC conference is also well-known for its student poster contest, in which students of the various professional schools present posters summarizing research on selected topics. I was among the three judges who selected the top seven posters, and those students received a financial award. This year, six students received a \$500 award, and one (Rich Mulrenin, from Forest Institute) a \$1,000 award. The IACFP contributed funds to help sponsor these student awards.

All in all, it was a great conference, and plans are already underway for next year's conference. The conference will again be in Chicago, and continue to focus on the latest issues and concerns of community reintegration.

IN BRIEF

Mental Health Issues and Forensic Evaluations. Vermont's Department of Mental Health (VDMH) has proposed legislative changes in hopes of expediting and simplifying processes involving individuals with mental health issues. The VDMH is suggesting that individuals under 14 be admitted to treatment facilities with the consent of a parent or guardian, with the understanding that they will become inpatients and are doing so under no duress. The VDMH is also recommending stricter criteria and faster processing of forensic evaluations for criminal defendants who use "not guilty by reason of insanity" as their defense. About 120 individuals undergo competency/sanity assessments a year in Vermont.



Robert R. Smith, Ed.D.
The Correctional Psychologist Executive Editor
625 Richardson Road
Fortson, GA 31808

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