ON THURSDAY, WE BEGAN TO TREAT CRIMINALITY

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Assessment of Criminal Thinking

Examination of MMPI item endorsements for Subjects who scored high (T-scores 65 and above) on each of the "criminal thinking" factor scales suggested, for each STFB factor, a set of cognitive, affective and behavioural reactive mechanisms (STFB items) which, along with the associated motivational and psychopathological features (MMPI items) common to those scoring high on each of the factor scales, was felt to provide a more complete and understandable picture of the dynamics underlying criminal thinking than had previously been obtained. It portrayed the six factors as representing a series of reactions to perceived life experiences, eventuating in a variety of **angry distress-rejecting attitudes** which might be characterized follows:

Factor 1: Rejection of Guilt Feelings. Based on the items, it would appear that the dynamics take the following course:-

> Guilt-Tripping ---> Felt Rejection, Guilt Sensitivity and Guilt Proneness ---> Compulsive Cautiousness and Depression ---> Resentment, Anger and Paranoidal Feelings of Mistreatment ---> Guilt Intolerance, Affect Inhibition and Boredom ---> Excitement Seeking ---> Criminal Behaviour.

Factor 2: Rejection of Failure and Inferiority Feelings. Based on the items, it would appear the dynamics take the following course:-

> Attention Deficit Disorder/Hyperactivity/Paroxysmality and Punitive Reinforcement ---> Failure Experiences and Felt Rejection ---> Inferiority Feelings, Victim Identity and Depression ---> Anger and/or Paranoidal Feelings of Mistreatment ---> Hypomanic Grandiosity, Egocentricity and Attention-Seeking ---> Risk-Taking and Impulsiveness ---> Anti-Social/Criminal Behaviour.

Factor 3: Rejection of Insecurity. Based on the items, it appears that the dynamics of this factor take

the following course:-

Impaired Mothering, Autonomic Nervous System Reactivity and Emotional Distress ---> Felt Rejection, Closeness Anxiety, Discouragement/Distrust/Disappointment and Emotional Distancing ---> Introversive Hostile Fantasies, and Feelings of Guilt and Inferiority ---> Guilt Intolerance, Affect Inhibition and Boredom ---> Social Withdrawal and Obsessional Defence ---> Accumulation and Periodic Expression of Rage ---> Anti-Social/Criminal Behaviour.

Factor 4: Rejection of Sensitivity. Based on the items, it would appear that the dynamics take the following course:-

Societal Expectations/Demands and Low Intellect---> Failure Experiences and Felt Rejection ---> Inferiority Feelings, Victim Identity and Depression ---> Anger and/or Paranoidal Feelings of Mistreatment ---> Affect Inhibition and Boredom ---> Social Withdrawal and Obsessional Defence ---> Dependency/Independency Conflicts and Withdrawal from Academic Interests ---> Accumulation and Periodic Expression of Rage ---> Defensive "Isolation" ---> Concrete, Simplistic Thinking

---> Failure to Learn from Experience ---> Criminal Behaviour.

Factor 5: Rejection of Closeness. Based on the items, it appears that the dynamics of this factor take the following course:-

Routinized, Rationalizing, Rule-Governed Parenting ---> Emotional Insecurity, Closeness Anxiety, Discouragement and Emotional Distancing ---> Victim Identity, Distrust/Disappointment, Introversive Hostile Fantasies and Feelings of Guilt and Inferiority ---> Distress Intolerance, Affect Inhibition and Boredom ---> Social Withdrawal and Obsessional Defence ---> Rationalized, Rule-Governed, Dichotomous Thinking ---> Accumulation and Periodic Expression of Rage ---> Anti-Social/Criminal Behaviour.

Factor 6: Rejection of Discipline. Based on the items, it appears that the dynamics of this factor take the following course:-

Lack of Parental Discipline ---> Under-Controlled, Under-Disciplined --->

Neglected/Rejected, Depressed/Discouraged and Angry ---> Distress Intolerance, Affect Inhibition and Boredom ---> Failure Anxiety, Distrust and Sensitivity to Others' Attempts to Provide Controls---> Anti-Social/Criminal Behaviour.

Treatment of Criminal Thinking

On the Thursday following this elucidation of the dynamics underlying criminal thinking, we assembled a group of offenders who had completed the Survey of Thoughts, Feelings and Behaviours (STFB) and began the process of treating criminality.

Treatment of Elements Generic to Criminal Thinking

Examination of the dynamics underlying the six criminal thinking factors reveals that there are a number of common elements which might be said to be generic to criminality. They include feelings of anxiety, rejection, anger, depression and boredom, and obsessive rumination. These elements can be presumed to require treatment regardless of the pattern of factor scores.

1. Anxiety: Anxiety is commonly understood to be the core of the neuroses. It is not so commonly recognized as the root cause of the personality disorders, although the acknowledgement is there in the psychotherapeutic literature, primarily as it relates to primitive internalized object relations (Volkan, 1976). Relief from the aversive affective states, such as anxiety, which provide the motivational drives underlying all maladaptive behaviours, are most reliably obtained through the use of behaviour therapy methods such as systematic desensitization. The time and effort required to implement these behavioural treatment strategies is significantly less than that required for the more traditional psychotherapies. Recently, however, a number of new and exciting cognitive-affective-behavioural treatment methods have been developed (Bandler and Grinder, 1979; Bandler, 1985; Andreas and Andreas, 1987; James and Woodsmall, 1988; Wolpe, 1991) which have further significantly shortened the time required to effect desensitization to most stressor stimuli. And finally, Quirk and Reynolds (1991) have demonstrated that many of these old and new procedures

can be used effectively with groups composed of as many as seventy inmates at once.

The stressor stimuli which have been identified as common among groups of inmates include dirt, heights, people, and criticism; and desensitization to any of these stimuli will result in a decrease in arousal levels, making it easier to address problems in other areas of the offender's life. The stressor stimuli which are of most importance to criminal thinking, however, are those related to guilt, rejection, failure, inferiority, criticism, closeness, dependency, loss of control and strong affect. It is the treatment of the distress engendered in the individual by these stressor stimuli which will have the greatest ameliorative affect on criminal thinking.

Treatment Alternatives:

(a) Stress/Anxiety Management Programmes: Several programmes exist for the management of anxiety, the most "generic" of which is Stress/Anxiety Management Training. This programme, which may be offered in large-group format, teaches clients about the functioning of the autonomic nervous system and its "fight or flight" response. It then employs a variety of relaxation and meditation methods for physiological and cognitive quieting before proceeding to systematic desensitization of the aforementioned stressor stimuli, thereby reducing the intensity of anxiety arousal so that it can be contained or better controlled.

(b) Change Personal History: Each of us exists in both an objective reality and a subjective reality. That is, it may be assumed that the universe exists, but our only contact with it is through the energy which impinges on our sense organs and the way in which our brains structure that experience. The reality that we live in, on a day-to-day basis, is the reality that we have constructed in our own minds. It is composed of the pictures and sounds and tastes and smells and feelings that are formed in our brains from the sensory information that we receive through our visual, auditory,

gustatory, olfactory and kinaesthetic senses, plus the language that we use to structure those sensory experiences.

Time exists for us only as memories of the past and fantasies of the future. The

present moment in which all time is experienced is infinitely short but constantly shifting, so that it is continually sweeping the future into the past. The past exists for us in the present only as we recall the subjective reality -- the sensory experiences and the language through which we structured them -- that existed for us at the time our memories of past events were created. Because our experience of the objective reality of those events was entirely subjective, and conditioned by who we were at the time, with whatever strengths and weaknesses we had at that time, it would have been different if we had been different. However, because it only exists for us as we experience it in the present, it can become different for us if we can learn to experience it differently.

We can learn to experience the past differently by reliving it in memory, but with those resources, both personal and interpersonal, which we have now but which we did not have then. Feelings of anxiety having their roots in past conditioning and fearful anticipation of the future impact on the present only to the extent that they have been stored as memories and/or fantasies with associated negative emotions. Such memories can be located in the person's history as recorded in memory and, by means a variety of corrective emotional experiences, such as the Dissociative Phobia/Trauma Cure (Bandler and Grinder, 1979) and James and Woodsmall's (1988) Time-Line procedure, and their negative emotional charges can be removed. This alters the person's emotional experience of the past and frees him from the impact of the past upon the present and future.

2. Feelings of Rejection: The feelings of rejection experienced by the potential criminal might be thought of in terms of anxiety, e.g., sensitivity to rejection, and treated the same way; and this would be quite appropriate. However, it might also be appropriate to consider them a separate although related problem, resulting in impaired self esteem, deserving treatment of its own.

(a, b) Desensitization to Rejection and Change Personal History: The procedures suggested for the treatment of anxiety, as described above, are equally appropriate here.

(c) Self Esteem Procedure: The following Self Esteem procedure, adapted from materials provided by Cameron-Bandler (1985), has been designed to address low self-esteem such as

that experienced by the client who has felt rejected by significant others in his life. It consists of five major steps, and directs the client to attend to, evaluate, and respond to himself in ways that result in a strong and positive self-concept. The five steps in this programme are as follows:

(i) The first step establishes a dissociation by asking the client to think of himself as the person he wakes up with -- the person he interacts with and takes care of every day of his life. The purpose of this step is to allow the client to identify his (or her) present concept of self and to evaluate the judgments he is making about himself. (ii) The second step leads the client to evaluate and change behaviours, as well as place behaviours into appropriate contexts. The purpose of this step is to develop a self-concept that is based on a set of positive attributes, and to provide a way for the client to maintain feelings of personal worth.

(iii) The third step creates for the client an experience of worthiness that extends across contexts and through time.

(iv) The fourth step helps the client to establish criteria, limits, and outcomes for how he treats himself and how he allows others to treat him.

(v) The final step past- and future-paces the benefits of this entire procedure.

3. Anger: The element of anger in these individuals is related to and will benefit from treatment of the anxiety which underlies much of their distress and its associated symptomatic defences. In addition, it also involves a variety of other features, including quick anger reactivity (low frustration tolerance), violence (weak controls over anger), hostility (projection of blame to others), rage (anger which is intensified by being inhibited), and the like.

Treatment Alternatives:

(a) Stress/Anger Management Programmes: From a physiological point of view, the distressing affects of anxiety and anger may be treated as virtually interchangeable. That is, as the "fight or flight" response of the autonomic nervous system, they are very similar physiologically, and they are amenable to the same kinds of treatment approaches. For example, although most of the behaviour therapy research has been conducted with neurotics

and anxiety, there are enough cases of the use of systematic desensitization in the treatment of anger to demonstrate that this "behavioural" approach is effective with this affect as well. Rational-Emotive Therapy (Ellis, 1962) focuses attention on the cognitive errors by which the person makes himself anxious or angry. Anger/Aggression Control Training as it is presented in this setting develops further and more effective controls over anger and aggression through teaching the individual to delay his responses in the face of provocation. Biofeedback Conditioning may be used to correct error epileptiform stimulation of brain centres involved in specific kinds of anger and aggression. A "Relating Without Violence" programme addresses the roots of domestic conflict in faulty communications between people. Finally, Assertiveness Training helps to modulate the anxiety and anger responses and teaches the client to use his or her energy in socially-effective ways. These programmes can be drawn upon as required to address the types of anger triggering sequences involved in the make-up of the individuals and/or groups undergoing treatment.

(b) Change Personal History: Feelings of resentment, anger and rage from the past may impact on the present as a result of transference or generalization, but only to the extent that they have been stored as negative affects associated with memories of particular events. As in the case of anxiety, such memories can be located in the person's history as recorded in memory and, by means a variety of corrective emotional experiences, and their negative emotional charges can be removed. This alters the person's emotional experience of the past and frees him from the impact of the past upon the present and future.

4. Depression and Boredom: Depression takes many forms among offenders, from apathy to sadness, from discouragement to somatic depression, from bouts of self-depreciation to obsessional anhedonia. However, in almost all cases, the depression is either a defensive avoidance of involvement in emotional living or is associated with other emotional states. The same is true of boredom. When it is a defensive reaction, it should be corrected by addressing the underlying state from which it is derived. When it is associated with other emotional states, it should be corrected by addressing the associated emotional states. Except in those instances where it is a derivative of

grief resulting from a significant loss, it should **not** require specific treatments of its own.

Treatment Alternatives:

(a) Goal Finding Programme: Goal finding is a "life management by objectives" programme designed to help participants develop and achieve two types of goals, namely personal development goals and achievement goals. The former refer to those personal qualities which they would like to have as attributes of their "ideal self," while the latter refer to vocational, acquisitive, relational, familial, leisure, health and community service goals. Although ostensibly designed to help the individual to become better organized, this programme has been found to be very helpful in the modification of depressive affect.

(b) Affect Expression Programme: Depression robs people of the ability to experience the many opportunities for joy which exist in life. Furthermore, it tends to be self-perpetuating as a result of the reinforcing effect of feeling special in suffering. Desensitization to positive emotional experiences, cognitive restructuring to increase tolerance for positive feelings towards others, and various methods from assertiveness training free the client to experience and express the positive emotions.

(c) Grief Programme: Although grief is a common and natural reaction to loss of a significant other, it can become an unnecessary burden when it is unduly prolonged. However, a programme for the treatment of grief reactions has recently been developed (Andreas and Andreas, 1988) which employs the client's internal representations of and values associated with grieved and not-grieved missing others to "heal" the grief reaction and return the person to normal, productive living.

5. Obsessive Rumination: Obsessive rumination and compulsive actions appear to be common to most if not all of the criminal thinking factors in one way or another. This is not surprising from many points of view. Obsessions and compulsions provide a certain "stickiness" or rigidity in maintaining habits of thought and action, whether or not these habits of thought and action are socially appropriate. They create the withdrawal which isolates the person from the development

of normal socialization and the influence of pro-social peers. They create inhibitions which prevent the expression of anger and other feelings until they have accumulated enough energy to demand expression, usually as rage and/or violence. They tend to drive the person's attention to "red herring" irrelevancies of situations or living, which leads to unusual or aberrant actions. Although these features, like depressions, are largely defensive, they probably cannot be left without direct therapeutic attention because they tend to maintain old habits in a person's repertoire -- habits which can easily grow again in a "malignant" manner.

Treatment Alternatives:

(a) Obsessive Programme: Obsessionality has traditionally proven to be one of the most difficult forms of psychopathology to treat. A few of these people will respond favourably to medications such as Anafronil, but most do not. For these people, a specific programme has been assembled which addresses all of the known features of obsessionality. It begins with an explanation of the structure and adaptive function of obsessions and compulsions, including the role of introversion (with its implied verbal mediation of behaviour) and extraversion (with its relative disinhibition of behaviour). It proceeds with desensitization to ambiguity and uncertainty, training

in controlling pressure of thought, modification of introversiveness, and instruction on the necessity of avoiding avoidance.

Application of the treatment programmes described above requires some precision, in the sense that anxiety and anger, for example, are affects that occur in response to specific stimuli which may vary from factor to factor. In addition, there are certain components which are specific to one or two of the factors rather than all six of them. Precision in the application of generic treatments and these factor-specific components are discussed below.

Factor 1: "I can't stand guilt"

The elements associated with this Factor which require treatment:

1. Guilt Proneness/Sensitivity: This element includes a sense of guilt, of interpersonal failure, and regret for the past. In essence, it reflects a heightened sensitivity to anything that can be construed as blame for wrongdoing.

Treatment Alternatives:

(a) Desensitization to Blame/Guilt: Wolpe's Reciprocal Inhibition Therapy (RIT) and its Neuro-Linguistic Programming variation, the Dissociative Phobia/Trauma Cure, are designed to reduce the affect associated with learned sensitivities of any kind, including guilt sensitivity.

(b) Change Personal History: As described for anxiety in general, guilt-producing experiences can be located in the person's history as recorded in memory and, by means a variety of corrective emotional experiences, can have their negative emotional charges removed, as noted above.

(c) Examination and Affirmation of Personal Standards: The procedure for Resolving Guilt has been developed by Andreas and Andreas and accompanies their videotape of the same name. "Overall, the Guilt Resolution pattern first eliminates the feeling of guilt in response to not meeting your own standards." Then it teaches a decision process to examine the standard, and determine: (a) whether the person wants to keep this standard, or some modification of it, for himself, and (b) what the person wants to do in response to this situation. Alternatively, you could condition in the person an automatic cognitive-emotional change from the realization that they have violated their own standard to seeing themselves able to decide what standard they want standard they are going to uphold.

(d) Values Review/Restructuring: Values provide the initial motivation determining what we do, and the after-the-fact means by which we evaluate what we have done. The latter attribute of values implies that guilt feelings, a sense of failure, and regret are by-products of the person's values. Values can be in conflict with each other, or can themselves be conflicted. Sense of failure implies that the up-front motivations may have been weak or competing with each other. Guilt and regret imply that the motivations for actions were in

competition/conflict with other evaluating values. Examination and restructuring of values allows the individual to retroactively re-evaluate earlier actions, and helps to prevent future errors of motivation and thus of after-the-fact negative evaluations -- thus rendering unnecessary the inhibition of guilt, anxiety and anger (affects), as well as anti-social excitement seeking.

(e) Success Training: Negative evaluations, resulting from internalization of others' evaluations, become part of the individual's self-definition before being externalized onto others as the source of difficulty in life. If the client can re-discover his ability to succeed, to plan and to accomplish, his self-esteem can begin to heal itself, and

he can perhaps create a sense of psychological "distance" from his past and into the future with better grace and confidence.

There are also means to help the person to experience his own successes, to plan strategies by which he can be successful in achieving his goals, to build his self-confidence, and to internalize positive attitudes and rewards so that he no longer feels "at the mercy" of others. Enhancing successes permits the client to move into the future without needing to inhibit positive emotions or to be mistrustful, impatient and excitement seeking.

2. Inhibition of Affect and Behaviour, and their Sequelae: This element comes from the person's intolerance of his strong (negative) emotions of guilt, depression and anger, and tends to inhibit emotions. The result is, that to gain a sense of pleasure or happiness, he must seek stimulation from external sensory events. This focus on external stimulation quickly creates adaptation to (diminishes the impact of) "ordinary" events, demanding increasing levels of intensity or excitement, which can only be achieved by means of "risk-taking" excitement seeking. This element also includes the person's felt need to inhibit his actions (since they lead to criticism/guilt tripping, failure and regret) which, by preventing energy use/release, enhances impatience and anger.

Treatment Alternatives:

(a) Desensitization to Stressor Events: The desensitization procedures referred to above can

also be helpful in preventing the vicious circle of intolerable affect which leads to more intolerable affect (e.g., as in being anxious about being anxious.

(b) Change Personal History: The change personal history procedure referred to above can be used to help the client re-evaluate his experiences in the light of those resources, both personal and interpersonal, which he has now but which he did not have then, thus altering his emotional view of the past and freeing him from the impact of the past upon his present. Removing the root cause of his inhibition of his emotions should disengage him from the need for future anti-social risk-taking/excitement-seeking.

(c) Personal Time Restructuring: With the intense-affect-related sensitivity reduced, it then becomes possible to consider the extent to which the individual is associated into or dissociated from his experiences. Those who are associated into their life experiences are likely to experience their emotions more intensely than those who are dissociated from them. With the intensity of affect reduced, it then becomes possible to help the individual to associate into his experiences, with the result that he is less likely to require a focus of attention on external events to create excitement and risk-taking.

(d) Affective Training: Inhibition of emotions, along with its consequences in mistrust and externalization of attention to create stimulus-hunger, can also be corrected by a programme for affective training which has been in use as a Treatment Workshop for some time. This brief programme employs a simple model to facilitate the person's understanding, and several adaptations of conventional methods from assertive training to free inhibited emotions and re-orient the person toward the experience of positive emotions in place of negative ones. It should obviate the need for externalization of attention in risk-taking/excitement-seeking.

(e) Assertive Training: The conventional procedures of assertive training have the effect of increasing the expression of self and of feelings, and of increasing the availability of energy use to the person. This set of procedures is ideally suitable for this purpose, and they tend at the same time to reduce both anger and impatience in the person. This should result in a reduction of the anger which "fuels" the anti-social conduct of these people.

(f) Rational-Emotive Therapy: The conventional procedures of rational-emotive therapy also have the effect of reducing the inhibitions which rigidify people's behaviour, and of helping the person to relocate the source of his anger in himself and thus under his own control. This set of procedures reduces inhibition, thereby freeing anger and other feelings so that they do not accumulate to too great a degree for control to master. At the same time, they reduces anger and redirect it in ways such that it can be controlled by the person.

Factor 2: "I can't stand Failure/Inferiority"

The elements associated with this Factor which require treatment:

1. Attention Deficit Disorder/Hyperactivity and Paroxysmality: Since a large part of this factor is associated with attention deficit disorder, perceptual handicap and paroxysmality (and thus learning disability), it is often useful to address these features even before attending to the feelings of failure and inferiority which are their frequent sequelae. The term paroxysmality has been used above to refer to those epileptiform symptoms which have also been termed partial or complex seizures.

Treatment Alternatives:

(a) SMR-SCARS Biofeedback Conditioning: The original Biofeedback Lab at the O.C.I. was established specifically to treat these kinds of disorders. Two studies have demonstrated the effectiveness of this programme in reducing criminal recidivism among offenders having these characteristics. The method involves conditioning the body to increase both its physiological calmness (Stimulus Conditioned Autonomic Response Suppression, SCARS) and its production of an electrical activity of the brain called sensorimotor rhythm (SMR) which permits production of neural inhibition -- the means by which the brain functionally insulates nerve fibres and bundles. This programme continues to be available for this purpose.

(b) Attention Retraining: Attention Deficit Disorders (ADD) are easier to treat in adults than in children. Ritalin is less useful with adults than with children, but the greater maturity of the adults often makes it possible for them to (i) re-tune auditory attention by exposure to

properly paced early-life vocal auditory experiences, (ii) establish a renewed sense of time in which to "organize" experience by fairly simple exercises in timing and partitioning time by the use of a metronome and simple patterned activities, and (iii) develop re-structured learning strategies by which they can experience success in learning and accomplish both discrimination and generalization skills. It is sometimes necessary in such people to address the sub-clinical drowsiness which is often observed in them. This can be achieved with the help of Ritalin, or by systematic (RIT) or biofeedback (SCARS) desensitization for the stimulus triggers for their soporific behaviour. The result tends to be reduced impatience, among other things.

(c) Hyperactivity Retraining: Hyperactivity may be rooted the same problems as ADD. If so, the common roots can usually be identified by tests, and can be treated

by the same methods mentioned in the preceding paragraph. When the roots are different, hyperactivity needs to be addressed separately. In this case it will usually yield to guilt de-training (see above, Factor 1, #1) or to perceptual discrimination training and biofeedback desensitization (SCARS) -- which address the two most common separate factors underlying hyperactivity as a psychological, rather than a psychophysiological, disorder. This usually results in a decrease in restlessness.

2. Failure and Inferiority: These elements are equivalent to the feelings of guilt, failure and regret of Factor 1, and can be addressed in an equivalent way.

Treatment Alternatives:

(a, b, c, d, e) Desensitization to Failure, Change Personal History, Examination and Affirmation of Personal Worth, Values Review/ Restructuring, and Success Training as in the treatment programme for guilt sensitivity. Examination and Affirmation of Personal Worth is similar to Examination and Affirmation of Personal Standards. It uses a procedure developed by Andreas and Andreas for Resolving Shame, which is quite similar to their procedure for Resolving Guilt.

3. Vengefulness: The sense of failure and inferiority experienced by the ADD child is accompanied by a sense of mistreatment, distrust and vengefulness. The client's hyperactivity (which is irritating to adults) and his probable learning disability (which is bewildering to adults) continue to exist into adulthood, the former as restless activity and the latter as impatience with the continual frustration of his failures. Perceiving others as at least part of the source of his problems, in their perceived mistreatment and misunderstanding, he increasingly feels the need to get back at them -- vengefulness.

Treatment Alternatives:

(a) Vengefulness does not require special treatment, as it tends to be relieved when mistrustfulness and the anxiety about close emotional relationship has been properly addressed. However, it may sometimes be appropriate to facilitate the release of vengeful feelings by helping the person to "make peace" within his own mind by a simple and direct counselling procedure which can be embedded in any other ongoing treatment programme.

4. Superiority Feelings/Grandiosity and Egocentricity: These elements are direct defensive derivatives of the feelings of inferiority. These attributes tend to offend others, with the result that they try to undermine these feelings by trying to "cut the person down to size". This almost never works. The problem is **not** the person's sense of superiority, but rather his sense of inferiority and even worthlessness. If self-depreciation, failure-proneness and inferiority feelings can be addressed successfully (see above), then the apparent sense of self-importance, grandiosity and being special in some way is likely to evaporate without specific treatment. Of course, this does **not** mean that other people should "try to build the person up" or magnify his successes or existing feelings of grandiosity. That, too, would be counter-therapeutic. The best way to address this kind of behaviour is just to treat the underlying feelings of inferiority, as in 2 above.

Factor 3: "I can't stand insecurity"

The elements associated with this factor are similar to those associated with Factor 2. Again, the

anxiety is closer to shame than to guilt. However, the individual is even less able to relate his felt rejection to his sins of either commission (as in the case of guilt) or omission (as in the case of failure). In this case, he feels rejected because of what he is rather than because of anything that is even potentially within his control.

1. Closeness Anxiety: This element is expected to be amenable to some of the same kinds of treatments prescribed for the feelings of guilt, inferiority and failure found in Factors 1 and 2.

Treatment Alternatives:

(a, b, c, d, e) Desensitization to Closeness, Change Personal History, Examination and Affirmation of Personal Worth, Values Review/ Restructuring, and Success Training as in the treatment programme for guilt sensitivity.

Factor 4: "I can't stand other people and their put-downs".

The elements associated with this factor which require treatment:

1. Failure and Inferiority: These elements are equivalent to the feelings of failure and inferiority of Factor 2, and can be addressed in an equivalent way.

Treatment Alternatives:

(a, b, c, d, e) Desensitization to Failure, Change Personal History, Examination and Affirmation of Personal Worth, Values Review/ Restructuring, and Success Training as in the treatment programme for Factor 2.

2. Social Isolation: This element is rewarded by the comfort of feeling free from criticism, misunderstanding others and feeling misunderstood. Even if these features no longer exist in the person's daily social contacts, the isolation may continue since it is the anticipation of future events, rather than current events, which perpetuate it. Therefore, it may need to be addressed in treatment for its own sake.

Treatment Alternatives:

(a) Enhancing Social Motives: Motivationally, there are two human phenomena which push people to relate to one another in social groups. The first of these is the fact that each person

receives help and support for his own life and needs in society

-- that is, society exists because it is easier to specialize such that each person supplies his skills and energies in exchange for those of others. Pressure to develop independent and different specializations works fairly well with this group of people because of their habits of acquiescence. This is accomplished by slowly building micro-specializations within each existing group structure (including the treatment group) which can be recognized and appreciated by others, and which others will **not** help the person undertake (which would foster his dependency). The second social motive is loneliness. Loneliness is a poignant sense of yearning for the company of others which is experienced if the person is not in close or emotionalized relationship to others. But it is also a motive to push people into relationships with others. Loneliness can be used in treatment groups to demonstrate the reduction in that unpleasant feeling by the use of simple practice in simple relating skills.

(b) Group Therapy: Interactive therapy with a moderately stable group of others tends to pull people out of their isolation into relationship experiences. After the initial establishment of rapport in a group, it is often possible to accelerate the process of group relationship development by the use of stimuli (poems, topics)

which foster each of the successive stages of issues through which a group must grow -- e.g., anger, them loneliness, then self-depreciation, etc.

3. Acquiescence and Dependency: These elements define what is commonly referred to as "the follower". They seem to derive from a failure to develop "independence" in the process of development. Treatment of these elements, which include the depression which is common to all factors, requires that the person learn the independence which he failed to develop during childhood -- so that he can take on the task of socialization for himself.

Treatment Alternatives:

(a) Assertive Training: The conventional forms of assertive training need to be supplemented for this purpose with additional training in (i) personal energy use (e.g.,

exercise and extensor gestures) to contact the long inhibited energies, (ii) freeing energy (repetitive, intense energy output), (iii) training in decisiveness (immediate action), and (iv) training in response variation (response repertoire increase). These strategies can be implemented in the large-group setting, but they do require an extended assertive training programme.

(b) Personal Direction-Finding: This programme is a special case of the Goal-Finding programme mentioned earlier. Goal-finding is particularly difficult for these people partly because of their unwillingness to make decisions and partly because of their concreteness of thought (inability to abstract and to relate actions to one another). A multiple-choice form of approach to goal-finding needs to be used to shepherd them through this process in order to help them to discover that they can be self-directed, future-oriented and able to connect events together at least in linear chains. The focus in the Personal Development goals is likely to be set around assertiveness and decisiveness as to-be-developed personal qualities.

(c) Independence Training: Independence means many things to different people. In treatment it reduces to a limited number of specific operations including (i) the development of a sense of "security" while assuming responsibilities (in vivo desensitization), (ii) the modulation of expectations from others and from the world to realistic limits -- essentially, the world is not going to look after you, and you will probably not be a super-human being, (iii) the development of a sense of "challenge" in assuming self-selected responsibilities and obligations, and (iv) the growth of the readiness/willingness to accept the costs or consequences of one's own actions. The order of this progression of tasks is important to the possibility of therapeutic success.

4. Concrete Thinking: This element seems to be quite common among those scoring high on this factor. This phenomenon impedes the person's growth, socialization and even his ability to learn from experience. Although it is a result of the above elements, it may interfere with treatment to modify the above, and so it needs to be addressed for its own sake.

Treatment Alternatives:

(a) Negative Practice: One way to correct an error response is to have the person practice it to boredom and fatigue. Methods such as perceptual discrimination training and repeated administration of the Categories test or an Inference-Proneness test (GAP-), by supporting the concrete will often enforce the break-down of concreteness and result in flights to variation. If, as if true of other aspects of criminal thinking, compulsivity plays a big role in their concreteness of thought, negative practice in the form of flooding or conditioning inhibition, as mentioned earlier, may prove helpful.

(b) Divergent Thinking: In order to disrupt stereotypes which are a large feature of concreteness, it is possible to intersperse negative practice with training in divergent thinking -- almost the opposite of the former. In divergent thinking training, the person is exposed to tasks involving abstract words and ideas, and is encouraged, with the reward of enjoyment and fun, to incorporate, or at least flirt with, unusual and contradictory meanings and issues associated with them. The effect is to limit conceptual stereotypes and to free the person from ritualization.

Factor 5: "I can't stand closeness. I must be coldly aloof"

The elements associated with this Factor which require treatment are:

1. Closeness, Social Anxiety: These elements seem to lie at the core of this Factor, although it is hard to determine whether the Closeness, social anxiety is a derivative of the social isolation of introversion, or is the motivation for the introversion (see below). In either case, however, it needs to be addressed therapeutically. Desensitization (to Closeness, Social Anxiety) is the first line of attack on this essentially phobic problem.

2. Introversion and Verbal Mediation of Experience: These related elements create limitation of available response alternatives and a certain "stickiness" or rigidity of thought which interfere with the person's capacity to change as a result of therapeutic interventions. Introversion, by turning the person's attention inward, reduces the person's susceptibility to change by reducing his access to

external evidence and to change in the external world. Introversion most centrally involves the inhibition of action in favour of verbal mediation of experience and repeated review of verbal contents (thought) in contemplation. As such it imposes on the person the constraints (words restrict response options and rigidify by not changing) of words and meanings and stultifies change. These elements require treatment intervention for themselves, as well as to render therapeutic change possible.

Treatment Alternatives:

(a) Obsessive Programme: As treatment issues, introversion and verbal mediation are equivalent to obsessionality. Obsessionality has traditionally proved to be one of the forms of psychopathology which is particularly resistive to treatment. A few of these people will respond favourably to medication such as Anafronil. Most do not. For these people a specific programme has been assembled which addresses all of the known features of obsessionality. The programme has not yet been tried out in large-group format, although it appears that it should work in that setting since it seems to work well in individual psychotherapy, and since its elements all lend themselves to large-group application.

(b) Thought Stopping: It is impossible to prevent thought. The brain is constantly active. However, a number of ways have been found to limit or control thinking or to diminish the amount of pressure of thinking. Thought stopping is a procedure to help the person to control his thinking and to erase temporarily disturbing thoughts -- which are strongly represented in people scoring high on this Factor. Methods to diminish the pressure of thought and the disturbances and worries which accompany thoughts include Transcendental Meditation and Zen and other eastern meditation methods, brief-interval time-tabling, or motility training. These latter methods work by increasing concentration and by distracting attention to non-arousing stimuli. Any and all may be used as needed.

3. Social Isolation/Withdrawal: This element is a fairly natural result of all the other elements described above as involved in this Factor. It is probably unnecessary to address this element, since

it is very likely to correct itself following the therapeutic applications mentioned above for this Factor. In the event that it is necessary to address this element directly, the procedures prescribed for Factor 4 #2 may be employed.

4. "Ideals", Rationality and Emotional Coldness or Emptiness: This group of elements underlies the joyless and unfulfilling lives common to people in this group. Introversion and verbal mediation breed the development of ideals and a reliance on rationality and logic. The experienced failure of the external world to "match" ideals or "reasonably" established expectations, results in constant "short-falls" perceived in the world and repeated disappointment in self and others. The result is joylessness (anhedonia). Even if introversion were to stop, these consequences of it would not necessarily stop unless the person accidentally discovered the roots of joy. These roots, of course, include seeing the good/happy in the external world, trusting others, attaching interest, caring and love to things and people, and expressing or using the internal emotions which "colour" life.

Treatment Alternatives:

(a) Goal-Finding -- Personal Development: The Goal-Finding programme mentioned earlier contains a procedure for finding and achieving personal qualities. The personal development goals which need to be fostered in people scoring high on this Factor would include qualities such as "outgoing", " trusting", "spontaneous", "active", "emotional", "expressive", "interested", "loving", etc. Achievement of these kinds of personal goals is effected by self-directed operant conditioning which, itself,

fosters "discovery" of positive views of self and others. This begins the corrective process.

(b) Affective Training: Emotional coldness or emptiness, rationality and anhedonia, along with some aspects of social insecurity, can be corrected by a programme for affective training which has been in use as a Treatment Workshop for some time. This brief programme employs a simple model to facilitate the person's understanding, and several adaptations of conventional methods from assertive training to free inhibited emotions and re-orient the person toward the experience of positive emotions in place of negative ones. It should

extend the capacity of the person to experience and express his (especially positive) emotions, increase joy in living (thus reducing depression) and at the same time reduce some of the inhibition and rigidity which pose therapeutic problems with these people.

(c) Change Personal History: Negative feelings about the world and the inability to "find good" in the world are critical factors which induce some of the anger in these people. These feelings about the past impact on the present only to the extent that they have been stored as memories with associated negative emotions. Such memories can be located in the person's life-time histories and, by means of several available varieties of corrective emotional experiences, can have their negative emotional charges removed, thus altering the person's emotional view of the past and "freeing" him from the impact of the past upon his present. Removing the root cause of his negative feelings and anger should disengage him from the need for future anti-social/risk-taking actions.

(d) Values Review/Restructuring: This programme is similar to that employed with anxiety, as described above. Examination and restructuring of values may permit retroactive re-evaluation of earlier actions, and ought to prevent future errors of motivation and thus of after-the-fact negative evaluations -- thus fostering positive motivations and interest in the person, thereby increasing his emotional empathy for others and thus interfere with future victimization of others.

5. Polar/Black-and-White Thinking: This element becomes a resistant habit which needs to be addressed in treatment. Untreated, it is apt to result in rationalized extremism which, in turn, may eventuate in criminal activity which the person has "justified" for himself.

Treatment Alternatives:

(a) Cognitive Retraining: A number of procedures are needed to correct some of the cognitive habits underlying this sort of polar thinking or "splitting". This sort of thinking in based on (i) inference proneness or over-inclusiveness of thought, which can be addressed by inference detraining, (ii) stimulus over-generalization which can be addressed by

perceptual discrimination training, (iii) mistrust of others' judgement which can be addressed by repeated use of the Categories test or other human-feedback tasks, (iv) the need to "control" or possess others (for fear they make mistakes) which can be addressed by fair witness training and in vivo desensitization, and so forth. These methods may reduce the need pressure slightly and diminish its habit strength, but they do not yet relieve the anxiety underlying the need.

Factor 6: "I can't stand Discipline, Rules and Control"

The elements associated with this factor which require treatment:

1. Delayed Socialization: This element seems to spring from an undisciplined upbringing with weak development of delay of gratification and inadequate adaptation to others needs and wishes. The result is less one of overt anti-social conduct and more one of under-socialized conduct. One result of this, of course, will be that he is fairly constantly in conflict with others.

Treatment Alternatives:

(a) Relationship Discipline: By this term is meant the application of formal discipline demands in a warm and caring relationship. The former will not "take" unless the latter is in place. Strictly applied time constraints on programme attendance need to be enforced, formal or politeness manners need to be observed for purposes of modelling, quiet insistence needs to be made concerning conversational activities including completion of thoughts, staying on topic, accurate use of words, and the like. The purpose of these constraints on relationship activities is to provide some gentle external discipline of kinds that the person can eventually internalize in the social contacts.

(b) Socialization Experience: The amount of a person's socialization experience can always be supplemented by interaction with a consistent, loving, interested and concerned well-socialized other. This will not only provide modelling and experience in socialization, but will also facilitate moral reasoning development and the human quality of reciprocity in relationships. This can be provided by professionals, case management staff or volunteers

exercising normal social skills.

(c) Daily Routines: Use of any daily routines, even down to the regularization of meals and sleeping times, and up to regular duties and work, and even self-regulated study habits, can be of benefit in the basic tasks of learning socialization and the delay of gratifications. If behaviour modification tactics (e.g., token economies) are used, their control and operation should be turned over to peers as soon as possible.

2. Failure and Inferiority: These elements are equivalent to the feelings of failure and inferiority of Factor 2, and can be addressed in an equivalent way.

Treatment Alternatives:

(a, b, c, d, e) Desensitization to Failure, Change Personal History, Examination and Affirmation of Personal Worth, Values Review/ Restructuring, and Success Training as in the treatment programme for Factor 2.

Conclusions

Although the above programmes seem rather extensive and time-consuming, it must be remembered that there is absolutely no reason to believe that the treatment of criminal thinking will be quick and simple. Fortunately, however, most of the programmes described are both susceptible to large-group application (and are thus highly cost-efficient) and really relatively short-term (some taking as brief a time as a couple of hours). It seems likely, therefore, both that the suggested treatments will perform the tasks set for them, and that the overall programme is reasonable practical to mount.