Knowledge Is Not Power—Knowledge Is Obligation

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J Am Acad Psychiatry Law 30:533–40, 2002

The public's abandonment of rehabilitation is in large part due to the absence of leadership from the mental health professions about how to make our country a safer place to live. Forensic psychiatry and psychology, especially their academic and scholarly manifestations, have historically focused on assessment and prediction as their most visible and highly valued functions, but in an America filled with fear of interpersonal violence, assessment alone is increasingly revealing itself to be hollow and self-serving. Prediction without reduction of risk may well serve no useful societal function at all. Some argue that the best role for forensic clinicians is assisting courts in making fair and accurate dispositional decisions, but the public sees one of us on each side of every question, and the decisions we help the courts make may simply be between two inadequate and ineffective systems of rehabilitation: hospitals or prisons. After more than 50 years of studying violence, it is time for the best forensic clinicians to leap into the fray, by working to change systems of care and engaging in treatment of those individuals who pose the highest risk of violence.

Some forensic clinicians exclusively confine their practice to assisting courts and juries in making judgments, for example, about whether people are to be found not guilty by reason of insanity or, in the alternative, guilty of a serious crime. The premise is that it is better for courts to make correct judgments than incorrect judgments, but such judgments are not mere academic pronouncements, and they are not the "right" answers to some test. These judgments are rulings that profoundly affect human lives. If such decisions are to be helpful, we must look to their consequences.

I have worked in and run prison mental health and forensic psychiatric facilities, yet I know that there is virtually no evidence to suggest that, as they now exist, one system is particularly better than the other at making the world safer. As the research stands today, we cannot tell whether our "correct" judgments about where to send someone have any tangible value beyond their "correctness." Many forensic hospitals across the country have been sued, some successfully, and criticized, some justifiably, for giving "treatment," the sole purpose of which is to create easily manageable patients. Being sent to a hospital instead of a prison thus may not be as beneficial to the defendant as some would believe, and so it is not surprising that some offenders actually prefer a fixed prison term to indefinite psychiatric commitment.

Further, those instruments that actuarially predict interpersonal violence, at least so far, have leaned most heavily on static historical variables that omit the course of hospital treatment entirely, as if treatment does not matter. I am unaware of any data that suggest that a period spent in a hospital or prison lowers recidivism at all. In short, we are as yet unable to prove that removing offenders from the community does anything except to keep them away from potential free-world victims until they are released.

As correctional and forensic mental health systems now exist, it is at least arguable that neither prisons nor psychiatric hospitals are particularly good ways to treat people whose psychiatric conditions have led

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to interpersonal violence. If all that we have to offer is to help judges and juries make relatively insignificant dispositional decisions more accurately, it would be hard to argue that our field is worthwhile—if that is all we have to offer.

Judgments and Labels: What Do They Mean?

If dispositional decisions do not matter, then what are the consequences of our expert opinions? When we determine whether a person is mentally ill at the time of an offense, we are assigning a label to that person. The power to label is an enormous power to have over another human being. There is only one truly appropriate reason to apply labels to anything and that is to provide information. If labels are to be justifiably attached, the information they convey must be accurate and more helpful than harmful.

In so many ways, this immense power of diagnosis to name is especially critical and crucial to forensic clinicians, because for some forensic clinicians, that is all they do. They assess and evaluate; they name things and they name people. They label behavior and they label the people who behave. I am not sure that we pay adequate attention to the awesome responsibility that this power entails.

A diagnosis can harm, however, by "totalizing" the person who carries it. In other words, one becomes one's label. The person who acquires a diagnosis of schizophrenia ceases to be a brother, a poet, a carpenter, a baseball player, or a friend. Instead, he becomes "a schizophrenic," and everything he does, thinks, feels, or says gets totalized into one pejorative, stigmatizing, and persistent label.

When we label someone schizophrenic, none of us means it as a hopeful thing. Yet when someone says, "I do not choose to have a chronic debilitating fatal disease, I choose to think that perhaps I'm creative or eccentric," we proclaim that the person lacks insight. Is that a lack of insight—or is that resilience? It depends on whom you ask.

"Lack of insight" is an allegation that frequently appears in forensic reports, indeed in psychiatric and psychological reports of all kinds. Actually, what we call lack of insight can have a much less pejorative label in other contexts, such as hope or resilience. When someone who is dying of cancer says, "I am going to beat this thing," we do not accuse them of a lack of insight; we celebrate their courage. Yet, when someone with a diagnosis of schizophrenia does not immediately embrace the belief that he or she will never again be well, we accuse the person of lacking insight and threaten to take away his or her freedom.

Some clinicians might respond that we label behavior, not people. When we label behavior, however, there are also consequences. For example, when we say that an otherwise criminal behavior was "insane," it sends a message about responsibility that has both clinical and public policy implications—that people with mental illness are not responsible for what they do. Suppose someone voluntarily stopped taking medication that was preventing him or her from being psychotic and then became psychotic and committed a crime. In this hypothetical case, the person was clearly psychotic at the time of the offense and met the usual legal criteria for insanity. Yet, there is also no question that the person bears some significant moral responsibility for making the decision to stop taking the medication. It is neither good public policy nor good clinical practice to give this person the message that he or she is not responsible for the decision or its consequences. It is not good for the person, and it is not good for us. On the other hand, a decision that a person did not meet the criteria for the insanity defense may contribute to the criminalization of mental illness itself and the intolerably high prevalence of mental illness in jails and prisons that remain ill-suited to provide treatment. We have only two choices, and as long as we fail to fix the systems they imply, both of them are bad.

My goal is to encourage forensic psychiatrists and psychologists not just to make better labels or better judgments or better assessments, but to intervene to make the world a better and safer place. A clinician can accomplish such intervention on an individual level, by providing treatment to people with histories of violence. On a group level, one can become a prison psychiatrist, spend time teaching, or provide case consultation in forensic psychiatric hospitals or prisons. Finally, on a public policy level, we can help to change these systems so that they actually help people live safer lives, instead of warehousing people, merely keeping them safe for the limited period of time that they are separated from the rest of civilization.

Just as someone who is labeled with schizophrenia should not be totalized, the same might be said of forensic clinicians. There is no need to limit one's self to one role. There is nothing about front-line psychiatry that prevents someone from being a writer, a

teacher, or maintaining an academic appointment. Everyone does not have to quit his or her job as director of a research foundation; in fact, that would be harmful. Instead, like sociologist Henry Steadman, one could create a National GAINS Center, whose job is to share practical information with front-line providers, such as how to treat people with co-occurring mental health and substance abuse diagnoses. In short, I am suggesting that we find a way to make our knowledge matter.

Intervention at the Individual Level

The Psychopath Conundrum

Let us start with intervening at an individual level, using the example of treating psychopaths. The systematic study of psychopaths is a positive development in psychology, with potential to influence treatment positively. If there are people who share a particular pathway to violent crime, understanding them should guide us to intervene in ways that are specific to their patterns of behavior. Instead of helping, however, this line of research has created an unjustified atmosphere of therapeutic nihilism about this disorder. One study, by Rice and her colleagues,[1] compared psychopaths to nonpsychopaths treated with the same modality, and reported that the nonpsychopaths got better, (i.e., lower detected recidivism rates leaped), whereas the psychopaths got worse. Despite the narrow focus of this finding, which studied only one modality, many researchers and clinicians took it to mean that psychopaths are, *per se*, untreatable! Researchers and clinicians alike leaped to an erroneous conclusion and overgeneralized from this very good but narrow study to suggest that psychopaths and psychopathy are not amenable to treatment.

The mentality that psychopaths are just "bad guys" and thus untreatable is a seductive one, because it axiomatically excuses and explains all treatment failures with that population. Their failure to respond to treatment then ceases to be our fault. This belief is based on far too little information, and has recently been challenged. Jennifer Skeem *et al.*,[2] using different treatment modalities, have recently reported that psychopaths demonstrate the same treatment benefit as nonpsychopaths. Further, Gretton and coworkers[3] reported that, for those psychopaths who remain in treatment, there is measurable improvement, reflecting the importance of therapeutic engagement and motivation of patients.

In 1974, Martindale[4] published his famous "nothing works" study, a bitter pill that the entire correctional and forensic mental health establishment seems to have swallowed whole. We not only gave up on treatment and rehabilitation, we gave up on correction itself. Shame on us. In fact, what Martindale studied was a litany of poor efforts at treatment; what he evaluated were the treatment methods, not the viability of offender treatment itself. It is not surprising that poor efforts at treatment yielded poor results. I cannot tell you that I know how to treat psychopaths successfully or how to create citizens out of criminals, but I can tell you that no one knows it cannot be done. We have yet to see what good treatment of criminals and psychopaths could accomplish. I believe that well-trained forensic psychiatrists and psychologists are just the people to make this effort, and that we have moral, ethical, and professional obligations to try.

Reducing the Risk of Individual Interpersonal Violence

If understanding and predicting violence is to progress from rhetoric to reality, we have to work with the population most at risk for lifestyle violence. Our understanding of violence must allow us to intervene in ways that prevent it. Historically, our efforts in this regard have been limited to prediction and assessment of violence. There are three axes that must be taken into account in assessing the risk of violence: severity, imminence, and likelihood.

For public policy purposes, the stakes of failure are determined largely by severity, which is determined, quite simply, by identifying the worst thing that the person has done so far. Although criminal history is usually included in actuarial assessments, it is most often treated as an all-or-none variable, with no attention paid to severity. This historical definition of severity, while perhaps attractive to politicians, is almost useless clinically, because one cannot change the past. Yet, reductions in severity of violence would be extremely desirable outcomes of treatment.

Imminence of violence is amenable to certain treatment modalities, especially those that provide structure, support, and scrutiny. Many individuals are able to avoid violent exacerbations of their mental illnesses by regularly taking medicine or remaining safely housed. We can intervene in ways that prevent,

slow down, or delay the opportunities subjects have to commit crimes. Better yet, we can affect the situations or skills deficits that may make it more or less likely that they will do so.

Likelihood of violence has been the subject of considerably more research. There are three different methods of predicting the likelihood of future acts of violence: the actuarial method, the clinical method, and the anamnestic method.[5]

Actuarial Measures

Actuarial measures are clearly the most accurate way of establishing the likelihood of acts of interpersonal violence. In my opinion, the most recently introduced instrument, and one whose publication in software form is eagerly awaited, was developed by the MacArthur Group (see e.g., Refs. 6 and 7). It is the most accurate instrument yet developed and in many ways the most useful, but, generally, actuarial methods only address likelihood, while ignoring the equally important questions of severity and imminence. Further, actuarial indicators are largely static and historical, and thus they ignore situational determinants of violence.

Clinical Method

Clinical predictions of interpersonal violence, to date, have been fairly criticized as unsystematic and in many cases undertaken by people who were not particularly well trained. There has been no good study of clinical predictions using psychiatrists and psychologists with specialized forensic and risk-assessment training and experience. My guess is that their performance as predictors of violence would be far better than those we have seen so far. To the extent that clinical predictions of violence focus solely on individuals and ignore the situations in which they find themselves, such predictions continue to be found wanting. Mulvey and colleagues[8] at the University of Pittsburgh demonstrated that short-term clinical predictions by emergency room nurses, when they were allowed to take situations into account, were much more likely to be accurate than long-term predictions based solely on individual factors. For clinical predictions to maximize their accuracy, however, the clinician must take better account of the violence-related data contained in careful study of the subject's life.

Anamnestic Method

Anamnestic assessment of the risk of violence is far superior to what is usually called clinical prediction, though the two terms should soon become synonymous. Anamnestic assessment looks at the person in context and over time, examining and learning from his or her life story. In a sense, it is an ethnographic way of studying people. To some old-timers, it may seem to be what a good clinical evaluation was always supposed to be. In fact, it is exactly how good clinicians are supposed to operate. When examining a person who has committed multiple acts of violence, an anamnestic assessment would identify the subject's personal history as a victim (if applicable) as well as a perpetrator of violence. In assessing a person who has committed multiple acts of violence, the clinician seeks to identify incidents of violence, though the same method would apply to other risks as well, and the often repetitive clinical and situational circumstances in which the event occurred, as well as specific precipitators. We are all creatures of habit, including people who engage in acts of interpersonal violence. There tend to be repetitious patterns, especially in the context of their situations, in the lives of people who commit repetitive acts of violence. Similarly, there tend to be patterns in other life failures, such as losing one's job, relapses of substance abuse, losing custody of one's children, divorce, and homelessness. Anamnestic evaluation looks first to the patterns of negative outcomes in a person's life, asking, for example, under what circumstances the person is likely to commit an act of interpersonal violence.

The second step is to work with subjects to explore the personal characteristics that make them likely to commit acts of violence in response to these situations that other people are able to negotiate without resorting to interpersonal violence. Often, the result of that query reveals a lack of some essential skill that many of us take for granted. For example, some people engage in acts of interpersonal violence when they are confronted with rejection or perceive themselves to have been insulted. Although most people find such events unpleasant, the ability to cope appropriately with such situations is a skill that many of us use without even thinking. Once the clinician is able to identify the skills that matter most, the lack of which make people vulnerable to these risk-laden situations, treatment becomes a lot less daunting. It becomes a matter of teaching cognitive, emotional, be-

havioral, and interpersonal skills, things we know very well how to do. To the extent that successful treatment modalities are developed and researched, they do not guarantee success. Obviously, successful treatment outcomes are affected by client motivation, but in the absence of any realistic hope on the part of clinicians, the chances that a given client will become motivated to change diminishes greatly.

To be sure, some people choose not to change the patterns of their behavior, even in the face of an opportunity to do so. I have known a very few people who are such extreme examples of psychopathy that they appear to have no realistic likelihood of ever engaging in treatment. Although some offenders use violence to solve problems, there are indeed people who simply like violence, but the assumption that all psychopaths fall into this group is unwarranted. A short time ago, most offenders were imprecisely labeled as having an antisocial personality disorder. Although the study of psychopaths has sharpened the diagnostic categorization of offenders, even the category psychopath may remain over broad. Some offenders, labeled psychopaths, are the victims of this self-fulfilling prophecy that one cannot successfully treat a psychopath. Until we try, it is unlikely that they will try, and we will never know.

Cognitive behavioral and psychosocial rehabilitative methods, in fact, are very successful in teaching people skills. Psychologists such as Anthony[9] and psychiatrists such as Liberman[10] have shown us how to teach skills to people with diagnoses of mental illnesses and how to help people to acquire the skills that they need to avoid negative outcomes, including interpersonal violence. Their contributions, in my opinion, lead us to what ought to be the primary purpose of public mental health systems, which is to teach people how to live safely with mental illness—safely for them and safely for us.

Even personality disorders, long thought to be unamenable to change, have responded well to cognitive behavioral treatment. Linehan *et al.*[11] have demonstrated marked improvement in patients with a diagnosis of borderline personality disorder, using well established skill-building modalities. For more than eight years, the forensic unit at the Colorado Mental Health Institute (Pueblo, CO) has been applying these same methods to the treatment of mentally ill offenders.[12]

These are things that forensic psychiatrists and psychologists are uniquely qualified to do. These are our skills: to look at a person's life and identify the cogent variables that seem to contribute to violence and to identify the situations that seem to present the most risk and the skill deficits that seem to make people susceptible to committing acts of violence when they are confronted with these situations. We must, however, take it one step further, one step beyond identification. Once again, knowing is of little value unless we intervene in a helpful way.

The relapse-prevention literature suggests some basic skills, skills that offenders can use to derail the violence train. The first is to identify the situations that present the greatest risk to the person, before such situations are actually encountered. Unidentified risks cannot be avoided, and avoiding these risk-laden situations is the second relapse-prevention skill. Next, as every behaviorist knows, no behavioral plan is perfect, and so there must be a contingency plan to help the person respond to failure. In other words, when a subject fails to identify a risk-laden situation in advance, or fails to avoid it, he or she must learn how to withdraw safely from the situation, to escape. Finally, even in situations from which escape is not possible, there may still be a way to lower the cost—that is, to reduce the negative consequences of failure.

For these individual interventions to successfully improve the odds of living a violence-free life, it is not necessary for them to succeed in every case. The clinician who is able to change the odds so that offenders have a choice to reoffend or not to reoffend has done them a great service. When the odds are changed so that fewer offenders actually choose to reoffend, the entire community had been done a great service. This type of intervention is valuable to the people who are clients, it is valuable to the communities in which we live, and it is desperately needed. Any forensic psychiatrist or psychologist who solely engages in assessment is not contributing in that regard.

Some forensic clinicians claim that to engage in treatment presents some conflict of interest, because it somehow infects the purity of their objective assessments. Such arguments fail, not only because they are illogical, but also because so many extraordinary evaluators have proven them wrong. Ignorance is not particularly purifying; the more the clinician knows about how to change people, the better assessments the clinician makes.

Intervention at the Group Level

Prisons and hospitals all over the United States contain groups of people who desperately need to be treated more effectively, medicated more effectively, and taught better skills. Sad to say, some prison and hospital systems must still hire any psychiatrist who applies; the employers can make no selections. Luckily, some of the ones who apply happen to be good, but institutions always recruit clinicians of better quality when they can pick and choose. When such settings are staffed by people who bring forensic expertise, by clinicians with knowledge of violence and its causes, the community will be safer when the inmates and patients they treat are eventually released. With a more competent and appropriately prepared clinical staff, prisons and hospitals will do a better job in helping the people who live there to change, thus making such people safer neighbors for all of us.

Mental health professionals have effected positive change in prisons all over America and have fundamentally changed the way prisons are operated. It is no longer constitutionally permissible to warehouse people. If people are mentally ill and incarcerated in prison or jail, they receive treatment, largely because of these forensic psychiatrists.

As I said earlier, if all we do is send the right person to the wrong prison, we have done nothing. If all we do is send the right person to a bad hospital, we have helped no one. By making that hospital or prison a more effective place of recovery, treatment, and learning skills, however, we are in a position to change things for the better. If we make that prison or hospital a place where people can actually learn the skills that they need if they choose not to reoffend, we can change things for the better. That is a way of making the world a better and safer place and of making the hard work of forensic mental health professionals meaningful and rewarding.

Intervention at the Public Policy Level

Even for those who simply do not enjoy providing treatment, either to individuals or groups, there is still much to be done, because there is a desperate need for people to work toward change public policy. Many psychiatrists also have advanced degrees in public health. The public health perspective, when applied to violence, leads to changes that would make the world safer. It leads us toward efforts like those currently under way at the Centers for Disease Control, which is finally looking at interpersonal violence as the near epidemic that it has been, using public policy to change the circumstances of its transmission, and they need our help.

We know a great deal about what has been called the cycle of violence. From Perry *et al.*,[13–15] we have learned that the brains of children who are severely neglected or abused—in some cases, literally tortured—develop in ways that are different than would have been the case without abuse. These changes to their brains are permanent and may contribute to later psychopathy or dissociative disorders. Who better to put this etiology together than forensic psychiatrists and psychologists who have studied interpersonal violence and human tragedy. Once we identify and isolate the damage that is done to people through abuse, it increases the chance that we will establish treatment to help people to live among us more safely in the aftermath of their abuse. Obviously, the best thing to do is to fight abuse and neglect more effectively, and forensic mental health professionals ought to be at the forefront of that fight. Until we can do that, we have to remember that most victims of abuse and neglect do not take out their pain by victimizing others. By looking at those who have triumphed over trauma, by identifying protective factors, we can learn to help victims to avoid lives of violence, sadness, or tragedy. Who better than forensic clinicians to transform this knowledge into action?

Without ever engaging in therapy, you can make a difference through public policy. Examples abound. Bloom and colleagues[16,17] have helped Oregon to set up and study its Psychiatric Security Review Board. Steadman, Monahan, and others (18, 19) have worked with public policy-makers to change the counterproductive and countertherapeutic policies that, in the name of law and order, make this country a more dangerous place in which to live.

Ironically, some of the best thinking that forensic psychiatrists do is shared largely in rooms full of other forensic psychiatrists, but is not our real challenge to change policies that lie far beyond the scope of forensic psychiatry? For example, one can look at the politics of law and order. Many politicians claim that they are for law and order, but their actions only support punishment that further damages and enrages criminals who will one day be released. We have a duty to explain to the American public that there is a difference between being tough on criminals and

being tough on crime. Ironically, simply being tough on criminals may make it more dangerous in our communities, not less, because the offenders learn nothing useful, except to be more angry. Are we not the very best people to teach our country that there are ways we can actually be safer?

The United States, for most of my lifetime, has been engaged in a collective, almost limbic temper tantrum about crime. We have given up on being safer and are willing to settle for "kicking butt" in futile retribution against the people who make us feel unsafe. Instead of being passive victims, it seems, we have decided to fight back, even if our efforts will not make us any safer. The trouble is that the people who scare us most, people with mental illness, are not the threat we make them out to be, and retributive responses to crime only feed the anger and fear that spawned violence in the first place.

We are the ones to teach the public and its political representatives that there is a better way to be tough on crime and that there really is a way to be public safety advocates. Americans believe that retributive punishment is the only answer to crime because we have not taught them otherwise, surrendering the field to politicians and talk radio. The mental health professions must teach Americans that there really ought to be no difference between a strong right-wing law-and-order position and an equally strong left-wing human-service position, as long as they share the goal of public safety. If we can do a better job of protecting America's children from abuse and poverty, we are going to have less crime; if we improve education, we are going to have less crime; and if we create jobs and give people the skills to do them, we are going to have less crime. How is it that we have allowed social services and public safety to appear to be oppositional or antagonistic positions? We have failed in our duty to lead the public to a safer country.

Summary and Conclusions: Incrementalism

It is time to take this knowledge, expertise, wisdom, and power that we have and use it for something other than impressing each other and some lawyers. In many ways, forensic mental health professionals represent the very best of psychiatry and psychology. They take on the toughest cases, and they have taken the trouble to learn a great deal about human violence. Many of them have been extraordinarily well trained in their residencies or forensic fellowships. They have made it their life's business to learn about crime and its antecedents. It is time to put that knowledge to work.

Forensic mental health professionals must look among themselves for models that have intervened in behalf of the public well-being. Look at people who work hard every day, putting one foot in front of the other, treating criminals the very best way they can, using their knowledge to try to give someone a chance to choose a law-abiding life when they are released. Look at the people that change public policy. Let these people who matter be the role models of this wonderful profession.

It is time to wipe out the pejorative connotation assigned to people who work in the trenches of forensic hospitals, prisons, jails, and county hospitals and to say instead that this is the business we were trained for. The people who live in these settings are the people who need us most. Forensic psychiatrists and psychologists, along with our colleagues in social work, nursing, and activity therapies, are the ones who have the most to offer to these people, these settings, and the world.

Finally, I would like to close with a special message to those who did not need to read this, who are already doing exactly as I am suggesting. This is for those professionals who are working in the toughest settings with the toughest patients. Some of you, to my way of thinking, have chosen to do the right thing, although it is often the hard thing, and this open letter is to you:

> In my travels across the country, my work as a consultant or expert witness has often led me into conditions that were not only unconstitutional, but horrifying. Yet, in those same systems, I have seen seemingly decent and hard-working mental health professionals, working tirelessly to provide solace and hope to people in very difficult straits.
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> Some ethicists argue that participating in unacceptable systems is wrong. They argue that the participation of credentialed professionals legitimizes and thus perpetuates these systems. They admonish such professionals to simply walk away, to refuse to play in such a filthy sandbox—and these arguments seem reasonable.
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> When I meet the people who have stayed, however, I do not find them less ethical or less moral for it. To the contrary, many of these psychologists, nurses, psychiatrists, social workers, correctional officers, and psychiatric technicians have become heroes to me. To maintain one's standards of decency and professionalism in the face of an apparently uncaring political system takes courage, tenacity, and goodness of heart.
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> These observations lead to several important questions. How then does one make sense of this dilemma? How bad can the

system be before it is time to walk away? How does one walk away from people in such dire need?

I have learned over the years that I am not a perfectionist. It is way too depressing, and perfectionists, of course, never succeed at anything. Their lives are spent climbing a ladder that has no top rung. (No offense to those of you who are perfectionists; in fact, my heart goes out to you.) Since I actually enjoy making creative mistakes, for me, perfectionism is especially uninviting.

No, my friends, I am, to the core of my being, an incrementalist. I believe in trying to leave everything just a little better than I found it. I believe in the hokey "starfish" story with all of my heart. I believe that if everyone who visited a park would take just one extra piece of trash with them when they leave, the park would be spotless in a week. Granted, to many of you, it does not seem like much of an assignment, but it is my assignment, and I have accepted it.

What about perpetuating evil? Nonsense. Watch what happens when a psychologist or psychiatrist quits in moral indignation. See if the place closes down. It will not, and no matter how good the quitter feels about having quit, if he or she was any good, it is the clients who have been hurt, not the system.

To me, the moral thing, the ethical thing, is not to cut and run. It is to maintain one's dignity and professionalism in the face of bad circumstances. It is to understand the difference between reasonable flexibility and selling out. It is speaking with honor and humility (even in court) about how it ought to be and resisting the understandable temptation to sink into self-righteous and angry denunciations. It is protecting your own hope against all assaults, because hope is the most precious gift you share with your clients.

So, to those of you who do good work in bad settings, I have something to say. Not only are you behaving in a morally and ethically acceptable manner, but also, to me, you are heroes. Your jail or prison or hospital or free clinic is a little better each day because you are there. You leave your clients a little better than you find them and occasionally foster hope in people for whom hope is but a distant memory.

The time to quit? That's an easy one. Quit when you run out of gas. Quit when it hurts you more than it helps your clients. Quit when the system will not let you help, even a little bit. Quit when you become an instrument of harm. Until then, Godspeed to you, and thanks [adapted from "Confessions of an Incrementalist"].[20]

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