

Forensic/Correctional Psychology Tips For Effective Service Delivery And Measures In Nigerian Prisons: A Training Guide

John Egbeazien Oshodi

Department of Psychology, Nasarawa State University

P.M.B 1022, Keffi, Nasarawa State, Nigeria

Tel: +234-81-26909839 E-mail: jos5390458@aol.com

Abstract

There is the increasing concern about insecurity in the nation and the modern Nigerian Prisons Service has a crucial role to play in the fight for adequate national security. Being proposed in this article is a psychologically based training manual for the Nigerian Prisons Service with the focus of enhancing inmates' rehabilitation and reformation through the enrichment of the training standards of officers and welfare workers. It is argued that a psychologically prepared officer is essential in order to effectively protect life and property of the people. It is argued that a highly functional prison system usually begins with a psychologically competent prison officer, as such, a psychologically based manual is being proposed in this paper. Inmates' psychological needs are shown to be enormous but the services in the NPS remains full of challenges with regard to meeting these needs. In this paper attempts are made to point out the need for updated mental health training for welfare counselors and security officials. For rehabilitative purposes basic explanations of psychological disorders with regard to issues of psychopathology, personality, and other clinical problems common to inmates are given. The importance of correctional risk assessment with regards to the evaluation of various types of risk assessments posed by inmates is given in this paper. The behavioral characteristics of inmates are indicated through psychological screening and evaluation tools are given. The names and the purposes of various screening and psychological measuring instruments are identified. This paper points out different roles of correctional psychologists with regard to the better classification and management of inmates and the issues of mental health crises, dangerousness, suicide, or emergency situations in prisons are explained.

Keywords: Prisons, Corrections, Psychopathology, Screening, Officers, Procedures, Nigeria

1. Introduction

The Nigeria Prisons Service (NPS) is about 150 years old. Like many prisons worldwide the issue of security and safety is the main mission (Enuku, 2001). The Decree No. 9 of 1972 aims to utilize the Nigerian Prisons Service to detain, correct, and rehabilitate prisoners prior to their return to the society (Orakwe, 2011). The health and social welfare directorate of the Nigerian Prisons Service is the main section to assist in the area of inmate behavioral screening and management. The Nigerian Prisons Service also has a major goal in the area of re-integration of ex-inmates back to the society (Obioha, 2011).

Presently, inmates occupy about 144 prisons and 83 satellite prisons and no less than five prison hospitals exist currently (Orakwe, 2011). In recent times the Nigerian Prisons Service has been mentioned by international bodies as in need of general improvement. The United Nations Organization on Drugs and Crime (UNODC) has recently assisted in reviewing the Training Manual of the Nigerian Prisons Service with a strong focus on enhancing inmates' rehabilitation and reformation. This objective is to be satisfied through the enrichment of the training standards of officers and social welfare workers along the lines of an international standard in Corrections (Zakama, 2011). Chukwuemeka (2010) reported that the current inmates' psychological needs are enormous but the services in the NPS remains below acceptable standard globally. Still abounding in the Nigerian prisons are inadequate mental treatment services for inmates and paucity of updated mental health training for welfare counselors and security officials (Okoza, Imhonde & Aluede, 2010). In the last five years professional training of officers/counselors and the provision of

rehabilitative services appears to be moving towards the side of positive development, however much work is needed for recognizable improvement.

2. Defining Psychopathology

Mental illness is essentially a weakening condition that affects many humans and extends to a great number of prisoners and detainees. The number of mentally ill persons in prison is higher compared to the general population (Correia, 2009).

2.1 Psychological Disorders

What is abnormality? Any behavior defined and categorized as a psychological disorder is viewed as a psychopathology. Psychopathology as a term ordinarily refers to psycho (mind) pathology (disease); and it refers to a pattern of thoughts, emotions, and behaviors that are disruptive and maladaptive for the affected individual and to other people around the disturbed person. Psychopathology or mental illness manifests itself through disturbed or dysfunctional thinking, emotions, and actions in the affected individual.

How do psychologists explain abnormal behaviors? Psychologists use several criteria or standards to judge whether a person's thinking, emotions, and behaviors are abnormal. For example, behaviors that most people show are considered as marked by normality and behaviors that are statistically infrequent or unusual or uncommon are classified as abnormal. The instrument psychologists (and psychiatrists) use is the Diagnostic and Statistical Manual of Mental Disorders or what is generally known as the DSM-IV. The DSM-IV is a sister to the ICD-10 but the DSM-IV is culturally and objectively broadened (America Psychiatric Association, 2000).

It is important to look at the content of the behavior, the context (socially and culturally) of the behaviors, and the consequence of the behavior for the person and for others. Factors like culture, tribe, age, gender, religion, environment, or situation matter when explaining psychopathology.

3. Possible Causes Mental Illness or Psychopathology

From the beginning of time or civilization, possible causes of disturbed behaviors have included evil spirits and demonic possession. In recent psychological studies many factors have been shown to cause psychological disturbances. One major cause of mental illness is the biological or psychophysiological factor. The biological factors underneath mental illness could include physical or bodily imbalances, neurological or medical influences, as well as genetic factors and could result in psychopathology (Hockenbury and Hockenbury, 2011). There are psychological factors in mental illness which could include Freudian elements as they relate to unresolved internal conflicts beginning in childhood. Social-Learning factors relate to bad learning, bad experiences, and bad teaching, which could result in behavioral and personality disorders. Social-cultural factors revolved around where one lives: A stressful neighborhood, family conflicts, stressful physical situations, marital conflicts, extreme poverty, age, and religious factors—all could affect one's mental health. A humanistic approach to mental/psychological disturbances focuses on negative personal qualities such as not being able to fulfill one's potential, poor awareness of personal environment, and poor expression of one's true feelings.

4. Examples of Major Clinical Syndromes/Psychological Disorders

Anxiety disorders are fears that result in distress to the individual, thereby affecting the person's day-to-day functioning. They are disruptive fears. For example, a phobia is an anxiety disorder that involves extreme and irrational fear of a thing or situation. Subsets of phobias include (a) Claustrophobia, fear of enclosed spaces, and (b) Agoraphobia, an extreme fear of leaving a safe place or a dread of open places. Other major examples of mentally disruptive illnesses include Panic Disorder, an anxiety attack that occurs without warning and without obvious cause. Panic attacks are marked with sweating, sudden heart

palpitations, dizziness, chest pain, etc. Mood Disorder refers to extreme emotional state like depression or bipolar disorder. Mood is internal emotional state that affects the external emotional state. Psychotic Disorder simply refers to a break with reality, for example, the condition of schizophrenia, which refers to an extreme pattern of distorted thinking, emotion, perception, and behavior. A psychotic disorder has symptoms like hallucinations, that is, distorted or false perceptions of objects or events, and delusions or false beliefs.

5. Types of Personality Disorders

A personality disorder is indicated on AXIS II in the DSM-IV. Personality disorders are maladaptive, long standing, chronic, and inflexible ways of behaving. Dysfunctional personality styles severely affect the troubled person and are troublesome to others. Personality disorders are not as severe as schizophrenia. Personality disorders are grouped into three clusters, the odd-eccentric cluster that includes three disorders: The paranoid personality disorder which refers to distrust of others, suspicious behavior, seeing others as hostile and seeing him or herself as morally correct; and the schizoid personality disorder, which results in poor social relationships, personal detachment, and shyness, as well as restricted emotions. Schizoid personality types are viewed as “cold” people. In the schizotypal personality disorder the person has strange, odd behaviors and has magical thinking as a central belief.

There is the anxious-fearful cluster, which includes the obsessive-compulsive personality disorder where the person is preoccupied with control, orderliness, productivity, stubbornness, perfectionism; the dependent personality disorder where the person is helpless, submissive, indecisive, wants to be taken care of, is quick to agree with others, and is always afraid to be alone; the avoidant personality disorder where the person is socially inadequate, oversensitive to criticism, has low self-esteem, and suffers from timidity.

The dramatic-erratic or emotional problematic cluster includes the histrionic personality disorder where the person is impressionistic, tends to overreact, and is overly dramatic, sexually seductive, provocative, and emotionally shallow; the borderline personality disorder where the person is full of anger, interpersonally tense, engages in self-mutilating behaviors, and is highly impulsive, unpredictable, and self-destructive; the narcissistic personality disorder where the person is highly arrogant, has an unrealistic sense of self importance, is grandiose, is preoccupied with fantasies, takes advantage of others, and lacks empathy; and the antisocial personality disorder where the person is non-conforming to laws, deceitful, aggressive, reckless, irresponsible, and violates other people's rights.

6. Psychological Disorders of Childhood

Children are always undergoing physical, cognitive, emotional, and social changes. Childhood behavior problems fall into two categories, the externalizing and the internalizing disorders. The externalizing, or the under-controlled, includes behaviors that disturb people in the child's environment. For example, the Conduct Disorder involves a pattern of stable, destructive behaviors where the child is very disobedient, takes high level risks, bullies others, is assault-driven, cruel to animals, cruel to people, steals, and generally lacks self-control. Conduct disorder is more common in boys beginning at the age of 10 to 12. Another externalizing disorder is the Attention-deficit Hyperactivity Disorder (ADHD). The ADHD occurs before the age of seven and is marked with inattention, carelessness, poor listening skills, impulsiveness, lack of coordination, hyperactivity, fidgeting, and always “on the go.” The internalizing or over-controlled children experience problems like separation anxiety disorder, (constantly) worrying that he or she will be lost, becoming overly anxious when separating from parents or from home, thinking harm is going to befall them, refusal to go to school, complaining of physical symptoms, and nightmares. This disorder occurs before the age 18 years. There is the line of substance abuse and its related disorders.

7. Correctional Risk Assessment

There is no doubt that mental health professionals like psychologists, social workers, family therapists, psychiatrists, occupational therapists, and psychiatric nurses are fully concerned about safety and security

in prisons or correctional settings, as such are needed in assessing various types of risk assessments. However the care of the inmates is essential to their work.

8. Mental Health Procedures in Correctional Settings

During the first admission of an inmate into the prison, some form of mental health screening occurs. This screening helps in the identification of prisoners who are functioning within normal limits, have various risk levels, as well as those with various levels of mental illness. Usually prisoners with severe mental illness or with special needs must receive treatment and prisoners with severe mental illness will not leave prison without adequate care.

9. The Need for Behavioral Screening

Behavioral screening could include the following: (1) Is the inmate excessively isolating himself or herself from prison officials and other inmates? (2) Is the inmate's behavior persistently odd and/or bizarre? (3) Are the sleeping and eating patterns of the inmate causing concern? (4) Has there been a sudden unexplained change in the inmate's presentation, such as stopping work for no obvious reason? (5) Has the inmate's personal hygiene appeared strange, changed suddenly, or deteriorated? (6) Are there any other symptoms that are likely to show that the inmate has a mental illness? (If yes, then specify).

10. Psychological Screening and Evaluation Tools

There is what is generally called the in-take or reception health screening of inmates, which usually takes place at a centralized prison and initially involves a diagnostic interview, clinical observation, and various screening and psychological measuring instruments such as the Oshodi Sentence Completion Index (OSCT), the Rorschach (infrequently used with inmates), the Thematic Apperception Test (TAT), the Millon™ Adolescent Clinical Inventory (MACI), the Derogatis Psychiatric Rating Scale (DPRS), the Minnesota Multiphasic Personality Inventory-2™ (MMPI-2), the Quality of Life Inventory (QOLI), the California Personality Inventory (CPI), Draw a House-Tree-Person (HTP), and others (Oladimeji, 2005, Birmingham & Mullee, 2005).

11. Roles of Correctional Psychologists

A correctional psychologist is ideally a doctoral level academician with training in correctional philosophy, correctional systems, forensic report writing, psychotherapy, and outcome research. The roles of a correctional psychologist include: (1) Classification agent for new entrants for better management and assess them for dangerousness and risky behavior; (2) As a trainer for an area of in-service training and staff development; (3) As a management consultant to prison officials in regard to strategies of managing difficult inmates; (4) As an evaluator in regard to conducting research and developing programs; and (5) Assisting with individual, supportive, and group therapy.

12. Mental Health Crisis

A mental health condition occurs when a person is experiencing a crisis. It involves a reduction in one's ability to function on a day-to-day basis and could result in an emergency situation. The client could be placed in a mental health or psychiatric hospital or other restrictive location. Precipitating factors in a prison setting could include a developmental crisis (e.g., sudden home change or dislocation or robbery). A situational crisis could result from a situation in which one's partner goes off to prison or you leave the family for prison, a rape, or the sudden death of a loved one.

13. What are Some of The Goals of Crisis Services?

These include the promotion of the safety and emotional stability of individuals with mental illness or

psychological crises; minimization of further worsening of individuals with mental illness or emotional crises; assisting individuals with mental, psychological, or illness/ emotional crises in acquiring ongoing care and treatment; and the prevention of placement in settings that are more demanding or more restrictive than clinically necessary to meet an individual's needs.

14. Components of Working Out A Crisis Situation

The first few minutes of a crisis contact could determine if the individual will continue to pursue some form of assistance in their crisis situation or not. Setting a therapeutic tone for a crisis session will be very essential in the outcome of the situation. Engaging family members when possible to get some information and clarity of the crisis situation is helpful.

15. Intervention Screening

A psychological screening determines the problem and needs of the person as well as provides guidance for crisis prevention and/or early intervention. Before initiating any crisis assessment service, some sort of screening of the potential crisis situation must be conducted.

16. What Is Included In A Formal Crisis Intervention Screening?

The screener must gather basic background information, determine whether a crisis situation may be present, identify the situation, and determine an appropriate level of response. The screener should have supportive listening skills to determine if a crisis needs a face-to-face clinical assessment. The initial screening should consider all available services to determine which service intervention would best address the person's needs and circumstances.

17. What Are Crisis Telephone Answering Skills?

The manner in which the agency's crisis telephones (rare in Nigeria) are answered sets the tone for each crisis call. All calls on the phone are required to be answered in a uniform, polite, and professional manner. The telephone should be answered as soon as but within at least five (5) rings. If the crisis assessment determines that crisis intervention services are needed, the intervention services must be provided as urgent or emergent. A trained, credentialed, and/or approved mental health professional should be the one conducting the crisis assessment and intervention and could be a licensed psychiatrist or psychologist.

18. How Soon Must A Crisis Intervention Plan Be Developed?

As part of the crisis intervention services, the crisis services provider must develop a crisis intervention plan during the initial face-to-face assessment. The plan must address the needs and problems noted in the crisis assessment and refer to identified services to reduce or eliminate the crisis (Zealberg & Santos, 1996).

19. What Are Mental Health Crisis Stabilization Services?

If the crisis service provider determines that the person requires mental health crisis stabilization services, such as crisis respite or crisis stabilization, the crisis services provider must arrange for the provision of these services either directly or through other resources. Mental health stabilization services are individualized mental health services that are provided to a person following a crisis assessment. Crisis stabilization services are designed to assist the person in returning to his or her prior functional level or improved level of functioning, if possible (Roberts, 1995). Crisis training guides in this paper comes directly from training from the Tennessee Crisis Manual and the Minnesota Crisis curriculum manual

20. Some Stages Of Working Through A Crisis Situation

These stages include the following: 1. Assessing lethality and safety needs; 2. Establishing rapport and communication; 3. Identifying the major problems; 4. Dealing with feelings and providing support; 5. Exploring possible alternatives; 6. Formulating an action plan; and 7. Conducting follow-up measures.

Also, it is important to find out if the person is alone. Does the person intend harm to self or others? Does the person have the means to carry out his or her intentions? These screenings must be done with sensitivity.

21. What Are Minimal Encouragements?

Minimal encouragements include a broad range of activities from saying “yes” or “go on” or asking “what happened next?” to non-verbal encouragement such as making eye contact and nodding.

22. What Is Validation?

Perhaps the most important support to give to a person in crisis is validation. Validation is conveying that it is okay to feel whatever it is the client is feeling and that he or she is not alone. No attempt should be made to dispute the person’s reality of experiencing delusions or hallucinations; be aware of threatening statements and take them seriously.

23. The Issue Of Dangerousness

It is essential to remove any dangerous articles from the area. Encourage clients to use more appropriate behavior to get what they want. Work with other staff or any significant others available as appropriate in defusing a crisis. Give an agitated client time and space to calm down, negotiate temporary solutions to buy time, and be respectful toward the client. Leave a physical escape route for both yourself and the client, do not get into an argument or power struggle with the client, and do not become an authoritarian or demanding. Tell clients you are not frightened even if you are, do not argue with clients over the reality of hallucinations or delusions, and do not overreact to the situation. Do not insist that a client discuss a situation if he or she doesn’t want to and do not confront a client under the influence of substances.

Harm assessment (suicide, homicide, or injury to self or others) as it relates to dangerousness to self or others (Roberts, 1991) could be understood in the following manner: Learn the dangers of depression in conjunction with drugs and alcohol and discuss some basic guidelines for interacting with a person who is potentially violent.

24. Dealing With Someone Who May Be Considering Suicide

Two key elements in any crisis are grief/loss and anxiety. No one can predict exactly what a grieving person will feel like. However, there are stages identified by Elizabeth Kubler-Ross (1997) which are seen in most people experiencing grief. Here are the five stages: (1) denial; (2) anger; (3) sadness/depression; (4) bargaining; and (5) acceptance. Each individual has his/her own history and reasons for thinking of suicide. If someone is suspected to be thinking of suicide, the best thing to do is ask directly, “Are you thinking of killing yourself?” or “Share with me your thoughts of killing yourself?” By asking directly you are actually giving the person permission to talk about it. Talking it through is the best way to prevent a suicide. You will not be putting the idea of suicide to someone’s head. Ask open-ended questions. Let the person talk about what happened, who else is involved, how long has he/she been thinking of suicide, what would happen if he/she went on living, how others would react, etc.

Predisposing factors leading to suicide include a chaotic or disjointed life style; mental illness, especially depression; negative coping patterns (i.e., hostile, no sense of humor, overly sensitive thinking everything is meant negatively toward them); poor communication skills; low self-esteem; anti-social behavior; drug/alcohol abuse or addiction or gambling addiction; depression; a low mood that persists; change in

eating or sleeping habits; an inability to enjoy anything; feelings of irritability; a hopeless, helpless outlook; feeling guilty for no apparent reason; and crying or weeping with little or no provocation.

Risk factors in suicide attempts include co-occurring mental, alcohol, or substance abuse disorders; family history of suicide; personal history of abuse-physical, sexual, emotional victimization; hopelessness; impulsive and/or aggressive tendencies; barriers to accessing mental health treatment; relational, social, work, or financial loss; physical illness; easy access to lethal methods, especially guns; or an unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts. Other factors could include psychomotor agitation or retardation (as noted by observation); fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate; indecisiveness; and recurrent thoughts of death, suicidal ideation or a suicide attempt. These symptoms must cause significant distress or impairment in functioning. Suicide precipitating factors could include life stressors such as a conflict with family member or love relationship; failure to get a job, get a promotion, or achieve something; loss of money, income, material goods; legal problems; DUI (drinking under influence); injury or illness; and pregnancy.

25. Conclusion

Concern about national insecurity in the nation remains active in the minds of the Nigerian citizens, and security institutions like the modern Nigeria Prisons service have a crucial role to play in the fight for adequate national security. As a result there should be more efforts go towards producing a psychologically-competent corrections personnel. Any future training manual for the Nigerian Prisons Service should fully involve professional psychology tools with the focus of enhancing inmates' rehabilitation and reformation through the enrichment of the training standards of officers and welfare workers. It has been contended in this paper that a psychologically prepared officer is essential in order to effectively protect life and property of the people, as such a highly serviceable prison system should begin with a psychologically competent prison officer, and such a psychologically-based manual is needed. Inmates' psychological needs will continue to be enormous therefore, rehabilitative-based psychological services in the NPS should remain a top priority for the government. The roles of correctional psychologists are abundant, in regards to better classification and management of inmates and the issues of mental health crisis and related issues; as such the government should show great interest in these areas of correctional psychology.

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