Challenging Current Strategies of Rehabilitation and Reintegration of Offenders: Reasons for Hope

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Introduction

When asked, I gladly accepted the invitation to speak about the optimistic hope I have for our future.

Optimism that is not fanciful but grounded in good solid evidence.

My intent is to infect you with the same optimism and to recruit you to think about our pervasive human malaise in an empowered way.

IMAGE 1

But before we get into the positive - we need first to look at some negatives.

The negatives being symptoms and from where they come. -- Dare I say what is causing them. After all we cannot begin to fix a problem if we are preoccupied with only the symptoms. And don't ask what is causing them.

So I will focus on 4 troubling symptoms, the ones that irk me the most.

I will then offer an operationally defined explanation of what's causing them and then to illustrate my premise use as a case example how most conceptualize criminal behaviour, - which is yet another symptom, - and as a result respond with incoherent and irrelevant intervention strategies.

And then I will offer an alternative conceptual model based on the root problem.

I will conclude by describing what we have done in the past and continue to do in some settings - that is relevant to addressing the root causes of criminal behaviour.

The core theme throughout my talk is the critical importance of environment.

And insofar as we create environments in our homes, schools, work places, some good some not so good, when better informed, we can deliberately create environments optimally conducive to achieving what we want.

Being informed in this way, can be incredibly empowering and the positive results equally incredibly rewarding.

The Symptoms

I will start with – in no particular order of irkness....

Platitudes

IMAGE 2

The intent of positive thinking has been hijacked. The intent has been hijacked, I would like to believe, with good intentions, albeit, markedly misinformed.
The intent of Norman Vincent Peale's The Power of Positive Thinking was never to engage in unwarranted platitudes -- but to empower us to solve problems. Of this we are extremely capable and have done exceptionally well.

Just read Harvard psychologist Steven Pinker's ***Enlightenment Now***.

At excruciating length he cites how well we have solved all kinds of technical, biological and social problems. Each problem solved, so he makes the point, started with it being identified as a problem.

Similarly, Canada's environmentalist David Suzuki extensively chronicled in, ***Good News for a Change***, how well we can solve what we identify to be a problem.

Engaging in platitudes about how great we are, or how great we were and can be again was never the intent of positive thinking.

The intent was to empower and convey what is possible once we recognize a problem and apply ourselves to fixing it.

Platitudes promote stagnation – getting stuck.

Biological Psychiatry

The next symptom I want to focus on is how we have allowed the infiltration of biologically based psychiatry into every nook and cranny of our world.

Of all the groups that have ever existed psychiatry, along with its pharmacological industry partner, has been the most successful imperialistic organization.

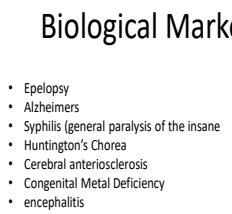
IMAGE 3

Bad behavior has steadily evolved into illness and we are all too eager to abdicate personal, familial, community and social responsibility for creating it.
(Egs of Bad Behaviour)

We eagerly embrace an organic cause, and look to biologically based psychiatry to fix it. And biologically based psychiatry, with its partner the psychopharmacological industry,

is all too willing to take on the burden of fixing bad behaviour allegedly caused by biochemical imbalances.

IMAGE 4



Even the American Psychiatric Association has acknowledged its quest has failed for finding biological causes for all but some 10 disorders listed and described in their ever expanding DSM -- now in its 5th version.
130 pages to 1,000 pages

Sadly, most medical practitioners did not get the memo and continue to refer to chemical imbalances which they proport to treat with their drugs.

So biologically based psychiatry's success is firmly entrenched -- even in spite of significant, credible scholarly, scientifically sound opposition to it.

The validity and reliability of it's DSM5 is vigorously contested as well as the efficacy of various mind intoxicating drugs, but to no avail.

American psychiatrist Peter Breggin along with an impressive group of scholars have challenged the mainstream practice of the speciality in numerous books and journal articles.

To the general public, however, they remain largely unknown. Their success is mostly relegated to out of court settlements lest the legal outcomes become publicly known.

Hope

The third symptom of my focus is how we conceptualize hope and then behave accordingly.

For the 6th edition of Dr. Turner's, ***Social Work Treatment*** I wrote a chapter on hope theory.

In spite of the intrigue this concept generates I wrote that it is markedly not well understood and seldom, if ever, incorporated into what social workers and other disciplines do in their practice.

By definition hope is a positive expectation for the future.

As such it has been extensively studied in the field of expectation theory. The most significant empirically supported finding has been that people behave according to what they hope for or expect.

IMAGE 5

Unfortunately, most people hope for very little because most people treat hope as a zero sum experience.

You either have it or not. You are either hopeful or hopeless.

If you are hopeful you resort to experiencing it as a cliché. At your child's wedding you say: "I hope they will be happy". If you are without hope the only cliché available is "One day at a time".

In the chapter - I argue that we cannot, and I emphasize cannot, do not know how to, hope for a future of the kind the prophets and others tell us is available to us.

Notwithstanding that we hope to win the lottery -- at best we hope to have our primary needs satisfied which will make us happy and hope that there is truth to getting our just deserves in the after-life.

IQ

Last, but by no means least, the symptom I want to focus on is the stubbornly persistent unwarranted great weight we continue to give cognitive intelligence (IQ).

This includes the will and or talent to memorize information. We have and continue to do this in spite of considerable robust data to the contrary.

IMAGE 6

IQ	+	EQ	+	Cognitive Develpemnt	=	Sucess
10%	+	45%	+	45%	=	100%

People like Steven Stein and Howard Book have laid out very credible empirically supported evidence that IQ and memorizing stuff matters less than 10% in the equation of success.
Most of success is attributed to emotional intelligence (EQ) and I add to that development of how we reason about our experiences.

Because how we reason determines how we feel, behave and then feel again afterwards.

Underlying Problem

So far, the symptoms we have all seen/experienced as described meet the observable criteria of an operational definition of a problem.

The following meet the measurable criteria of an operational definition.

There are at least two measures of emotional intelligence. I have used both to great advantage for over thirty years.

There are three or more ways of measuring, locating, the cognitive perspective of individuals on an invariant hierarchical sequence of development.

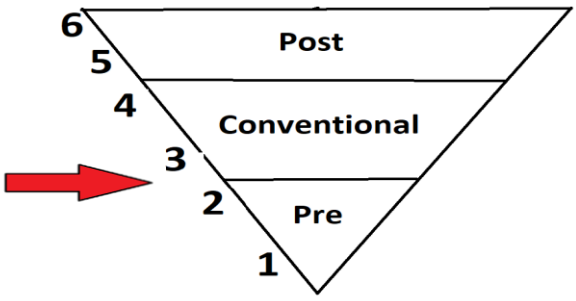
I have also used the three of them to considerable advantage for these past thirty years.

My position is that the data support, with considerable confidence, the conclusion that the underlying cause of the symptoms discussed, and many others, first and foremost, is obstructed cognitive development and delays in the acquisition of emotional intelligence**.**

The good news is that since both are environmentally induced, once we identify obstructed cognitive development and delayed learning of emotional intelligence as root problems, we can then go about fixing them.

So you might ask -- where are we stuck and what do the symptoms reveal about us?

IMAGE 7



The short answer is that on a good day, most of us, function at the reference group/tribal cognitive developmental Stage 3 perspective.

We are less concerned with facts or evidence than we are with subscribing to the beliefs, values and prescribed behaviours of our tribe.

That's on a good day, of which there are few for many of us.

On most days, under siege or duress, we regress to the previous concrete, survival, self-serving,

Immediate need gratification stage 2 perspective.
At this stage we easily create pleasing fantasies otherwise known as platitudes**.**

At this stage we also cannot understand that there are broad and long term consequences to our actions and eagerly embrace any idea that allows abdication of

responsibility, as for example, responsibility for raising children who grow up to be badly behaved adults.

The medical model and use of diagnostic labels becomes a way out and we eagerly embrace it.

ADHA

While prophets, scholars and philosophers have and continue to tell us what is possible, their message is so far removed from where we are developmentally stuck that we cannot relate to the possibilities.

Our hope for the future is very simple and mostly expressed as a cliché: "I hope they will be happy".

Last, since cognitive intelligence is more innate than less, something over which we have little control, placing such great weight on it allows for the abdication of responsibility for failing to create environments in which our children can thrive, develop, or more precisely,
- actualize the potential with which they were born.

While once popular because it was useful - applying a cognitive developmental perspective analyses, however, has fallen out of fashion.

It is far easier to create pleasing fantasies about how great we are, or were and can be again, abdicate personal, familial, community and social responsibility for creating people who are badly behaved, settle for hoping to live another day and perhaps be rewarded for

our earthly suffering in the here after and fatalistically accept IQ, over which we have little control, as the most important variable to success.

The exacerbating conundrum to the easy is that at the reference group tribal perspective and the stage below that, it is virtually impossible, to see obstructed development as the problem, let alone do something about it.

I for one have seen very little reference to obstructed cognitive development identified as a problem for a very long time, although there are some very tenacious people who continue to beat the drums about the importance of emotional intelligence.

The good news about what I have said so far is that at the rotten or healthy core are environmental conditions.

If we can create adverse environments not conducive to cognitive development and becoming emotionally intelligent we can also create environments conducive to it.

Let me illustrate this with a brief case example.

A case example which is yet another symptom of the underlying problem…

Criminality

Rehabilitation And Reintegration

IMAGE 8

How we conceptualize criminal behaviour and how we respond to it illustrates what I have said so far. We have struggled with a conceptual framework for centuries and have gradually settled on a medical model of it. In so doing we have essentially abdicated responsibility for creating it.

My premise for saying that we have settled *(albeit mostly inadvertently)* on the medical model is based on two concepts,

Rehabilitation and reintegration.

But let me digress for a moment:

In my early years I worked on a spinal cord team.

Our mandate was to rehabilitate, return as close as possible to pre-injury physical and mental functioning, the patient.

Once rehabilitated our next mandate was to reintegrate the patient who became alienated from family and community because he or she was hospitalized for a long time.

While the work was challenging because the conceptual model was and continues to be relevant, we had great successes.

Soon after this experience I started my career in corrections. During orientation I was told that our mandate is to rehabilitate and reintegrate offenders to reduce recidivism rates.

At first I thought, no problem, I know how to rehabilitate and reintegrate, it must be the same here as it was on the spinal cord team.

It didn't take me long to realize the conceptual medical model of rehabilitation and reintegration does not apply to the problem of criminal behaviour.

There were no offenders I wanted to return to some former state or way of functioning. Moreover, since none of them ever felt to be part of their broader community -- how can they be reintegrated?

Whatever knowledge and skills I learned in the spinal cord team were not relevant to what I was facing in the prison setting.

Fortunately I was not alone in this realization. And it did not take us long to get our conceptual house in order.

We had the resources to research our problem and to thoroughly assess each offender on admission.

Through our research we discovered that work was already being done, tested and published about a different conceptual model and concomitant interventions.

We also discovered that our assessment of each offender produced remarkably similar results.

Almost all our offenders were exposed to adverse environmental conditions during their formative and subsequent years.

Most suffered relationship trauma (failed attachment) and manifested a host of later life negative consequences.

The most significant of these later life negative consequences were:

- Each was developmentally stuck at the preconventional level of reasoning;
- Each was alienated from the community in which they lived;
- Many were addicted addicts which they denied by using pleasing fantasies, often platitudes about themselves and from where they come;
- Many, because they were developmentally stuck, experienced hope at it's most basic form, hoping to be alive for another day, (one day at a time);
- Life skills, which letter evolved into what we now call Emotional Intelligence, for most was limited to basic survival skills”
- Many had been DSM labelled and for various periods of time “medicated” – which they rejected and replaced with street drugs or alcohol;

- Most if not all had at least average, some even better than average, cognitive intelligence.

Our assessment almost always concluded with the phrase:

→ **significant undeveloped potential.**

Segnificant
Undeveloped
Potential
In need of
Habilitation
And
Integration

IMAGE 9

So, we went about actualizing their potential and started calling it habilitation.

Simultaneously we immediately started working on an integration discharge plan.

Cognitive challenge + relationship/community building + power of possibilities = Therapeutic Community

IMAGE 10

Our primary mode of intervention was the environment. We were at the beginning of the Democratic, Therapeutic or Just Community Approach to Corrections.
One criteria: everything must be conducive to growth and development.

Cognitive challenge + relationship/community building + power of possibilities = Therapeutic Community

We measured everything which included monitoring the environment.

Our outcomes paralleled that of Harvard's Lawrence Kohlberg and his colleagues using the same conceptual model and intervention strategies.

As the cognitive developmental perspective and emotional intelligence of our offenders improved so also did their behaviour.

It was especially rewarding to see that at a higher level of reasoning it became virtually impossible for them to sustain the creation of pleasing fantasies about themselves, and their circumstances.

They actually developed the cognitive developmental ability to hope for a future beyond just surviving today to live for another day. This was of great benefit for creating and implementing realistic integration discharge plans.

All this started in the 1970s and since then I have been beating this same conceptual drum.

I am pleased to say that there are converts. There continue to be prison and residentially based therapeutic communities and occasionally I hear people talk of habilitating and integrating offenders.

Example: St. Leonard's Society of Canada

I, however, hear virtually nothing about what is at the root of the symptoms I described at the beginning of this talk.

As such, I can only conclude that obstructed cognitive developmental potential and delayed EQ continue **not** to be perceived as problems to be solved.

I hope therefore, that my comments today, and the references provided will serve to infect and mobilize you to not only worry and address symptoms (any and all) but also

include in your thinking and actions a focus on underlying causes. Obstructed cognitive developmental potential and delayed emotional intelligence.

Once we identify problems, hopefully I have convinced you, we can be very good at solving them.

Thank you very much.

REFERENCES

Breggin, Peter (1991). **Toxic psychiatry.** New York: St. Martin's Press.

Breggin, Peter (2008). **Medication madness: The role of psychiatric drugs in cases of violence, suicide, and crime.** New York: St. Martin's Griffin.

DeLeon, George (2000). **The therapeutic community.** New York: Springer Publishing Company.

Kohlberg, L. (1976). Moral stages and moralization: The cognitive developmental approach. In T. Lickona (Ed.), **Moral development and behaviour.** New York: Holt, Reinhart and Winston.

Kohlberg, L., Kauffman, K., Scharf, P., and Hicke, J. (1974). **The just community approach to corrections: A manual.** Moral Education Research Foundation: Harvard University.

MHS (2018). **EQ – i: emotional Quotient Inventory 2.0.** Toronto, ON. MHS Publishing.

Pinker, Steven (2018). **Enlightenment now.** New York: Viking.

Parker, Michael (2007). **Democratic therapeutic communities in prison**. London & Philadelphia: Jessica Kingsley Publishers.

Polgar, Alexander T. (2009). **Because we can – we must: Achieving the human developmental potential.** Hamilton, Ontario: Sandriam Publications.

Polgar, Alexander T. (2017). Hope theory and social work treatment. In F. J. Turner (Ed.), **Social work treatment: Interlocking theoretical approaches**. Sixth Edition. New York: Oxford University Press.

Polgar, Alexander T. (2019). A brief history of how bad behaviour evolved into illness. In R.E. Reynolds (Ed.), **Miscellaneous musing's.** Toronto.

Rest, Jim (1980. **Defining Issues Test.** University of Minnesota Center for the Study of Ethical Development.

Reynolds, R.M. (1980). **Opinions about social problems.** Brampton, ON: Ontario Correctional Institute.

Stein, S. and Book, H. (2000). **The EQ edge.** Toronto: Stoddart Publishing.

Suzuki, David (2003). **Good news for a change: How everyday people are helping the planet.** Vancouver, British Columbia: Greystone Books.