

“Are They Mental Health or Behavioral?”:
Toward Object Relations Translation for Corrections Officers

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Abstract

Correctional institutions, particularly correctional security staff (corrections officers, deputies and other custodial staff), are increasingly relied upon for the management of some of the most severely disturbed and impaired members of society. Lack of mental health training for correctional staff poses problems to include safety risk, lack of empathy, inmate abuse, staff burnout and trauma, as well as missed opportunities for rehabilitative efforts. This paper proposes that salient concepts from psychoanalysis, particularly object relations theory can and should be integrated into training for correctional security staff. Using the acronym “PSYCHIATRIC”, relevant object relations concepts are translated into practical correctional language. Increasing accessibility to object relations theory offers opportunity for interdisciplinary collaboration and effective use of correctional staff members’ time and expertise, while supporting the mental health of inmates and staff members. The case vignettes of Jack and Kayleen explore staff/inmate dynamics through an object relational lens. Further exploration, implementation and evaluation of object relations informed training tools are suggested to evaluate impact and efficacy.

“Are they Mental Health or Behavioral?”: An Introduction

Countless times, in the midst of inmates acting out, causing disruption and presenting with bizarre and dangerous behaviors, members of correctional security staff have stopped me to ask, “Is this guy Mental Health or Behavioral?”. It is the most common question I have been asked over my ten years working in correctional mental health and strikes at the heart of the most important issues of incarceration. The exact phrasing varies by region and facility. On the East Coast, the question was “Is this guy really MO?”, MO being jail vernacular for an inmate who requires “Mental Health Observation” housing in a facility. The questions can take other forms to include “Is this one for real?”, or “Is he/she playing with a full deck?”. While a simple answer would be convenient, it does not exist. The question however provides us an opportunity to consider the complex way that correctional security staff members understand, engage with, help and harm the deeply troubled people entrusted to their care. Psychoanalysis, in particular object relations theory, helps us get closer to some of these answers, providing invaluable tools for understanding and intervening with the often extreme and unimaginable behaviors, situations, histories and humans hidden away in jails and prisons around the country.

The Keepers and the Kept

In recent years, jails and prisons have become some of the largest providers of treatment for the nation’s mentally ill population and as such are increasingly relied upon “to serve the medical and behavioral healthcare needs of...the most impoverished and disenfranchised members of the community” (Lurigio, 2016, p.3). As of 2016, there were 1,505,400 inmates serving time in prisons across the country with another 740,000 inmates held in local jails. Each year, nearly 12 million people are processed through local jails nationally (Bureau of Justice Statistics, 2016; Lurigio, 2016). Of these inmates, it is believed that approximately 26% of jail

inmates and 14% of prison inmates “met the threshold for serious psychological distress (SPD) in the past 30 days” (bjs.gov, 2016). Following the de-institutionalization of the 1970’s (Lamb and Weinberger; Montross, 2016) and the past several decades of mass incarceration, people with chronic mental health needs are “ten times more likely to reside in correctional facilities than in state psychiatric facilities” (Mulay, Kelly and Cain, 2017, p.143). As Parker (2009) reports, for the past 20 years “the prevalence of mental illness in jails and prisons has been a growing concern for state correctional agencies, state mental health agencies, and advocacy organizations” (p.640). For the care, custody and control of these disturbed inmates, the Bureau of Labor Statistics (2016) reports over 430,000 “corrections officers/jailers” work in some capacity in correctional institutions (prisons, jails, forensic psychiatric units) in addition to nearly 90,000 probation officers and correctional treatment specialists.

Among the collateral consequences of the mass incarceration of the mentally ill, is a workforce of correctional security staff members that is unprepared for the massive needs and risks of working with this high-need population. Within the walls of all correctional institutions there are different players, who in many moments, function with unison and collaboration, but often, function with fear, paranoia, threat and realization of violence. Correctional institutions are comprised of inmates, security staff, administrators, medical staff to include nurses, doctors, midwives, mental health professionals and contracted staff such as food service vendors and outside group facilitators (Dvoskin and Spiers, 2004, p.43). Each of these players brings a different background, perspective, set of expectations/demands, ability level and motivation. “Despite the inherent power differential, inmates and staff unequivocally rely upon one another in order to maintain the safe and effective functioning of their facility” (p.43).

With the reality that jails and prisons are now among the nation's largest providers of mental health treatment, correctional security staff, carries the weight of trying to manage the needs of sick and volatile inmates. While many correctional officers and mental health treatment staff "share common goals of decent and humane treatment of inmates" (Parker, 2009, p.643), stark differences in role, education, ability and philosophy remain. Traditional training for correctional staff, has focused primarily on tactical responses to inmate behavior while neglecting psychologically informed training on the symptoms and effective interventions that help inmates cope with their mental health needs. Correctional officers frequently report responding to inmates with serious mental health needs to be among the greatest challenges of their work (Applebaum, Hickey & Packer, 2001; Parker, 2009). Further, these officers often express great interest in training on work with these types of inmates. Describing the role of correctional officers in correctional facilities, Parker (2009) wrote:

Dvoskin and Spiers...argued that correctional officers could play important roles in the provision of mental health services to offenders in a therapeutic manner, talking about the offenders as part of the mental health consultation process and observing medication effects and side effects. (p. 643)

We have tasked hundreds of thousands of correctional staff members to intervene with and manage the sickest members of our communities. "Our society has placed the correctional line staff member in a very stressful environment, often without adequate training, and does not even acknowledge the extent to which he/she performs the very difficult role of therapeutic agent" (Dvoskin and Spiers, 2004, p.56). What remains a highly challenging population for even the most seasoned mental health professionals is even more confounding for correctional staff who lack formal training on etiology, symptoms and effective management of mental illness.

Further, correctional staff is often ill-equipped to interpret and manage their own, understandably, severe reactions to this high-risk and needy clientele.

It seems unsurprising that this set-up can be damaging to all involved...the inmates serving time and the staff responsible for their custody. Stories of brutal violence between inmates and correctional staff, neglect of medical care, sexual abuse and excessive use of force and solitary confinement seem endemic to the environment. "When one considers the challenges of their work environment, it is not surprising that correctional officers who work on special housing units have been reported to be physically and psychologically abusive to inmates under their supervision" (Parker, 2009, p. 644). Correctional staff abuses may take the form of physical and verbal use, excessive force, neglect of needs and in some cases, sexual exploitation. Like those that they keep, correctional staff are likely turning to perpetration, to manage their own experience of victimization.

How Can Object Relations Help?

Whether one enters jail or prison through the metal detectors (as a staff member), or through the sally port (as an inmate), facing the harsh realities within the walls is jarring at best, and deeply dangerous and traumatic at worst. Most correctional security and treatment staff who have spent time in these institutions can easily recall their initial fears and anxieties, as well as formative lessons and experiences that helped them gain skill and competence in navigating their careers in locked facilities. Having begun my own correctional career while still an MSW student, it was not until I developed an understanding of object relations theories and interventions that I felt able to understand and practice effectively within the harsh realities of incarceration.

Among the most influential object relations theorists is Melanie Klein, whose concepts of splitting, the paranoid-schizoid position and projective identification give us valuable tools for understanding incarceration. “Klein (1935, 1946)...provided a basis for paranoid fears as a universal aspect of the human condition” (Auchincloss and Samberg, 2012, p.187). Rooted in “paranoid anxieties that results from the projection...of primitive sadism and aggression”, Klein defined the paranoid-schizoid position as “characterized by active splitting of good and bad aspects of internalized object relations, accompanied by violent projection (later projective identification of the bad” (p.187). These are defining features of incarceration as are the damages of being unaware of these dynamics.

Evidence of splitting and the paranoid-schizoid position can be found in nearly all elements of our system of incarceration. Splits of “good versus bad”, “us versus them”, “right versus wrong” (and many would argue, “black versus white” regarding race), are the bedrock of the criminal justice system. “The prison makes the ephemeral dynamics of the paranoid-schizoid position concrete: free staff are all good, the inmates are all bad, and we know this by the uniforms that they each wear” (Kita, 2012, p.54). Inmates and staff are in constant fear of annihilation in the form of physical assaults, and these fears are as much reality as fantasy. “With this in mind, it is unsurprising that many staff are profoundly affected by their work. On the receiving end of patients’ powerful projections, they also become distressed and defend themselves through the use of projection...a paranoid-schizoid projective system is established” (Aiyegbusi and Tuck, 1994, p.24).

Comprised of elements of the primitive defense of projection, projective identification “is defined by Klein (1946) as a defensive process by which parts of the self are forced into the object so as to control the object from inside” (Auchincloss and Samberg, 2012, p.203). Building

upon the work of Klein, Ogden published *On Projective Identification* (1979) and described the following three-part process:

First, there is the fantasy of projecting a part of oneself into another person and of that part taking over the person from within; then there is pressure exerted via the interpersonal interaction such that the 'recipient' of the projection experiences pressure to think, feel and behave in a manner congruent with the projection; finally the projected feelings, after being 'psychologically processed' by the recipient, are reinternalized into the projector. (p.357-373)

This sequence is evident in many interactions between correctional staff and inmates. Through projection, introjection, internalization and externalization, inmates psychologically force into correctional staff, their unwanted thoughts, feelings, fantasies and aspects of self. Ogden points out that, "This is not an imaginary pressure. This is a real pressure". Unaware and unsuspecting, correctional staff members internalize the projection without an understanding of what is happening or how to avoid its control. Instead, they often become retaliatory (to inmates or in their personal lives), acting out the projected feelings and fantasies in congruence with the projection.

Projective identification is one of the key psychological concepts that could benefit correctional officers in evaluating their actions and understanding their relationships with inmates and throughout their careers. Longevity in corrections provides an opportunity to reflect on shifts seen in staff behavior over time and it is not uncommon to see drastic changes (for better and for worse) as correctional staff progress through their careers. Significant research has been done on the concepts of "stress" and "burnout" in correctional staff (Cheek and Miller, 1983; Cieslak, Korczynska, Strelau and Kaczmarek, 2008; Dowden and Tellier, 2004; Lambert

and Paoline, 2017). In sum, researchers have found that morale, quality of supervision, safety risk, organizational issues and role conflict were among the most important variables linked to stress and burnout on the job.

A psychoanalytic consideration would posit that “burnout” alone is a drastic minimization of what contributes to correctional staff turnover, excessive use of force, psychological distress and other abuses. Subject to constant and severe projective identification, correctional staff has minimal psychological defense or preparation to navigate the projection. While much is written about the impact of projective identification on analysts and therapists, we have neglected addressing its impact on correctional staff. Drastically outnumbered by very disturbed inmates, correctional staff serve as a psychologically unprepared receptacle for the rage, desperation and violence that inmates strive to rid themselves of daily. With the knowledge that mental health professionals have on symptoms, risks and management of projective identification, finding ways of sharing this information with correctional staff is not just a matter of safety, but of ethics.

The work of D.W. Winnicott deepens our understanding of the dynamics of incarceration through his concepts of ruthlessness, the “holding environment” and the “good enough mother/environment”. Ruthlessness is comprised of the primary aggression of a baby, directed at an external object for the purpose of exploring the object’s capacity for survival of the destruction (Abram, 2007; Winnicott, 1945). This “primitive ruthless self” is demanding, dependent and aggressive. In a separation from Klein, for Winnicott, the object’s “survival” of destruction is what helps make the baby whole. Winnicott’s ruthlessness can be a powerful tool in interpreting inmate behavior as a series of ongoing attempts to “destroy the object and have it survive”. But the ruthlessness of the baby pales in comparison to the safety risk of the

ruthlessness of a hardened inmate. Thus, the necessary feature of the object's survival without retaliation is generally eliminated in jails and prisons. Inmate attacks are often so extreme that use of force incidents may be required and are subsequently experienced as retaliatory.

Minne (2008, p.26) describes forensic patients as having "experienced highly depriving and rejecting early carers" and "are likely to present with disturbed personalities and ways of relating which ensure that the environment replicates their experiences through the relationships they have with carers and the relationships the carers have with each other". She reminds us of the importance of remaining "available as a thoughtful, non-retaliatory, non-abandoning object" and to avoid "enacting what is provoked" with forensic populations. Ongoing training for correctional staff on the importance of measured, interdisciplinary, non-retaliatory responses to inmate ruthlessness could provide opportunities for inmates to experience the object's survival of their destruction.

Through Winnicott, we can consider that recidivism rates, and inmates deemed "frequent flyers", provide evidence that correctional institutions are being relied upon to serve some role of a "holding environment". Winnicott's holding environment was comprised of dependence on responsive caregivers, provision of safety, physical and psychological holding. Incarceration can provide shelter, clothing, sustenance, medical care, sobriety, a degree of safety provision and in some cases, education and employment. Often, correctional staff plays the paternal role of father while treatment staff (therapists and nurses) play the caretaking role of the mother. For deeply traumatized and marginalized populations, incarceration may serve as the closest thing to care and stability they have experienced in their lifetimes. In fact, it is common to hear inmates remark on their view of incarceration as "three hots and a cot" and for staff to express resentment over the complete dependence that inmates often place on the system. In his now famous phrase

“there’s no such thing as a baby”, Winnicott captures a key feature of incarceration...that there’s also “no such thing as an inmate”. Every inmate exists in connection to a facility, a judicial district, some form of a victim, a medical staff, a correctional officer, a judge, a jury, an attorney, and all of the inmate’s past experiences. Each of these personal and environmental factors, offers an opportunity for us to help or to harm.

When people inevitably ask me how and why I have chosen work in locked facilities, my usual answer is “jails and prisons are full of life”. While the perception and often reality is that prisons are damning places of wasted potential, I have found work with inmates to be full of vitality and energy. These facilities are filled with people trying to survive existence in creative ways beyond the average person’s wildest imagination. In his 1956 paper on “The Antisocial Tendency”, Winnicott stressed the importance that “the antisocial act” should be interpreted as “an expression of profound need” and further, should also be seen as “an expression of hope” (Abram, 2007, p.57).

Keeping “hope” in mind, we should wonder what it would take, for jails and prisons to function not exclusively as harsh, oppressive, traumatic, human warehouses, but to find ways to effectively take on the role of Winnicott’s good enough mother/good enough environment. While it seems impossible that anyone could find comfort, protection, soothing and/or meaning in correctional institutions, those who have spent time within the walls have seen it occur. Indeed, healing, caretaking, and transformation takes place in locked facilities “with a group of people considered refractory to treatment and in a place often hostile to it”, (Kita, 2012, p. 41), against all odds.

Like Winnicott’s holding environment is Wilfred Bion’s concept of containment. “Bion emphasized the relationship between the container and the contained and contended that early in

life we rely on the mind of the (m)other to contain the content of our otherwise chaotic experience” (Kita, 2012, p.44). Due to their histories of trauma and neglect, many inmates never experienced adequate maternal containment and now as adults, suffer impaired thinking and reasoning, absence of empathy and reliance on primitive mechanisms of projective identification. Containment must be forced upon these inmates through incarceration.

In pursuit of forced containment, the entire criminal justice system is what Bion would call an “attack on linking” (Bion, 1959). “Bion described one of the central ways the mind attacks its own processes as “*attacks on linking*”, in which the connections among things, thoughts, feelings, people, are all broken” (Mitchell and Black, 1995, p.104). Incarceration offers an extension of what most inmates have already been experiencing throughout their lives. They have been defined by broken relationships and inability to forge links and bonds with individuals, families and the communities they reside in. The Bureau of Justice Statistics (2016) reports that nearly 95% of inmates will eventually return to the community after incarceration. It seems imperative that rather than foster systems that support attacks on linking, our focus must shift to interventions that forge and strengthen links for these inmates.

During my clinical correctional career, I have relied on object relations theories as lifelines to understanding and intervention. I cannot imagine facing days working or living in correctional facilities, without the knowledge of object relations, or the lens of psychoanalytically informed theory. It is exposure to this knowledge that has enabled me to function outside of the paranoid-schizoid position and offer help and hope to my incarcerated patients and colleagues. Over time, however, it has seemed increasingly unjust that there is such a vast array of theoretical concepts and treatment interventions available to myself and other

clinicians, while corrections officers who work in such close proximity to inmates, sometimes for over 40 hours per week, are not given those same tools.

Jack & Kayleen: Case Illustrations

The following composite case vignettes are based on actual incarcerated clients I have worked with. They are illustrative of the value that object relations-based training for correctional staff could provide both staff and inmates.

Jack

Jack is a 51-year-old Caucasian male, incarcerated on charges of attempted murder of his girlfriend and her alleged lover. A career criminal, Jack has been institutionalized, in group homes, psychiatric facilities or prisons since his early teens. The son of a violent, alcoholic father and a severely depressed mother, he was abused throughout childhood, as well as enduring sexual abuse by multiple male staff members in group homes growing up. In an event that taught Jack these risks of attachment (Sinason, 2001, p.48), as a child, his father forced him to shoot and kill the family's cat because they "couldn't afford to feed it". Upon being sent to prison, he witnessed frequent assaults between inmates and staff, to include multiple inmate on inmate murders.

Jack presents, primarily in splits and extremes. On some days, he presents as gentle, compassionate, reflective, generous, intelligent and polite. And on others, he is wicked, aggressive, assaultive, suicidal, self-injurious and enraged. He idealizes and devalues staff and himself depending on which end of the split he is on. I served as his primary therapist for nearly two years relying heavily on object relations theories for assessment and interventions. On several occasions, in response to Jack's increasing desperation and mounting ruthlessness, I would stand outside Jack's, locked, cell door and let him scream and shout about whatever he

needed. During these moments, and many other moments of clinical intervention, correctional staff would grow irritable and warn me that it “wouldn’t help” and that I was “wasting my time”. His rage was powerful and expansive but his opportunity to feel, process and unleash it, in the container of his cell, while unable to physically harm me, nearly always de-escalated Jack. I earned value to Jack because of my survival of his destruction of me.

Jack had a particularly provocative influence on staff members. He elicited a range of extreme protection and care, and extreme aggression and retaliation from staff. On his bad days, Jack would make up a narrative to share with the correctional officers about some “promise” he perceived I had made and broken. It was common for correctional staff to become drawn into the projection. Feeling Jack’s rage, feelings of injustice and splits, some of these officers would lash out at me accusing me of “lying” to Jack, making “false promises”, “stirring him up” and “creating this situation”. Despite there being no truth, by any stretch of interpretation, to these claims, the staff members believed this was “not his fault”. These were often officers that I had great working relationships with for many years. I couldn’t help but feel in those moments, that these officers were overcome with Jack’s projective identification. They felt taken advantage of and abused, they felt aggressive and accusatory, they felt like they could relate to Jack. So with little understanding of what was happening, they, like Jack, resorted to primitive defenses of denial, projection, splitting and acting out.

On one occurrence, a typically professional and measured correctional staff member, uncharacteristically attacked Jack in an excessive use of force. The incident also resulted in the destruction of a sentimental Bible that Jack kept with him from his days of freedom. While Jack was not religious, the Bible had been a gift and served as a transitional object to him and was his sole remaining item from what would turn out to be his last days as a free man. Jack had

previously antagonized this staff member with threats though never acted out physically against the officer. Part of the narrative for the officer's retaliation was that Jack "brings out the worst" in people. This narrative was accepted as fact without attention paid to why he brought out their worst and what could be done about it.

Weekly interdisciplinary meetings about Jack were frequently contentious. It was as if Jack were sitting in on those meetings, dressed as an officer, criticizing, regressing, disrupting. Many staff members would emotionally argue about issues related to Jack, even when they were actually agreeing on assessment and plans. Correctional staff frequently felt victimized by decisions made regarding Jack, and responded with victimization...of Jack, of mental health staff and of one another. Jack would have several weeks of improved stability and affect regulation, showing insight and reflection. Then inevitable impingements would arise through court, family scenarios or issues with other inmates and he would regress. Correctional staff had a very difficult time holding the good and bad aspects of Jack and seemed shocked and dismayed each time that Jack regressed. Their justification was that it must be "mental health's fault" if Jack regressed in disbelief that such extremes could exist, on their own, in one person.

While there were moments of insight and collaboration (and ultimately, psychoeducation of correctional staff resulted in monumental strides), I couldn't help but wonder, how much better could we have served Jack if there had been an earlier and shared understanding of some of the psychological dynamics playing out? And for those who would never empathize with Jack, due to the heinousness of his crime and the rarity of his redeeming virtues, how much better could correctional staff have served and supported one another through his time in custody, with knowledge and tools for managing the complicated psychological dynamics unfolding?

Kayleen

Kayleen was a 22-year-old, Mexican and Caucasian female incarcerated on a minor drug possession charge that escalated to multiple felony charges while in custody. Originally facing less than a year of incarceration, and more likely, a treatment program in lieu of prison time, her behavior while incarcerated resulted in competency evaluations, forensic hospitalizations and restorations, dozens of assaults on staff and a potential sentence of eight years in prison.

While in custody, Kayleen experienced drastic mood swings, dissociation, and severe aggressive/assaultive behavior. She routinely and relentlessly unleashed her ruthlessness upon staff putting everyone's safety at risk. Initially, correctional staff responded with typical and appropriate use of force tactics. Kayleen was routinely restrained, placed in a special management cell, restricted from time with other inmates and shrouded in a spit hood as her behavior dictated.

Over several months, exhaustion, confusion and helplessness (all feelings Kayleen routinely experienced) set in for staff. It was very common to hear Kayleen described as being "possessed" or appearing "demonic", all characterizations that were very rare for our staff to make. These dehumanizing descriptions were also reflective of the emerging fear and desperation felt by all. On one occasion, it was reported that a generally empathic, correctional staff member stated that she deployed her pepper spray in excess so the residue would linger later into the day and burn Kayleen as she showered. The use of force was clearly indicated in this instance. Kayleen had attacked a nursing staff member during medication pass and the spray was used to subdue her as getting close to Kayleen would result in further injury. The

excessive use of pepper spray however, was abuse, and indicative of a growing trend of staff member's excessive aggression and retaliation against Kayleen's volatile presence.

Initially completely resistant to my engagement efforts, I continued to visit Kayleen daily and daily I was met with a barrage of profanity, threats and assaults on the door that separated us from one another. Through a steady pattern of holding, handling and object presenting (with a dose of cheap sarcasm and persistence), Kayleen began to turn in to my presence. Kayleen and I developed a strong therapeutic bond during that time. It became evident that much of her acting out was intended to elicit the use of force from male staff members, which she found sexually gratifying in a repetition of her childhood experiences of being violently sexually abused and restrained. Her transference response to correctional staff was that as adults in power in her world, they were going to abuse and traumatize her as adults had in the past. The magnitude of the danger she presented to the staff was such that the countertransference response left no choice but use of force, congruent with the projective fantasy and solidifying her belief that she will always be victimized.

During multidisciplinary staff meetings, I tried to explain these dynamics. Senior correctional staff members were initially resistant, but based on our years of collaboration, they were also open to influence. We ultimately developed a response plan that minimized male staff response to these incidents, and took calculated safety risks, in the hopes of disrupting the cycle between Kayleen and correctional staff. The common correctional staff response was "we don't understand it, but we have nothing to lose". The efforts were effective and required use of force was substantially decreased. Because of the severity of Kayleen's disturbance and the drastic response to her behavior management plans, mental health had a major breakthrough in communication with correctional staff, opening the door for further psychoeducation.

Most staff members were positively impacted by our management plans however some dissented. Evidence was found in response to my use of a transitional object with Kayleen. As part of our treatment plan, I placed a tracking chart on the outside of Kayleen's cell door since she had a history of destroying anything that was placed in her cell. It was small and discrete so as not to obstruct the view into her cell and was approved by senior staff. On the chart, I included a photo of a parrot, symbolic of a joke we had frequently shared in our work together. The chart was intended to track Kayleen's incidents of smearing feces in her cell and included our established goals, rewards and repercussions. Kayleen was delighted to know there was a name for fecal smearing, "scatolia" (Mason, 1996) and she found relief in using what she deemed a "scientific" word to describe her behaviors. On the days that the chart remained intact, Kayleen adhered to her treatment plan and refrained from scatolia. While the chart itself was not curative, the fact that I had placed it there was and offered a way for Kayleen to hold me in mind when I was not around. It became a routine occurrence for members of security staff to tear down and throw away the chart, in retaliation against Kayleen, citing it as a "security risk". I would re-create the chart to be as identical as possible, just to have it torn down again. On the days the chart was torn down, scatolia ensued.

After the third incident of Kayleen's scatolia-tracker being torn down, I called a meeting with several senior correctional staff members. I provided an overview of my case conceptualization, treatment interventions, and my outcomes thus far. By that time, they had been showing increasing understanding of the importance of the therapeutic relationship I had with my most severe clients. In meetings they began to state with confidence things such as, "it's not just the meds that keep her stable, it's also her therapy" and "we need to be sure she is able to get her therapy as the mental health team orders, that's what really helps her". With the

support and intervention of senior staff, who had an emerging sense of psychological concepts, we were able to keep the chart intact, and scatolia at bay, for the remainder of our work. Continued collaboration ultimately resulted in Kayleen drastically progressing out of her isolation cell and moving into an open-bay, general population area.

The State of Correctional Mental Health Training

Central to issues related to incarceration and mental health is the dual mandate of jails and prisons as places with competing interests of punishment and rehabilitation (Applebaum, Hickey & Packer, 2001; Kita, 2012). Correctional staff are at a complicated crossroad of the two, tasked clearly with the punishment/containment aspect of incarceration, while their roles as caretakers and healers are greatly underestimated, in their own mind and by others. “Prison officers are allergic to the idea that they care for their prisoners...But this contempt for caring is curious...Bonds develop between the two groups, with a shared commitment and identification to the wing and the prison they are both placed in” (Morris, 2001, p.97).

On good days, correctional staff talk, laugh, and joke with inmates. On worse days, correctional staff save inmates’ lives through heroic responses to attacks, medical crises and suicide attempts. Correctional staff is also frequently involved in the development of programming to help support stability on their units. In some cases, they even develop highly organized interventions that are administered by identified and interested correctional staff. Correctional staff has unique and specialized knowledge of the inmates on their units as well as the culture of staff members and the facility. They are often acutely attuned to the needs, risks and resources available to them, frequently, to a greater degree than the assigned mental health treatment providers. It seems that we are undertraining correctional staff on issues of mental

health and the dynamics between themselves and inmates, and that we are underestimating their role as potential change agents throughout their institutions.

Considered one of the seminal texts on understanding and interacting with inmates is Allen and Bosta's (1982) bestseller, *The Games Criminals Play: How You Can Profit by Knowing Them*. The book focuses on "manipulation" and it describes various "set-ups" that inmates undertake to manipulate correctional staff members. While *Games Criminals Play* gives relevant and provocative examples of problematic patterns between inmates and staff, the book ignores the etiology of the behavior as well as neglecting possible solutions that target the roots and manifestation of the symptoms. The authors state, "once in prison, members of this society learn that by acting out, refusing to cooperate...modifying their keeper's behavior, circumventing or disobeying rules, and being willing to do these things regardless of the punishment, give them status among their peers" (p.9-10). The book not only normalizes the paranoid-schizoid position, but endorses it, in a further perpetuation of the "all good versus all bad" split. A psychoanalytic perspective would counter this knowing that these adaptations emerged long before incarceration, in response to long histories of neglect and developmental trauma. The psychoanalytic perspective opens us up to empathy, interpretation, and intervention. Despite being in print for decades, there are no references or citations in the book, yet it remains one of the most relied upon works in the correctional environment for understanding inmate behavior.

Fortunately, in recent years, there has been a substantial movement in corrections to expand mental health education and training for corrections officers and these trainings are proving highly effective with high-risk offenders (Hogan, Barton-Bellessa and Lambert, 2015; Parker, 2009). One approach many agencies employ is training on Mental Health First Aid (MHFA) whose website (mentalhealthfirstaid.org) states a goal of making MHFA "as common

as CPR”. It is an impactful start with a curriculum that addresses depression, anxiety, psychosis, substance use disorders and eating disorders. Mental Health First Aid gives practical and highly effective techniques for de-escalation and stabilization of people in mental health crisis. While MHFA is invaluable to correctional staff on the aforementioned issues, it makes no reference to symptoms, reactions and interventions with people with severe personality disorders. These symptoms include severe interpersonal difficulties, impulsivity, destructive behavior, paranoia, splitting, self-injury, attention seeking, fantasies and excessive clinging and rejection, all of which require highly skilled responses from correctional security staff.

Even more in depth mental health training for law enforcement can be found in Crisis Intervention Training (CIT) a 40-hour intensive training on de-escalation and crisis response taught by law enforcement and mental health professionals. CIT has made a significant impact on jail diversion as well as re-arrests (nami.org) and offers training and practice in “common crisis situations” for law enforcement. Like MHFA, CIT also reflects an absence of discussion, education or preparation related to personality disorders. While the movement toward enhanced psychoeducational training for correctional staff continues to grow, there remains a notable absence of reference, or training related to personality disorders which are pervasive in forensic clientele. With this absence comes the missed opportunities to discuss the fear, paranoia, projections, retaliation, feelings of manipulation and other deep pathologies that plague correctional staff and inmate dynamics. Exploring the dynamics of personality disorders in prison, Morris (2001) articulated the challenges correctional staff face:

Having a personality disorder (as most prisoners do) means that one’s psychopathology is expressed in relationships. Whereas psychotic patients’ psychopathology is manifested in their own minds in the form of delusions and hallucinations...this is not the case with the

personality disordered. Here, the psychopathology is actually expressed in the relationships that the person has, in the space or area of intimacy that opens up between two people who get to know each other. Usually this area of intimacy, once established, is used for psychological assault. This hurts and it will be the daily experience of prison officers who work day in and day out with society's most disturbed personalities. (p.97)

For many inmates, the most accessible relationships available to them, are with correctional staff and their pathology, needs, attacks and opportunities for healing are manifested between them, daily. Gordon (2008) urges consideration of a psychoanalytic perspective, particularly "in secure (hospitals and) units where the ingredients for institutional ill-health are potent and the personality disorders are, basically contagious", claiming that psychoanalysis can provide "a degree of immunity to the contagiousness through treatments, supervisions, consultations and training, but especially by bringing to attention the unconscious aspects" (p.28).

So...Are They "Mental Health or Behavioral"?

In the interest of clarity and simplification, I used to try to answer the "Mental Health or Behavioral" paradox with an explanation from the DSM IV-TR. I would zealously try to explain to correctional staff the difference between Axis I and Axis II disorders and describe the differences in Mood, Trauma, Psychotic and Personality Disorders. This was well received, and staff remained curious and inquisitive, albeit, teasing me about providing excessive information for what they saw as a very simple question. Though I am not sure they'd admit it, many staff members seemed proud to have a surface level understanding of a piece of psychological terminology. I knew however, that this answer was not enough and while grateful to hear a shift in correctional staff language during meetings..."Is this guy Axis I or Axis II?", I knew it did not

accurately describe what was psychologically happening with these inmates. Further reducing my explanation, the DSM 5 (2013) removed the multi-axial assessment system altogether.

Upon return from their forensic assessment and hospitalizations, I was disappointed to see reflected in Jack and Kayleen's charts, what I had seen so many times before. Jack was diagnosed with "Antisocial Personality Disorder (ASPD)" with no mention of any of the clear mood and trauma related issues he faced. Kayleen was diagnosed with "Mood Disorder with Psychotic Features", with no mention of her clear symptoms and history of trauma and Borderline Personality Disorder. Subsequently, their treatment plans were not reflective of the complexity of their mental health needs. Consistent with the frequent pattern of splitting throughout the criminal justice system, even the forensic hospitals appeared to draw the line between what is institutionally considered "Mental Health or Behavioral".

We were fortunate that over the course of Jack and Kayleen's periods of incarceration, mental health staff and correctional staff were able to make, what in our facility amounted to monumental progress. Jack and Kayleen were both sent to prison and the likelihood that they will get the attention and interdisciplinary collaboration that proved effective in our facility, is bleak. Kita (2012) highlighted this dilemma of assessment, diagnosis and intervention with forensic populations. Reflecting on the challenges of diagnosing trauma and personality disorders she wrote:

That PTSD and ASPD are both so frequently diagnosed among inmates can cause cognitive dissonance...PTSD is an acknowledgement of one's victimization, while ASPD indicates perpetration. It can be quite difficult to tolerate the reality that inmates are often both victims and perpetrators...These two identities however – of victim and perpetrator – often coexist in the same person. The combination of PTSD and ASPD may develop in

response to the traumatogenic conditions in which many inmates live...prisons house, “contain” – this group of people are who are not reflected in mainstream diagnostic systems. (p.64)

For these reasons, we must be cautious not to silo inmates into one category or another. As Rotter, Way, Steinbacker, Sawyer and Smith (2002) found, behaviors that appear indicative of personality disorders, in the incarceration setting, may be both “understandable and adaptive”. Despite people with personality disorders being “overrepresented in the correctional setting...They are not, however, all antisocial” (p.347). The answer to the “Mental Health or Behavioral” question, lies in the correctional system’s progression past the splits and fears of the paranoid-schizoid position, toward an educated and empowered approach to conceptualizing and intervening with these highly complicated, traumatized people.

Toward Object Relations Informed Training

Several years ago, I was offered the opportunity to develop and teach a new Suicide Prevention curriculum to hundreds of law enforcement and correctional staff members. In preparation, I met with a law enforcement staff psychologist to discuss my ideas and solicit advice. In consultation, I excitedly shared my hope of discussing some of the feelings and behaviors that inmates elicit from staff members, why they are elicited and what can be done to respond constructively versus aggressively. I wanted to discuss transference and countertransference dynamics. I wanted to explain projective identification and its deleterious impact on correctional staff’s own mental health...but I knew that the key was in translation. Dr. Trivette advised, “You need to talk to them about their gut...they won’t hear those words, they need to hear it in a language they can understand...they understand and trust their gut” (personal communication, 2016). It was powerful advice that turned into a long-term challenge.

While formal outcome data was not collected following the training, anecdotally, feedback from correctional staff was enthusiastic. The attention that drifted during other parts of my training, was attentive and intense as correctional staff spoke about their own psychological responses and “gut level feelings” (countertransference) to their daily work with inmates. Many staff members stayed after the training to ask me further questions or provide examples. They were inquisitive, curious, and empowered with even a small amount of object relations understanding of themselves and inmates.

It has become evident over the course of my correctional career, that the adaptation and integration of psychological concepts into the correctional world, relies heavily upon effective and practical translation of the topic to the intended audience. There are phrases that float around jails and prisons for people who put too much emphasis on mental health issues or are too empathic toward inmates. “Bleeding heart”, “inmate lover”, “softie” or adapting the “hug-a-thug” approach are all harsh criticisms of people employing what correctional staff deems (and can become), dangerous warmth or empathy toward inmates. Attempts to infuse psychological concepts into training, should take into account, the cultural risks of doing so and should adapt in a way that minimizes these risks.

In response to the challenge of translation, I have developed and am proposing the following training tool for correctional staff, utilizing the acronym “PSYCHIATRIC” to highlight the object relational terms most salient to the daily lives of correctional officers. The correctional system leans heavily on acronyms and jargon, so this is an attempt to integrate that reality of correctional culture to make the concepts more readily accessed and accepted. This information is intended for correctional staff members who are more advanced in their careers and already have an established baseline of mental health training. See Figure 1.

Figure 1: PSYCHIATRIC Training Tool: Object Relations Translation for Corrections Officers

	Object Relations Concept	Key Points for Corrections	Correctional Examples	Common Correctional Staff Feelings/Reactions	Correctional Considerations
P	Projective Identification	<ul style="list-style-type: none"> - Process where unwanted feelings, emotions, traits of one person are psychologically forced into another person - Goals to eliminate the traits from one and see how receiver deals with those traits 	<ul style="list-style-type: none"> - Staff experiencing inmates' feelings as though they are their own - Staff acting similar to inmates - Inmates who seem to "hijack" the emotions of others (inmates, staff and family members) 	<ul style="list-style-type: none"> - Dysregulated emotions - Feeling "out of control" - Acting "out of character" - Excessive empathy, feeling you know exactly what the inmate is going through - Feelings of rage, anger, aggression after interacting with certain inmates 	<ul style="list-style-type: none"> - Awareness of physical and mental states - Tuning in to body - Use trusted friends (inside and outside of corrections) as a mirror - Have ways of modifying physical and emotional states
S	Splitting	<ul style="list-style-type: none"> - Rigid separation in the mind of good/bad, positive/negative, right/wrong - Idealizing and devaluation 	<ul style="list-style-type: none"> - "Black & White" thinking - "All good or all bad" thinking - "Us versus Them" mentality - Second guessing staff members you used to trust/respect 	<ul style="list-style-type: none"> - Feeling "played" or "had" - Feeling suspicious or excessively frustrated with colleagues - Believing inmates' false claims about staff behaviors/promises/statements 	<ul style="list-style-type: none"> - Utilize multidisciplinary team meetings - Direct communication and documentation - Notice and mitigate triangulation
Y	Youth Experience	<ul style="list-style-type: none"> - Consideration of a person's developmental experience - Includes primary caregivers, culture, history of trauma, victimization, strengths, resilience - Consideration that people can become fixated at a developmental stage 	<ul style="list-style-type: none"> - Inmates acting similar to very young children - Inmates reliving/re-enacting their childhood traumas while in custody 	<ul style="list-style-type: none"> - Demanding "grow-up", "man up", "get past it" - Minimizing role/impact of childhood trauma - Resentment of childlike behaviors - Infantilizing inmates 	<ul style="list-style-type: none"> - Awareness that jails and prisons are filled with adults who are stuck at childhood age emotional development. - Incarceration recreates a childlike scenario of inmates' total dependence on the facility to provide food, shelter, clothing, safety, healthcare
C	Countertransference	<ul style="list-style-type: none"> - Emotional responses to another to include feelings, reactions, impulses - Reactions to another person's transference (Transference is how a person experiences, reacts and responds to another, based on earlier life experiences) 	<ul style="list-style-type: none"> - The feelings and reactions you have to how an inmate treats you - These feelings may be intense, surprising, unexpected - May have positive/negative feelings 	<ul style="list-style-type: none"> - Feeling like an inmate is acting out against you based on their experience with someone else - Feeling like you remind an inmate of someone from their past - Having an inmate remind you of someone from your past 	<ul style="list-style-type: none"> - Awareness of range of mood and thought responses - Patience with self for having emotional responses - Mindful and intentional reactions
H	Holding Environment	<ul style="list-style-type: none"> - Concept of a satisfactory, supportive environment for a baby to grow up in where they are adequately cared for and tended to - Lack of holding environment may result in problems throughout life 	<ul style="list-style-type: none"> - Inmates relying on incarceration as a "holding environment" where they are fed, clothed, offered protection, offered medical care - Inmates who appear to "live" at certain jails and prisons - "Homesteading" in housing areas. - High recidivism rates 	<ul style="list-style-type: none"> - Feeling like you are "babysitting" - Feeling that inmates are acting like little children with endless needs/demands - Emergence of parental feelings/actions toward inmates (positive and negative) - Excessive feelings of need to protect - Belief that jails and prisons should remain uncomfortable, violent and dangerous for deterrence 	<ul style="list-style-type: none"> - Keeping in mind that a safer facility for inmates translates into a safer facility for staff - Measured responses to inmate needs - Avoid excessive minimization or excessive accommodation of inmate needs/demands - Treat inmates with appropriate responsiveness, equality and consistency
I	Identification with the Aggressor	<ul style="list-style-type: none"> - Victim of aggression or violence/abuse acting like their abuser - Way of seeking safety, approval and similarity with abuser 	<ul style="list-style-type: none"> - Inmates who have been victimized now victimizing others (may happen over years or during one incarceration) - Inmate self-harming behaviors - Staff taking on characteristics of dangerous facilities/staff members 	<ul style="list-style-type: none"> - Feeling victimized, helpless - Blame toward the inmate - Fear of what inmate may do next - Increased anger, hostility, aggression - Justifying excessive use of force (your own or your colleagues) 	<ul style="list-style-type: none"> - Awareness of your own feelings of being victimized - Reflection on your past history of being victimized (at home and at work) - Develop ability to accept feedback from trusted friends/co-workers

			- Staff feeling oppressed by their agencies or legal system and taking it out on inmates		
A	Aggression	-Thoughts, actions or wishes intended to cause harm, destruction or abuse of another - Some aggression is healthy - Can be used to be productive - Excess aggression is dangerous/destructive	- Screaming, throwing, passive aggressive behaviors, threats, smearing feces, self-harm, suicide attempts - Inmate on inmate assaults - Inmate on staff assaults - Possession of shanks	- Fear - Defensiveness - Rage - Aggressive fantasies - Post-Traumatic Stress Disorder or symptoms - Offensive tactics	- Awareness of inmate and own aggression - Seeking out support network: friends, therapy, career mentors - Develop techniques for self-de-escalation at home and work - Find constructive outlets to release your own aggression - Team collaboration/assessment
T	Turning Against the Self	- Process of turning emotions, anger and aggression at self instead of toward someone else	- Inmate self-harming behaviors - Cutting, swallowing, punching self, hunger strikes - Inmates provoking use of force - Inmates enjoying use of force - Inmate self-deprecating humor	- Confusion/shock about behaviors - Broad-brushing these inmates as “crazy” - Defining these inmates exclusively as “manipulative”, “attention seeking” - Fear of repercussions when an inmate self-harms	- Report any stated suicidal thoughts - Avoid of deliberate provocation - Consult mental health professionals - Restrict dangerous items - Thorough and timely documentation
R	Ruthlessness	- Primitive demands a baby places on parent: feeding, physical and emotional comfort - Aggression, neediness and selfishness of a baby - Screaming, throwing, grabbing - Baby needs to consistently know that these needs can be met by the caretaker in order to believe they are safe and cared for in the world	- Inmates’ unbridled aggression, demands, lashing out, selfishness - Assaults - Inmate acting as though they are the only person in their ward/facility - Attention seeking behaviors - Constant demands for meals, clothing, housing adjustments, toilet paper	- Feeling fear, rage, desperation - Excessive use of force - Losing control during a use of force - Attempts to “get even” with inmates - Going “tit for tat” - Seeking revenge - Post-Traumatic Stress Disorder or symptoms	- Self-awareness when being emotionally attacked - Ability to recognize excessive feelings of rage and aggression back at inmates after provocation - System of processing these reactions - Have techniques to de-escalate yourself before, during and after incidents
I	Impingement	- Events that occur that disrupt a course of events - Can be damaging or strengthening - Pattern of reacting to impingements emerges	- Inmate’s making progress on treatment plan but new stressors occur such as assaults, bad news from court/family - Staff may make progress with one inmate but another inmate disrupts the unit - Plans for inmate treatment/release are delayed or disrupted	- Feeling of “one step forward, two steps back” - Feeling that “no good deed goes unpunished” - Staff attempting to help but are criticized or told to stop - Surprise at inmate’s sudden regression or acting out	- Patience with inevitable impingements - Plan for and anticipate these disruptions to plans, the ward, inmate functioning - Develop awareness of how personal impingements impact your functioning
C	Containing	- Process of developing ability to think about one’s own thinking - Derived from effective parenting where children developing thinking skills, empathy and processing feelings - When missing from childhood, missing from adulthood	- Inmates who seem to prefer incarceration to freedom - Inmates who appear to enjoy cell housing vs. open bay - Inmates demanding single-cell housing - Inmates who require frequent restraints (chair, belts, spit hoods, helmets)	- Resentment toward inmates who are repeatedly incarcerated - Belief that inmates who do not want to be released and live in the public are “crazy” - Assumption that no one actually wants to be incarcerated - Having expectations in excess of inmate abilities	- Consideration that inmates may rely on jails and prison to make them feel contained - Awareness that inmates may realize how dangerous or out of control they can become and on some level believe they must be incarcerated

Conclusion

These ideas are in no way assertions that we should attempt to morph corrections officers into psychologists, psychiatrists or psychoanalysts. Nor are they attempts to disrespect or disregard the breadth and intensity of psychoanalytic knowledge. But one does not need years of psychoanalytic training to develop awareness and consideration of many relevant and practical psychoanalytic concepts. We continue to fail the sickest members of our society when the concepts that we *know* are critical to treatment and safety are restricted to ivory towers and training institutes, inaccessible to the desperate needs of the forgotten staff and inmates in the concrete warehouses of our jails and prisons. Practical and creative translation can help keep inmates, staff and subsequently, communities safer. Efforts to introduce relevant elements of psychoanalytic ideas, can help correctional staff raise their baseline understanding of mental health needs and concepts, mitigate retaliation and bolster insight and empowerment.

While the proposed tool requires further screening, evaluation and data collection on usefulness, it proposes a new way of bringing the powerful ideas of object relations theories to correctional staff. If we are going to teach correctional staff about criminogenic behaviors, then we should also teach them about trauma. If we are going to teach correctional officers about “use of force” we should teach them about the psychological variables that justifiably and wrongfully evoke the need for a use of force reaction. If we are going to provide correctional staff with physical tools to handle inmate attacks (pepper spray, zip cuffs, restraint chairs) then we should also arm them with the knowledge and psychological lines of defense to physically and mentally protect themselves and other staff from inevitable ruthless attacks. We must teach correctional staff that with perpetration, there has nearly always been victimization and that correctional staff’s own professional victimization, puts them at risk of perpetration as well.

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