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Treating Depression and PTSD Behind Bars

An Interaction Schemas Approach

Key Sun

The Need for Treating Depression and PTSD in Incarcerated Clients

Among the growing population of mentally disordered offenders in the prisons and jails across the correctional system, a large proportion suffer from depression and/or post-traumatic stress disorder (PTSD) (Bureau of Justice Statistics [BJS], 2006; Heckman, Cropsey, & Olds-Davis, 2007). For example, a BJS report (2006) indicated that about 23% of state prisoners and 30% of jail inmates reported symptoms of major depression. A review by Heckman et al. (2007) showed that PTSD rates among prisoners were also very high, reaching approximately 21% among male inmates, 48% among female prisoners, and 24–65% among male juvenile offenders. These rates were much higher than the 5–12% PTSD rates observed in community samples.

In spite of the critical need to treat the depressive and PTSD symptoms of incarcerated clients, the majority of cognitive-behavioral treatments (CBT) in facilities of confinement appear mainly focused on issues related to reducing recidivism (e.g., antisocial values, criminal peers, low self-control, dysfunctional family ties, substance abuse, and criminal personality; see Hansen, 2008), rather than on treating mental disorders. Although some research shows that a CBT-based approach can successfully reduce depressive and PTSD symptoms in incarcerated offenders by increasing coping and problem-solving skills, improving anger management, and reducing stress (e.g., Heckman et al., 2007; Smedley, 2010; Spiropoulos, Spruance, Van Voorhis, & Schmitt, 2005), a number of issues, including how different schemas regulate cognitive processes (e.g., appraisals, interpretations, explanations, adjustments), remain to be examined.

The Intrinsic Association Between Depression and PTSD

Depression and PTSD are best treated as a combined problem in cognitive therapy for incarcerated clients because research has demonstrated that there is an intrinsic connection between depression and PTSD symptoms for offenders. Although the *Diagnostic and Statistical*

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Manual (4th edn., text revision) (DSM-IV-TR; American Psychiatric Association, 2000) classifies depression as a mood disorder and PTSD as an anxiety disorder, both share similar symptoms, such as: feelings of ineffectiveness, shame, despair, or hopelessness; feelings of worthlessness or excessive guilt; insomnia or hypersomnia, feeling permanently damaged; a significant change in previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change in previous personality characteristics. The correlation between depression and PTSD is also demonstrated by the high frequency that they precede, follow, or emerge concurrently with one another.

Foa, Ehlers, Clark, Tolin, and Orsillo (1999) found that the most typical PTSD symptoms include negative cognitions about self, negative cognitions about the world (e.g., the world is entirely dangerous; distrust of others), and self-blame, which were correlated moderately or strongly with depression and general anxiety symptoms. In addition, clinical observations (e.g., Sun, 2008; Wolff & Shi, 2010) suggest that the overwhelming majority of offenders with mental disorders have been the victims of interpersonal violence (e.g., childhood sexual or physical abuse, domestic battering). Nevertheless, it is important for therapists to pay attention to the unique symptoms of PTSD, which include: (i) exposure to a severe stressor resulting in intense fear, helplessness, or horror; (ii) re-experiencing the trauma; (iii) avoidance/numbing; and (iv) increased arousal (Heckman et al., 2007), as well as the fear to express emotions, and intrusive recollections, thoughts, and flashbacks (Clark & Beck, 2010).

Treating Incarcerated Clients Poses Unique Challenges

Counselors/therapists working with offenders in a facility of confinement would be wise to take into consideration three factors: (i) the setting, (ii) client characteristics, and (iii) the unique counseling/treatment process. Each of these factors may influence the effectiveness of counseling practice with correctional clients.

First, correctional centers (e.g., federal and state prisons, jails, and juvenile detention centers) do not represent a very salubrious environment for therapy. Not only is the architectural design of the physical environment (particularly if the prison is fortress-like) not conducive to counseling and treatment, but also the punitive atmosphere and unavoidable interpersonal conflicts (e.g., dysfunctional interactions with inmates and custody staff) can undermine the best treatment efforts and aggravate existing mental disorders. Another disadvantage of correctional environments includes the clients' isolation stemming from a lack of support from their families and communities. Thus, treatment personnel would be wise to take into account the physical and interpersonal aspects of a correctional settings and how these factors might influence the effectiveness of interventions (see Sun, 2008).

Second, not all correctional clients have the same degree of responsivity to correctional interventions. Responsivity factors can include the offender's verbal ability, motivation, personality factors, interpersonal competence, and/or learning style (Andrews & Bonta, 2006, 2010). Some inmates have resistant attitudes toward counseling and treatment characterized as uncommunicative, hostile, detached, mistrustful, avoidant of self-disclosure (e.g., refusing to share personal problems with his/her therapist/counselor or treatment group), cynical (e.g., the belief that prison counseling is useless "bull" sessions), as well as a tendency to minimize and deny problems. Developing a therapeutic alliance, which has been found to be strongly associated with better client outcomes, can pose a significant challenge with correctional clients. The therapeutic alliance is defined as the collaborative relationship between

therapist and client that is characterized by agreement between the counselor and the client on the goals of intervention, a joint effort in developing and completing treatment goals, and therapeutic values (e.g., trust, respect, acceptance, empathy, and support) (see Matthews & Hubbard, 2007).

For female offenders with depression and PTSD, therapists may need to consider the potential impact of what have been referred to as *gender-responsive factors* on treatment. An accumulating body of literature suggests that risks and needs are somewhat different for male and female offenders, with female offenders more likely to be impacted by trauma and abuse, unhealthy relationships, parental stress, depression, substance abuse, anger/hostility, poverty, and concerns for personal safety (Salisbury, Van Voorhis, & Spiropoulos, 2009; Van Voorhis, Wright, Salisbury, & Bauman, 2010). For more comprehensive discussion of working with female offenders see Van Dieten and King (Chapter 16).

Third, for incarcerated clients, the counseling process (assessment, intervention, and termination/follow-up) also poses some unique challenges not commonly encountered in outpatient therapy. For example, the concept of termination carries a different meaning in a correctional counseling setting. More often than not, the counseling process for a correctional client is terminated not because treatment goals have been reached, but because the client must be transferred to another correctional institution or unit. Further complicating treatment, for security reasons, the counselor may not be allowed to inform the client about the transfer until the day before. Correctional counselors in prison settings will seldom complete treatments as planned.

Furthermore, the unprepared treatment termination tends to produce a wide variety of negative feelings and behaviors from the clients. According to Baum (2005), clients are inclined to show great resistance, anger, rage, anxiety, and frustration regarding treatment termination when it is abrupt and outside their control and desire. On the other hand the more clients believe that they have attained their therapeutic goals and have some degree of choice in ending treatment, the more positive feelings and reactions they have toward the termination. This problem may, to some extent, aggravate the client's depression because it generates a sense of unpredictability and instability. One way to prevent or alleviate the client's anger and negative behavior in response to an unwanted termination is to inform him or her early on in treatment about the possibility of an unanticipated counseling termination and to develop a plan to handle the negative reactions when they occur.

The Interaction Schemas Approach

The interaction schemas approach is a cognitive model to explain mental and interpersonal experiences (Sun, 2008, 2013). This perspective is similar to other cognitive schema models (e.g., Beck, 1991; Martin & Young, 2010) emphasizing that distorted cognition leads to conflict in the mental and interpersonal domains; while successfully modifying distorted cognition creates and maintains emotional well-being and interpersonal harmony. However, the interaction schemas approach differs from other schema models in its definition of cognitive schemas, cognitive distortions, and in the underlying treatment rationale. For example, the interaction schemas approach views self-appraisals as determined by accurate or inaccurate cognitive structures (pattern and interpersonal schemas) representing interpersonal reality and its patterns. In contrast, other cognitive models regard self-appraisals (self-schemas) as primary, in that self-schemas serve as both the main source of mental conflict and the solution. The term "interaction

schemas" is used to emphasize that self-appraisals are derived from cognitive (knowledge) structures regulating interactions with actual or imagined others and environments. There are at least three important differences that separate the interaction schemas approach from the other popular cognitive models. For detailed discussions of the application of other schema models to offenders, see Seeler et al. (Chapter 2) and Keulen-de Vos et al. (Chapter 4).

First, in contrast to traditional cognitive therapy (e.g., Beck, 1991), which sees the self-concept as the essential content of schemas, the interaction schemas approach posits that our cognitions (schemas) comprise three interrelated mental representations: *self-schema*, *pattern schemas* (perceived patterns or rules governing human behavior and interactions), and *interpersonal schemas* (cognitions about others and situations in interaction with the self). Self-appraisals result from applying the pattern and interpersonal schemas to the evaluation of the self's attributes and experiences in terms of perceived validation and invalidation from the others and situations. Although there is some overlap between the notion of "invalidation" in the current interpersonal schemas approach and the conceptions of "disconnection" and "rejection" in Young's (Martin & Young, 2010) schema therapy, the other theoretical premises are different.

Second, traditional cognitive therapy (e.g., Beck, 1991; Clark & Beck, 2010) seems to view a negative or maladaptive self-schema as the locus of distorted cognitions that serve as a main source of mental conflict. The current model, however, regards distorted cognition as including distorted pattern schemas and interpersonal schemas, which engender maladaptive self-appraisals and interpersonal behavior.

Third, in terms of treatment, rather than emphasizing modifying the negative beliefs about the self, the interaction schemas approach suggests focusing on identifying and modifying the client's distorted pattern schemas (cognitions about what regulates human interactions and psychological experiences) and interpersonal schemas.

The following sections of this chapter will highlight the characteristics of the interaction schemas approach and its application to correctional clients.

Self-appraisals are regulated by the interaction schemas

It is necessary to first specify the meaning of schemas in the human domain. They refer to cognitive (knowledge) structures or organized mental representations of social entities (e.g., self, others, human interaction, and/or events). In this chapter, the terms such as schemas, cognition, perception, and belief are used interchangeably to designate the same structured cognitive system.

As noted above, instead of viewing the self-concept as the essence of schemas, the current approach maintains that people's schemas about human reality consist of three interrelated mental components, including: (i) self-schema (e.g., cognition related to self's attributes, actions, and experiences); (ii) pattern schemas (e.g., cognitions about why people act the way they do; or standards, rules, and criteria that are assumed to explain and control human behavior and interpersonal reality); and (iii) interpersonal schemas (e.g., cognitions about how actual or perceived others validate or invalidate the self). The three related schemas can be simplified as our mental representations of "how" and "why" regarding human reality. The mental representations of "how" include interactions of self and interpersonal schemas. The cognition of "why" contains pattern schemas that underline perceived reasons or causations related to the interactions between self and other entities.

For instance, correctional clients may have several (distorted) pattern schemas (e.g., violence, intimidation, wealth, beauty, physical or other types of perfection) that are believed to

regulate and explain their experiences in interacting with others. Take the belief in physical perfection or beauty as an example. Many depressed offender-clients are inclined to explain their interpersonal frustrations and rejections as caused by their defective or inferior physical appearance. This self-appraisal is based on the cognition that physical perfection has a transcending power over others, and, if they are deviant from the pattern schema (i.e., an inconsistency between the self's attributes and the pattern), they will not be able to meet their needs or expectations in interpersonal situations. It should be noted that although the pattern schemas are subjectively conceived and vary with individuals, the content of the patterns is independent from the self-schema. For instance, a correctional client may feel excessive guilt over a minor mistake, because she considers her error to be a serious violation of a moral code. The moral code is not a part of her self-schema, but is a part of her pattern schema and serves as an important criterion for self-appraisal.

Pattern schemas are a dominant part of cognitive structures about human reality because people are implicitly or explicitly aware that patterns or laws regulate psychological experiences (e.g., emotions, motivations, cognitions, perceptions, attitudes), and human behavior and interactions, similar to those patterns or laws administering the operations of physical phenomena in the natural world. They also have the awareness that the subjective experience of success or frustration is related to their relations (i.e., consistency or inconsistency) with the patterns. However, individuals are often unaware that their schemas are inaccurate or distorted, blindly assuming that their pattern schemas represent "what is" about the patterns governing human reality.

In addition, interpersonal schemas are an integral part of cognition (e.g., Cloitre, Cohen, & Scarvalone, 2002). Examples of correctional clients' interpersonal schemas include representations of other people who are (as perceived by the offenders) interacting with them – from family members such as father, mother, spouse, brothers, and sisters, to peers, teachers, children, friends, enemies, law enforcement officers, prosecutors, judges, correctional officers and counselors, and other staff. The most essential elements of interpersonal schemas involve perceived validation and invalidation from the others. Validation in interaction can be defined as the processes in which a person's communications and messages (including intentions, desires, evaluations, judgments, and emotions) are recognized, accepted, encouraged, and confirmed by others. Invalidation refers to the process in which a person's communication, intentions, emotions, and judgments are denied, dismissed, or nullified by the others. Both the validation and invalidation in interaction are perceived, therefore an individual's cognition of the two processes may be accurate or distorted.

Pattern schemas and interpersonal schemas regulate self-appraisals in several ways. To begin with, self-appraisals depend upon evaluating the self according to the pattern schemas. For example, correctional clients' self-appraisals are influenced through the process of discerning consistency and inconsistency between the self's attributes or experiences and existing pattern schemas. A perceived consistency between a client's attributes and the pattern schemas s/he subscribes to generates positive assessments of the self (e.g., self-confidence, jubilation, and tranquillity). Perceived deviation or inconsistency from the pattern schemas results in negative self-evaluations and related emotional suffering (low self-esteem, diffidence, guilt, unworthiness, fear, depression/anxiety, self-blame, and anger). Interpersonal schemas (perceived invalidation, frustrations, rejections, acceptance, or validation, rewards from the interacting others or situations) also contribute to the process of self-appraisals by serving as the stimuli that promote the person to evaluate his/her consistency/inconsistency with the pattern schemas. In other words, a positive or negative self-appraisal regarding interactions with others is

mediated through the perceived alignment with the pattern schemas. For example, an inmate has developed depressive symptoms after being rejected by a woman with whom he has been corresponding. The negative stimulus (e.g., social rejection) initiates and aggravates his negative self-concept only when he explains the rejection by seeing his attributes (e.g., being older) as having violated his pattern schemas (e.g., desirability of youthfulness). In addition, the experience of validation or invalidation in interpersonal situations can also change people's cognitions about what constitute the true patterns that regulate human behavior. For example, a client who has suffered chronic abuse and experienced a long history of frustrations in finding love may change his previous pattern schemas (e.g., being nice represents the transcending power over interacting others) to a new pattern schema that emphasizes dominance and manipulation in close relationships.

Individuals use their pattern and interpersonal schemas to appraise and explain the self's (and others') attributes and to understand experiences of validation and invalidation in the social world. Individuals, including correctional clients, who are aware that human behaviors and the world are governed by patterns or rules, typically try to make sense of their experiences of validation or invalidation by discerning the type of patterns or rules regulating human behavior and interactions and determining whether their own attributes or actions have violated or followed the patterns or rules. Negative self-appraisals result from the perceived infringements.

In addition, although self-appraisals may influence how the mind processes (e.g., attending, encoding, perceiving, evaluating, and attributing) self-related information, the valence (being either positive or negative) of self-appraisals does not provide people with accurate understanding of their experiences. For example, possessing a positive self-concept has little to do with the ability either to avoid or understand and overcome frustrations or invalidations.

The meaning of distorted cognitions

In contrast to the view that regards negative self-schemas as a main cognitive source of mental conflict, the interaction schemas approach considers distorted pattern schemas and interpersonal schemas as the primary cognitive constructs responsible for generating maladaptive self-appraisals. Thus, inaccurate self-evaluations (e.g., erroneous interpretations of experiences, selective abstraction, overgeneralization or exaggeration of negative experiences) are seen as symptoms, but not the root of cognitive distortions, because they are not the psychological reason *why* clients hold these beliefs.

The interaction schemas approach maintains that therapists who treat correctional clients suffering from depression and/or PTSD need not only to recognize the symptoms but also to discern and modify distorted pattern schemas and interpersonal schemas, which cause and sustain negative or inaccurate self-schemas, mental conflicts, and dysfunctional emotions (e.g., excessive sadness, guilt, shame, hopelessness), and problematic interpersonal behaviors (e.g., distrust, manipulation, lack of empathy).

Correctional clients' distorted pattern schemas may include cognitions that violence, intimidation, wealth, beauty, adherence to certain moral codes, and physical or other types of perfection epitomize the patterns that explain their interpersonal success or failure. Those cognitions are distorted, not because some of them are not useful values but because those ostensible rules represent misunderstandings about human behavior and interactions. Such rules often do not adequately explain the experiences of invalidation and frustration in interpersonal situations even though they are used as guidelines in human interaction.

Additionally, distorted interpersonal schemas include the misunderstandings of intentions, feelings, needs, motivations, cognitions, and evaluations of the interacting others, such as mistaking others' goodwill as a sign of hostility or misidentifying others' disdain as an indication of admiration. The following examples illustrate how negative self-concepts and dysfunctional behaviors are influenced by distorted pattern and interpersonal schemas.

Correctional clients with depressive or other mental health symptoms tend to appraise and explain the experience of frustration or failure in various domains by assessing the self's attributes (e.g., their inmate status or other categorical memberships such as physical imperfection, chronic disease, learning disabilities, and childhood victimization) according to some distorted pattern schemas such as elevated standards of perfection or social desirability, which are viewed as laws governing human interactions. When clients regard their shortcomings (e.g., physical defects, undesirable category memberships, and/or childhood victimization) from the pattern schemas as the explanation for their experience of interpersonal frustrations, rejections, and invalidations, they will maintain a sense of vulnerability, negative self-perceptions, and a pessimistic view of their future.

Interpersonally, distorted interpersonal and pattern schemas serve as the cognitive cause for dysfunctional actions. For example, many offenders' distorted interpersonal schemas include misconstruing neutral, or even positive, gestures of others as actions with hostile intention. Further, it is also believed that aggression and violence are the universal standards that control and regulate human behavior. As the result, such clients are inclined to use violence or aggression to get what they want in interpersonal situations (e.g., others obeying their orders or satisfying their needs).

Similarly, some correctional clients' lack of assertiveness stems from their misunderstanding of how to reach validation and overcome invalidation in situations of power disparity. A repeated theme in correctional counseling involves childhood trauma such as being sexually or physically abused. In situations in which the abuser (the powerful adult) had power over the child, victims experience fear in communicating feelings because they believed that the powerful adult, who generally dislikes unpleasant stimuli, will treat any negative communication as a sign of provocation, triggering more abuse. The same issue can persist for many correctional clients throughout their lives as they continue to misunderstand how to overcome the interpersonal abyss or disconnection between the self and others. For instance, some correctional clients told this author that they are afraid to make friends with fellow inmates by initiating conversations, or in communicating their authentic feelings to an authority figure because they fear their efforts will be invalidated. The nature of the issue of predicting failure, however, involves the victims' use of their distorted pattern and interpersonal schemas as the guideline to assess their alleged undesirable attributes and actions.

Modifying distorted cognitions

Differing from cognitive therapies that modify negative self-schemas by challenging and restructuring present automatic thoughts, the interaction schemas approach suggests that cognitive interventions need to discern and modify distorted pattern and interpersonal schemas that serve as the guideline for self-appraisals and interpersonal actions.

In this approach the therapist investigates how the clients' past experiences of invalidation have produced and maintained their misunderstanding of others and the patterns governing interpersonal reality and human behavior. It has been well documented (e.g., Krause, Mendelson, & Lynch, 2003) that early childhood traumas and a history of childhood emotional

invalidation (i.e., psychological abuse and parental punishment, minimization, and distress in response to negative emotion) are strongly associated with chronic emotional inhibition and psychological distress in adulthood (i.e., ambivalence over emotional expression, thought suppression, and avoidant stress responses, as well as depression and anxiety symptoms). Clinical observations also suggest that many offenders have experienced severe frustrations in meeting their basic human needs and have an inability to accurately understand and handle conflict. They have suffered interpersonal conflicts, family tensions, and/or other human tragedies, had experience with trauma and abuse (sexual, emotional, and/or physical), and domestic violence in the home, with few opportunities for legitimate employment (e.g., Sun, 2013; Wolff & Shi, 2010). Juvenile offenders may have school difficulties, delinquent peer associations, and socioeconomic disadvantage (Howell & Egley, 2005; Tarolla, Wagner, Rabinowitz, & Tubman, 2002). However, the interaction schema model provides a unique take on how people learn from negative experiences. It argues that negative experiences do not impact the negative self-schema (e.g., self-blame and other depressive or PTSD symptoms) directly, but develop and exacerbate the perceiver's misunderstandings of interpersonal reality and the governing patterns, resulting in his or her distorted interpersonal and pattern schemas by which the self is appraised. For correctional clients, these frustrations and invalidations in life have created strong pressures to organize and explain their experiences of invalidation by discerning how the self's attributes and actions are deviant from conveniently available, yet unrealistic, models such as physical perfection and/or social desirability (see Sun, 2008).

This current approach views treatments that repress or change negative beliefs about the self as insufficient in healing mental or emotional injuries. Focusing on the positive aspects of the self may temporarily insulate individuals from their emotional anguish but doing so is not a panacea for understanding mental conflict and interpersonal experiences of invalidation. Rather, the interaction schemas approach helps correctional clients comprehend that negative self-concepts are the symptoms rather than the cognitive source of conflicts. They need to be made aware that their distorted pattern and interpersonal schemas are responsible for their maladaptive self-appraisals, distorted explanations for their past frustrations in meeting important needs, and their inaccurate anticipations about the future. To modify distorted interpersonal schemas, clients should be provided with opportunities to share their interpersonal perceptions with one another in a safe and secure environment; thus they each can recognize the discrepancy between their interpersonal schemas and interpersonal reality through honest interpersonal communications with others. It is also helpful to recognize that others' dysfunctional interpersonal behaviors toward them are likely influenced by the others' distorted pattern and interpersonal schemas. Furthermore, although it is not easy to tell correctional clients what represents exactly accurate pattern schemas, practitioners can teach clients that accurate pattern schemas have at least the following characteristics.

First, because they accurately represent human reality, accurate pattern schemas can generate mental peace and more harmonious interactions with others than distorted pattern schemas. Second, a person's individual identity is defined by his/her cognition of human reality, rather than by fixed categories (e.g., physical looks, inmate status, or perfection in a range of areas). Third, accurate pattern schemas give individuals more choices or alternatives in perceiving, interpreting, evaluating, and reacting to others or events. In other words, increased alternatives and flexibility indicate more accurate and less distorted pattern schemas. These intervention strategies are based on the consideration that offenders are not just criminals or patients who need to be corrected or treated but are individuals who use their cognitions to understand and explain their crimes, mental disorders, interpersonal experiences, and/

or need areas. People are motivated to minimize the disparity between their belief of "what is true" and the actual truth about human reality and patterns. Of course, cognition can be modified and become increasingly more accurate as a result of encountering new information, social stimuli, and successfully adapting to new situations.

The Treatment Plan

The treatment plan based on the interaction schemas approach shares the fundamental cognitive propositions that cognitive activity affects emotions and behavior. Developing positive psychological and emotional experiences may be produced through cognitive change. The interaction schemas approach suggests that treatment should modify inaccurate pattern and interpersonal schemas that sustain mental conflicts, distorted appraisals and explanations, and maladaptive actions.

When treating depression and PTSD, it is best for practitioners to keep in mind that correctional counseling is intended to help clients balance their important relationships, and understand and overcome their internal and external conflicts through developing more accurate social cognitions about themselves and others as well as the patterns governing their interactions. Like the general public, incarcerated clients have two basic psychological needs: mental peace and interpersonal harmony. It is important to see offenders as individuals who seek to understand and solve their problems and to balance their mental and interpersonal relationships. The issue of mental peace includes such topics as how to create and maintain inner tranquility, how to experience healing and joy, and how to unlearn past emotional hurts and extricate oneself from fear, anxiety, and depression. The issue of interpersonal harmony covers such areas as how to obtain and maintain love and good relationships, improve communication, increase cooperation, create a better future, achieve success, and avoid or overcome human discord, tribulation, and calamity. In addition to understanding and ameliorating negative symptoms, practitioners help clients master the cognitive principles of interaction schemas that can provide them with the ability to appraise and react to experiences of invalidation in an accurate and adaptive way, and thus, develop a sense of cognitive control and emotional freedom.

Treatment goals are achieved by employing the following strategies: (i) psychoeducation; (ii) using the client's narratives of victimization and trauma (which also serve as imaginal exposure stimuli); and (iii) fostering cognitive growth and understanding about mental and interpersonal experiences. Psychoeducation involves teaching the client about the symptoms of his/her mental disorders, psychological theories or explanations for the disorders, and the treatment processes. The narratives refer to the client's written or oral descriptions or recollections of past trauma and victimization. Cognitive growth and understanding represents the intervention strategy that develops the client's more accurate cognitions about the self, others, interpersonal reality, and patterns.

The treatment also addresses the issue of recidivism in addition to treating the client's mental disorders. Offenders' crimes and criminal behavior are often just symptoms of dysfunctions that are rooted in their distorted cognitions about themselves, others, the environment, and the patterns that regulate their conflict-ridden interactions. Although a criminal conviction is the official reason a person enters the correctional system, counseling efforts that focus only on their crimes miss causal factors that led to the violation of the law. The most important causal factor, among those variables that can be addressed by correctional counseling, involves

the client's distorted cognitions for evaluating, explaining, and adjusting personal experiences and actions. It is offenders' cognitions that mediate how they understand and explain conflicts and whether they react in a prosocial or criminal way (Sun, 2008).

Assessment and Intervention: A Case Vignette

This section describes a case vignette and illustrates how to use the interaction schemas approach to perform assessment and intervention for incarcerated clients with both depression and PTSD.

A.L. is a 43-year-old male offender residing in the mental health unit of a state prison. When meeting with his therapist, he reports being depressed for as long as he can remember, and that both he and his younger brother were sexually and physically abused by their father, who was an alcoholic. A.L. also reports that he suffers from regular nightmares and frequent flashbacks of his abuse. He has been afraid to share information about his childhood trauma because a previous therapist told him to forget it and not to ruminate about a past that he could not change. With a sign of irritability, he also tells his current therapist that he plans to physically fight with a correctional officer who tries to get on his nerves. Another source of his frustration comes from his difficulty and struggle in completing the adult basic education program in prison. His current symptoms meet diagnostic criteria for both PTSD and major depressive disorder.

The assessment concentrates on the following:

1. Assess A.L.'s symptoms of depression and PTSD through a clinical interview and careful attention to the client's narratives.
2. Let the client recount his frustrations and past hurts (e.g., being sexually and physically abused). His narratives about his trauma not only help the counselor gather information and obtain a basic understanding of his trauma history, but also serve as an effective means of imaginal exposure (i.e., exposure to trauma memories), which is likely to lead to less emotional reactivity in the future. He is also encouraged to talk about his current issues, including his struggle in the adult education program and his conflict with the correctional officer.
3. Assess how A.L. explains and copes with frustrations and depression, including how he evaluates and interprets the others' (the abuser– his father – and the officer) actions and their mental states (emotions, motivations, perceptions).
4. Identify A.L.'s distorted pattern schemas and interpersonal schemas, which serve as the maladaptive guidelines for evaluating and interpreting his mental and interpersonal experiences. These appraisals are performed by analyzing the information revealed in the clinical interviews, conversations, and his narratives. The results of these discussions reveal that A.L. possesses several distorted pattern and interpersonal schemas. For example, A.L regards his membership in some unchangeable categories (e.g., inmate status; physical imperfection) as deviant from his pattern schemas (e.g., social desirability and perfection in a range of areas). Specifically, he sees his inmate status as unchangeable and as being attached to him throughout his life. He also believes that his physical imperfection (a visible and permanent scar on his head) makes him unattractive to others and causes him to never be able to find love in life. Interpersonally, his pattern schemas manifest in two behavioral tendencies: the use of violence and being submissive (see Box 22.1 for a list of distorted schemas that are

Box 22.1 Typical Distorted Interaction Schemas for Correctional Clients with Depression/PTSD

Pattern schemas

1. Social desirability (e.g., youthfulness, good health, wealth) governs interpersonal relations.
2. Perfection (in physical looks or other categories) governs interpersonal relations.
3. Violence can get you what you want.

Self schemas

4. I feel guilty constantly because I have violated some moral standards and must be punished.
5. I will always get rejected because I am physically imperfect (deviant from the perfection standard).
6. I am vulnerable to rejection because I really look ugly.
7. I deserve rejections from others because I am too old.
8. I deserved being abused because that was my fate.

Interpersonal schemas

9. Others respect threat and violence because they are afraid of punishment and pain.
10. I must always be agreeable with others because being nice is a universal rule.
11. What I know about the others (e.g., correctional officers, fellow inmates, and therapist) is what I have observed (unaware of the self's distorted cognitions about the others' mental states).

typical for correctional clients with depression and PTSD). These cognitive distortions are the product of his maladaptive learning experiences. His belief in violence comes from his exposure to interpersonal violence from childhood. He indicates that his submissiveness or lack of assertiveness comes from being a victim of abuse. He reports that he could take the abuser's perspective and understand what he wanted, but he was unable to make the abuser understand his viewpoint without eliciting retaliation in a situation of power disparity. He was also too young to physically defend himself.

In terms of treatment and intervention, the practitioner focuses on the following strategies:

1. Validating, rather than disputing or challenging, A.L's narratives about his past hurts and experiences is crucial in motivating him to work on his depression and PTSD. Like other people, he possesses the need for developing cognitive control through understanding social reality by seeking meaning in his social and mental experiences. In fact, his flashbacks and ruminations on the negative experiences indicate, at least in part, an involuntary effort to understand and make sense of his experiences so that he will know how to avoid or deal with similar events in the future.

   Because of his impulsivity in dealing with interpersonally challenging situations, he is encouraged to practice small steps toward the treatment goals (i.e., "*A journey of a thousand miles begins with a single step.*").

2. The treatment starts w
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develop more accurate

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2. The treatment starts with psychoeducation about understanding depressive and PTSD symptoms from the perspective of interaction schemas. The psychoeducation activities include the counselor's explanation of relevant psychological principles, such as emotions, cognition, schemas, and distorted cognitions; and the principle that mental and interpersonal conflict result from a failure to correct distorted pattern and interpersonal schemas. In addition, the client is informed that the focus of the treatment involves helping him develop more accurate cognitions about the self, others, and patterns.

   The client is also made aware that, in the counseling process, the therapist/counselor may challenge his false schemas by communicating information about a new reality. For example, A.L. has core cognition that his physical imperfection is responsible for his experience of rejection and frustration in interpersonal relationships. The therapist challenges the belief by pointing out that it was his distorted cognitions about what regulates human interactions – about a woman he previously met and his subsequent failure to respond to her goodwill communications, prior to his incarceration – that actually ruined the relationship. It had nothing to do with his alleged physical defect. This type of challenging is intended to help A.L. modify and adjust his cognitive system by seeing the discrepancy between his perception and the reality of what actually guided the interaction.
3. The counselor helps A.L. view his negative self-appraisals (e.g., self-blame) and his dysfunctional interpersonal behavior as produced by his use of distorted pattern (e.g., his category-based belief systems, including comparing his inmate status and physical imperfection with the standard of social desirability) and interpersonal schemas. His cognitive distortions generate and sustain his depressive and PTSD symptoms, and other problems in several ways. His distorted cognitions, related to frustration and invalidation, mislead his perceptions of interpersonal reality and generate dysfunctional and self-defeating actions toward others. The therapist helps A.L. modify his pattern and interpersonal schemas by re-evaluating experiences of frustration and invalidation. He also learns to attribute his victimization to the abuser's distorted cognitions about him. That is, this intervention requires the client not only recount what the abuser did to him, but also recognize how the abuser's distorted cognitions about his emotional pains, reactions, and cognitions contributed to the abuse against him. In addition, homework assignments include identifying and practicing how to use the newly learned principles to reinterpret his frustrations in the past and at present.

   The solution to mental conflict and the strategy for creating peace (e.g., high self-confidence and esteem, psychological well-being and/or joy) is based on revising misperceptions about the reality and on discerning the true patterns governing human interactions (see Box 22.2 for a list of common homework assignments used in correctional settings).
4. Assisting A.L. in responding more effectively to interpersonal conflicts is the last component of treatment. This intervention consists of developing or expanding his alternative (more accurate) cognitions about interpersonal relationships, including helping him to evaluate, perceive, interpret, and react to frustrations in an alternative or more accurate way. This approach includes helping the client understand how to interact with others whose mental cognitions better match human reality; and also how not to validate others' distorted pattern and interpersonal schemas by using strategies emphasizing fear, coercion, intimidation, or violence. Belligerence in dealing with human conflicts is counterproductive because violence only corroborates the interacting partners' cognitive distortions about the validity of violence. The client also practices how to differentiate between blockages and opportunities in interpersonal situations. For example, he learns

Box 22.2 Common Homework Assignments for Correctional Clients

1. Write and rewrite narratives about trauma and victimization.
2. Rehearse the principle that cognitive distortions (misunderstanding about interpersonal reality and patterns) are responsible for mental conflicts and dysfunctional interactions; use personal examples to validate the principle.
3. Reaffirm the belief that the client can overcome mental conflicts once a new cognitive understanding about patterns regulating human interactions is developed.
4. Reattribution of the victimization experience to the abuser's cognitive distortions of social reality.
5. Understand and make sense of experiences of frustration from the cognitive perspective; seeing rumination related to trauma and negative emotion as an effort to learn from the negativity.
6. Develop the cognition that for every problem, there are always multiple and more constructive solutions; and for every goal or need, there are always multiple ways to achieve it. Learn to use alternative ways to evaluate, interpret, and react to situations.
7. Encourage the client to practice small steps toward treatment goals and to keep in mind that "A journey of a thousand miles begins with a single step."
8. View negative self-appraisals (e.g., self-blame) as produced by distorted pattern schemas (e.g., category-based belief systems, including inmate status and physical imperfection).
9. Reaffirm the principle that in conflict situations violence will likely validate the cognitive distortions of the interacting others.
10. Practice assertiveness with fellow inmates and recognize the rationale for doing so from the interaction schemas perspective.

how to detach from blockages (e.g., conflict situations, such as the one where an inmate tries to provoke a fight); and how to grab opportunities, including registering for prison programs (e.g., horticulture, computer repair classes) that develop skills for employment, and pursuing communications with fellow inmates who have a sincere intention for connecting socially.

The practitioner also suggests that A.L.'s plan to resort to aggression against the officer does not help solve the conflict. After learning and rehearsing new social skills (e.g., peaceful conversations and non-violent communications), A.L. talked directly with the officer. Following the honest exchange of opinions, the officer stopped his former aggravating practices and the client's anger was greatly reduced. In this case A.L. learned not only to practice assertiveness as a way to deal with conflict, but also to understand the rationale for doing so from the interaction schemas perspective.

Suggested Modified Methods in Group Sessions

In group treatment the basic principles, assessment, and intervention issues will remain the same; however, the practitioner can take full advantage of the group as a social microcosm. In the group, clients can be taught to practice assertiveness and other communications skills in

interpersonal situations, and work on a common task (e.g., a math problem) by generating multiple solutions. Group settings also encourage members to share their feelings, learning to trust and gain support from others in the group, learning to accept their own painful feelings about past traumas, and promoting the sense of belonging. Additionally, when members confront one another directly and immediately in an authentic manner, the social interaction helps to rectify members' distorted cognitions of interpersonal reality and develop new and accurate cognitions and constructive interpersonal behavior.

Conclusions

This chapter provides an overview of the interaction schemas approach to the treatment of depression and PTSD in incarcerated clients. This approach emphasizes that evaluations, explanations, perceptions, and emotional and behavioral reactions represent an interconnected mental system. Namely, the schemas comprise three interrelated mental representations of human reality: self-schemas, interpersonal schemas (cognitions about others in interaction with the self), and pattern schemas (perceived patterns or rules governing human behavior and interactions). Self-appraisals result from applying the pattern schemas to evaluate the self's attributes and experiences in responding to perceived validation or frustration and invalidation from others. Therefore, revising distorted pattern and interpersonal schemas is central to modifying negative and maladaptive self-appraisals. Treatment is focused on psychoeducation about the model, eliciting the client's narratives of victimization and trauma, and modifying distorted schemas in connection with past and present social interactions.

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Suggestions for Further Learning

Book

Sun, K. (2013). *Correctional counseling: A cognitive growth perspective* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Journal article

Cloitre, M., Cohen, L. R., & Scarvalone, P. (2002). Understanding revictimization among childhood sexual abuse survivors: An interpersonal schema approach. *Journal of Cognitive Psychotherapy, 16* (1), 91–112. doi: 10.1891/jcop.16.1.91.63698