Probation officer prototypes: Perceptions of probationers with and without mental illness

Paula M Emke-Francis
University of Nevada, Las Vegas

Follow this and additional works at: https://digitalscholarship.unlv.edu/rtds

https://digitalscholarship.unlv.edu/rtds/2103

This Thesis is brought to you for free and open access by Digital Scholarship@UNLV. It has been accepted for inclusion in UNLV Retrospective Theses & Dissertations by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.
PROBATION OFFICER PROTOTYPES: PERCEPTIONS OF PROBATIONERS WITH AND WITHOUT MENTAL ILLNESS

by

Paula M Emke-Francis
Bachelor of Arts
University of Nevada, Las Vegas
2002

A thesis submitted in partial fulfillment of the requirements for the

Master of Arts Degree in Clinical Psychology
Department of Psychology
College of Liberal Arts

Graduate College
University of Nevada, Las Vegas
May 2007

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
INFORMATION TO USERS

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleed-through, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.
Thesis Approval
The Graduate College
University of Nevada, Las Vegas

September 18, 2006

The Thesis prepared by

Paula Emke-Francis

Entitled

Probation Officer Prototypes:
Perceptions of probationers with and without mental illness

is approved in partial fulfillment of the requirements for the degree of

Master of Arts in Psychology

Examination Committee Chair

Dean of the Graduate College

Examination Committee Member

Examination Committee Member

Graduate College Faculty Representative
ABSTRACT

Probation Officer Prototypes: Perceptions of Probationers
With and Without Mental Illness

by

Paula M Emke-Francis

Dr. Douglas Ferraro, Examination Committee Chair
Professor of Psychology
University of Nevada, Las Vegas

In recent years the criminal justice system has managed large numbers of persons
with mental illness, many of whom are supervised in the community on probation. Given
that probation agencies are stretched to the maximum and have little extra time to take on
additional challenges, probation officers (PO) may use typifications or “perceptual
shorthand” as a means for efficiently managing their caseloads. Despite the role
typifications may play in the processing of probationers, to date no research has
attempted to characterize PO typifications.

The reason for the dearth of literature in this area appears to be the result of many
factors, including the lack of a solid operational definition for typifications. Fortunately,
the widely studied and empirically validated psychological construct of prototypes can be
utilized to help lay the foundation lacking in the typifications literature. Using this
foundation, this study’s primary goal was to elicit, characterize and compare PO
prototypes of both the typical or routine probationer (TRP) and the probationer with
mental illness (PMI).
Participants were 61 adult PO who completed a survey describing either their
prototype of TRP or PMI. Qualitative analyses of the survey responses revealed that PO
have multifaceted and unique prototypes of both TRP and PMI. The implications of these
prototypes and directions for future research are discussed.
# TABLE OF CONTENTS

ABSTRACT .......................................................................................................................... iii

LIST OF TABLES AND FIGURES ..................................................................................... vii

ACKNOWLEDGMENTS .................................................................................................... viii

CHAPTER 1 INTRODUCTION AND LITERATURE REVIEW ........................................ 1
  Research on probation and mental illness ................................................................. 1
    Characterizing the probationer with mental illness .............................................. 2
    Examining outcomes for probationers with mental illness ......................... 10
  Probationers with mental illness: Responding to the challenges .................. 13
    Background on probation: Contextualizing the problem.......................... 13
    Responding to the probationer with mental illness ................................. 17
  Defining typifications and their influence ............................................................. 30
    Defining typifications ......................................................................................... 30
    The influence of typifications ........................................................................ 32
    Limitations in typifications research ............................................................... 38
    Typifications and prototypes ........................................................................ 39

CHAPTER 2 METHODOLOGY ..................................................................................... 48
  Participants ................................................................................................................. 48
  Research Team ......................................................................................................... 53
    Data collection ..................................................................................................... 54
    Data preparation ................................................................................................. 54
  Measures .................................................................................................................. 55
    Prototype elicitation instrument .................................................................... 55
    Demographic questionnaire .............................................................................. 56
  Procedure ................................................................................................................ 56
  Data preparation ..................................................................................................... 58
    Transcription and feature extraction .............................................................. 58
    Feature categorization ....................................................................................... 59
    Feature combination ......................................................................................... 60

CHAPTER 3 DATA ANALYSES AND RESULTS ......................................................... 62
  Aim 1: To characterize participants’ TRP prototypes ......................................... 62
CHAPTER 4 DISCUSSION

The TRP prototype

Finding 1: PO did not report sub-prototypes of TRP
Finding 2: TRP not free from psychological symptoms
Finding 3: PO described TRP using primarily negative descriptors

The PMI prototype

Finding 1: PO reported unique prototypes of PMI
Finding 2: PO described PMI as severely disordered and potentially dangerous
Finding 3: PO described PMI as non-compliant with treatment
Finding 4: PO predict bleak futures for PMI
Finding 5: PO are taxed by their work with PMI

Implications and directions for future research

REFERENCES

APPENDICES

Appendix A: Calling script
Appendix B: Call log
Appendix C: Description of probationer (Version I)
Appendix D: Description of probationer (Version II)
Appendix E: Background survey
Appendix F: Invitation letter
Appendix G: Cover letter
Appendix H: Feature extraction instructions
Appendix I: Feature extraction practice transcripts
Appendix J: Feature coding manual

VITA
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Lurigio et al's (2003) Psychiatric Conditions Prevalence Rates</td>
<td>5</td>
</tr>
<tr>
<td>Table 2</td>
<td>Reasons for elimination by number of respondents</td>
<td>50</td>
</tr>
<tr>
<td>Table 3</td>
<td>DPS-1 and DPS-2 participants: Gender and ethnicity</td>
<td>53</td>
</tr>
<tr>
<td>Table 4</td>
<td>DPS-1 and DPS-2 participants: Age, education probation experience</td>
<td>53</td>
</tr>
<tr>
<td>Table 5</td>
<td>DPS-1 derived themes</td>
<td>64</td>
</tr>
<tr>
<td>Table 6</td>
<td>Number of features per category for DPS-1 responses</td>
<td>67</td>
</tr>
<tr>
<td>Table 7</td>
<td>List of resulting combined features of TRP</td>
<td>69</td>
</tr>
<tr>
<td>Table 8</td>
<td>Percentage of DPS-1 respondents per category</td>
<td>71</td>
</tr>
<tr>
<td>Table 9</td>
<td>DPS-2 additional or modified themes</td>
<td>80</td>
</tr>
<tr>
<td>Table 10</td>
<td>Number of features per category for DPS-2 responses</td>
<td>82</td>
</tr>
<tr>
<td>Table 11</td>
<td>List of combined features of PMI</td>
<td>85</td>
</tr>
<tr>
<td>Table 12</td>
<td>Proportion of TRP and PMI extracted features by category along with statistical analyses of the differences between these proportions by category</td>
<td>98</td>
</tr>
<tr>
<td>Table 13</td>
<td>Percentage of TRP and PMI participants by category</td>
<td>100</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

I would like to thank my committee chair, Dr. Douglas Ferraro, as well as Drs. Kim Barchard, Karen Kemtes, and Joel Liberman for their support in the development and completion of this project. Specifically, I would like to thank Dr. Ferraro for supporting and refining my ideas, having faith in my abilities and standing beside me through the rough terrain that accompanied the data collection and analyses portions of this project. In addition, I would like to extend my sincerest appreciation to Dr. Jennifer Skeem, who dedicated her resources, intelligence and commitment to the development of this project and without whom this project would not have been possible. I would also like to thank Carl Wicklund, the Executive Director of the American Probation and Parole Association, who stood behind this research and has been instrumental in creating a bridge between psychological science and criminal justice practice in field of probation. I would also like to thank the Psychology and Law Laboratory Research Team, including but not limited to Denee’ Adams-Shrewsbury, Kristin Asher, Jacqueline Camp, Jason Dickens, Robert Durette, Jennifer Eno Louden, Lindsay Mejia, Deanna Molinar, and Natalia Tabisaura, for their tireless efforts and work toward the completion of this project. Finally, I would like to thank my husband, daughter, parents and friends for their constant support, love and understanding during the many hours of work I have devoted to this project and degree over the past four years, I love you immeasurably.
CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

Research on Probation and Mental Illness

Each year the criminal justice system is called upon to supervise an ever increasing number of offenders. In fact, Glaze (2003) reports that 6.9 million offenders are currently under correctional supervision in the United States today. Notably, between 7 and 16% of these offenders (approximately 0.5 - 1.1 million) suffer from mental illness (Abram, & Teplin, 1991, American Probation and Parole Association, 1995, Daniel, Robins, Reid, & Wilfley, 1988, Ditton, 1999, Guy, Platt, Zwerling, & Bullock, 1985, Steadman, Fabisiak, Dvoskin & Holohean, 1989, Teplin, 1990).

Despite the large number of offenders with mental illness, until recently criminal justice research has largely overlooked this unique population. The recent research on the offender with mental illness has focused on three primary areas: (1) characterizing the population of offenders with mental illness (epidemiology), (2) exploring the relationship between mental illness and criminal behavior, and (3) the potential for criminalizing the mentally ill (Daupinot, 1999). What is notable about this research is that it focuses almost exclusively on jail and prison inmates rather than on offenders sentenced to probation.

The dearth of literature on probation and mental illness is surprising, given that nearly 60% of all offenders in the correctional system are on probation (Glaze, 2003). Moreover, probationers with mental illness are more readily accessible for study, since unlike jail...
and prison inmates, probationers are supervised in the community. This means, of course, that any possible risk for violence or recidivism posed by probationers with mental illnesses (PMI) has the potential to directly impact the public. Thus, the characteristics of and outcomes for PMI have substantial direct relevance to the community in which they live. A handful of researchers have recognized the importance of examining the characteristics and outcomes of PMI and have begun research in this area. Specifically, several studies have published findings regarding the prevalence of PMI, their demographic breakdown and their social risk factors. Also, a second, related small body of literature has examined risk for recidivism and other outcomes for PMI. This literature is reviewed in what follows.

Characterizing the Probationer with Mental Illness

Similar to the incidence of mental illness in other correctional populations, extant research suggests that mental illness is quite prevalent among probationers. However, extant prevalence estimates vary widely. Specifically, although several studies have sought empirically to determine the prevalence of mental illness in the probation population (Boone, 1995, Dauphinot, 1997, Ditton, 1999, Lurigio, Cho, Swartz, Johnson, Graf, & Pickup, 2003, Roberts, Hudson, & McCullen, 1995, Wormith & McKeague, 1996), these studies have arrived at a wide range of prevalence estimates (16-23%). This variation is most likely due to the use of disparate methodologies and different operational definitions of ‘mental illness’. For example, methods employed have included interview assessment (Lurigio, Cho, Swartz, Johnson, Graf, & Pickup, 2003) archival record reviews (Boone, 1995, Dauphinot, 1997), probationer survey (Ditton, 1999), and probation officer survey (Roberts, Hudson, & McCullen, 1995, Wormith, & McKeague,
Definitions of mental illness have also varied greatly, ranging from relatively strict criteria, *two or more prior mental health diagnoses* (Dauphinot, 1997) and more lenient criteria, including *reporting an overnight stay at an inpatient facility* (Ditton, 1999). Applied to the probation population size reported by Glaze (2003) prevalence estimates of 16% to 23% suggest that between 662,000 and 952,000 mentally ill offenders are currently under the supervision of probation agencies today.

The most widely cited study regarding the prevalence and demographic breakdown of PMI was conducted by the Bureau of Justice Statistics during 1995 (Ditton, 1999). This study's primary goal was to determine the demographic, mental health, substance use and legal case characteristics of the national probation population. Stratified random sampling was employed to select 167 probation agencies from the 2,627 state, county and municipal probation agencies in the USA. From those agencies the researchers reviewed the legal records of 5,867 probationers, and completed personal interviews with a subset of 2,030. Researchers classified participants as mentally ill if the probationer reported that they were currently suffering from a “mental or emotional condition” during the interview or if they ever been given “[overnight] admittance to a mental hospital”. Based on these data, Ditton (1999) estimated that the prevalence of mental illness in the probation population was approximately 16%.

Although often-cited, this study is limited by a number of methodological problems. First, the study did not directly assess for the presence of a mental health diagnosis but instead operationally defined mental illness by probationer self-reports (Ditton, 1999). This definition assumes that (a) PMI have been diagnosed and are able and willing to report it, and (b) anyone admitted for an overnight stay in a mental health facility has a
major mental illness. Secondly, the high rates of interview refusal in this study (only
38% of those invited to be interviewed actually participated) suggest that the sample is
not a representative one. Instead, it is likely that the sample is biased toward probationers
who presented for probation appointments more frequently and/or who were more
compliant (Ditton, 1999). Third, the author’s decision to systematically identify
probationers for interview rather than randomly selecting them also may have introduced
bias. The exact criteria for the procedure used were not specified.

Recently a study was published by Lurigio et al. (2003), which attempted to directly
assess for the presence of psychiatric symptoms and diagnoses in a random sample of
probationers from a large urban Illinois probation agency. A total of 627 probationers
were interviewed using the Mini International Neuropsychiatric Interview 2.2 (MINI), a
structured interview designed to elicit symptoms and arrive at diagnoses for 15 major
Axis I disorders and one Axis II diagnosis (antisocial personality disorder). Though a
general prevalence estimate was not reported, prevalence estimates for a mix of DSM
disorders and other symptom clusters were reported (for a complete list of the prevalence
estimates reported see Table 1). Notably, Lurigio (2003) reports that there were relatively
high percentages of a current major depressive episode and lifetime and current psychotic
disorders as compared with the general population. However, the comparison statistics
for this finding were not available in the document.

As was the case for the Ditton (1999) research, the research by Lurigio et al (2005) is
limited by a number of factors. Most importantly, data were not presented regarding an
overall prevalence rate, making it difficult to determine whether a large number of
offenders presented with a wide variety of disorders or if there is a smaller population of
Table 1


<table>
<thead>
<tr>
<th></th>
<th>Non-Substance Abuser</th>
<th>Substance Abuser</th>
<th>p</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current psychiatric disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depressive episode</td>
<td>10.6</td>
<td>16.9</td>
<td>*</td>
<td>13.2</td>
</tr>
<tr>
<td>Manic episode</td>
<td>1.9</td>
<td>4.5</td>
<td></td>
<td>3.0</td>
</tr>
<tr>
<td>Hypomanic episode</td>
<td>3.3</td>
<td>9.4</td>
<td>**</td>
<td>-</td>
</tr>
<tr>
<td>Suicide risk</td>
<td>13.6</td>
<td>24.1</td>
<td>**</td>
<td>18.1</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>1.9</td>
<td>4.9</td>
<td>*</td>
<td>3.2</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>10.3</td>
<td>12.4</td>
<td></td>
<td>11.2</td>
</tr>
<tr>
<td>Mood disorder with psychotic</td>
<td>6.9</td>
<td>12.7</td>
<td>*</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Lifetime psychiatric disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depressive episode, recurrent</td>
<td>4.2</td>
<td>10.2</td>
<td>**</td>
<td>6.7</td>
</tr>
<tr>
<td>Manic episode</td>
<td>3.9</td>
<td>12.4</td>
<td>***</td>
<td>7.5</td>
</tr>
<tr>
<td>Hypomanic episode</td>
<td>8.1</td>
<td>21.7</td>
<td>***</td>
<td>13.9</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>15.5</td>
<td>23.2</td>
<td>*</td>
<td>18.8</td>
</tr>
<tr>
<td>Antisocial personality disorder</td>
<td>9.7</td>
<td>24.3</td>
<td>***</td>
<td>15.9</td>
</tr>
</tbody>
</table>

*p<.05.  **p<.01.  ***p<.001 (chi square test)*


very seriously disordered offenders. Further, the data reported appeared to overlap in unexpected and unexplained ways. For instance, the authors reported that 18.1% of the sample was currently at risk for suicide, yet only 13.2% of the sample was currently suffering from a major depressive episode.

Despite its limitations, Lurigio et al’s (2005) study remains the only published research attempting to examine the prevalence of mental illness in the probation
population via actual clinical assessment of probationers. As noted previously, several other studies attempting to establish the prevalence of mental illness in the probation population exist, however these prevalence estimates are limited by their reliance on questionable methods for identifying PMI. Specifically, both Boone (1995) and Dauphinot (1997) attempted to establish prevalence by completing an archival records review and counting those with a history of mental health diagnoses as PMI. The accuracy of these prevalence estimates rests on the untested assumption that mental illness is adequately identified and recorded by the legal system. Another strategy researchers have employed for identifying PMI, is to question probation officers regarding the number of PMI they currently supervise (Roberts, Hudson, & McCullen, 1995, Wormith, & McKeague, 1996). The accuracy of prevalence estimates established via this route relies on probation officers' familiarity with the mental health histories of their probationers. Given the numerous demands on probation officers' time, to be discussed at length below, this assumption appears precarious at best. Given the questionable reliability and validity of the available research, a definitive prevalence rate remains unknown. However, collectively the literature does suggest that mental illness is quite prevalent among the probation population and, thus, warrants further investigation.

In addition to prevalence, a handful of researchers have also attempted to examine PMI for their unique demographic characteristics. Extant research suggests that, relative to those probationers without mental illness, PMI are more likely than the average probationer to be female and older (Ditton, 1999, Roberts, Hudson & McCullen, 1995, Wormith & McKeague, 1996). However, differences in the ethnic background of PMI are less clear, with some research finding higher prevalence rates of PMI among Caucasians.
(Ditton, 1999) and other research indicating higher prevalence rates of PMI among African-Americans (Dauphinot, 1997). For example, Ditton (1999) found that PMI were significantly more likely to be Caucasian (19.6% vs. 10.4% African-American and 9% Hispanic), female (21.7% vs. 14.7%), and older than traditional probationers (37.1% of probationers over 45 had a mental illness).

Finally, another small body of research has sought to examine the social risk factors faced by PMI. Wormith and McKeague (1996) did the most thorough examination of PMI risk and needs in their survey of probation officers in Canada. Data were collected on 2500 probationers randomly selected from the caseloads of 101 probation officers (PO) in Ontario, Canada. PO were asked to identify mental health problems via several routes including (1) record review (to identify a documented history of mental illness and/or psychiatric hospitalization), and (2) assignment of a Global Assessment of Functioning (GAF) score calculated by the probation officer according to a series of instructions. Probationers were considered mentally ill if they had any documented DSM-IV mental illness, had a previous psychiatric hospitalization, or if their GAF score was below 50. PO were also asked to characterize the probationers on 21 different potential problem or need areas and to indicate the magnitude of need (high, moderate, low, or nil).

Results suggested that PMI disproportionately faced a number of hardships as compared to probationers without mental illness including: (1) homelessness or inadequate community accommodations (5% vs. 1%), (2) residing in some sort of institutional setting (including hostels, boarding houses, hospitals, etc.) (42% vs. 13%), (3) isolation (PMI more likely to live alone (22% vs. 11%) and less likely to live with a
spouse (19% vs. 24%)) and (4) unemployment (72% vs. 43%) (Wormith & McKeague, 1996).

Consistent with PMI substantial social disadvantages, PO reported that PMI had increased needs for counseling, drug and alcohol abuse treatment, and social and vocational skills training. However, despite their bleak circumstances, large numbers of PMI were not receiving social services. For example, only 63% of PMI with a moderate to high need for counseling were actually receiving help. This often appeared due to under-referral on the part of PO. For example, 29% of probationers with a moderate to high need for therapy had not been referred to counseling by their PO. However, PO primarily attributed this unmet need for treatment to lack of motivation on the part of the PMI.

Although this study by Wormith and McKeague (1996) has several implications for characterizing the experiences of the PMI, it has methodological limits. For example, the authors’ operational definition of mental illness was in some ways over-inclusive (e.g., including antisocial personality disorder) and in some ways under-inclusive (e.g., excluding those without prior diagnoses). Moreover, needs were assessed solely by PO impressions, which assumes that all PO are familiar with the needs of all of their probationers on their large caseloads. Nevertheless, this study’s results combined with findings from a handful of other studies (Dauphinot, 1997, Ditton, 1999, Solomon, Marcus, & Draine, 2001, Zohn, 2001) suggest that PMI are at increased risk for numerous social hardships. These include substance abuse and relapse (Ditton, 1999, Zohn, 2001), unemployment (Dauphinot, 1997, Ditton, 1999, Wormith & McKeague, 1996), homelessness (Ditton, 1999, Wormith & McKeague, 1996), isolation (Wormith &
McKeague, 1996), HIV-infection (Solomon, Marcus, & Draine, 2001), history of sexual and/or physical abuse (Ditton, 1999) and being housed within the foster care or other institutional setting (Ditton, 1999).

Notably, there is a small body of literature that is aimed at characterizing the relationship between substance abuse and psychiatric disorder. The most relevant article on this topic attempted to establish the prevalence of mental illness among substance abusing probationers (Lurigio et al., 2003). This research, which was described above, involved a brief interview format designed to assess for the presence of a mental illness and/or substance abuse problem in a random sample of 627 adult probationers in Cook County. The study suggested that substance-abusing probationers were at significantly increased risk for a number of psychiatric problems as compared with non-substance-abusing probationers including a current major depressive episode (16.9% vs. 10.6%), current risk for suicide (24.1% vs. 13.6%), and lifetime psychotic disorder (23.2% vs. 15.5%). (for a complete list of these findings see Table 1).

In sum, only a small body of research exists that explores the demographic and social characteristics of probationers with mental illness. The studies which do exist, though methodologically limited, suggest that compared to the typical or routine probationer, PMI are a unique group characterized by increased risk for numerous social hardships, including unemployment, homelessness, and substance abuse, which in many cases go unaddressed. Further, preliminary research indicates that a history of substance abuse amongst probationers may correlate with higher risk for mental illness. Though it remains unclear how this latter finding impacts the PMI population, it does suggest that dual diagnosis may be common in this population. What is clear is that PMI, even more so
than the typical or routine probationer, appear to face varied difficulties both cognitively, emotionally, and socially, which are all likely to impact their treatment and outcome while on probation.

*Examining Outcomes for Probationers with Mental Illness*

Logically, one would expect that a group of probationers with mental illness, distinguished by such pronounced social disadvantage, would have relatively poor outcomes. However, research has only begun to assess the extent to which PMI differ from the typical or routine probationer (TRP) in their criminal histories and probation outcomes.

What research there is consistently indicates that, relative to TRP, PMI have more prior arrests and are more likely to be supervised for a violent offense (Dauphinot, 1997, Ditton, 1999, Roberts, Hudson, & McCullen, 1995). For example, based on the study described earlier, Ditton (1999) found that PMI were more likely than traditional probationers to be currently supervised for a violent offense (28.4% vs. 18.4%), or a sexual assault (6.8% vs. 4.1%).

Dauphinot (1997) found similar results in her archival, controlled study of probationers in Tarrant County, Texas. At present, this is the only systematic study of differences in probation outcome for PMI. The PMI sample was identified by reviewing all computerized records of persons placed on probation between 1990 and 1991 to identify those who met both of the following criteria: (1) diagnosed at least two times with the same severe mental disorder by the local mental health system, and (2) diagnosed with schizophrenia, major affective disorders, and non-organic disorders (not substance-induced) with psychotic features. Analyses compared the resultant 115 PMI...
with 518 probationers who had never been diagnosed with a mental illness on demographic characteristics, criminal histories, and three year follow-up rates of probation revocation and rearrest.

With regard to criminal history, Dauphinot found that when compared to non-disordered offenders, PMI had significantly more prior arrests for misdemeanor offenses than TRP. Notably, PMI did not have longer histories of serious violent or felony crime than standard probationers.

In contrast, with regard to the current offense, Dauphinot found that PMI were significantly more likely than TRP to be currently supervised for a felony offense. In fact, almost one quarter of PMI were supervised for a violent felony offense compared to one in ten of TRP.

Finally, and most importantly, Dauphinot found that PMI evidenced higher rearrest and revocation rates than TRP (54% vs. 30% were rearrested and 37% vs. 24% had probation revoked). Interestingly, despite these higher revocation and rearrest rates, PMI were not more likely to have probation revoked for a new felony offense (36% of PMI vs. 35% of TRP). Instead, PMI were substantially more likely than TRP to have probation revoked for technical violations. Specifically, PMI (36% vs. 0%) were more likely to have probation revoked for “other” technical violations including failure to work, failure to allow home visits, failure to attend class, or failure to perform community service. It should be noted that no statistical analyses were documented for these latter findings. Dauphinot reports that the small sample size (n=43 PMI who were revoked) limited the power for these analyses.
Though interesting, Dauphinot's results are limited by a number of factors. The first limitation is that comparison probationers were not matched to the PMI group on demographic or historical variables, thus these differences may better account for PMI increased risk for failure. Secondly, closer inspection reveals that PO often cited multiple reasons for revocation. Dauphinot reports no attempt to control for this. Thus PMI reasons for revocation overlap and there is no way to determine the primary reason for revocation (new arrest or technical violation). Finally, Dauphinot's small sample size, limited the power for statistical analyses. Thus, these results are more suggestive than conclusive.

Still, Dauphinot's research does indicate that PMI are at increased risk for failure. What remains to be seen, are the specific factors that determine poorer outcome for PMI. Although numerous factors are likely to contribute to PMI outcome, one potentially important issue is probation agencies response (or lack thereof) to PMI. Dauphinot's results highlight this issue by hinting at a revolving door cycle, beginning with arrest for a misdemeanor or "nuisance" offense and ending in probation revocation for a technical violation. Thus, it appears as though PMI are arrested and sentenced to probation for displaying symptoms of mental illness in public and subsequently have probation revoked for manifesting the same untreated symptoms. Clearly, examining probation agencies role in this cycle may help to illuminate the reasons for PMI negative outcomes. In the next section I will address the extant literature examining probation agencies response to PMI, as well as provide the reader with a brief background on the field of probation as a whole.
Probationers with mental illness: Responding to the Challenges

A handful of studies have sought to characterize the response of probation agencies to the challenge of supervising PMI. Generally speaking, these studies suggest that while some probation agencies have developed innovative strategies for working with PMI, the majority of probation agencies are ill-equipped to handle the probationer with mental illness. However, before embarking on a discussion regarding this literature, it is first necessary to understand how the probation system developed and operates separately from PMI. This background is designed to familiarize the reader with the social context and illustrate the difficulties currently faced by probation agencies and officers. Specifically, it allows the reader to fully comprehend the added stresses probation agencies and officers feel with regard to adapting the system to supervise and aid PMI.

*Background on Probation: Contextualizing the Problem*

*The Probation System*

The probation system as we know it has its roots in the altruistic story of John Augustus (Abadinsky, 2000). John Augustus, taken by the situation of a young drunkard, began by bailing him out of jail and supervising his release into the community. Augustus, moved by this man’s recovery, continued to offer this opportunity to other similar offenders and helped them to find housing, employment and generally lead a crime-free lifestyle. Though originally based on the principles of benevolence and rehabilitation, probation has evolved overtime; moving out of the control of volunteers (like John Augustus) and falling under bureaucratic control. Probation is now considered a moderate criminal sanction and is commonly defined as the supervised release of offenders into the community (Mumola, 1995).
In contrast to its almost uniform evolution toward bureaucracy, probation has in other ways developed quite differently across the U.S. Depending on the specific jurisdiction, the same offender is likely to have very different experiences. Specifically, different legal jurisdictions vary in their lengths of probation sentence (anywhere from 10 months to 5 years), auspices of oversight (federal, state, county, or municipal), and standard conditions of probation (Abadinsky, 2000).

Despite wide variability, the general process of probation seems to follow similar rules. First, a sentence of probation has historically been reserved for first time offenders and/or offenders who have been convicted of less serious crimes, (Abadinsky, 2000). For example, many states exclude particular types of offenders from receiving a sentence of probation (e.g. those convicted of murder, rape, or kidnapping). However, recent research suggests that this may no longer be the case. For example, Glaze (2003) reports that equal proportions of probationers are serving time for misdemeanor and felony offenses.

Second, when sentenced to probation the offender is required to agree to certain conditions prior to release. Though the conditions of probation were originally designed to reflect the individual risks and needs of the offender, the current bureaucratic nature of the legal system does not allow for this. Almost all probationers are required to conform to their jurisdictions standard conditions of probation. These vary greatly, but generally include abstaining from drug and alcohol use, securing and maintaining housing and employment, and avoiding criminal friends and activities. In some cases the judge may impose additional or “special” conditions of probation. However, these are usually simply checklist style options which the judge can decide to include or not. These conditions are put in place to guide probationers toward a crime-free lifestyle. Third,
probation violation may result in revocation and a sentence of imprisonment. There are two types of probation violations: technical violation (when any of the conditions of probation are violated) and new offense (when violation involves a new crime). The amount of discretion in processing of probation violations varies widely from agency to agency, but generally the decision to prosecute or seek revocation is in the hands of the probation officer. Thus the PO plays a substantial role in the life of the probationer.

**The Probation Officer**

After being placed on probation, the offender is assigned a PO (Abadinsky, 2000). PO have routinely been called upon both to aid in probationer rehabilitation and to protect the community from further crime. The rehabilitative role varies from agency to agency but ranges from providing referrals to social service agencies (e.g. Alcoholics' Anonymous, vocational training, etc.) to directly providing said services. Aside from promoting rehabilitation, the PO is also called upon to monitor probationers' compliance with their conditions of probation and to protect the community from further crime. Though not always the case, the rehabilitative and community safety roles are often in competition within both the probation agency and the PO. Thus, probation agencies, as well as PO, can differ dramatically with regard to their relative orientation toward rehabilitation ("care") or community safety ("control"). Specifically, when demonstrating a more "care" orientation, a PO is likely to educate, advocate and enable their probationers. In contrast, when presenting a more "control" orientation, a PO is likely to monitor behavior and enforce the law. Though historically PO have primarily had a more "care" orientation, as caseloads have expanded individualized attention has diminished. This, combined with the current public focus on "zero tolerance" policies, has pushed the majority of
probation agencies and officers into a more “control” oriented position (Abadinsky, 2000).

Practically, PO are much like all social service agents, overworked and under-funded. In fact, the number of offenders supervised in the community has grown by 75% in the recent past (Glaze, 2003). Thus, PO are now forced to supervise caseloads in the hundreds. Specifically, Skeem, Emke-Francis, & Eno Louden (2006) identified an average caseload size of 130 probationers among a national sample of traditional PO. Using the American Probation and Parole Associations “caseload to workload” formula, this affords PO less than 1 hour per month per probationer. Within this hour, PO are expected to complete a variety of tasks including: (1) monthly face-to-face meetings with probationers both in the office and in the field, (2) collecting, recording and reviewing probationers fines or fees, and (3) completing the probationer’s paperwork including processing of probation violations (Abadinsky, 2000). In order to meet these near impossible demands, most PO rely heavily on routine (Abadinsky, 2000).

Clearly the experience of probationers varies widely depending on the qualities of the agencies and officers to which they are assigned. Furthermore, unrealistic demands on PO time may severely limit the ability of PO to address probationer’s needs. Though discouraging for all probationers, this is especially likely to negatively impact the experience of the PMI. Despite the likely implications for PMI outcome, there is a dearth of literature on the topic of PO response to PMI. Below is a review of the existing literature in this area.
Responding to the Probationer with Mental Illness

As discussed previously, PMI are a unique population characterized by increased risk for numerous social hardships and high rates of probation revocation. Though the reasons for PMI negative outcomes remain unclear, research does suggest that PO and agencies limited time and resources may play a role. Specifically, prior research has suggested that PMI are under-referred to social services (Wormith & McKeague, 1996) and common sense suggests that PO are barely capable of meeting the needs of TRP (see the "caseload to workload" discussion above). Thus, PMI social and cognitive disadvantages pose a substantial drain to the criminal justice system. Recognizing the substantial impact of the offender with mental illness, The Council of State Governments (2002) remarked that:

The current situation not only exacts a toll on the lives of people with mental illness, their families and the community in general, it also threatens to overwhelm the criminal justice system (pg. 6, emphasis added).

The gravity of this problem spurred the Criminal Justice/Mental Health Consensus Project, a two-year national effort coordinating input from federal policymakers, criminal justice employees and mental health professionals. The result was forty-six policy statements designed to guide the criminal justice system’s response to the offender with mental illness (Council of State Governments, 2002). The Consensus Project issued recommendations at all levels of the criminal justices system from arrest to release, including recommendations for the management of offenders with mental illness sentenced to probation. It explicitly recommended that probation agencies develop specialized caseloads for PMI. As described in the project handbook, specialized caseloads are characterized by exclusively mental health caseloads, reduced caseload size

17

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
and specially trained or experienced PO. Although the development of specialized caseloads sounds promising for positively impacting PMI outcomes, to date no research has been published offering empirical support. However, a handful of studies do exist examining the varied implementation of specialized caseloads. Specifically, these studies have sought to characterize how specialty agencies differ from traditional agencies, and to examine the extent of heterogeneity among specialty agencies.

*Specialized Caseloads*

Extant research suggests that specialized caseloads offer a unique approach to supervising PMI. Moreover, in contrast to the wide variability found among probation agencies in general, extant research suggests that truly specialized probation agencies (probation agencies with two or more specialized mental health caseloads) are fairly homogenous in their approach to supervising PMI (Skeem, Emke-Francis & Eno Louden, 2006). This approach includes all of the core characteristics set forth in the *Consensus Project’s* recommendations (exclusively mental health caseloads, reduced caseload size, and specially trained or experienced PO). In addition, specialty agencies uniformly differ from traditional agencies in their orientation towards rehabilitation (Skeem, Encandela, & Eno Louden, 2003), emphasis on collateral relationships (especially with treatment providers) (Emke-Francis, Skeem, Camp & Eno Louden, 2005) and use of problem-solving strategies to address noncompliance (Emke-Francis, et al., 2005, Skeem, Emke-Francis & Eno Louden, 2006).

The most extensive study to date that explicitly focused on characterizing specialized probation agencies was a national survey of probation supervisors conducted by Skeem, Emke-Francis & Eno Louden (2006). This study’s primary aims were to (1) identify
specialized probation agencies, (2) characterize these agencies differences from traditional agencies, and (3) examine differences, if any, among specialized agencies.

In order to address these study aims, the researchers utilized a multistage process. The first stage sought to identify as many of the specialty probation agencies in the United States as possible (Skeem, Emke-Francis & Eno Louden, 2006). This was accomplished via three routes: (1) systematically contacting probation executives at all levels, (2) publishing announcements in probation journals soliciting information, and (3) utilizing a “snowballing” approach by having probation executives identify potential specialized agencies. This process resulted in the identification of 137 probation agencies with at least one caseload that included probationers with mental illness. However, several of these agencies (22) were ineligible to participate because their caseloads were not exclusive to PMI. In these agencies PMI shared caseloads with general probationers (50%), sex offenders (14%), or other non-mentally disordered groups (35%). Thus, this study identified only 115 truly specialized agencies.

The second stage further screened specialized agencies to include only those agencies with two or more specialty PO (73 total). This resulted in a final sample consisting of 66 specialty (90% participation rate) and 25 traditional (96% participation rate) probation agencies matched for geographic region and population size. Probation supervisors were chosen as the target population due to their knowledge of both day to day operation and agency-wide policies and procedures. All participants were asked to complete a combined telephone and mail survey designed to assess for: (1) general agency characteristics (e.g., number of officers, caseload size), (2) agency policies and procedures for supervising PMI, (3) the nature of treatment mandates in the agency (e.g.,
what orders mandate), (4) how PO typically monitor and enforce treatment compliance in the agency, (5) the perceived utility and practicality of specialty caseload components, and (6) the perceived effectiveness of the agency in supervising these probationers.

Five categories of relevant findings resulted from this study (Skeem, Emke-Francis & Eno Louden, 2006). First, both specialized and traditional probation agencies reported on the difficulties with supervising PMI. Interestingly, both types of agencies reported that PMI increased need for time and resources was the primary challenge associated with supervising these offenders.

Second, both agencies gave their impressions of the utility and practicality of specialized caseloads. Although both types of agencies agreed that specialized caseloads would be helpful in supervising PMI, only specialized agencies perceived these caseloads as practical. In fact, a common complaint among traditional probation supervisors was the impracticality of implementing specialized features, for example adding additional collateral contacts to their traditional caseloads.

Third, the specialized probation agencies were examined for heterogeneity. Results from the cluster analysis revealed that specialized agencies are similar enough to be evaluated as a single prototype characterized by five key features: (1) exclusive mental health caseloads, (2) reduced caseload size, (3) sustained officer training, (4) active integration of internal and external resources, and (5) the use of problem-solving strategies as the chief means for addressing PMI treatment noncompliance.

Fourth, specialty and traditional agencies were compared in their strategies for monitoring and enforcing mental health treatment compliance. Specialty agencies, as noted above, chiefly employed problem-solving strategies for addressing treatment
noncompliance. Traditional agencies, in contrast, chiefly employed threats of incarceration for addressing treatment noncompliance.

And finally, relative adherence to this prototype was examined to identify its impact on treatment monitoring and enforcement strategies. These analyses suggest that reduced caseload size plays an instrumental role in the implementation of specialized caseloads. Specifically, as caseload size increases, the agencies strategies for monitoring and enforcing treatment compliance become more and more similar to traditional agencies strategies until they are indistinguishable. Specialized agencies with caseloads similar to traditional agencies are less likely to endorse implementing problem-solving strategies and more likely to implement threats of incarceration.

This study’s findings are relevant to the experience of PMI in several ways. First, although this study suggests that specialized caseloads represent a unique and promising approach to supervising PMI, it does not empirically support the claim that specialized caseloads result in better outcomes for PMI. Secondly, this study suggests that truly specialized caseloads are extremely rare. Specifically, extant research suggests that approximately 5% of probation agencies offer some type of specialized caseload services for PMI (Compare Skeem, Emke-Francis & Eno Louden, (2006) research identifying 137 probation agencies reporting a specialized mental health caseload and Ditton’s (1999) article reporting a total of 2,627 probation agencies in the United States). Of the 5%, many of these “specialized caseloads” (16%) are either “kitchen sink” caseloads and include specialized probationers of various backgrounds (offenders with mental illness on a caseload with sex offenders, gang offenders, etc.), or the “unlucky officer” caseload where a traditional probation officer supervises all of the PMI in addition to her general

21
caseload. Furthermore, if the agency does have a truly specialized mental health caseload but the caseload size increases to traditional size, the agency behaves indistinguishably from a traditional agency with regard to monitoring and enforcing treatment compliance. Consequently, the specialized caseload is not likely to have made a substantial impact on the experience of the PMI and it appears as though the majority of PMI are currently supervised as part of large general caseloads managed by traditional PO.

**Traditional Caseloads**

Despite the large numbers of PMI supervised as part of traditional probation caseloads, only one study has sought to examine traditional probation agencies responses to PMI. This study, completed by Skeem, Encandela and Eno Louden (2003), sought to compare and contrast traditional and specialty probation agencies with regard to: (1) their specific methods of monitoring and enforcing mental health treatment compliance, and (2) the perceived efficacy of these strategies in working with PMI. These study aims were addressed via a focus group design. A total of five focus groups were conducted (two with PMI and three with PO) including a total of 52 participants (32 PO and 20 PMI). Participants were drawn from both specialized and traditional probation agencies located across three states. Discussion topics included: (1) general experiences in supervising PMI, (2) experiences with monitoring treatment compliance (i.e. what specifically is monitored, either treatment attendance or medication adherence) and specific monitoring strategies used, and (3) experiences with enforcing treatment compliance (i.e. specific enforcement strategies used and their perceived efficacy). Qualitative analysis of the focus group discussions yielded four relevant themes.
The first theme involved PO conceptions of PMI. Specifically, both traditional and specialty PO described PMI as requiring, “substantially more time and attention from, and became more dependent on, their PO (Skeem, Encandela, & Eno Louden, 2003, p. 440).” However, traditional and specialty PO did differ in their view of the “routineness” of PMI. Specifically, traditional PO characterized PMI as differing substantially from their more routine or typical cases, which are characterized by their lack of mental health issues and uniform motivation to move through the probation system with as little interaction with the PO as possible. Therefore, the traditional PO “typical probationer” wants to maintain the status quo and avoid “rocking the boat”. In contrast, traditional PO viewed PMI as atypical or “problem cases”, whose mental health issues result in increased dependency on the PO and whose need for mental health treatment and other social resources make them different and potentially dangerous. This is in stark contrast to specialty PO conceptions of the routine or typical case, which were characterized by the presence of mental health problems and increased needs for help in navigating the social service system.

The second relevant theme involved the relationship between PO conceptions and the apparent ease with which probationers are processed. For traditional PO the “routine or typical” probationer is viewed as easy to process, requiring very little PO time. PMI, in contrast, are viewed by traditional PO as time and resource intensive and nearly impossible to supervise. For example one traditional PO commented:

we have got to fit them into a square, and there’s no separate one for mental health. In other words, we can declare that they’re a minimum supervision level [to] a maximum supervision level... and basically they’re done on a... score sheet that we do on everybody else. So basically you have to fit them in – put them into that. Any time you spend in addition to the level that you’ve
declared them... is off another offender’s case because of the limited amount of time (Skeem, Encandela, & Eno Louden, 2003, p. 442).

Thus, for traditional PO, PMI are viewed as an obstacle to efficiently managing their large caseloads. In order to maintain efficiency traditional PO report biding their time until the PMI is either transferred to another PO or terminated. For example, one traditional PO stated:

If there’s a nutso on my case and he’s just taking up too much time, when there’s an opportunity to transfer to another officer, I’ll transfer him (Skeem, Encandela, & Eno Louden, 2003, p. 442).

Another traditional PO commented:

No, [we haven’t found anything that works] ... we’re stalling. We’re babysitting until we get them off of our caseload whether we’re stalling them out, throwing them in and out of jail to get them through their minimum [sentence] or we’re ignoring them or we’re handing them off to different officers (Skeem, Encandela, & Eno Louden, 2003, p. 442).

In contrast, specialty PO described differentiated subtypes of PMI. The “routine” or “typical” PMI was characterized as seeking additional time and attention from the PO. Routine PMI were viewed as invested in the process of rehabilitation and specialty PO found it comfortable and easy to advocate for them. The “difficult”, “atypical” or “problem” PMI, was contrarily characterized by non-compliance with treatment mandates and avoidance of the PO. These PMI were viewed as having low motivation to complete treatment or to better their situation and, thus, were difficult to supervise.

The third relevant theme involved the uniform perception that relationship quality strongly influences PMI performance while on probation. Specifically, PMI from both traditional and specialty agencies reported desiring a more collaborative, less authoritarian relationship with their PO. Although the majority of traditional PMI (60%)
described their current PO-probationer relationship as more caring than controlling, many felt that they had just “gotten lucky” and feared being assigned to a PO who was more condescending, rigid and controlling. For example, one traditional PMI described his impressions of a hostile interaction with his traditional PO and department:

My PO- I sometimes have the feeling he’s kind of looking down his nose at me – and then again I get that feeling from just about everybody at that office... [Once], there was those two people standing right in the doorway, practically letting themselves in the room almost when I’m talking to my PO. And when we come out of the room here they are. We practically got to squish against the door to get past them – and one of them is chuckling to the other one... and nods his head over towards me and says, ‘You can tell when he’s lying cause his lips are moving’ (Skeem, Encandela, & Eno Louden, 2003, p. 444).

In addition, PMI in traditional agencies perceived that their current positive relationship with their PO was contingent on compliance with the conditions of probation. PMI in specialty agencies differed from their traditional counterparts in three ways: (1) specialty PMI reported that their PO many times went beyond acting congenially and acted as advocates and supporters, (2) specialty PMI reported that warm interpersonal relationships were the rule rather than the exception, and (3) specialty PMI did not report contingencies in their relationships with their PO. Instead they felt their PO warmly and honestly managed their conflicting roles (e.g. advocate vs. enforcer).

Notably, besides being generally more desirable, differences in relationship quality were viewed as substantially impacting PMI compliance and eventual outcome. Specifically, both specialty and traditional PMI reported that collaborative relationships yielded numerous positive results including: (1) mutual trust that allowed for open communication about compliance with probation conditions, (2) increased willingness of the PMI to comply with the PO, and (3) increased confidence of the PMI successfully to
meet the conditions of probation. Conversely, more controlling, authoritarian
relationships were viewed as producing negative outcomes for PMI. For example, one PO commented:

Because what happens is you create more anxiety when you’re threatening to send them to jail. They don’t want to go to jail – they’re not stupid – they’re a little bit crazy. And then they’ll stop coming in because they’re afraid – ‘I talked to a policeman last week and my probation officer knows about it, and he’ll probably be mad at me, so he’ll probably arrest me (Skeem, Encandela, & Eno Louden, 2003, p. 454).

The final relevant theme involved the types and perceived efficacy of PO strategies for monitoring and enforcing PMI compliance with mental health treatment. Specifically, traditional PMI and PO agreed that traditional PO primarily implement threats of incarceration to motivate PMI to comply. PMI perceived this as damaging to their success. As one traditional PMI commented:

My mental condition is something of a severe emotional turbulence… and anything that causes me an additional bit of unease or anything, you know, additionally bad in my life, contributes to the strain of a situation that is already teetering on the brink of suicide (Skeem, Encandela, & Eno Louden, 2003, p. 455).

On the other hand, traditional PO report frustration with their limited strategies for addressing noncompliance:

We do not have the ability to deal with it. Our agency does not have the ability to deal with it (Skeem, Encandela, & Eno Louden, 2003, p. 442).

In contrast, specialty agencies reported having numerous tactics outside of threats of incarceration for addressing treatment noncompliance, including both proactive strategies (preventative problem-solving discussions) and reactive strategies (problem-solving discussions, persuasion, inducements, graduated sanctions and reminders).
In addition to lacking strategies overall, traditional PO also acknowledged that threats are largely ineffective. Specifically, traditional PO and probationers alike saw these strategies as damaging relationship quality. Furthermore, PO viewed threats of incarceration as the “ultimate bluff” because most judges would not revoke probation based entirely on noncompliance with mandated treatment. As one PO put it:

You bluff. ... Yeah, but when your bluff is called, you have nothing left (Skeem, Encandela, & Eno Louden, 2003, p. 451).

In sum, this study’s relevant findings are numerous and have serious implications for the potential experiences and outcomes of PMI managed as part of large traditional caseloads. First, PMI are perceived as needy and time consuming by traditional PO who are accustomed to monitoring probationers primarily concerned with limiting their interactions with the PO. This difference in presentation combined with most traditional PO unfamiliarity with mental health problems causes traditional PO to view PMI as “problems to the system” who are atypical, potentially dangerous and extremely difficult to supervise. Furthermore, the ill-fit between traditional PO conceptions and PMI characteristics appears to result in PMI largely being ignored, either by being passed from PO to PO or the PO avoiding the PMI until they can be discharged. Consistent with this negative climate, PMI perceive the typical traditional PO as condescending and controlling, forming warm and collaborative relationships only to revoke them at the first sign of noncompliance.

Despite these negative perceptions, the majority of traditional PMI were happy with their relationships with their current PO. This is encouraging because a fair, collegial relationship between PO and probationer was seen as key in successful treatment compliance and positive outcome. However, traditional PO heavy reliance on threats of

27
incarceration to enforce compliance with mandated treatment, suggests that positive relationship quality between traditional PO and PMI is precarious at best. The general climate of mutual distrust, negative conceptions, combined with the prolonged use of threats of incarceration to induce treatment compliance is quite likely to result in negative relationship quality between PO and PMI and, thus, negative outcomes.

Though compelling, this study’s findings are limited by several factors. First, like all focus group research, the descriptions are based on a very limited sample (PO and probationers from a total of 3 probation agencies) and as such the results may not generalize to other probation agencies. This is especially true for the information presented on traditional PO and probationers as they were all drawn from a single traditional probation agency. Secondly, the study’s findings are a reflection of perceptions and discussion rather than empirical inquiry and are, therefore, limited by a myriad of likely perceptual biases. Third, although many of the study’s findings are suggestive of plausible causal relationships (e.g. poor relationship quality yields poor outcome; threats of incarceration negatively impact relationship quality), the focus group design does not allow for causal mechanisms to be explored.

Overall, this body of literature paints a bleak picture for the future of PMI managed as part of traditional caseloads. Specifically, it suggests that PMI may be involved in a revolving door cycle, where they are sentenced to probation for misdemeanor offences related to their untreated mental health problems and then either overlooked, purposely ignored or revoked for a technical violation.

Although it is likely that many factors contribute to this cycle, one potential influence, as suggested by the above literature, is traditional PO negative conceptions of
PMI. These conceptions appear to have their roots in the very nature of PO work. Specifically, as discussed previously, traditional probation agencies divide probationers among large general caseloads. In fact, the average traditional agency caseload size found in Skeem, Emke-Francis & Eno Louden’s (2006) national survey was 130 probationers. This caseload size is well above the American Probation and Parole Association’s “workload to caseload” recommendation of 60 medium risk probationers per officer (American Probation and Parole Association, website).

These large caseloads, often soaring into the hundreds, severely limit the amount of time available for supervising individual probationers. Consequently, PO have a high need for efficiency in supervising their caseloads (Council of State Governments, 2000). Extant research suggests that PO manage these demands by developing conceptions regarding the routine or typical case (Skeem, Encandela & Eno Louden, 2003). The Skeem, Encandela and Eno Louden (2003) study, described in detail above, was the first to apply the sociological term “typifications” to PO conceptions about typical probationers and PMI.

The construct of typifications has its roots in the sociological literature interested in determining how professional agents are capable of efficiently managing large numbers of people. Typifications are most often defined as a type of “perceptual shorthand” designed to aid professionals in the efficient recognition and categorization of persons (Bond, 2001, Frohmann, 1991, Skeem, Encandela & Eno Louden, 2003 Spohn, Beichner, Davis-Frenzel, 2001). Once activated, typifications provide a method for sorting clients into categories and suggest a standard course of action or treatment. Typifications serve to simplify and routinize what would otherwise be psychologically taxing work.
Furthermore, typifications allow for overextended agencies efficiently to identify and handle common situations (Bond, 2001, Farrell & Holmes, 1991, Sudnow, 1965).

Skeem et al. (2003) described traditional PO “typifications” of the TRP as a non-mentally disordered individual who wants to maintain the status quo and avoid “rocking the boat”. However, PMI increased needs for attention, time and resources do not readily fit these “typifications” and cost the PO his most precious commodity: efficiency. Thus, PMI are “square pegs” or “problem cases” which elicit frustration on the part of traditional PO.

Given the potential impact of typifications on PMI processing and outcome, further research is needed to clarify the nature of traditional PO typifications of PMI and build the foundation for future research designed to assess for their impact on probationer outcome. The current research study is designed to build on this literature by taking a closer look at traditional PO typifications. However, evaluation of the outcome of this research requires that the construct of typifications be fully understood. The next section of this review is devoted to: (1) further defining typifications, (2) reviewing the relevant research on the impact of typifications, and (3) discussing the limitations of the existing typifications research.

Defining Typifications and their Influence

*Defining Typifications*

As discussed previously, the construct of typifications has its roots in the sociological literature interested in determining how professional agents are capable of efficiently managing large numbers of people. Sudnow (1965) published the most seminal piece of literature defining typifications as part of his observational fieldwork study examining
plea bargaining processing within the public defender's office. Specifically, Sudnow suggested that public defenders, judges and district attorneys develop shared typifications designed to aid the efficient processing of offenders. Sudnow proposed that typifications develop when specific demographic and case characteristics are recognized as being associated with particular types of offenders and crimes. To the courtroom actors, these cases become routine and are immediately recognized as such. Sudnow called this identifying "normal offenders" committing "normal crimes". Over time, courtroom officials learn to rely heavily on these typifications to aid expediency and limit the amount of conflict over each case. Thus, each player recognizes the features of the "normal offender committing the normal crime" and immediately engages in the routinized strategy for their disposition. Typifications of "normal crimes" imply "normal sanctions". Stated another way, courtroom professionals engage in a feature matching process whereby each case is examined for the extent to which its characteristics fit the typifications of the "normal offender". To the extent that the case matches, the sanctions apply.

Sudnow's (1965) work has far reaching implications. Clearly courtroom typifications could substantially impact the processing of offenders and result in a number of unfavorable side effects including institutional biases against particular offenders or crimes. Furthermore, questions are raised regarding typifications potential to compromise an offender's due process rights. Subsequently, Sudnow's research has given rise to numerous other studies examining the use of typifications in other populations and investigating their possible influence on decision-making and treatment.
The Influence of Typifications

Decision making

As Sudnow's work suggests, typifications develop among the overworked courtroom actors. Thus, players in the legal system have commonly been examined for their use of typifications. The majority of this research has focused on the legal decisions made by district attorneys (DA) regarding charging decisions.


One of the most prominent studies in this field examined for the influence of DA typifications on the decision to prosecute in sexual assault cases. Unlike other studies inferring typifications from biases in prosecution statistics, Frohmann (1991) examined DA typifications via observation of the case screening process and personal interviews with DA regarding their decision of whether or not to prosecute. The results from this qualitative study caused Frohmann to conclude that victim's allegations were taken more seriously if they matched up with the prosecutors "repertoire of knowledge" regarding the "typical rape". A replication of this study conducted by Spohn, Beichner, Davis-Frenzel...
(2001), using DA written accounts to infer typifications, identified similar results. The data suggest that with regard to sexual assault cases “typifications of rape-relevant behavior” (Frohmann, 1991, pg. 217) are used to determine victim credibility and justify DA decisions not to prosecute. For example, consider a rape victim who fails to report the rape for several days. This violates what Frohmann calls the “typification of rape reporting,” which causes the DA to sort the victim into the non-credible category and fail to press charges.

However, DA are not the only group of legal decision makers shown to utilize typifications. Judges (Bock & Frazier, 1984, Frazier & Bock, 1982, Steffensmeier, Ulmer and Kramer, 1998), police officers (Boyd, Berk, & Hamner, 1996, Hunt, 1985) and PO (Bond, 2003, Drass and Spencer, 1987, Frazier, Bock & Henretta, 1983) have all been shown to use typifications to aid expediency. For example research has shown that judges use typifications to quickly determine an offender’s culpability and dangerousness when making sentencing and bond decisions (Bock & Frazier, 1984, Frazier & Bock, 1982, Steffensmeier, Ulmer and Kramer, 1998).

Specifically, Bock and Frazier (1984) examined for the influence of case characteristics on judge’s bond decisions in 286 bond cases. Data in this study were gathered via observation of bond proceedings and review of the official court decision documents regarding bond decisions. Results suggest that while numerous other legal and demographic characteristics were examined, the combination of seriousness of offence and demeanor in court were the most highly correlated with the decision to release on recognizance. The researchers suggest that these findings indicate underlying
typifications related to judges inferences regarding the offenders overall character, motives for crime, and potential for positive outcome.

Outside of Skeem et al.'s (2003) work (discussed in detail above), the literature examining PO typifications has focused exclusively on PO who complete pre-sentencing investigation reports for the courts. These studies have provided evidence that PO utilize typifications of the “high risk” defendant, (Drass and Spencer, 1987), “male juvenile delinquent” (Webb, 1984) and juvenile defendant’s “youth’s vulnerability” (Bond, 2003) when making recommendations to the court.

All these studies suggest that typifications in legal decision-making contexts influence case processing. However, the PO that interact with PMI are not strictly employed to influence legal judgments (recall that the bulk of PO work with PMI involves aiding rehabilitation and monitoring and enforcing the conditions of probation.) Though at some level these PO do influence legal decisions (i.e. they decide whether or not to seek probation revocation or recommend early release), typifications are likely to assert their influence in these situations in a more ongoing way. Thus far no research has examined the impact of PO typifications in this setting. However, research on mental health clinicians, case managers, nursing home and hospital nurses, and day care workers suggests that even those professionals who interact with the same people repeatedly create typifications and that these typifications influence treatment (Gilliland & Brunton, 1984, Jeffery, 1979, Peyrot, 1982).

**Ongoing Relationship**

The quintessential study of the influence of typifications on ongoing relationships was published by Jeffery (1979), who examined the typifications of casualty doctors and
nurses in three departments in an English city. Data were collected via observation and
tape-recorded interview over seven months. Jeffery found that casualty staff had
typifications of “good patients” and “rubbish”. Good patients were characterized by the
interesting nature of their conditions or other medical characteristics. Typifications of
good patients were somewhat diffuse, but the consequences were clear: good patients
received more expedient and higher quality treatment. As described by Jeffery, one
“good” patient was visited and examined by twelve different doctors. The typifications of
“rubbish” incorporated several subtypes including the “trivia”, the “overdose” and the
“tramp”. Rubbish cases were characterized by their social characteristics. For example,
the tramp was described as a filthy, wayward, homeless person looking for a place to
sleep. Rubbish cases were systematically punished as such, most often suffering long
waiting periods, verbal hostility and insensitive treatment.

Another study of ongoing typifications was conducted by Peyrot (1982), who
engaged in a 4-month field study of case-managers examining the features influencing
client assignment to particular services. Findings reported were obtained via personal
observations, interviews and group discussions with case managers. The results indicated
that case managers utilize typifications of client “suitability” in order to justify the
allocation of scarce treatment resources. Thus, those clients who were typified as
“suitable” were more readily assigned to treatment services than those clients deemed
“unsuitable.”

Clearly, typifications have an impact even in situations where the professional has
increased contact with the person. It seems likely then, that PO utilize typifications and
that these typifications have an impact on the treatment of the probationer. Furthermore,
these typifications seem to be at times attitudinally loaded. This is evidenced in Jeffery’s (1979) study with the frequent derogatory terms exchanged by the staff including “tramp”, “rubbish” and “trivia”. It is likely that typifications may exert influence both practically, as suggested by Skeem et. al. (2003) (e.g. no routinized strategies for processing), and attitudinally, as suggested by Jeffery (1979) (e.g. “rubbish” is intentionally punished).

Atypical Case

A handful of studies have directly addressed the issue of typifications influence on the atypical case. Specifically, extant research suggests that those who do not fit the mold or typification are likely to face unfavorable consequences. For example, recall that previously referenced research examining DA typifications of the credible victim. The results from this study suggested that victims of sexual assault who do not fit typification of the “credible victim” are less likely to have their case prosecuted (Frohmann, 1991, Spohn, Beichner, Davis-Frenzel, 2001).

Another study investigating biases against the atypical case was published by Webb (1984). Researchers in this study examined the case files for 1,212 juvenile offenders in an attempt to identify and describe any differences in the sentencing practices applied to female versus male juvenile offenders in England and Wales. The results from this examination suggested that officials (specifically juvenile PO and social workers) have typifications regarding “male juvenile delinquents.” Specifically, “male juvenile delinquents” were viewed as exhibiting normal ‘boy’ behavior (i.e. “boys will be boys”). On the other hand, young female offenders committing the same offenses were viewed as atypical, expressing unusual, alarming behavior. Thus, the ‘atypical’ female juvenile
delinquent was sentenced to harsher criminal sanctions for the same delinquent behavior as the 'normal' male juvenile delinquent. For example, only 45% of the male juvenile delinquents were sentenced to supervision for their first offence vs. 75% of female juvenile delinquents.

Though the research in this area is limited, it does suggest that being viewed as atypical or unusual can result in unfavorable consequences. One potential explanation for the unfavorable treatment of the atypical case was proposed by Farrell and Holmes (1991) in their review of the typifications literature on legal decision making. Specifically, they suggested that the atypical case requires increased consideration. This required increase in attention presents a problem to the system, where efficiency is sacrificed. Given that the legal trade off is often efficiency for leniency (Sudnow, 1965), the pattern of increased contemplation for atypical cases is likely to result in more stringent sanctions.

In summary, the typifications research suggests that PMI are likely to suffer negative consequences as a result of their differences from the TRP. These consequences may result from their marginalization or atypicality (consequently PO are unable to effectively address PMI problems with their routine strategies) or they might result from the presence of negative typifications or being sorted into PO relative “rubbish” category (resulting in negative attitudinal biases). However, it is most likely a combination of both of these factors. In order to fully explore this issue, the current research seeks to expand on the extant research identifying PO typifications of PMI by comparing them to their conceptions of TRP.
Limitations in Typifications Research

While a substantial body of literature exists regarding the impact of typifications, this research is limited by a series of widespread methodological issues. First, typifications have historically been defined in very abstract terms. Specifically, the most consistent theoretical definition of typifications is “perceptual shorthand” designed to aid professionals in the efficient recognition and categorization of persons (Bond, 2001, Frohmann, 1991, Skeem, et al., 2003 Spohn, Beichner, Davis-Frenzel, 2001). The abstract nature of this definition has resulted in wide variability in its operational definition. Explicitly, researchers have employed various and inconsistent methods to measure typifications. For example, some researchers have inferred typifications from biases identified in written justifications or other forms of records review (Drass and Spencer, 1987, Hawkins, 1981, La Free, 1980, Schmidt & Steury, 1989, Spohn, Beichner, Davis-Frenzel, 2001, Spohn, Gruhl, & Welch, 1987, Spohn & Spears, 1980, Steffensmeier, Ulmer & Kramer, 1998, Webb, 1984), other researchers engaged in months of fieldwork to observe typifications in action (Hunt, 1985, Jeffery, 1979, Sudnow, 1965), and still others simply assessed typifications via individual interviews (Boyd, Berk, & Hamner, 1996, Frohmann, 1991).

Second, typifications have only been studied via qualitative methods or correlational studies involving record review. Although qualitative methods are necessary to lay the foundation for empirical observation, no one has yet followed up this research using a prospective design. In other words, no one has yet attempted to measure typifications and then substantiate their impact or even establish a solid operational definition.
Third, no research has directly addressed the underlying cognitive representation of typifications. Because the construct of typifications resides almost entirely within the sociological literature, no one has attempted to examine how typifications are created, stored and applied at the individual level.

In sum, the typifications research is limited by its lack of a consistent operational definition, missing prospective empirical support and absent explanation for typifications creation and maintenance at the individual level. Given these limitations, the current study has turned to the relatively well established and defined construct of prototypes to aid in operationally defining the construct of typifications.

**Typifications and Prototypes**

As stated previously, typifications have most consistently been defined as “perceptual shorthand” designed to aid professionals in the efficient recognition and categorization of persons (Bond, 2001, Frohmann, 1991, Skeem, et al., 2003 Spohn, Beichner, Davis-Frenzel, 2001). Furthermore, the extant research on typifications suggests typifications exert their influence via a series of three steps. First the professional assesses each individual’s characteristics or features for their relative fit within the agent’s existing categories of people. Subsequent to this assessment, the individual is sorted into the categories of persons with whom he/she shares the most features. Finally, each category suggests a standard course of action or treatment for the individual. Thus, typifications can be operationally defined as incorporating two essential components: (1) conceptions or categories of persons and (2) matching sets of strategies for interacting with or disposing of each category of persons.
Similarly cognitive psychology's prototype theory attempts to explain how humans efficiently categorize others. Specifically, prototype theory asserts that categorical knowledge is represented in memory by a set of abstract features of hierarchical importance or "prototypes" (Rosch, 1978, Rosch & Mervis, 1975). Therefore, prototypes are essentially the "averaged", "quintessential" or "typical" members of any given category (Hilton & von Hippel, 1996, Rosch & Mervis, 1975, Skeem & Golding, 2000). These prototypes serve as a basis for comparison when making categorical judgments, with constructs or objects that share more features with the prototype being more likely to be categorized as a group member.

The first essential component of typifications or the "conception component" appears to be encompassed by the cognitive construct of "prototypes". Therefore a workable operational definition of typifications replaces the vague "conception component" with the well researched and empirically measured construct of "prototype."

In sum typifications appear substantially to impact the processing and treatment of offenders in the criminal justice system. However, extant research in the field of typifications is limited by the absence of a solid operational definition. Fortunately, prototype theory appears to be a promising vehicle for the examination of PO typifications. The following section seeks to further define prototypes and examine their implications for measuring the "conception" or prototype component of PO typifications.

Prototypes

Defining Prototypes

The concept of prototypes was initially developed through the seminal work of Eleanor Rosch (1978, see also Rosch & Mervis, 1975). Rosch proposed that humans
engage in categorization to maximize information retention while conserving cognitive energy. This is accomplished, according to Rosch (1978), by the development of prototypes or groups of defining features for objects in the world. Therefore, decisions regarding categorization of group membership are a function of an underlying feature matching process whereby those objects that share the most features with the prototype are determined to be category members.

Fundamental to prototype theory is the presumption that most categories do not have clear-cut boundaries (Rosch, 1978). Thus, prototype theory differs from the classical model of categorization in a number of ways. First, the likelihood of category membership is determined by the total number of features a given object shares with a given category rather than requiring the presence of all features to determine category membership. Second, category members can vary substantially in terms of the number of features shared with the prototype. This concept, referred to in the prototype literature as "typicality," suggests that some members of a category are more typical than others. Specifically those objects that share more features with the prototype are deemed to have higher rates of typicality, whereas those sharing fewer features are considered atypical or borderline cases. For example, given the prototype of "bird" an example of high typicality might be "cardinal" whereas an example of low typicality might be "penguin".

Rosch (1978) further asserts that prototypes are developed in a socio-historical context and are products of experience. People with different experiences are likely to have different prototypes for the same category. One often cited example of this is the multiple prototypes for "boot" (Kempton, 1981, Skeem & Golding, 2000, Eno Louden,
unpublished masters thesis). When asking a Londoneer one might expect them to identify an army boot, whereas a Texan is likely to identify a cowboy boot.

Further research has extended this concept to examine the influence of familiarity on prototypes. Extant research suggests that the more experienced or familiar people are with a particular category the more likely they are to develop subtypes to the original prototype (Cantor & Mischel, 1979). Returning to the example of a prototype for "boot", a lay person is likely to have one prototype for "boot" whereas a shoe salesman may exhibit several subtypes (e.g. work boot, cowboy boot, granny boot, etc.).

These studies suggest a number of potential considerations when examining the prototype component of PO typifications. First, prototype theory suggests that clear cut boundaries between PO prototypes are not likely to exist. For example, PO prototypes of the TRP and PMI are likely to share some features (e.g. history of misdemeanor offenses or substance use). Therefore to aid expediency, PO categorization of probationers will rely more on those features that are the most central to the category and/or distinguish the category from other similar categories. In other words, PO prototypes of the PMI will be defined by the qualities that are unique to PMI rather than qualities shared with other types of probationers (e.g. history or mental health diagnoses rather than low income).

Second, recall that prototype theory asserts that prototypes are the byproduct of experience. This suggests two important concerns: (1) that prototypes can vary greatly from individual to individual, and (2) that people with similar experiences are likely to have similar prototypes. When applied to the development of the current research, this suggests individual variation in PO prototypes is likely to exist. Further, this variation is likely to be magnified for PO from different backgrounds.
Finally, prototype research asserts that with increased familiarity comes differentiation. Therefore, PO are likely to have sub-prototypes of probationers with whom they are particularly familiar. Thus we should expect that PO are likely to have more than one prototype of TRP. It is also possible that PO may have more than one prototype of the PMI; however this is much less likely given their relatively limited exposure to PMI.

Prototypes of People

Although originally conceptualized as being used to categorize objects, further research has extended the use of prototypes to the categorization of people. One example of this is Cantor and Mischel's (1979) study investigating prototypes of personality traits. Specifically, Cantor and Mischel (1979) used a recognition memory task to test for prototype’s effects on memory for the personality traits of introversion and extroversion. This was accomplished by presenting a series of sentences consistent with characteristics of either the prototypical introvert or extrovert to a group of twenty-six undergraduate participants. Participants were then given a recognition test for these features. Results suggested that participants more accurately remember features consistent with their prototype. A second study was also reported in the same article utilizing a free recall rather than recognition task, and similar results were obtained. This series of studies suggests that people do rely on prototypes in their categorization of people.

Genero and Cantor (1987) extended these findings to include prototypes of mental illness diagnoses. Specifically they hypothesized that the typicality of patient’s features influences the ease and reliability with which cases are diagnosed. The authors tested this hypothesis via a two study research design. In the first study, the authors asked forty-six
trained undergraduates to make mental illness diagnoses under two sets of conditions. In
the first condition subjects were asked to determine the diagnosis based on a list of
diagnostic features. Each feature was assigned a feature weight designed to familiarize
the participant with the association between the given feature and the larger diagnostic
category. In the second condition, participants were asked to make diagnoses based on
vignettes of patients, rather then lists of features. Both conditions presented multiple
patterns of features ranging from atypical to highly typical of the particular diagnostic
category. Results supported their hypothesis that typical cases were more easily and
reliably diagnosed than atypical cases. The second study replicated these findings on an
18 participant sample of psychiatry residents and clinical psychology graduate students.

These studies suggest that humans do indeed use prototypes to categorize people.
Thus this research lends further support to the assertion that the first essential component
of typifications (conceptions of the TRP or PMI) are represented and stored in memory as
prototypes.

Adjunct Note: Why not Stereotypes?

Finally, the construct of the prototype bears a striking resemblance to a similar
concept: the stereotype. Though defined in numerous ways, the stereotype has at times
been conceptualized as a subset of prototypes related to strong negative attitudes (Hilton
& von Hippel, 1996). Though typifications and prototypes can at times be negatively
affectively loaded (e.g. “rubbish”), this is not exclusively the case (e.g. the “good
patient.”) Thus, prototypes and typifications are not bound to attitudes, simply related to
them. Thus to avoid the biased association and negatively loaded associations to the
construct of stereotypes, this research will exclusively employ the term “prototype.”
Study Aims

The present work had one overarching goal: to utilize traditional prototype methodology to extend and clarify previous research identifying PO typifications of PMI. This goal was focused explicitly on eliciting and characterizing the "conception" or prototype component of PO typifications of PMI. There were three specific aims associated with this goal.

The first aim was to examine PO prototypes of TRP (the typical or routine probationer). The purpose of this examination was to provide a comparison or control for the PMI prototype. The control group was necessary because previous research suggested that PO may not have distinct typifications of PMI, and instead simply view them as "atypical" or different from TRP. Thus, this research was designed to help determine whether or not PO have distinct prototypes of the PMI. In addition, prototype theory asserts that category membership is determined by emphasizing those features which are exclusive to the prototype and de-emphasizing those features which are not. Therefore, by comparing the PMI prototype to the TRP prototype(s), we were better able to determine which features centrally defined the PMI versus TRP prototypes.

To date, no other research has sought exclusively to identify PO prototypes of TRP. Thus, informed predictions about the specific types and features of PO TRP prototypes were not possible. However, two bodies of literature allowed for some minor predictions. First, prototype research suggested that, due to their increased exposure to TRP, traditional PO were likely to have differentiated sub-types of TRP. Second, Skeem, Encandela and Eno-Loudens' (2003) work suggested that the prototypical TRP would be characterized as: (a) requiring very little time to process, (b) possessing a high desire to
move through the probation system with little interaction with the PO, and (c) free from mental health problems.

The second and third aims were designed to examine PO prototypes of PMI. The second aim was to elicit and characterize PO prototypes of PMI independently from their prototypes of TRP. The third, and final aim, was to compare and contrast PO prototypes of PMI and TRP in order to gain a clearer understanding of the PMI prototype. These aims have allowed for the replication of previous research identifying PO typifications of PMI and the distilling of a specific list of features that define PO prototypes of PMI and TRP.

Skeem, Encadela and Eno Loudens' (2003) research suggested two potential outcome paths regarding the PMI prototype:

The first path predicts that PO would not report unique prototypes of PMI. On this path, PO descriptions of PMI were predicted to be either: (1) identical or very similar to their descriptions of TRP, or (2) characterized exclusively by their differences from TRP.

The second outcome path predicted that PO would report unique prototypes of PMI. On this path, PO prototypes of PMI would differ from their TRP prototypes in the following ways:

(1) PMI would be distinguished by their pronounced and unmet psychological, social and financial needs (Skeem, Emke-Francis, & Eno Loudent, 2006, Skeem, Encandela, & Eno Louden, 2003, Wormith & McKeague, 1996).

(2) PMI would be described as difficult or challenging to work with (Skeem, Emke-Francis, & Eno Louden, 2006, Skeem, Encandela, & Eno Louden, 2003).
(3) PMI would be described as “needy” or “dependent” on the PO (Skeem, Emke-Francis, & Eno Louden, 2006, Skeem, Encandela, & Eno Louden, 2003).

(4) PMI would be described as unpredictable and potentially dangerous (Skeem, Encandela, & Eno Louden, 2003).

(5) PMI would be described as at fault for their mental health problems and other needs due to their lack of motivation to change (Wormith & McKeague, 1996).

By exploring the above study aims, the overarching goal of characterizing PO prototypes of PMI could be approached. In addition, given that no previous research has sought explicitly to examine PO prototypes of TRP, this study offers a unique contribution to the literature with regard to PO conceptions about probationers in general. Thus, this study may be used to inform future research designed to measure and examine the impact of PO prototypes on probationer outcome.
CHAPTER 2

METHODOLOGY

Stated again, the three specific aims of this study were: (1) to elicit and characterize PO prototypes of the “typical or routine probationer” (TRP), (2) to elicit and characterize PO prototypes of “probationer with mental illness” (PMI) and (3) to compare and contrast the elicited prototypes. Consistent with other prototype literature, prototypes were elicited via the administration of a free-elicitation instrument to a convenience sample of 61 PO attending a national conference (see Cantor, Mischel, & Swartz, 1982, Skeem & Golding, 2000, and Eno Louden & Skeem, manuscript in preparation).

Participants

Potential participants were randomly selected from a publicly available list of 548 registered conference attendees to a national conference for probation and parole officers (the American Probation and Parole Association Winter Training Institute in Anaheim, CA). Because administrators, parole officers and other legal officials attended this conference, prior to selection, the list was filtered to include only those attendees whose title indicated that they work with adult probationers. Common titles for this included: “adult probation officer,” “PO,” “probation/parole officer” or “community supervision officer”.
Juvenile and specialty probation officers were screened out both by title (most juvenile and specialized PO identify themselves as “juvenile PO” or “specialized PO” rather than simply “PO”) and screening procedures. Juvenile probation officers were excluded because, despite their similar title, the organizational directives and practices that govern their work are quite distinct from those of adult PO (Abadinsky, 2000). Specialized PO were screened out for three primary reasons: (1) specialized caseloads represent a small proportion of caseloads nationwide, (2) PO may specialize in a wide variety of areas (ex. sexual offenders, mental illness, DUI, etc.) and, thus, their exposure to PMI might either be expanded or limited, and (3) extant research suggests that PO who specialize in mental illness have increased familiarity with PMI and, thus, have differentiated conceptions of them (Skeem et al., 2003). Consequently, inclusion of specialty PO might serve to obscure traditional PO prototypes.

Screening resulted in a final sampling frame consisting of 234 adult probation officers. Of these 234 officers, 148 potential participants were randomly selected and contacted to request participation. The remaining PO were later solicited to participate in another similar study running concurrently and thus, were no longer eligible for participation in the current study.

Of the 148 people contacted, 20 potential participants were deemed ineligible because they were no longer adult probation officers, several having either resigned their post or retired (for a breakdown of all reasons for elimination see Table 2). Another 15 potential participants were eliminated due to inaccurate contact information. It should be noted that great efforts were taken to secure accurate contact information. If a potential participant’s address or phone number was found to be inaccurate, several sources were checked to
identify the correct contact information. This procedure included looking up the telephone number and/or address for the potential participant's probation department in the National Probation and Parole Directory. If this was unsuccessful, a series of internet searches for the address and/or telephone number for the potential participant's probation department were conducted.

Table 2

<table>
<thead>
<tr>
<th>Reason for elimination</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resigned Post</td>
<td>9</td>
</tr>
<tr>
<td>Not a PO</td>
<td>4</td>
</tr>
<tr>
<td>Juvenile PO</td>
<td>3</td>
</tr>
<tr>
<td>Retired</td>
<td>3</td>
</tr>
<tr>
<td>On leave of absence</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
</tr>
</tbody>
</table>

The remaining 113 potential participants were directly solicited for research participation. Of these potential participants, 65 agreed to participate and returned the study materials. Four of these participants are excluded from analyses because their materials were completed incorrectly.

Thus, 48 potential participants refused participation in the study either by directly declining participation (13 PO) or by never returning the study materials (35 PO). This resulted in a refusal rate of 43%. Notably, study participants did not differ significantly from non-participants with regard to gender or version of survey mailed. Because the
majority of participants who refused participation (96%) were administered study materials via mail, it was impossible to compare responders and non-responders for ethnic or age differences.

The final sample consisted of 61 adult probation officers from various probation agencies located throughout the United States (see Figure 1 for the geographic distribution). It is noted that two probation officers who worked with both juvenile and adult probationers were allowed to participate. They reported their impressions of adult PMI separately from their impressions of juvenile PMI and the results for juvenile PMI were not used in the data analyses to follow. With regard to demographic composition, participants were primarily Caucasian (79%), well educated (16.6 years of education on average), female (61%) probation officers with an average of 13 years of experience in probation. Notably, participants reported wide variability in their exposure to PMI ($M$ number of PMI supervised = 69, $SD = 87$, range 0-400), some reporting little to no experience with PMI and others reporting working with many PMI throughout their careers.

The final sample of 61 participants was divided into two groups which completed two different versions of the free-elicitation instrument. Specifically, 29 participants completed the Description of Probationer Scale Version 1 (DPS-1) and 32 participants completed the Description of Probationer Scale Version 2 (DPS-2). Importantly, a combination of $\chi^2$ and independent t-test analyses revealed that participants who completed the DSP-1 did not differ significantly from those completing the DSP-2 with regard to gender, ethnicity, age, years of education, or years of experience as a PO (see Tables 3 and 4).
Table 3

DPS-1 and DPS-2 participants: Gender and ethnicity

<table>
<thead>
<tr>
<th>Variable</th>
<th>DPS-1 Respondents</th>
<th>DPS-2 Respondents</th>
<th>( \chi^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Number (Percentage)</td>
<td>Number (Percentage)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15 (51.7%)</td>
<td>9 (28.1%)</td>
<td></td>
</tr>
</tbody>
</table>
| Female   | 14 (48.3%) | 23 (71.9%) | 3.55<br>
| Ethnicity | Number (Percentage) | Number (Percentage) |          |
| Caucasian| 22 (75.9%) | 25 (78.1%) |          |
| African American | 3 (10.3%) | 3 (9.4%) | 0.04<br>
| Hispanic | 4 (13.8%) | 4 (12.5%) |          |

*Note.* \( ^a p > .05 \).

Table 4

DPS-1 and DPS-2 participants: Age, education probation experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>DPS-1 Respondents</th>
<th>DPS-2 Respondents</th>
<th>( M )</th>
<th>( SD )</th>
<th>( M )</th>
<th>( SD )</th>
<th>( Df )</th>
<th>( t )</th>
</tr>
</thead>
</table>
| Age      | 40.9 | 9.4 | 41.2 | 8.7 | 59 | - .126<br>
| Years of education | 16.6 | 1.9 | 16.8 | 1.0 | 59 | - .79<br>
| Years of probation experience | 13.5 | 8.7 | 13 | 8 | 59 | .234<br>

*Note.* \( ^a p > .05 \).

Research Team

A team of 12 research assistants, 10 advanced undergraduate assistants (UA) and 2 graduate assistants (GA), contributed to the completion of this project. The 10 UA were divided into three teams which, correspondingly, completed tasks associated with data collection, data entry and data analysis. The 2 GA were involved in both data collection and preparation.
Data collection

All 10 UA were actively involved in the solicitation of research participants. Specifically, 6 UA were involved in contacting potential participants prior to the conference and the remaining 4 UA were involved in contacting potential participants after the conference. All UA were required to manage caseloads of approximately 13-15 potential participants. Caseload management involved: (1) training on and utilizing a calling-script to initiate contact with potential participants (a copy of this script can be found in Appendix A), (2) overseeing and making calls to potential participants, (3) identifying and maintaining accurate contact information for potential participants on their caseload, (4) keeping detailed logs of all contacts with potential participants on their caseload (a copy of a blank call log can be found in Appendix B), and (5) participating in a weekly meetings regarding progress on contacting and securing potential participants.

Both GA contributed to data collection by aiding the PI at the conference. Specifically, GA were trained to: (1) review the informed consent form with participants and secure research participation, (2) administer all research materials, and (3) provide answers to common questions about study participation.

Data Preparation

Four UA were responsible for data entry on the project. Specifically, these UA transcribed participants' responses into text formatted documents. Three of these UA and both of the GA were involved in either the extraction, categorization or combination of prototype features from the participants' responses. A detailed description of the procedure for data analyses and the RAs involvement can be found below.
Measures

Prototype Elicitation Instrument

The Description of Probationer Scale (DPS) is a free-elicitation device designed to assess PO prototypes. The DPS has two versions (see DPS-1 in Appendix C and DPS-2 in Appendix D). Both versions of the DPS request that respondents describe in detail either their “routine or typical probationer” (DPS-1) or their “typical probationer with mental illness” (DPS-2). This instrument was developed using traditional prototype methodology (see Cantor, Mischel, & Swártz, 1982, and Skeem & Golding, 2000) and asked participants to call to mind the quintessential member of a category and describe it. The two versions were used to assure that features specific to both types of probationers were elicited.

Given that research suggests that PO may have sub-prototypes of either TRP or PMI, participants were directed to complete separate questionnaires for each prototype that came to mind. However, we also attempted to ensure that sub-prototypes would be identified and accurately interpreted by including the following questions as an additional refinement to both of the Description of Conception Scales:

Considering your previous description...

1. Does this represent a single “type” of probationer or does it include multiple subtypes?
2. If this is a single “type”, what proportion of the probation population is this type?
(3) If this person represents multiple subtypes: Please name, describe them and estimate what proportion of the probation population is accounted for by each subtype.

Demographic Questionnaire

In addition to the DPS scales, all participants completed a brief demographic questionnaire designed to assess for age, ethnicity, education and experiences as a probation officer (see copy in Appendix E).

Procedure

All potential participants were invited to participate in the study via mail (see Appendix F for a copy of the letter). In order to increase participation rates, invitees were contacted via telephone approximately one week later to answer any questions and secure participation in the project. Several invitees scheduled appointments to complete the study materials at the conference (35 PO or 58%). However many participants (26 PO or 42%) were not reachable prior to the conference and were invited to complete the study materials via mail.

Those PO who scheduled an appointment at the conference reviewed the study materials with a GA. PO that chose to participate signed the consent forms, kept a copy for their records, and then completed the study materials. These PO were then randomly assigned to one of two groups to complete the study materials. Those in Group 1 completed the demographic questionnaire and the DPS-1. Those in Group 2 completed the demographic questionnaire and the DPS-2.
A between subjects design was chosen for this study to minimize participation time and carry over-effects. With regard to administration, both groups who completed the materials at the conference were asked to complete the demographic questionnaire first followed by their respective version of the DPS. Block random assignment was used to approximate equal sample size.

Those PO who did not complete the study materials at the conference were asked to do so via mail. The PO involved in the mail survey were given a brief overview of the study by phone prior to mailing the study materials. Those PO who expressed interest in participating in the survey were then mailed the study materials including a cover letter explaining the study, a copy of the informed consent form, the demographic questionnaire and a version of the DPS. In order to assure that the study materials were completed correctly, the cover letter included detailed instructions on completion and the survey materials were presented in sealed envelopes to be opened in a specified order (a copy of the cover letter for the mail surveys can be found in Appendix G). Notably, there is no way to ensure that study participants completed the materials in the specified order.

In order to increase participation rates for those who completed the study materials via mail, UA routinely made follow-up calls to answer questions and encourage prompt completion of the study materials. In fact, all PO who were mailed study materials were contacted a minimum of 2 times. In many cases PO were called several more times. In fact, the average number of calls per PO was 5.25 with 40% of potential participants receiving 7 or more calls. Despite these efforts, 38 surveys were not returned after 3 months. These participants were counted as “soft refusals” and constitute part of the refusal rate discussed above.
Once participants completed their study materials (either at the conference or via mail) they were given a $15.00 Starbucks Card.

Data Preparation

The DPS scales elicit data in the form of hand written, free-form narratives or feature lists describing participants' prototypes. In order to facilitate the description and comparison of the features elicited by the DPS scales, the participants' responses were prepared in the following way. First participants' responses were transcribed into individual text formatted documents. Then participants' responses were segmented into distinct features. Next each feature was placed into a theme relevant category. Finally, the features within each theme relevant category were combined in order to identify the most prevalent and, therefore, most salient features across participants. The specific procedure utilized for each of these steps is discussed in detail below.

Transcription and Feature Extraction

A research team, including the PI and four UA, was created to facilitate the transcription and extraction of features from the DPS responses. First, the four UA transcribed all of the DPS responses into text formatted documents.

Next the research team was trained in the identification and extraction of features from the transcribed responses. Training included a series of meetings and assignments. During the first meeting the UA reviewed the operational definition of a feature, went over the instructions for extracting the features from the raw data and segmented a fictional transcript with the PI (for a copy of these instructions and fictional transcript see Appendix H). Next, the UA independently extracted the features from 5 additional
fictional transcripts (for copies of these transcripts see Appendix I). These practice transcripts and their proper segmentation were reviewed at a subsequent meeting. Finally, the UA were given 3 actual transcripts, previously examined by the PI, from which to extract prototype features. Three UA reached adequate reliability with the PI on these transcripts with regard to errors and omissions (defined as reaching 85-89% agreement over all features and reaching 100% agreement on at least one transcript), the fourth RA was reassigned. After reaching reliability, the three remaining RA independently divided the transcribed prototype descriptions into segmented features. The research team continued to meet weekly to discuss and resolve any problems.

*Feature Categorization*

After the extraction process was completed, a second research team (including the PI and one GA) was created to divide the features into categories. The goal of this step was two fold: (1) to ease the process of feature combination and elimination and (2) to generate quantitative frequencies for the features in each category.

The *N5* software package for qualitative data analyses was used to aid in this process (Richards, 2000). In order to facilitate use of *N5*, the participants’ extracted feature lists were transcribed into text formatted documents and imported into the software. Also entered into *N5* were twelve categories to be utilized for the cataloging of the prototype features. These categories were intuitively derived from the examination of the participants’ complete responses (for a detailed description of these analyses see the results section of this document). In addition, a separate category (“miscellaneous”) was also created to code features that did not fit into any of the derived categories.
Prior to independent feature categorization, the PI adapted a prototype feature coding manual (see Eno Louden, unpublished master’s thesis) using the twelve categories (for a copy of this training manual see Appendix J). Subsequently, the PI and GA reviewed the manual and coded three practice transcripts. Next, baseline reliability for categorizing features was established by computing the kappa statistic for these practice codes. Kappa (a.k.a. chance-corrected agreement) is a reliability statistic that allows for the computation of overall agreement that controls for chance agreement (Janes, 1979). The kappa statistic is generally interpreted as follows: poor agreement is less than .20, fair agreement is .20 to .40, moderate agreement is .40 to .60, good agreement is .60 to .80, and very good agreement is .80 to 1.00 (Altman, 1991).

After the first training session, agreement on the placement of features into categories was very good (kappa = .84). The PI and GA continued training on two further practice transcripts to increase accuracy and ensure the validity of the initial kappa statistic. This resulted in a slight increase in agreement (kappa= .90). The PI and GA then independently categorized the features from the remaining transcripts. Ten percent of the transcripts were overlapped to examine for potential inter-rater drift. Agreement results from analyses of these transcripts suggest that inter-rater drift was avoided (kappa= .88).

**Feature Combination**

Once all of the features were categorized, the feature lists needed to be condensed in order to identify and describe the most common features occurring across participants. In order to accomplish this, each category was examined independently by two GA and the PI who met as a group to arrive at a consensus for each of the following steps. First each group member independently examined the feature lists and combined all features they
believed were clearly synonymous or identical. Next, the group met to identify and resolved any conflicts with regard to this step. This resulted in the combination of only those features which were nearly identical. For example, the following two features were combined: “demands immediate attention” and “demands attention”. Next, the group worked together to combine those features that were not identical but “meant the same thing”. For example, the combined feature of “Dependent, needy or demanding attention,” was created to encompass the following five independent features: “dependent on the system”, “demands immediate attention”, “demanding”, “neediness” and “demands attention”. After all features that were identical or “meant the same thing” were combined, the idiosyncratic features (those features that were not combined with any other features) were removed from further analyses.

Once all data were prepared, the N5 software package for qualitative data analyses was utilized to generate frequencies for the combined features of both the TRP and PMI prototypes. A detailed description of the results of the data preparation and N5 analyses are covered in the results portion of this document.
CHAPTER 3

DATA ANALYSES AND RESULTS

Recall that the present work was designed to elicit and contextually characterize PO prototypes of PMI. This overarching goal was addressed via the following three specific aims: (1) to characterize participants’ prototypes of the TRP, (2) to characterize participants’ prototypes of PMI, and (3) to compare and contrast the elicited TRP and PMI prototypes.

Aim 1: To Characterize Participants’ TRP Prototypes

Participants’ TRP prototypes were obtained via the DPS-1, a free-elicitation instrument which requests that participants provide feature lists or narratives describing their prototypical TRP. Analyses of the DPS-1 data were conducted as follows. First, PO whole, un-segmented responses were examined by the PI for general quality and themes. Second, in order to facilitate examination for themes across participants, DPS-1 responses were segmented into individual features that were then divided into theme relevant categories. Finally, the features within each theme relevant category were combined in order to identify the most prevalent and, therefore, salient features across participants.
General Quality and Themes

Overall, participants’ responses to the DPS-1 were dense, thoughtful features lists or descriptions with an average of 15 individual features. A feature was operationally defined as “any phrase or statement that contains one idea and is descriptive of the participant’s prototype”. Examination of the responses revealed that participants’ prototypes were characterized by twelve general themes including: (1) physical appearance, (2) demographic characteristics, (3) biological impairments, (4) personality traits, (5) social support, (6) current or past mental health symptoms, (7) ability to function in society or potential for future criminal recidivism, (10) criminal history and other anti-social behaviors, (11) substance use or abuse and (12) PO-probationer relations. These themes were used in later analyses to group features into categories. For a brief description of each theme and examples see Table 5.

In addition to examining for overall quality and themes, the PI also examined for the presence of multiple subtypes. Notably, no participants reported multiple subtypes of TRP by completing the measure as requested (i.e. completing two or more forms, each describing the individual sub-prototypes separately). However, 17% of participants did indicate the inclusion of multiple subtypes in their original TRP descriptions. Despite PO indication of sub-prototypes, content analysis of the required sub-prototype descriptions revealed that the actual sub-prototypes were ill defined and idiosyncratic. Specifically, 60% of respondents who indicated the presence of multiple subtypes listed between 2 and 4 “sub-prototypes” that were described as individually differentiated by a single feature. For example, one participant simply listed “hostile, drug abuser, and has thinking errors” as their subtypes with no further elaboration. Furthermore, participants reported subtypes
Table 5

DPS-1 derived themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical appearance</td>
<td>Includes all features that reference how the prototype looks.</td>
<td>Usually has poor hygiene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not well kept</td>
</tr>
<tr>
<td>2 Demographic characteristics</td>
<td>Includes all features that reference the prototype's gender, race, employment, anything having to do with education, marital status, income, and residential status.</td>
<td>May be uneducated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blue collar</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>3 Biological Impairments</td>
<td>Includes all features referencing &quot;medical model&quot; constructs or disorders that are assumed to be largely physically or genetically based.</td>
<td>General health is average or below</td>
</tr>
<tr>
<td>4 Personality Characteristics</td>
<td>This is a broad category and includes all features that reference the prototype's interpersonal traits (how the prototype &quot;seems&quot; to or interacts with his/her world).</td>
<td>No motivation to better themselves</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suspicious</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manipulative</td>
</tr>
<tr>
<td>5 Social Support Characteristics</td>
<td>This category includes features referencing prototype's relationships with others or the qualities or characteristics of the prototype's friends or family.</td>
<td>Come from a poor home environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family with alcohol or drug abuse</td>
</tr>
<tr>
<td>6 Current or Past Mental Health Symptoms</td>
<td>Includes all &quot;DSM-like&quot; descriptions of the prototype's current or previous mental health symptoms.</td>
<td>Distorted criminal thinking errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor impulse control</td>
</tr>
<tr>
<td>7 Ability to Function In Society or Potential for Future Criminal Recidivism</td>
<td>Includes all features that reference the prototype's potential for future recidivism or the prototype's more global ability to function in society.</td>
<td>Will eventually gain employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some [TRP] are productive members of society</td>
</tr>
</tbody>
</table>
that were inconsistent, suggesting that any existing subtypes were likely to be highly idiosyncratic in nature. Specifically, only two sub-prototypes of TRP occurred on more than one list, namely that of the “Drug abuser TRP” (listed by 3 participants) and the “Hostile or Aggressive TRP” (listed by 2 participants). Descriptions of the defining qualities of these sub-prototypes were basically absent; in almost all cases the participant merely indicated the presence of the sub-prototype.

Given that the vast majority of participants (97%) either did not list multiple subtypes or listed ill defined sub-prototypes further analyses considered all features as defining a single prototype of the TRP.
Extraction of Individual Features

Recall, that the participants' descriptions were first transcribed into text formatted documents. Next, a research team, trained in the identification and extraction of prototype features, independently extracted the features from the transcribed documents. This process, discussed in detail in the method section, resulted in the extraction of 432 TRP prototype features from the DPS-1 responses.

Feature Categorization

Remember, that after the extraction process was completed, a research team was created to divide the features into the theme relevant categories derived during the initial stage of data analysis. Explicitly, both DPS-1 and DPS-2 responses were categorized utilizing all 13 theme relevant categories derived from the overall examination of the groups' responses. The goal of this step was two fold: (1) to ease the process of feature combination, elimination and comparison and (2) to generate quantitative frequencies for the features in each category. Resulting category frequencies for the DPS-1 responses for the 13 derived categories as well as the "miscellaneous" category can be found in Table 6.

Briefly, these analyses suggest that the most salient features of participants' descriptions of TRP are the qualities associated with their prototype's demographic and personality characteristics (see Figure 2). Of substantially less, but still notable, importance to PO prototypes of TRP were features associated with the probationers' social support characteristics, current or past mental health symptoms, criminal history, current or past substance use or abuse, and relationship with the PO and/or probation in

---

1 Although only 10 categories were derived from the review of the DPS-1 data, two more categories were identified when examining the DPS-2 responses. See the descriptions for these additional categories in Table 9, below.
Table 6

Number of Features per Category for DPS-1 Responses

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Physical Appearance</td>
<td>8</td>
</tr>
<tr>
<td>2 Demographic Characteristics</td>
<td>119</td>
</tr>
<tr>
<td>3 Biological Impairments</td>
<td>4</td>
</tr>
<tr>
<td>4 Personality Characteristics</td>
<td>122</td>
</tr>
<tr>
<td>5 Social Support Characteristics</td>
<td>33</td>
</tr>
<tr>
<td>6 Impressions of Mental Illness</td>
<td>0</td>
</tr>
<tr>
<td>7 Diagnostic Labels</td>
<td>3</td>
</tr>
<tr>
<td>8 Mental Health Symptoms</td>
<td>26</td>
</tr>
<tr>
<td>9 Ability to Function</td>
<td>16</td>
</tr>
<tr>
<td>10 Criminal History</td>
<td>24</td>
</tr>
<tr>
<td>11 Substance Use or Abuse</td>
<td>39</td>
</tr>
<tr>
<td>12 PO-Probationer Relations</td>
<td>25</td>
</tr>
<tr>
<td>13 Miscellaneous</td>
<td>13</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>432</strong></td>
</tr>
</tbody>
</table>

general (each category accounting for 5-9% of all TRP prototype features). Of little relevance to participants’ prototypes, were the categories of physical appearance, impressions of mental illness, diagnostic labels, and biological impairment (each accounting for 2% or less of TRP prototype features).

Feature Combination

After all of the features were categorized, the feature lists were condensed in order to identify and describe the most common features occurring across participants. The process of feature combination, discussed in detail in the methods section, yielded a list of 70 combined features encompassing 341 of the original 432 features. This left 91 idiosyncratic features which were removed from further analyses. In order to reduce the resulting feature list into a smaller, more manageable set, all of the combined features

67
that were used by less than 9% of participants were also eliminated. This process yielded a list of 40 combined features, encompassing 61% (262/432) of the original features. A complete list of the 40 combined features can be found in Table 7.

Resulting Prototype Features: Describing the prototypical TRP

Analysis of the DPS-1 reveled that PO prototypes of TRP are multifaceted descriptions characterized by varied qualities falling into several categories. Given that category boundaries were established arbitrarily, in many cases distinct differences between each category do not exist. Thus, for ease of reading, those categories with similar resultant features will be discussed together.
<table>
<thead>
<tr>
<th>Category</th>
<th>Combined Features</th>
<th>Percentage of participants who endorsed the feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality Characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Blames other for their problems</td>
<td>24%</td>
</tr>
<tr>
<td>2</td>
<td>Unmotivated</td>
<td>21%</td>
</tr>
<tr>
<td>3</td>
<td>Can't plan ahead</td>
<td>21%</td>
</tr>
<tr>
<td>4</td>
<td>Low self-esteem</td>
<td>21%</td>
</tr>
<tr>
<td>5</td>
<td>Problems with authority</td>
<td>17%</td>
</tr>
<tr>
<td>6</td>
<td>Defensive</td>
<td>17%</td>
</tr>
<tr>
<td>7</td>
<td>Irresponsible</td>
<td>14%</td>
</tr>
<tr>
<td>8</td>
<td>Liar</td>
<td>14%</td>
</tr>
<tr>
<td>9</td>
<td>Lacks empathy for others</td>
<td>14%</td>
</tr>
<tr>
<td>10</td>
<td>Feels sorry for themselves</td>
<td>10%</td>
</tr>
<tr>
<td>11</td>
<td>Manipulative</td>
<td>10%</td>
</tr>
<tr>
<td>12</td>
<td>Anti-social</td>
<td>10%</td>
</tr>
<tr>
<td>13</td>
<td>In denial</td>
<td>10%</td>
</tr>
<tr>
<td>Demographic Characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Uneducated</td>
<td>42%</td>
</tr>
<tr>
<td>15</td>
<td>Male</td>
<td>38%</td>
</tr>
<tr>
<td>16</td>
<td>Poor</td>
<td>31%</td>
</tr>
<tr>
<td>17</td>
<td>Young adult (18-30)</td>
<td>31%</td>
</tr>
<tr>
<td>18</td>
<td>Unstable Employment</td>
<td>24%</td>
</tr>
<tr>
<td>19</td>
<td>Caucasian or White</td>
<td>21%</td>
</tr>
<tr>
<td>20</td>
<td>Blue collar</td>
<td>14%</td>
</tr>
<tr>
<td>21</td>
<td>Adult (30-50)</td>
<td>14%</td>
</tr>
<tr>
<td>22</td>
<td>Parent</td>
<td>14%</td>
</tr>
<tr>
<td>23</td>
<td>Unemployed</td>
<td>14%</td>
</tr>
<tr>
<td>24</td>
<td>Unstable housing</td>
<td>14%</td>
</tr>
<tr>
<td>25</td>
<td>High school education</td>
<td>10%</td>
</tr>
<tr>
<td>Substance Use or Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Abuses substances</td>
<td>52%</td>
</tr>
<tr>
<td>27</td>
<td>Alcoholic</td>
<td>28%</td>
</tr>
<tr>
<td>28</td>
<td>Abuses methamphetamines</td>
<td>10%</td>
</tr>
<tr>
<td>29</td>
<td>Drug use causes problems</td>
<td>10%</td>
</tr>
<tr>
<td>30</td>
<td>In denial about substance use</td>
<td>10%</td>
</tr>
<tr>
<td>Social Support Characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Dysfunctional or broken home</td>
<td>17%</td>
</tr>
<tr>
<td>Mental Health Symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Thinking errors</td>
<td>14%</td>
</tr>
<tr>
<td>33</td>
<td>Poor social skills</td>
<td>10%</td>
</tr>
<tr>
<td>34</td>
<td>Poor coping skills</td>
<td>10%</td>
</tr>
<tr>
<td>Category</td>
<td>Combined Features</td>
<td>Percentage of participants who endorsed the feature</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>PO-Probationer Relations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 Non-compliant</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>36 Hostile about probation</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>37 Submissive to PO</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Criminal History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Long criminal history</td>
<td></td>
<td>24%</td>
</tr>
<tr>
<td>39 Drug offender</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Disheveled and unkempt</td>
<td></td>
<td>21%</td>
</tr>
</tbody>
</table>

*Features associated with interpersonal presentation.*

Of key importance to participants’ descriptions of their prototypical TRP were features associated with their prototype’s personality and/or social relationships. These features were subdivided among two categories: (1) personality characteristics and (2) social support characteristics. Each of these categories is discussed here.

*Personality Characteristics.* Respondents’ prototypes of TRP were primarily characterized by features associated with their prototypes personality. In fact, 93% of participants used at least one personality characteristic when describing their prototypical TRP, making it the most frequently endorsed category of features for the DPS-1 (see Table 8, below). Consequently, almost 30% (126/432) of the DSP-1 total extracted features were included in this category. However, only 13 personality characteristics were listed by more than 9% of participants. For a complete list of these personality characteristics and the percentage of participants who endorsed them see Table 7, above.

Notably, participants’ prototypical TRP were characterized by numerous negative interpersonal qualities. For example, the most prevalent personality feature, listed by 24%
Table 8

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of DPS-1 respondents who endorsed at least one feature in the category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Appearance</td>
<td>24%</td>
</tr>
<tr>
<td>Demographic Characteristics</td>
<td>83%</td>
</tr>
<tr>
<td>Biological Impairments</td>
<td>3%</td>
</tr>
<tr>
<td>Personality Characteristics</td>
<td>93%</td>
</tr>
<tr>
<td>Social Support Characteristics</td>
<td>59%</td>
</tr>
<tr>
<td>Impressions of Mental Illness</td>
<td>0%</td>
</tr>
<tr>
<td>Diagnostic Labels</td>
<td>10%</td>
</tr>
<tr>
<td>Mental Health Symptoms</td>
<td>35%</td>
</tr>
<tr>
<td>Ability to Function</td>
<td>28%</td>
</tr>
<tr>
<td>Criminal History</td>
<td>41%</td>
</tr>
<tr>
<td>Substance Use or Abuse</td>
<td>72%</td>
</tr>
<tr>
<td>PO-Probationer Relations</td>
<td>41%</td>
</tr>
</tbody>
</table>

of participants, described the prototypical TRP as blaming of others for their problems. As one PO wrote:

[The TRP] presents as guarded, suspicious, and blaming. This person seldom admits that they are guilty of the crime that they were convicted of and they usually blame the Department of Corrections for many of their problems.

Other common, negative personality features applied to the prototypical TRP were unmotivated (21%), defensive (17%), dishonest (14%), irresponsible (14%), manipulative (10%), and lacking empathy (14%). The extremity of these negative perceptions of TRP is best understood in the context of the specific wording of respondents. For example, as one PO wrote:

[First], they all are sweet talkers. They are always trying to beat the system. They always inform you about the hardships that they experienced. *Whenever they open their mouths, nine out of ten times,*
it's a lie. … They blame society for everything. Most of my probationers tell me that they are the victim. In all said and done, I have to do my job. But, if you get caught up and become emotional, they have you hanging by the coattails. Remember, they will all try to get over [emphasis added].

Another respondent described the prototypical TRP in the following words:

They are usually angry to be on probation [and] do not accept responsibility for [their] actions. Most of them smoke cigarettes [even] though [they] have trouble paying fines/ court costs or treatment. Some descriptive terms that come to mind: angry, sullen, addicted, surly, lazy, unmotivated, irresponsible, [and] victim mentality.

Also notable, is the complete absence of positive personality qualities among the 13 combined personality features (see Table 7, above). Clearly, PO do not view TRP as possessing many, if any pro-social or positive personality characteristics.

Social Support Characteristics. In addition to features associated with the typical TRP personality, 59% of DPS-1 respondents also included at least one feature associated with their prototypes family and friends (see Table 8, above). However, only one combined feature from this category was listed by more than 9% of respondents. Specifically, 17% of participants noted that the prototypical TRP is the product of a dysfunctional or broken home.

Taken together, these results suggest that both personality and social support characteristics are central in defining PO prototypes of TRP, however there is considerable variability in the specific qualities used. Remarkably, the prototypical TRP is viewed as possessing numerous and varied negative personality characteristics and few if any pro-social ones. In addition, TRP are commonly described as coming from broken or dysfunctional homes.

Features associated with probation and outcome.
Three categories of features addressed TRP experience of probation and outcome: (1) ability to function, (2) PO-probationer relations and (3) criminal history. The resulting combined features distilled from these categories will be discussed here.

*Ability to function.* As mentioned above, 28% of participants utilized at least one feature associated with the prototypical TRP ability to function in society, potential for mental health remediation, or potential future criminal recidivism when describing their prototype (see Table 8, above). Despite this categories’ prevalence among participants’ responses, no combined features were distilled from this category. This was due to the wide variability among participants’ descriptions of TRP with regard to this matter. Specifically, 32% of the features listed in ability to function category were entirely idiosyncratic and as such could not be combined with any other feature. In addition, of the 4 combined features which were collapsed in this category, none of them were listed by more than 7% of participants. Thus, while PO prototypes of TRP certainly include features associated with ability to function and outcome, wide variability exists among their perceptions.

*PO-probationer relations.* Similarly, while 41% of DPS-1 participants described at least one feature associated with their prototypes response to probation (see Table 8, above), 48% of these features were idiosyncratic. Thus, only 3 moderately endorsed combined features (between 10-14% of respondents endorsed the features) were derived from this category. Specifically, the prototypical TRP was described as non-compliant and hostile about probation, but submissive to the PO in person (see Table 7, above). For example, one respondent wrote:

> In the office he is courteous and willing to please. But leaves the office with a slight sigh of contempt. His attitude concerning his conditions of probation
[is] positive stating things are going better than they typically are. When he describes his personal life he usually emphasizes the stresses and negative things going on, [then] uses these as an excuse [as to] why he cannot take care of his conditions of probation.

*Criminal History.* Finally, 41% of participants made some reference to their prototypical TRP criminal history. Specifically, almost one quarter of respondents described the prototypical TRP as having a long criminal history (see Table 7 above). For example, participants described the prototypical TRP using the following phrases: “known by police,” “has been arrested a dozen times,” and “[convicted on] multiple cases.” In addition, 10% of participants identified their prototypical TRP specifically as a drug offender.

To sum up, PO perceptions of TRP adjustment to probation and outcome vary considerably. While many participants described features associated with the prototypical TRP ability to function in society, PO-probationer relations and criminal history, 52% of these features were either completely idiosyncratic or listed by fewer than 10% of the sample. Those combined features that were listed across more than 10% of the sample describe the TRP as a drug offender with a long criminal record who is passively non-compliant and hostile about probation.

*Features associated with mental illness*

Three categories explicitly included features associated with the presence of mental illness: (1) diagnostic labels, (2) impressions of mental illness, and (3) current or past mental health symptoms. DPS-1 respondents’ results from these categories will be discussed here.

*Diagnostic Labels and Impressions of Mental Illness.* Consistent with the conception that TRP do not characteristically exhibit mental disorders, few participants endorsed
features that indicated the presence of a full blown mental health diagnosis (see Table 8 above). Specifically, only 10% of DPS-1 participants listed a mental health diagnosis in their description and no participants identified that they “sensed” a mental disorder in their prototypical TRP. Also, among those 10% of DPS-1 respondents who did indicate the presence of a mental health diagnosis, there was no consensus as to the type of disorder. Thus, no combined features were extracted from either the diagnostic labels or impressions of mental illness categories for the prototypical TRP.

**Current or Past Mental Health Symptoms.** Notably, the prototypical TRP was not described as free from psychological problems. Specifically, 35% of participants indicated at least one psychological symptom when describing their prototypical TRP. The most common of these symptom features, listed by 14% of participants, described the prototypical TRP as prone to “thinking errors”. For example, as one respondent put it:

> [The prototypical TRP possess] poor cognitive skills to make appropriate choices.

Another common mental health feature associated with the prototypical TRP was, “poor coping skills (see Table 7, above).” Finally, 10% of participants described their prototypical TRP as impulsive.

In sum, these results suggest that the prototypical TRP is not characteristically mentally ill. However, respondents did describe the TRP as typically exhibiting some mental health problems including cognitive deficits, poor coping skills and impulsivity.

**Other Features**

Participants also included features that did not reference either the TRP interpersonal relationships, adjustment to probation, or symptoms of mental illness. These features
were grouped into the following categories: (1) demographic characteristics, (2) substance use or abuse, and (3) physical appearance.

Demographic Characteristics. Eighty-three percent of DPS-1 respondents endorsed at least one prototype feature associated with their prototypes gender, race, education, work history or socio-economic status (see Table 8 above), making demographic characteristics the second most frequently endorsed DPS-1 category. Consistent with its relative importance to participants' TRP prototypes, this category resulted in the second highest number of extracted combined features. These 12 combined features are best considered as falling into three subcategories: (1) features describing physical and other static characteristics, (2) features describing educational background, and (3) features describing SES or employment.

Forty-eight percent of participants included at least one feature that described the prototypical TRP using physical or other static demographic characteristics (e.g. age, gender, ethnicity or marital/parental status). Specifically, 38% of participants described their prototypical TRP as male. In addition, 21% of participants described the prototypical TRP as Caucasian or White. Although 45% of participants agreed that their prototypical TRP was less than 50 years old, 32% described the prototypical TRP as between the ages of 18-30 and only 14% described the prototypical TRP as between the ages of 30-50. Finally, 14% of participants described the prototypical TRP as a parent.

In addition to the static demographic features, 48% of participants described PMI with regard to their educational background. Specifically, 42% of respondents described the prototypical TRP as uneducated (see Table 7 above). Contrarily, 10% of respondents described their prototypical TRP as possessing a high school diploma or GED.

76
Finally, 59% of DPS-1 respondents described their prototypical TRP with regard to their SES or employment. Specifically, 31% of participants characterized the prototypical TRP as poor. Consistent with a low SES, the prototypical TRP was further described as having an unstable, low paying employment history. For example, several participants noted that the prototypical TRP worked in seasonal or sporadic blue collar jobs (14%) or was unemployed (14%, see Table 7 above). As one participant described:

[The prototypical TRP is] Male. 19-26. Caucasian. "Blue collar"- works in the areas of roofing, construction, drywall, [or] painting. Work is or tends to be seasonal. Pay is about $6-10/ hour.

Also consistent with a low SES background and unstable employment history, the prototypical TRP was described as lacking stable housing.

Substance Use or Abuse. The prototypical TRP was also characterized as having a history of substance use or abuse. Specifically, 72% of the DPS-1 respondents used at least one feature indicative of alcohol or drug abuse when describing their prototypical TRP. Although over half of participants referred to “substance abuse or dependence” generally, a sizeable portion of participants (32%) went on to describe the specific substances used by their prototypical TRP. Explicitly, 28% of participants described their prototypical TRP as “alcoholic” and 10% of participants described the prototypical TRP as abusing methamphetamines. In addition to abusing substances, 10% of participants described the TRP as suffering life consequences due to their addiction. Also, 10% of respondents noted that their prototypical TRP is in denial about their substance abuse problem.
Physical Appearance. Finally, 24% of DPS-1 participants included features associated with the TRP physical appearance. Specifically, 21% of participants described the prototypical TRP as looking disheveled and/or messy. As one PO described:

[The prototypical TRP] appearance is not always well kept.

Summary

The data obtained pertaining to PO prototypes of TRP are best summarized in terms of the frequency of feature occurrence. Doing so leads to a description of the dominant TRP prototype as follows: PO see the TRP as prototypically an unkempt, Caucasian male, between the ages of 18 and 50, who is uneducated, underemployed (possibly working seasonally in blue collar employment) and poor. The prototypical TRP is also a parent who comes from a broken or dysfunctional home. Interpersonally, the prototypical TRP is described as possessing numerous and varied negative personality traits and few if any pro-social ones. Specifically, the prototypical TRP is almost uniformly described as unmotivated, defensive, dishonest, irresponsible and manipulative. In addition the prototypical TRP has a compounding substance abuse problem, most likely with alcohol or methamphetamines. Although the prototypical TRP is not mentally ill, he does exhibit some mental health problems including cognitive deficits, poor coping skills and impulsivity. Notably, PO perceptions of TRP adjustment to probation and outcome varied considerably. However, the prototypical TRP was described as a drug offender with a long criminal history who is passively non-compliant and hostile about his sentence of probation.
Aim 2: To Characterize Participants’ PMI Prototypes

Like participants’ TRP prototype features, PMI prototype features were drawn from participants’ responses to the DPS instrument. Analyses of the data collected via the DPS-2 followed the same procedure as the data from the DPS-1. Specifically, participants’ whole, un-segmented responses were first examined by the PI for general quality and themes. Second, participants’ DPS-2 responses were segmented and categorized. Finally, the features within each category were combined in order to identify the most prevalent and, therefore, salient features across participants.

*General Quality and Themes*

The overall quality and themes of participants’ responses to the DPS-2 were quite similar to those identified on the DPS-1. Specifically, participants’ responses to the DPS-2 were considered feature lists or narratives with an average of 17 individual features. Notably, an independent samples t-test indicated that the groups did not significantly differ with regard to either the number of features per participant (DPS-1 \( M = 15.2, SD = 7.4 \); DPS-2 \( M = 17.6, SD = 8.1 \)), or the number of categories used (DPS-1 \( M = 5.1, SD = 1.6 \); DPS-2 \( M = 6.2, SD = 2.2 \)).

Participants also utilized similar types of features when describing their prototypical PMI. Specifically, the themes derived from the DPS-2 were identical to those derived for the DPS-1, with two exceptions. First, DPS-2 responses included the additional themes of diagnostic labels and impressions of mental illness. This was expected, in that PMI by definition exhibit more substantial mental health problems. Second, though both groups of PO mentioned features associated with the probationer’s general ability to function in society, DPS-2 responses were also characterized by the participants impressions about
their PMI prototypes’ potential for mental health remediation, whereas DPS-1 responses were characterized by likelihood for future criminality. For a brief description of these additional and modified themes see Table 9.

Table 9

<table>
<thead>
<tr>
<th>DPS-2 additional or modified themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1 Diagnostic Labels</td>
</tr>
<tr>
<td>2 Impressions of Mental Illness</td>
</tr>
<tr>
<td>3 Ability to Function or Potential for Mental Health Remediation</td>
</tr>
</tbody>
</table>

Notably, 25% of participants indicated that they had multiple subtypes of PMI.

However, content analysis revealed that the sub-prototype descriptions lacked the rich
quality and descriptive detail of the original response. Specifically, 75% of respondents who indicated the presence of multiple subtypes listed between 2 and 4 “sub-prototypes” that were described as individually differentiated by a single feature, in most cases the prevailing diagnosis of the PMI. For example, one participant simply listed “anxiety, depression, bipolar and schizophrenia” as their subtypes with no further description. Furthermore, participants reported subtypes that were inconsistent, suggesting that any existing subtypes were likely to be highly idiosyncratic in nature.

One sub-prototype of PMI did occur across multiple lists, namely that of the PMI with a compounding substance use problem. Typically, descriptions of the differences between the substance using PMI and the non-substance using PMI were limited. In most cases the participant simply indicated the presence of the subtype. In the cases where elaboration was present, the participant typically described the substance-using PMI as presenting with more serious psychological problems and facing an increased risk for recidivism.

Given that 94% of participants either did not list multiple subtypes or listed ill defined sub-prototypes, further analyses considered all features as defining a single prototype of the PMI.

**Feature Extraction**

The process of feature extraction for the DPS-2, discussed in detail in the method section, resulted in the extraction of 560 PMI prototype features.

**Feature Categorization**

Like DPS-1 responses, after the PMI prototype features were extracted, they were categorized utilizing the 12 theme relevant categories. Resulting category frequencies for
Table 10

Number of Features per Category for DPS-2 Responses

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Physical Appearance</td>
<td>22</td>
</tr>
<tr>
<td>2 Demographic Characteristics</td>
<td>27</td>
</tr>
<tr>
<td>3 Biological Impairments</td>
<td>2</td>
</tr>
<tr>
<td>4 Personality Characteristics</td>
<td>79</td>
</tr>
<tr>
<td>5 Social Support Characteristics</td>
<td>23</td>
</tr>
<tr>
<td>6 Impressions of Mental Illness</td>
<td>9</td>
</tr>
<tr>
<td>7 Diagnostic Labels</td>
<td>31</td>
</tr>
<tr>
<td>8 Mental Health Symptoms</td>
<td>145</td>
</tr>
<tr>
<td>9 Ability to Function</td>
<td>82</td>
</tr>
<tr>
<td>10 Criminal History</td>
<td>13</td>
</tr>
<tr>
<td>11 Substance Use or Abuse</td>
<td>25</td>
</tr>
<tr>
<td>12 PO-probationer Relations</td>
<td>81</td>
</tr>
<tr>
<td>13 Miscellaneous</td>
<td>21</td>
</tr>
<tr>
<td>TOTAL</td>
<td>560</td>
</tr>
</tbody>
</table>

the DPS-2 responses for the 12 derived categories as well as the “miscellaneous” category can be found in Table 10.

Results from these analyses suggest that the most important features defining PO prototypes of PMI are associated with the probationers’ current or past symptoms of mental illness (see Figure 3 below). This makes intuitive sense because PMI are distinguished by their mental health problems. Also central to PO prototypes of PMI were features associated with the probationers’ personality characteristics, ability to function in society, and relationship with the PO and/or probation in general (each category accounting for 14-15% of all PMI prototype features). Of less, but still noteworthy, importance were features associated with the PMI physical appearance, demographic characteristics, family and social support network, mental health diagnoses, and history of substance use or abuse. Of little relevance to PO prototypes were the categories of
criminal history, impressions of mental illness and biological impairment (each accounting for 2 per cent or less of PMI prototype features).

Feature Combination

After all of the features were categorized, the feature lists were condensed in order to identify and describe the most common features occurring across participants. The process of feature combination, discussed in detail in the methods section, yielded a list of 94 combined features encompassing 473 of the 560 original features. This left 87 idiosyncratic features which were removed from further analyses. In order to reduce the resulting feature list into a smaller, more manageable set, any of the combined features that were used by fewer than 9% of participants were eliminated. This process yielded a
list of 59 combined features, encompassing 70% (389/560) of the original features. A complete list of the 59 combined features can be found in Table 11.

Resulting Prototype Features: Describing the prototypical PMI

Analysis of the DPS-2 revealed that PO prototypes of PMI are multifaceted descriptions characterized by varied qualities falling into several categories. In fact, the resulting combined PMI prototype features fell into eleven of the twelve original categories\(^2\). Given that category boundaries were established arbitrarily, in many cases distinct differences between each category do not exist. Thus, for ease of reading, those categories with similar resultant features will be discussed together.

Features associated with mental illness.

Three categories explicitly addressed features associated with PMI mental illness: (1) current or past mental health symptoms, (2) diagnostic labels, and (3) impressions of mental illness. The resulting combined features derived from each of these categories and their relevance will be discussed in turn.

Current or Past Mental Health Symptoms. Ninety-four percent of DPS-2 participants endorsed at least one prototype feature that was indicative of the PMI current or past mental health symptoms, making it the most frequently endorsed category overall (see Figure 4 below). Consistent with its relative importance to participants’ prototypes, the most combined features (16) were drawn from this category. These combined features can be divided into four broad subcategories: (1) features describing cognitive symptoms, (2) features describing behavioral symptoms, (3) features describing mood symptoms, and (4) features describing paranoid or psychotic symptoms.

\(^2\) The category of Biological Impairments was retained for comparison to the TRP features, but was eventually removed due to underutilization by both groups.

84
Table 11

List of combined features of PMI

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of participants who endorsed the feature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>1 Easily confused - difficulty comprehending/processing information</td>
<td>40%</td>
</tr>
<tr>
<td>2 Aggressive and/or Dangerous</td>
<td>28%</td>
</tr>
<tr>
<td>3 Unstable</td>
<td>18%</td>
</tr>
<tr>
<td>4 Suicidal or Self-harming</td>
<td>18%</td>
</tr>
<tr>
<td>5 Paranoid</td>
<td>16%</td>
</tr>
<tr>
<td>6 Unpredictable</td>
<td>16%</td>
</tr>
<tr>
<td>7 Psychotic or Out of touch with reality</td>
<td>16%</td>
</tr>
<tr>
<td>8 Manic</td>
<td>16%</td>
</tr>
<tr>
<td>9 Has difficulty understanding instructions</td>
<td>13%</td>
</tr>
<tr>
<td>10 Flat affect or Does not show emotions</td>
<td>13%</td>
</tr>
<tr>
<td>11 Has mood swings</td>
<td>13%</td>
</tr>
<tr>
<td>12 Difficulty sustaining attention</td>
<td>13%</td>
</tr>
<tr>
<td>13 Excessive or Extreme Behavior</td>
<td>9%</td>
</tr>
<tr>
<td>14 Hallucinates - hears or sees things which are not there</td>
<td>9%</td>
</tr>
<tr>
<td>15 Irritable</td>
<td>9%</td>
</tr>
<tr>
<td>16 Does not understand right from wrong</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Ability to Function</strong></td>
<td></td>
</tr>
<tr>
<td>17 Unable to function in society</td>
<td>31%</td>
</tr>
<tr>
<td>18 Needs medication to function</td>
<td>28%</td>
</tr>
<tr>
<td>19 Non-compliant with treatment and/or medication mandate</td>
<td>22%</td>
</tr>
<tr>
<td>20 Needs psychological treatment</td>
<td>16%</td>
</tr>
<tr>
<td>21 Medicated</td>
<td>16%</td>
</tr>
<tr>
<td>22 Capable of functioning</td>
<td>13%</td>
</tr>
<tr>
<td>23 Will recidivate</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Personality Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>24 Animated or Expressive</td>
<td>19%</td>
</tr>
<tr>
<td>25 Poor social skills or socially inept</td>
<td>16%</td>
</tr>
<tr>
<td>26 Does not take responsibility (ex. Blames others for own problems)</td>
<td>13%</td>
</tr>
<tr>
<td>27 Dependant, Needy, or Demanding Attention</td>
<td>13%</td>
</tr>
<tr>
<td>28 Socially withdrawn or Loner</td>
<td>13%</td>
</tr>
<tr>
<td>29 Distrusting or skeptical</td>
<td>9%</td>
</tr>
<tr>
<td>30 Wants Acceptance (ex. Tries to please others)</td>
<td>9%</td>
</tr>
<tr>
<td>31 Disorganized</td>
<td>9%</td>
</tr>
<tr>
<td>32 Irresponsible or Reckless</td>
<td>9%</td>
</tr>
<tr>
<td>33 Unintelligent or slow</td>
<td>9%</td>
</tr>
<tr>
<td>Category</td>
<td>Percentage of participants who endorsed the feature</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Combined Features</td>
<td></td>
</tr>
<tr>
<td>PO-Probationer Relations</td>
<td></td>
</tr>
<tr>
<td>35 Non-compliant</td>
<td>38%</td>
</tr>
<tr>
<td>36 Time intensive</td>
<td>19%</td>
</tr>
<tr>
<td>37 Difficult to supervise</td>
<td>16%</td>
</tr>
<tr>
<td>38 Wants to comply</td>
<td>13%</td>
</tr>
<tr>
<td>39 PO is unable to help</td>
<td>9%</td>
</tr>
<tr>
<td>40 Does not understand the conditions of probation</td>
<td>9%</td>
</tr>
<tr>
<td>41 Requires the PO to show patience and empathy</td>
<td>9%</td>
</tr>
<tr>
<td>42 Dependant on PO</td>
<td>9%</td>
</tr>
<tr>
<td>Demographic Characteristics</td>
<td></td>
</tr>
<tr>
<td>43 Low SES or Poor</td>
<td>22%</td>
</tr>
<tr>
<td>44 Homeless</td>
<td>13%</td>
</tr>
<tr>
<td>45 No stable residence or Nomadic</td>
<td>9%</td>
</tr>
<tr>
<td>Substance Use or Abuse</td>
<td></td>
</tr>
<tr>
<td>46 Self-medicates with alcohol or drugs</td>
<td>28%</td>
</tr>
<tr>
<td>47 Abuses drugs and/or alcohol</td>
<td>22%</td>
</tr>
<tr>
<td>Diagnostic Labels</td>
<td></td>
</tr>
<tr>
<td>48 Depressed</td>
<td>31%</td>
</tr>
<tr>
<td>49 Anxious</td>
<td>13%</td>
</tr>
<tr>
<td>50 Schizophrenic</td>
<td>13%</td>
</tr>
<tr>
<td>51 Bipolar or Manic-Depressive</td>
<td>9%</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td></td>
</tr>
<tr>
<td>52 Poor hygiene (ex. does not bathe, brush teeth, etc.)</td>
<td>25%</td>
</tr>
<tr>
<td>53 Disheveled or unkempt in appearance</td>
<td>22%</td>
</tr>
<tr>
<td>Social Support Characteristics</td>
<td></td>
</tr>
<tr>
<td>54 Isolated or Lacks social support</td>
<td>19%</td>
</tr>
<tr>
<td>55 Alienated loved ones or Drove family away</td>
<td>10%</td>
</tr>
<tr>
<td>56 Peers are negative influences or is part of the &quot;wrong crowd&quot;</td>
<td>10%</td>
</tr>
<tr>
<td>Criminal History</td>
<td></td>
</tr>
<tr>
<td>57 Criminal</td>
<td>10%</td>
</tr>
<tr>
<td>Impressions of Mental Illness</td>
<td></td>
</tr>
<tr>
<td>58 Vacant expression or blank look in their eyes</td>
<td>10%</td>
</tr>
<tr>
<td>59 Weird/Off/Visibly mentally ill</td>
<td>10%</td>
</tr>
</tbody>
</table>

Fifty-three percent of participants indicated that PMI suffer from symptoms consistent with cognitive deficits. Specifically, 41% of participants described PMI as
easily confused or exhibiting difficulty in adequately processing information. For example, one PO stated:

[The prototypical PMI] lacks the ability to understand rules and guidelines, [and] doesn’t comprehend how something applies or relates to them. [The prototypical PMI has a] very hard time thinking and processing information realistically.

In addition, 12% of participants noted specific deficits with regard to understanding instructions (e.g. “generally cannot appropriately follow directions well” and “someone who lacks the ability to understand rules”) and sustaining attention (ex. “can’t focus on things [over a] long term” and “some have difficulty with focus”). Finally, 9% of DPS-2 participants noted that the cognitive problems impacted the PMI ability to understand right from wrong.

In addition to cognitive deficits, 52% of participants described PMI with regard to their behavioral mental health symptoms. Specifically, participants described the prototypical PMI as unstable, unpredictable, and potentially dangerous (see Table 11 above). Another commonly mentioned behavioral symptom was risk of suicide or self-harm. Finally, some participants noted that PMI had a tendency to overreact or behave in extreme or excessive ways (ex. “throws childlike tantrums” and “yelling”).

Thirty-one percent of participants endorsed features descriptive of the PMI mood symptoms. Notably, several participants described the PMI as having mood symptoms consistent with bipolar disorder. Thus, the PMI were described by PO as manic, moody and irritable (see Table 11 above). In contrast, 13% of participants described PMI in a markedly different way, as expressionless or with flattened affect.
Finally, 34% of participants described the prototypical PMI as having symptoms consistent with paranoia or psychosis. Specifically, 16% of PO described the prototypical PMI as paranoid. For example, one PO wrote:

[The PMI] has talked openly of conspiracies against them (i.e. the government is ‘lurking’ or ‘after them’).

Participants also described PMI as psychotic and/or actively hallucinating (see Table 11 above). For example, the prototypical PMI was described as “out of touch with reality,” “openly hallucinating” and “psychotic.”
Diagnostic Labels. In addition to listing individual symptoms of mental illness, 41% of participants also discussed the specific diagnosis/es of their prototypical PMI. Interestingly, despite the near absence of individual depressive symptoms among the participants’ descriptions, (e.g. sadness, anhedonia, or hopelessness) depression was by far the most frequently mentioned mental health diagnosis, with 32% of participants endorsing this as a feature of their prototypical PMI. Other frequently mentioned diagnoses were schizophrenia, anxiety disorders and bipolar disorder (see Table 11 above).

Impressions of Mental Illness. In addition to the specific symptoms and individual diagnoses of the prototypical PMI, almost one fifth of participants also endorsed features associated with the “feeling” that the prototype invokes in others that signify that he/she is mentally ill (see Table 11 above). The two most common of these features were: (1) that the prototypical PMI has a “vacant, far off look” or (2) is just generally “weird” or “visibly mentally ill”.

In sum, psychological disorder is a central feature of participants’ prototypes of PMI. Specifically, participants described their prototypical PMI as suffering severe cognitive deficits which encumber his/her ability to understand the conditions of probation and more generally right from wrong. In addition, PMI were described as unstable, unpredictable and potentially dangerous with a high risk of harming themselves or others. The PMI was further described as experiencing disturbances in mood, most commonly depression and symptoms of bipolar disorder. Many participants’ descriptions also included mention of paranoia or psychotic symptoms in the prototypical PMI. Finally, respondents described the prototypical PMI as simply “weird” or “visibly mentally ill”.

89

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Features associated with probation and outcome.

Three categories contained features relevant to PMI experience of probation and the probable outcome: (1) ability to function in society, (2) PO-probationer relations, and (3) criminal history. The resulting combined features distilled from these categories and their implications will be discussed next.

Ability to Function in Society. The second most frequently endorsed set of features by DPS-2 respondents addressed PMI ability to function in society, potential for mental health remediation and potential future criminal recidivism. In fact, 78% of respondents reported at least one feature falling into this category (see Figure 4 above). Of the 75 independent features categorized here, 7 combined features were distilled. These features can be subcategorized as addressing: (1) PMI ability to function in society, (2) PMI use of/need for psychological or medical treatment and (3) PMI likelihood for recidivism.

Participant’s expressed diverging opinions with regard to the PMI ability to function in society. Specifically, the majority of participants reported that PMI were either not capable of functioning in society without outside assistance such as a financial planner or live-in family member (31%), or capable of functioning independently only with consistent use of medication (28%, see Table 11 above). For example, one PO commented that PMI are “barely able to engage in life” and are “incapacitated by [the] demands of ‘normal’ life”. Illustrative of the belief that proper medication is essential for functioning is a PO who wrote:

When stable on medication, they are functioning well in society but when medication is not taken (or substituted- self medicated/ drugs or alcohol) then the result is harm to self, others, or in many cases legal action as the result of bizarre, deviant, or criminal behavior.
Notably, a handful of PO were more optimistic, characterizing PMI as capable of functioning on their own. For example, one PO stated

[PMI] seem capable of taking care of themselves.

Consistent with the majority's view that PMI are not capable of functioning without assistance or medication, 25% of respondents noted that the PMI need for medication and/or psychological treatment was central to their prototype. Specifically, 16% of participants simply described PMI as “medicated” or “actively receiving [psychological] treatment” (see Table 11 above).

Finally, this category encompassed PO perceptions of PMI likelihood for criminal recidivism. Generally speaking, PO paint a bleak picture for the outcome of PMI. Specifically, almost one quarter of respondents noted that non-compliance with treatment and/or medication mandates is central to their conception of PMI (see Table 11 above).

For example, one PO commented that:

[PMI are] up and down with medications. Problems arise because all is going well and they think they don’t need them any more and they stop taking them.

Notably, 9% of participants did not see any hope for the future of PMI. As one participant noted:

It may not be possible for [PMI] to change.

PO-Probationer Relations. Also essential to participants’ prototypes of PMI were features associated explicitly with probation or PO-probationer relationships. These features fell into two general subcategories: (1) features associated with PMI adjustment to probation and (2) features associated with PO-PMI relationships.

With regard to features associated with PMI adjustment to probation, more than a third of participants described the prototypical PMI as noncompliant with the conditions
of probation (see Table 11, above). Participants cited several potential reasons for PMI noncompliance. The most prevalent explanation for noncompliance (mentioned by 9% of participants) was the perception that cognitive problems prevent PMI from fully comprehending probation directives. As one participant put it:

[PMI have] difficulty grasping [the] terms of [the] order.

Similarly, another participant wrote:

[PMI] are easily overwhelmed by their requirements.

Other, less prevalent, explanations for noncompliance included the interference of psychological symptoms (e.g. "paranoia makes it hard to convince them that you are trying to work on their behalf") and the improper supervision of PMI by probation.

Notably, participants did not indicate that PMI were overtly resistant to compliance. In fact, more than one tenth of the participants specifically noted that PMI desire to comply.

Consistent with the picture of the prototypical PMI as a severely disordered person struggling to understand and comply with the conditions of probation, 41% of participants described their work with PMI as taxing or requiring specialized skills. In fact, 19% of participants specifically noted the increased time and attention PMI require (see Table 11 above). As one participant noted:

[PMI] require more [intensive] supervision and officers must be more patient. Where most people on probation are relatively stable, mental health probationers are not. You must focus your attention towards the more simple problems in life...such as residence, money, and medications when dealing with the [PMI] offender.

In addition to requiring more time to supervise, 9% of participants also mentioned the prototypical PMI tendency for "neediness" or increased attachment to the PO. PMI were also described as requiring specialized skills with which to work. Explicitly, 9% of
respondents noted that PMI require the PO to show more patience and empathy than the traditional probationer. Finally, 9% of participants reported feeling overwhelmed and incapable of helping the PMI.

*Criminal History.* Finally, 25% of participants made some reference to their prototypical PMI criminal history. However, the only combined feature to result from this category describes the prototypical PMI as generally “criminal.” This combined feature seems to illustrate that some PO view PMI as no different from other offenders in their motivation for crime. As one PO put it:

> In many cases, legal action [against PMI was] the result of deviant, criminal behavior.

By way of overall summary, probation officer’s perceptions of PMI adjustment to probation and outcome are guarded at best. Most participants described the prototypical PMI as troubled, and in need of treatment and psychotropic medications to manage the demands of daily life. Despite their pronounced need, PO described the prototypical PMI as non-compliant with treatment and medication mandates. Furthermore, PO perceive that PMI symptoms of mental illness, more specifically their cognitive deficits, impede their ability to comply with even the standard conditions of probation. In addition, the prototypical PMI is viewed as taxing of the PO time and energy with participants generally not expressing much hope for the PMI future.

*Features associated with interpersonal presentation.*

In addition to features specific to mental illness or probation, 84% of DPS-2 respondents described probationers with regard to their general personality and social relationships. These features were subdivided among two categories: (1) personality
characteristics and (2) social support characteristics. Each of these categories is discussed here.

**Personality Characteristics.** PO prototypes of PMI were loaded with a variety of personality characteristics. In fact, 78% of participants used at least one personality characteristic when describing their prototypical PMI. Consequently, a total of 79 personality features (14% of the 560 total features) were extracted from PO descriptions. However, only 11 of these personality features were listed by more than 9% of participants. For a complete list of these personality characteristics and the percentage of participants who endorsed them see Table 11. What follows is a consideration of those personality characteristics in Table 11 that were either the most prevalent or played a role in defining the prototypical PMI interpersonal style.

Notably, 55% of the combined personality characteristics referenced the PMI interpersonal style. Specifically, participants’ prototypical PMI were characterized by interpersonal traits such as poor social skills (16%), socially withdrawn (13%), dependent or needy (13%), and distrusting or skeptical (9%). This paints the picture of the prototypical PMI as a very desperate or “clingy” individual that is simultaneously distrusting and skeptical of the world.

**Social Characteristics.** Some participants also included prototype features associated with the PMI relationships with family and/or friends. Specifically, almost a fifth of participants described the prototypical PMI as socially isolated with “few attachments” and “little or no family support.” Consistent with the perception of the prototypical PMI as exhibiting a difficult interpersonal style, 9% of respondents cited the PMI as responsible for their social isolation, noting that the prototypical PMI has “driven parents
and siblings away” or “alienate[d] many of their support systems.” Other participants’
descriptions noted that PMI tend to be involved in negative peer relationships. As one
participant put it:

If [the PMI] has friends, those are the ‘wrong’ friends.

In sum, results from the analyses of the prevalent features PO associate with the
prototypical PMI interpersonal characteristics suggest that the PMI is a socially inept
loaner who has few positive social supports.

Other Features

Participants also made reference to several features that did not reference either the
PMI mental illness, adjustment to probation or interpersonal relationships. These features
were grouped into the following categories: (1) demographic characteristics, (2)
substance use or abuse and (3) physical appearance.

Demographic Characteristics. Forty five percent of the DPS-2 participants made
note of their prototypes’ gender, race, education, work history or socio-economic status.
Notably, 67% of these characteristics concerned the PMI deprived social or financial
circumstances. Specifically, participants’ prototypes of PMI were colored by references
to PMI limited income (22%), lack of stable residence (9%) and probable homelessness
(13%).

Notably, the gender, racial, educational, and work backgrounds of PMI went almost
entirely unnoted. In fact, two participants actually remarked that race and gender did not
play a part in their prototype. As one PO put it:

[PMI] can be male or female, [there is] no specific race or ethnic background.
[I] have dealt with mental illness in all categories of race [and] gender.
Substance Use and Abuse. Substance use and abuse was also mention frequently in the DPS-2 respondents' surveys. Specifically, 44% of the PO described their prototypical PMI as struggling with a compounding substance abuse or dependence problem. Notably, more than half of these PO felt that the prototypical PMI was involved in substance use as a means for assuaging their symptoms of mental illness.

Appearance. Finally, 38% of DPS-1 participants included features associated with the probationers' appearance when describing their prototypical PMI. Specifically, participants described PMI as looking disheveled or messy and exhibiting poor hygiene. As one PO described:

[The prototypical PMI] is frequently unkempt in appearance, unbathed and malodorous.

Summary

As with the DPS-1 data, the data obtained pertaining to the PO prototypes of PMI can best be summarized in terms of the frequency of feature occurrence. Doing so leads to a description of the dominant prototype as follows: PO characterize the PMI as a prototypically unkempt, unhygienic, person who is “visibly mentally ill” or “weird.”

Consistent with their physical appearance, the prototypical PMI is also seen as severely psychologically disordered, experiencing disturbances in their mood, paranoid and psychotic symptoms and extensive cognitive deficits which impede their ability to function and conform to the conditions of probation. Notably, the prototypical PMI is further described as having a compounding substance abuse problem that is perpetuated by their desire to alleviate their severe mental health symptoms. In addition, the prototypical PMI is seen as unstable, unpredictable and potentially dangerous with a high
risk of harming themselves or others. Interpersonally the prototypical PMI is described as a socially inept loaner with few if any positive social supports.

Consistent with this bleak picture, PO perceptions of PMI adjustment to probation and outcome are guarded. Specifically, while participants describe the prototypical PMI as troubled, and in need of both medical and psychological treatment to cope with the demands of daily living, PMI are further described as characteristically non-compliant with their treatment and medication mandates. Thus, the prototypical PMI is viewed as taxing of the PO time and energy and has little chance of getting better.

Aim 3: To Compare and Contrast the Elicited Prototypes

The final aim was to compare and contrast the elicited TRP and PMI prototypes. Specifically, TRP and PMI prototypes were compared and contrasted at two levels. First, the PI examined whether differences existed in participants’ overall composition of the prototypes. This was accomplished by examining differences in the utilization of each of the derived categories. Next, the TRP and PMI prototypes were examined for differences in the specific combined features used to describe them.

Comparing Category Utilization

Participants’ category utilization was compared using two different types of analyses. First, TRP and PMI prototypes were compared for the distribution of features across categories. Specifically, the proportions of the groups total features contained within each category were compared by employing Steiger’s (2003) Two-sample Independent Sample Test for Equal Proportions or Z. This statistic is designed to test the null hypothesis that the two groups’ proportions are equal. Z is the calculated standard score.
Table 12

Proportion of TRP and PMI extracted features by category along with statistical analyses of the differences between these proportions by category.

<table>
<thead>
<tr>
<th>Category</th>
<th>Proportion of DPS-1 (TRP) Total Features</th>
<th>Proportion of DPS-2 (PMI) Total Features</th>
<th>Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>.060</td>
<td>.259</td>
<td>2.09</td>
<td>.036*</td>
</tr>
<tr>
<td>Symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to Function</td>
<td>.037</td>
<td>.146</td>
<td>1.46</td>
<td>.145</td>
</tr>
<tr>
<td>PO-Probationer</td>
<td>.030</td>
<td>.145</td>
<td>1.56</td>
<td>.118</td>
</tr>
<tr>
<td>Relations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td>.282</td>
<td>.141</td>
<td>1.35</td>
<td>.175</td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Labels</td>
<td>.007</td>
<td>.055</td>
<td>1.06</td>
<td>.289</td>
</tr>
<tr>
<td>Demographic</td>
<td>.276</td>
<td>.048</td>
<td>2.45</td>
<td>.014*</td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use or</td>
<td>.09</td>
<td>.045</td>
<td>.70</td>
<td>.481</td>
</tr>
<tr>
<td>Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>.076</td>
<td>.041</td>
<td>.59</td>
<td>.558</td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>.019</td>
<td>.039</td>
<td>.46</td>
<td>.644</td>
</tr>
<tr>
<td>Criminal History</td>
<td>.056</td>
<td>.023</td>
<td>.67</td>
<td>.505</td>
</tr>
<tr>
<td>Impressions of</td>
<td>.000</td>
<td>.016</td>
<td>.68</td>
<td>.494</td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05.

for the difference between the two groups, with Z scores of +/-2 indicating significant results (see Table 12, above). Steiger’s (2003) Two-sample Independent Sample Test for Equal Proportions was utilized here, instead of chi square (another common statistical analyses for the comparison of proportions) due to its ease of application to the available results. Specifically, N5 provides overall proportions for the groups that were easily entered into the Z formula.

As illustrated in Table 12, these analyses suggest that the distribution of features differed between the prototypes. Specifically, participants who described the prototypical
TRP versus the PMI utilized a significantly higher percentage of features associated with demographic characteristics (27.6% vs. 4.8%). The data also suggest a non-significant trend for PO to describe the prototypical TRP utilizing a higher percentage of personality characteristics than PO describing the prototypical PMI (28.2% vs. 14.1%). In contrast, participants who described the prototypical PMI utilized a significantly higher percentage of features associated with their prototypes' current or past mental health symptoms (25.9% vs. 6%). In addition PO describing PMI also showed a non-significant trend to emphasize characteristics regarding their prototype's ability to function in society (14.6% vs. 3.7%) and their relationship to their PO (14.5% vs. 3%).

Next, TRP and PMI prototypes were compared with respect to the percentage of participants that endorsed at least one feature in each category. Specifically, the Chi-Square Test for differences in group proportions was utilized to compare the groups. Chi-Square is a goodness-of-fit test that compares the observed frequencies to the expected frequencies given that the two groups are equivalent. The Chi-Square results, displayed in Table 13 below, are consistent with the previous analyses. Specifically, PO describing the prototypical TRP were significantly more likely to mention at least one demographic characteristic in their description than PO describing the prototypical PMI (82.8% vs. 43.8%, respectively). In addition, TRP descriptions were also significantly more likely to include at least one substance use or abuse characteristic than PMI descriptions (72.4% vs. 43.8%, respectively). There was also a non-significant trend for PO to more frequently utilize personality (93.1% vs. 78.1%) and social support (58.6% vs. 34.4%) characteristics when describing their prototypical TRP.
Table 13

Percentage of TRP and PMI participants by category

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of TRP participants who endorsed at least one feature</th>
<th>Percentage of PMI participants who endorsed at least one feature</th>
<th>( \chi^2 )</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Symptoms</td>
<td>34.5%</td>
<td>93.8%</td>
<td>23.67</td>
<td>&lt;.001***</td>
</tr>
<tr>
<td>Ability to Function</td>
<td>27.6%</td>
<td>78.1%</td>
<td>15.65</td>
<td>&lt;.001***</td>
</tr>
<tr>
<td>PO-Probationer Relations</td>
<td>41.1%</td>
<td>65.6%</td>
<td>3.60</td>
<td>.058</td>
</tr>
<tr>
<td>Personality Characteristics</td>
<td>93.1%</td>
<td>78.1%</td>
<td>2.71</td>
<td>.099</td>
</tr>
<tr>
<td>Diagnostic Labels</td>
<td>10.3%</td>
<td>40.6%</td>
<td>7.21</td>
<td>.007**</td>
</tr>
<tr>
<td>Demographic Characteristics</td>
<td>82.8%</td>
<td>43.8%</td>
<td>9.86</td>
<td>.002**</td>
</tr>
<tr>
<td>Substance Use or Abuse</td>
<td>72.4%</td>
<td>43.8%</td>
<td>5.11</td>
<td>.024*</td>
</tr>
<tr>
<td>Social Support Characteristics</td>
<td>58.6%</td>
<td>34.4%</td>
<td>3.60</td>
<td>.058</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>24.1%</td>
<td>37.5%</td>
<td>1.27</td>
<td>.268</td>
</tr>
<tr>
<td>Criminal History</td>
<td>41.4%</td>
<td>25.0%</td>
<td>1.85</td>
<td>.174</td>
</tr>
<tr>
<td>Impressions of Mental Illness</td>
<td>0%</td>
<td>18.8%</td>
<td>6.03</td>
<td>.014*</td>
</tr>
</tbody>
</table>

Note. \( p < .05 \), \( ^* p < .01 \), \( ^{**} p < .001 \)

Also consistent with the previous analyses, PO were significantly more likely to describe PMI utilizing features associated with mental health symptoms (93.8% vs. 34.5%), diagnoses (41.6% vs. 10.3%) and “feelings” that the person was mentally ill (18.8% vs. 0%). Notably, PO were also significantly more likely to utilize at least one feature regarding their prototypes ability to function in society (78.1% vs. 27.6%).
Finally, there was also a non-significant trend for PO to more frequently utilize features associated with PO-probationer relations when describing the prototypical PMI.

Taken together, these results suggest that PO do have unique conceptualizations of PMI. Specifically, participants’ prototypes of PMI encompass a different body of features than their prototypes of TRP.

Contrasting Participants’ Prototype Features of TRP and PMI

In addition to differing in their overall composition, participants used different specific features when describing the prototypical TRP or PMI. Comparison of the resulting combined prototype features revealed that participants’ prototypes of TRP and PMI differ in a number of ways.

Below is a detailed discussion of the similarities and differences of each of the following domains of combined features: (1) features associated with mental illness, (2) features associated with probation and criminal history, (3) features associated with interpersonal presentation and (4) features associated with other factors.

Contrasting features associated with mental illness

As discussed previously, participants’ prototypes of PMI are distinguished from their prototypes of TRP by their heavy reliance on features associated with mental health symptoms or diagnoses. However, 40% of participants describing prototypical TRP did include at least one mental health symptom or diagnosis. Recall that the most common of these TRP features, listed by 14% of participants, described the prototypical TRP as prone to “thinking errors”. This feature is in some ways similar to the PMI combined prototype feature of “easily confused, or has difficulty comprehending and processing information”.

101
Specifically, both of these features describe a person who is cognitively awkward or limited. For example, one participant described the prototypical PMI as:


Similarly, a different participant described the prototypical TRP as:

[possessing] poor cognitive skills to make appropriate choices.

What appears to differentiate these two features is that the TRP prototype is seen to have a more exclusive focus on making poor decisions regarding criminal behaviors. For example as one participant wrote:

[The prototypical TRP is] A person that has pro-social values, but has an underlying "issue" that allows him to commit an anti social criminal act. Those "issues" usually involve substance abuse, distorted criminal thinking errors, lack of empathy for others [emphasis added].

Contrarily, the prototypical PMI was described in the following way:

[PMI is] incapacitated by [the] demands of "normal" life, [they are] vulnerable, hopeless, [and] disengaged. Some offenders are severely limited cognitively, [with a] lack of basic skills and knowledge base, including hygiene.

Thus, participants described TRP as likely to commit “criminal thinking errors” and PMI as possessing more generally limited cognitive abilities.

Another common mental health feature associated with the prototypical TRP was, “poor coping skills.” Interestingly, participants did not describe the prototypical PMI as generally having poor coping skills. Instead, prevalent PMI features referenced needs or behaviors which imply poor coping skills. For example, PMI were commonly described as in need of psychological treatment and as self-medicating with alcohol or drugs. Both of these features imply that the PMI possess inefficient coping skills to deal with their psychological distress. This suggests that the prototypical PMI and TRP are similar in
their difficulties coping with stress, but that PMI may be distinguished by the psychological nature of their distress.

Finally, participants described both the prototypical TRP and PMI as impulsive. Notably, there was no statistically significant difference between the percentage of participants who used this feature when describing their prototypical PMI (6%) and the percentage of participants describing the prototypical TRP (10%), $\chi^2 (1, N = 61) = .339$, $p = .56$. Thus, it appears as though this feature does not serve to distinguish one prototype from the other. This may be the reason for this feature’s low endorsement overall.

In sum, PMI are viewed as prototypically mentally ill, whereas TRP are not. Notably, TRP and PMI are both characterized as struggling with thinking errors and poor coping skills. However, TRP are viewed as prone to criminal thinking errors while PMI are described as more generally cognitive disabled.

*Contrasting features associated with probation, criminal history and outcome*

As mentioned previously, participants’ prototypes of PMI utilized a larger number of features associated with probation than participants’ prototypes of TRP. However, 42% of TRP descriptions did include at least one feature associated with probation. Notably, while participants described both TRP and PMI as non-compliant, their descriptions of the nature of the non-compliance differed substantially between the two groups. For example, participants described the prototypical PMI as *unable* to comply:

[PMI] seem to desire compliance. Symptoms of their mental illnesses interfere with compliance and they oftentimes have limited vocational and educational skills. Additionally, they have many needs such as daily living, financial management, symptom management, and even transportation. They are usually on a fixed income and have little to no family support. The mentally ill offenders also have long-term substance abuse issues for reasons of self-medication, addiction, and having personalities that are prone to manipulation from others. As a result, they remain non-compliant and many times face
revocation. Throughout their term of probation their desire to do well seems apparent, but with many needs and little support, the face many challenges.

In contrast, the prototypical TRP is described as *unwilling* to comply:

[The typical TRP] views probation as non-serious ignoring conditions, taking risks by violating conditions until he is caught.

This negative perception of the prototypical TRP extends to participants’ descriptions of their general attitude towards probation. In fact, 10 per cent of the participants explicitly mentioned that the prototypical TRP is “angry” or “hostile about supervision.”

Contrarily, PMI are described as being motivated to do well on probation.

TRP and PMI are characterized as being “submissive” or “compliant” with the PO. However, the prototypical TRP submission is viewed as hollow or fake, whereas the PMI is seen as genuinely trying to comply. For example, one participant described the prototypical TRP submission in the following way:

[The] typical probationer puts on a good face to see his/her PO. But when they leave the probation office, do whatever they want. Say they are looking for work, but could care less about finding a job. Only make minimal efforts to help themselves or comply with conditions.

Contrarily, PMI were described as:

[PMI] may indicate they would like to comply with their supervision conditions but may lapse ... [because] they're internal feelings/ beliefs overshadow their desire to comply.

In addition to characterizing the prototypical PMI and TRP using features associated with probation, many participants also included features more generally associated with the probationer’s criminal history. As mentioned previously, this was more the case for descriptions of TRP than PMI. In addition, the features included in this category differed between the groups. Recall, that the only combined feature to result from this category for PMI was “criminal” which seemed to imply that PMI were motivated by the same
criminal mentality as other probationers. In contrast, TRP were described more specifically as drug offenders with long criminal histories. Thus, unlike PMI, the TRP prototype is more centrally defined by the person’s history of criminal activity.

Although criminal activity played a role in defining PO prototypes of TRP, the ability to function in society, potential for mental health remediation, and potential future criminal recidivism played a central role in defining PO prototypes of PMI. Specifically, participants described the prototypical PMI as troubled and in need of treatment and psychotropic medications to manage the demands of daily life. Consistent with this perception, PO were guarded in their predictions of PMI futures. In contrast, PO perceptions of TRP adjustment to probation and outcome varied considerably.

In sum, participant’s prototypes of PMI and TRP differ in several ways. With regard to probation in general, PMI are viewed as submissive and motivated but incapable, whereas TRP are described as resistant, hostile and false. Though some participants viewed PMI as having the same criminal motivations as other probationers, TRP are distinguished by their history of committing drug offenses and long history of criminal activity. Also PO had more universal perceptions about PMI outcomes, predicting a bleak future characterized by a cycle of compliance and non-compliance with mental health treatment, while perceptions of TRP outcomes varied from PO to PO.

Contrasting features associated with interpersonal presentation

In addition to describing PMI and TRP with regard to symptoms of mental illness and relationship to probation, both groups of participants also included features associated with their prototypes’ interpersonal presentation. In fact, participants’ prototypes of PMI and TRP overlapped somewhat with regard to personality characteristics. Specifically,
both the prototypical PMI and TRP were described as socially inept, disorganized, and irresponsible. In addition, participants described the prototypical PMI and TRP as blaming others for their problems.

Despite these shared personality characteristics, participants’ descriptions of PMI and TRP personality traits did differ. Recall that participants described the prototypical PMI as needy, distrusting and skeptical. In contrast, participants characterized the prototypical TRP as unmotivated, defensive and lacking self-esteem. In addition, the prototypical TRP was further described as cold, lying, manipulative and anti-social.

Overall, participants’ descriptions of TRP and PMI personality were similar with regard to their overarching negative theme. Neither group was described as having any positive personality characteristics.

In addition to features associated with personality, both TRP and PMI prototypes included features associated with family and friends. Specifically, the prototypical TRP was described as the product of a dysfunctional or broken home. In contrast, the prototypical PMI was characterized as possessing few interpersonal attachments and little or no social supports. Notably, some participants identified the PMI as responsible for “driving family and friends away” and/or associating with the “wrong crowd”.

Taken together, these results suggest that PMI and TRP share some difficult personality characteristics, as well as possess interpersonal deficits unique to their category. Specifically, although PMI and TRP were both described as socially inept, disorganized, irresponsible and blaming, PMI were distinguished as dependent, distrusting, and skeptical, while TRP were described as cold, unmotivated, and defensive. Interestingly, both sets of personality characteristics were overwhelmingly negative,
suggesting that PO are equally unimpressed with both types of probationers. With regard to social support, TRP were characteristically described as coming from a broken home, while PMI were socially isolated due to choosing the wrong friends or driving social support away.

Contrasting other features

Participants also referenced various features that were not included under interpersonal relationships, adjustment to probation, or symptoms of mental illness. These features addressed the following areas: (1) demographic characteristics, (2) substance use or abuse, and (3) physical appearance.

With regard to demographic characteristics, prototypes of TRP were much more heavily laden with demographic characteristics (see Tables 12 and 13 above) than prototypes of PMI. Specifically, PO described TRP as prototypically a Caucasian male, between the ages of 18 and 50, who is uneducated, underemployed (possibly working seasonally in blue collar employment) and poor. In contrast, descriptions of PMI lacked gender, ethnicity, educational, age and work history features. However, deprived social or financial circumstances were characteristic of both TRP and PMI prototypes.

Substance use and abuse was also mentioned frequently in participants’ descriptions of TRP and PMI. The primary difference between the two prototypes was the PO assertions that PMI utilize substances as a means of alleviating their psychological symptoms. In contrast, PO view TRP as simply “alcoholic” or “drug addicted” and in denial.
Finally, physical appearance was also mentioned by both groups of participants. Specifically, both TRP and PMI prototypes are characterized as unkempt, or messy individuals. PMI prototypes were further described as exhibiting poor hygiene.

Summary

By way of overall summary, PO prototypes of PMI are distinguished from their prototypes of TRP in several ways. First, PMI and TRP descriptions differed with regard to mental health features. Specifically, PMI were described as characteristically mentally ill, whereas TRP were not. Also, despite the fact that both groups of probationers were described as suffering cognitive deficits, PMI were described as more globally cognitively disabled rather than specifically prone to criminal thinking errors.

Second, descriptions of PMI and TRP differed with regard to criminal history probation and outcome. Specifically, even though PMI and TRP were both described as non-compliant, PMI were described as motivated but incapable, whereas TRP were described as resistant, hostile, and false. And, although some participants described PMI as having the same criminal motivations as TRP, TRP descriptions were distinguished by their inclusion of features associated with the probationers' specific criminal history. Also, PO were more homogenous with regard to their perceptions about PMI outcome (most predicting bleak futures characterized by a cycle of compliance and non-compliance with mental health treatment) while perceptions of TRP outcomes varied from PO to PO.

Third, descriptions of PMI and TRP differed with regard to the probationers' interpersonal characteristics. Although PMI and TRP were both described as interpersonally difficult, their descriptions differed with regard to particular personality...
characteristics. Specifically, PMI were distinguished as dependent, distrusting, and skeptical, while TRP were described as cold, unmotivated, and defensive. With regard to social support, TRP were characteristically described as coming from a broken home, while PMI were socially isolated due to choosing the wrong friends or driving social support away.

Finally, PMI and TRP differed with regard to other features. Specifically, PO relied much more heavily on demographic characteristics when describing TRP. However, PMI and TRP were both viewed as having substance abuse issues and a disheveled or “messy” appearance.
CHAPTER 4

DISCUSSION

The present work had one primary goal, to utilize traditional prototype methodology in order to extend and clarify previous research identifying PO typifications of probationers with mental illness (PMI). Recall that typifications have been previously defined as “perceptual shorthand” designed to aid professionals in the efficient recognition, categorization and treatment of persons (Bond, 2001, Frohmann, 1991, Skeem, et al., 2003 Spohn, Beichner, Davis-Frenzel, 2001). Although this theoretical definition has been somewhat consistent throughout the typifications literature, a consistent operational definition has been historically absent. Thus, this research operationally defined typifications as incorporating two essential components: (1) conceptions or “prototypes” of persons, and (2) a set of strategies for interacting with or treating each category of persons. The goal of this study was to elicit and describe only the first of these two components, the “prototype” component of typifications.

This goal was met via three specific aims. The first aim was to elicit and characterize PO prototypes of the “typical or routine” probationer (TRP). Specifically, TRP prototypes were elicited to provide a comparison group for the prototypes of PMI. The second aim was to elicit and characterize PO prototypes of PMI. The third aim was to compare and contrast the elicited prototypes. By exploring these three aims, a better understanding of PO prototypes of both TRP and PMI has been gained. This information
can be used to inform future research designed to determine whether and how PO prototypes are incorporated into PO typifications of probationers and to examine for the impact of PO prototypes or typifications on probationer outcome. The primary findings associated with the obtained TRP and PMI prototypes will be covered in the subsequent sections, followed by a discussion of the study’s implications and directions for future research.

The TRP Prototype

The study’s first aim was to elicit and characterize PO prototypes of TRP. Although the initial purpose of this characterization was to provide a comparison or control for the PMI prototype, analyses of the TRP prototype data yielded some interesting and important findings. Specifically, the study yielded three major findings regarding PO prototypes of TRP: (1) PO did not report sub-prototypes of TRP, (2) PO did not describe TRP as free from psychological symptoms, and (3) PO described TRP using primarily negative descriptors. Each of these findings will be addressed in turn.

Finding 1: PO did not report sub-prototypes of TRP

Extant prototype research suggests that with increased exposure to a given category of objects or persons sub-prototypes develop. Thus, it was predicted that PO would possess sub-prototypes of TRP, a group with whom they presumably have much contact. In order to address this possibility and ensure that each prototype was examined individually, we asked participants to: (1) report individual subtypes separately (utilizing multiple questionnaires), and (2) report if their original descriptions included features for more than one prototype of TRP. If the participant indicated the presence of more than
one prototype in their initial response, they were asked *again* to name and describe each
prototype individually. Although, no participant indicated the presence of sub-prototypes
by completing the measure more than once, 17% of participants indicated that their
original TRP description included features for more than one prototype. However, when
asked to describe the sub-prototypes individually, the feature lists or narratives lacked the
quality and depth of the participant’s original response. In fact, in most cases the sub-
prototype “descriptions” were in title only. Thus, essentially PO did not report the
existence of sub-prototypes of TRP.

There are several plausible hypotheses for PO failure to report sub-prototypes of
TRP. First, the failure to report could be an artifact of the study’s chosen methodology.
Specifically, PO may have been too fatigued or simply not motivated to compose another
or several more thoughtful descriptions. Another potential methodological artifact might
have occurred as a result of the specific wording of the instrument. Explicitly, PO were
asked to call to mind the “quintessential” TRP. Thus, PO could have interpreted
“quintessential” as “most prevalent.” In this way, they might have simply chosen the
most prevalent subtype of TRP and described that prototype only. Alternatively, PO
might have been reporting features at the super-ordinate level. Specifically, research on
prototypes has revealed that there are varying, hierarchical levels of categorization
(Rosch, 2002). For example, the TRP may be a super-ordinate category for the basic level
categories of “drug addicted probationer,” “first-time offender probationer” and “hostile
probationer.” In this way, PO may have included only those features shared by all of the
basic level prototypes. Finally, it is possible that PO do not have differentiated sub-
prototypes of TRP. Unfortunately the data obtained in this study do not allow for the examination of these hypotheses. However, this does suggest an area for future research.

**Finding 2: TRP not free from psychological symptoms**

In addition to predicting multiple subtypes of TRP, extant research suggested that TRP would be distinguished from PMI by their lack of mental health symptoms (Skeem, Encandela & Eno Louden, 2003). Consistent with this prediction, TRP were not described as characteristically mentally ill. However, a sizable number of respondents, 40%, did describe the TRP as exhibiting some psycho-pathological symptoms. The most common of the psychological symptoms listed was proneness to criminal thinking errors. TRP were also described as impulsive and possessing poor coping skills. Thus, this research suggests that PO do not view TRP as free from psychological problems. Instead it is their lack of severe psychopathology and absence of a mental health diagnosis that set TRP apart from PMI.

**Finding 3: PO described TRP using primarily negative descriptors**

Finally, Skeem, Encandela and Eno-Loudens’ (2003) work suggested that the prototypical TRP would be characterized as: (a) requiring very little time to process, and (b) possessing a high desire to move through the probation system without “rocking the boat”. Notably, neither of these characteristics was identified in the prototype descriptions. Instead, considerable variability existed in PO prototype descriptions of TRP with regard to PO-probationer relations and outcome. In addition, the most prevalent features in this category were not flattering towards TRP. For example, PO described TRP as passively resistant in their relationship with their PO. Explicitly, TRP were characterized as seemingly compliant (often expressing their willingness to comply...
during face-to-face contact), but actually being unwilling to comply with their conditions of probation. Also, TRP were described as angry and hostile about supervision.

The negative perception of TRP also extended to PO descriptions of TRP interpersonal qualities. Specifically, the prototypical TRP was described as unmotivated, defensive, dishonest, irresponsible and manipulative. Thus, it seems that PO have strong and pervasive negative conceptions of TRP.

These exceptionally negative descriptions of TRP suggest that PO are characteristically cynical regarding the “types of people” that are put on probation. The root of PO pessimistic conceptions about TRP remains unclear. For example, it could be that PO are pessimistic due to years of exposure to probationers who truly are uniformly unmotivated, calculating and false. It is also possible that those persons who gravitate toward probation officer positions are generally more authoritarian in character to start. A third possibility is that PO have formed these conceptions as the result of the numerous frustrations encountered in their line of work. For example, PO might be cynical due to repeated failures to enact change.

Regardless of their roots, research suggests that PO less than enthusiastic conceptions of TRP are likely to have a harmful impact. First, the available research suggests that negative typifications can directly result in substandard treatment. Examples of this include, Jeffery’s (1979) “rubbish” who suffered long wait periods, verbal hostility and insensitive treatment and Frohmann’s (1991) “non-credible” sexual assault victims whose assailants were not prosecuted. Importantly, the extant research also indicates that should PO negative bias translate to probationer stigmatization, probationers are at increased risk for recidivism (Petersilia & Turner, 1992, Sims & Jones, 1997).
The PMI Prototype

The second important set of findings involves PO conceptions about PMI. Specifically, this study obtained the following findings regard PO conceptions about PMI: (1) PO reported unique prototypes of PMI, (2) PO described PMI as severely disordered, (3) PO described PMI as non-compliant with treatment, (4) PO predicted bleak outcomes for PMI, and (5) PO felt taxed by their work with PMI.

Finding 1: PO reported unique prototypes of PMI

Previous research suggested two potential outcome paths for the PMI prototype (Skeem, Encadela & Eno Louden, 2003). The first path predicted that PO would not have unique prototypes of PMI. On this path, PO descriptions of PMI were predicted to be either: (1) identical or very similar to their descriptions of TRP, or (2) characterized exclusively by their differences from TRP. Results from this study do not support either of these predictions. Specifically, although PO prototypes of TRP and PMI both included similar categories of features, PO prototypes of PMI differed substantially with regard to the categories emphasized (i.e. emphasizing mental health symptoms, ability to function in society and PO-probationer relationships, rather than demographic variables) and in the specific features elicited. Thus, PO descriptions of TRP and PMI were not identical or even very similar. Next, PMI prototypes were not characterized solely by their differences from TRP. In fact, PMI descriptions were completely devoid of references to TRP. Thus, it appears as though PO posses a unique prototype of PMI that is characterized by its own set of specific features.

The notion that PO possess unique prototypes of PMI has implications for the experience of PMI. Specifically, the prevailing typifications research suggests that

Finding 2: PO described PMI as severely disordered and potentially dangerous

In addition to confirming that PO have unique prototypes of PMI, this study also identified numerous features that suggest PMI are characteristically viewed as severely disordered persons who are potentially dangerous. Specifically, PO in this study: (1) described PMI using extreme psychological symptom features and diagnoses, (2) described PMI utilizing personality features consistent with Dependent and Avoidant Personality Disorders, and (3) described PMI as in need of psychotropic medication to manage the demands of daily living.

With regard to psychological symptom features, results from this study suggest that PO view PMI as distinguished by marked and unmet psychological needs. Although the
specific psychological features and diagnoses varied considerably (some describing schizophrenia and others ADHD or bipolar disorder), PO descriptions were uniform in their characterization of severe psychological pathology. For example, the most frequently endorsed PMI feature (mentioned by 53% of participants) described PMI as suffering serious cognitive deficits. This finding is consistent with the prevailing literature, which also suggests that PO view PMI as psychologically needy (Skeem, Emke-Francis, & Eno Louden, 2006, Skeem, Encandela, & Eno Louden, 2003, Wormith & McKeague, 1996).

In addition to severe psychological symptoms, PMI were also described as behaviorally unstable, unpredictable and potentially dangerous. Specifically, PO commonly described PMI as presenting a risk of harm to themselves and others and as exhibiting bizarre and erratic behavior. This is consistent with the results from Skeem, Encandela and Eno Louden’s (2003) study, which identified PMI instability and dangerousness as primary concerns for PO.

Besides psychological and behavioral mental health symptoms, PO also described PMI as exhibiting a combination of offensive personality characteristics. Participants’ prototypical PMI were simultaneously characterized as socially inept and withdrawn, desperate or “clingy” and skeptical and distrusting. This unique combination of features is often found among persons suffering from Dependent or Avoidant personality disorders. This notion is furthered by the near absence of positive interpersonal qualities among PO descriptions. In fact, the only combined prototype feature with some positive connotation was “desires acceptance,” a feature also common among persons suffering from Dependent and Avoidant Personality Disorders. Again, this finding is substantiated
by the available literature, which suggests that PO find PMI “needy” or “dependent” upon the PO (Skeem, Emke-Francis, & Eno Louden, 2006, Skeem, Encandela, & Eno Louden, 2003).

Finally, contributing to the picture of PMI as severely disordered was the majority’s view that PMI were incapable of functioning in society without outside assistance and/or consistent use of psychotropic medication. Participants described the prototypical PMI as “incapacitated by [the] demands of normal life,” “barely able to engage in life” and a danger “when medication is not taken (or substituted- self-medicated [with] drugs or alcohol).”

Clearly, PO prototypes of PMI are laden with features consistent with severe psychological disorder. There are several plausible hypotheses for PO extreme view of PMI psychopathology. First it could be that the majority of PMI legitimately experience severe psychological distress. In this case, PO prototypes would simply reflect reality. Second, it is possible that PO are only aware of the severely disordered. For instance, less disordered offenders may attempt to “pass” as TRP to avoid perceived stigma or simply do not display psychological symptoms enough for PO to take notice. Third, it is possible that PO only remember those PMI who dramatically differ from the more “typical or routine” probationers. Finally, as the research on typifications suggests, PO negative perceptions of PMI may be the result of PMI requiring more time and energy to process. Recall, that typifications research suggests that players in the legal system prize actors that are efficiently processed and systematically punish those who are not (Webb, 1984). Thus, PMI, who truly exhibit only moderate psychological symptoms, are viewed as seriously disordered, “dependent” or “clingy” because they fall outside of PO routine.
Unfortunately, the current research does not allow for a differentiation of these hypotheses. However, future research, exploring the accuracy of PO perceptions is warranted.

**Finding 3: PO described PMI as non-compliant with treatment mandates**

Although PO described PMI as desperately in need of psychological treatment, PO were not optimistic about PMI motivation to comply with said treatment. Specifically, one quarter of participants included “non-compliance with mandated treatment” as a feature of their prototypical PMI. This is consistent with prior research, which suggests that PO view PMI as at fault for their continued struggles with mental illness due to their failure to present for and comply with treatment (Wormith & McKeague, 1996).

Again, the accuracy of PO descriptions of PMI is unknown. For example, it is possible that PO descriptions reflect the actual observed behaviors of PMI. It is also possible that PO jaded perceptions are based on a pre-existing negativistic point of view. Finally, it is also possible that PO are experiencing a bias in memory, recalling only those PMI who refused treatment and as such were more problematic to supervise. What is clear is that PO views of PMI psychopathology and lack of motivation toward treatment are associated with bleak predictions regarding PMI potential for remediation and outcome.

**Finding 4: PO predict bleak futures for PMI**

Consistent with their perceptions of PMI as psychologically disordered, potentially dangerous and unmotivated for treatment, PO predictions regarding PMI outcome were grim. Specifically, PO described PMI as (1) unable to comply with the conditions of
probation, and (2) involved in an endless cycle of drug abuse and relapse designed to alleviate their mental health symptoms.

Though this perception might have been formed or sustained for various reasons, it is notably consistent with the available literature on PMI actual risk for substance abuse and recidivism suggesting that substance abuse and relapse is common among PMI (Ditton, 1999, Zohn, 2001). Also, Dauphinot’s (1997) study of PMI risk for recidivism found that PMI were more likely to recidivate at three-year follow-up as compared to a matched sample of non-disordered offenders. Thus, it is probable that PO bleak predictions for PMI outcome is merely a reflection of reality.

However, given that PO have substantial influence over probationer re-arrest and revocation, it is impossible to examine probationer outcome independent from PO influence. Thus, it is possible that PO bleak predictions for PMI outcome beget a self-fulfilling prophecy. In this way, fearful and hopeless PO predict failure and then cause it by either under-referring to services (Wormith & McKeague, 1996), employing ineffective compliance strategies (Skeem, Emke-Francis & Eno Louden, 2006) or intentionally violating PMI to remove the perceived risk from their caseload (Skeem, Encandela & Eno Louden, 2003).

Clearly future research will be needed to determine the true nature of the relationship between PO perceptions and PMI outcome. Currently no prospective research exists in this field. Prospective empirical inquiry is needed in order to: (1) determine whether or not PMI are indeed at increased risk for criminal recidivism, and (2) ascertain whether and how PO perceptions influence PMI outcome.
Finding 5: PO are taxed by their work with PMI

Finally, consistent with previous literature, PO described PMI as difficult and time consuming to supervise (Skeem, Emke-Francis, & Eno Louden, 2006, Skeem, Encandela, & Eno Louden, 2003). Specifically, 41% of participants described their work with PMI as either taxing or requiring specialized skills. For example, PMI were not only described as characterologically dependent but specifically needy of the PO. Perhaps because of the increased demands for time, attention and specialized skills, some participants (9%) reported feeling overwhelmed and incapable of helping the PMI.

Implications and Directions for Future Research

The results of this study have paved the way for future research in several areas. First, this study has implications for research designed to examine PO prototypes and their relationship to PO typifications. The current study was designed to examine and measure only one of the two components of PO typifications, the prototype or conception component. Thus, future research will be needed to establish a link between the identified TRP and PMI prototypes and specific supervision or disposition strategies to substantiate the existence of differentiated PO typifications. To date no other research has attempted to establish the existence of typifications among PO who supervise probationers.

Of particular interest in this area would be the identification and characterization of any differences in PO strategies for supervising PMI versus TRP. Specifically, the typifications literature suggests better treatment for those who are either: (1) categorized and processed efficiently (i.e. trading expedience for lenience) or (2) categorized in pro-social or positive categories (i.e. the “good patient” versus “rubbish”). Results from this
study suggest that neither group of probationers is being categorized into a positive group. In fact, both groups of probationers were described with the conspicuous absence of positive characteristics. Thus, any benefits to TRP over PMI are likely the result of lenience rather than positive labeling. Consistently, any negative consequences for PMI are likely to result from their inefficiency rather than any increased negative bias on the part of PO. Still, no research exists characterizing PO strategies for supervising TRP and PMI. In sum, it is not clear if PMI are receiving “treatment as usual,” specialized treatment, or substandard treatment as a consequence of their differences from TRP.

Another venue for future research would be to determine the accuracy of PO prototypes of probationers. Specifically, as long as the actual characteristics of TRP and PMI diagnoses, personality and outcome remain unknown, it is difficult to make informed recommendations for interventions with these populations. For example, PO described PMI as characteristically unmotivated towards treatment compliance. If these perceptions are accurate, training PO in treatment motivation strategies would a viable recommendation for increasing PMI motivation to comply with mandated treatment. However, if PO perceptions are inaccurate, implementing strategies aimed at increasing PMI motivation are not likely to be effective.

Finally, this study has suggested an entirely new area of research geared at examining the source of PO negativity regarding their work with probationers. Specifically, although offenders typically suffer stigma at the societal level, it is alarming that they apparently suffer stigma at the relational level with their PO as well, a person historically present for the purposes of rehabilitation. Thus, identifying the source of PO negativity is necessary in order effectively to manage the risk it poses to probationers. For example, if a large
number of characteristically authoritarian people are drawn into the position of PO, interventions designed to build empathy and understanding may be warranted. On the other hand, if PO are simply suffering the emotional consequences of working with a population of unmotivated, callous individuals, interventions designed to decrease PO burnout may be justified.

Because successful outcomes for probationers (both PMI and TRP) are of great importance not only to the probationers themselves but to society as a whole, these findings should be explored in future research. More research in this area could lead to the identification and treatment of those behaviors or scenarios which are resulting in poor outcomes for PMI and may help to illuminate better strategies for managing probationers as a whole.
REFERENCES


125


APPENDIX A

CALLING SCRIPT

Typifications Calling Script

Name: ______________________

Date: ______________________

Number called: ______________________

Person spoke with: ______________________

If person answers:
Hello, I am ________________, from the University of Nevada. How are you today?

(If it sounds like a bad time): Well, it sounds as though you are pretty busy right now. Would it be okay if I called you back a little later?

(If No): Thank you for your time. → Refusal

(If Yes): Great! When would be a better time to call?

Time: ________________

Date: ________________

(If it sounds like a good time): I am calling to invite you to participate in a study that is supported by the American Probation and Parole Association.

You may remember us calling and sending a letter regarding this study around February, when you were scheduled to attend the APPA’s Winter Training Institute.
Our goal in this research is to better understand probation officers perceptions and attitudes about probationers with mental illnesses. I am calling to invite you because you were randomly selected back in February for participation from the probation officers attending APPA’s winter training institute. And we are currently asking probation officers, like yourself, to complete these same study materials via mail.

Am I correct in thinking that you supervise probationers or have supervised probationers in the past?

(If No): Really? You do not supervise probationers?

   (If Yes): I am sorry, there must have been a mistake. Thank you for your time.

   (If Yes): Great! I would love to mail you the survey. The study will only take between 25-30 minutes of your time to complete and you will be given a $15.00 gift certificate for completing the questionnaires.

1. Would you like the opportunity to participate in our research and be given a $15.00 gift certificate?
   _____ No (go to #2)
   _____ Maybe/Questions (go to #2)
   _____ Yes (skip to #3)

2. Do you have any questions or concerns about the study that are making you hesitate? I would be happy to answer any questions you have at this time. (Answers questions)

   Would you like to participate now that you know more?

   _____ No → It sounds like you are pretty certain that you do not want to participate. Is that the case? (If yes): Well thank you for your time. (If no): Probe for questions.

   _____ Yes (go to #3)

3. Wonderful! We will be mailing the surveys out within the next two weeks. Might I verify your contact information to make sure that we have the best address and phone number for you?

   ____________________________________________________________
   ____________________________________________________________

   ----------------

130
4. Closing: We will be calling you within a week of sending out the survey to answer and questions that you may have. Thank you so much for your time and willingness to participate. Have wonderful day!

If answering machine:

Hello, I am ______________ from the University of Nevada. I am calling to invite you to participate in an upcoming mail survey that is supported by the American Probation and Parole Association and will be taking place within the next few months.

The study will only take between 25-30 minutes of your time and can be completed at your convenience. You will also be given a $15.00 gift certificate for completing the questionnaires.

If you are interested in participating in this important research, please give me a call me back at __________ again that is __________.

I look forward to talking to you.
APPENDIX B

CALL LOG

Attitudes Study Contact Log Form

Contact Name: _______________________________ Study ID# _____
Phone Number: ________________________________

_EVERY attempt to reach the participant must be recorded_

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Result/notes</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C

DESCRIPTION OF PROBATIONER

VERSION I

This study is focused on your conception of the routine or typical probationer. By typical, we mean the person that best represents probationers as a group.

First, take a few minutes to form a mental image of the routine or typical probationer. We don't mean to use the word “image” in a strictly visual sense—we would just like you to bring to mind as complete, detailed, and vivid a mental representation of this typical probationer as you can.

Next, describe your conception in the space provided on the backside of this sheet or paper. There are three specific instructions:

1. Please be honest and candid in your description. Do not censor any features that are important to your conception.

2. Describe features that are common to probationers as a group. Your description might include the typical probationer’s attitudes or behavior while on probation, or his/her general appearance, personality, actions, and feelings. These are only rough guidelines—emphasize whatever features are important to your conception.

Example descriptions are provided below. Different people have different conceptions of things, so there are no right or wrong responses.

- typical extroverted person at a party: Talkative, outgoing, loud. Attractive. Seeks people out, drinks a lot. Loves the loud party atmosphere. Pretty entertaining and easy to talk to, but sometimes dominates the conversation and boasts. Feels self-assured and comfortable. Wants others to notice and pay attention to him. Wants to have fun. Not too serious about anything.
3. Your mental image of the routine or typical probationer might involve *multiple subtypes*. If your mental image involves different and distinct types of probationers, please use a separate form to describe each type.

An example of two descriptions for one category or multiple subtypes is provided below. Remember, different people have different conceptions of things, so there are no right or wrong responses.

- *typical work boot*: Black leather. Rubber sole. Steal, rounded toe. Lace up. 8-10 holes.

My conception of the *routine or typical probationer* is:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

134

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
UNDERSTANDING YOUR CONCEPTION:

Call to mind the description you created and answer the following questions:

(4) Does this description represent a single type of probationer or does it include multiple subtypes? (Circle one)

SINGLE TYPE

MULTIPLE SUBTYPES

(5) If this is a single type: What proportion of the probation population is this type?

_______ % of the probation population

(6) If this person represents multiple subtypes: Please name and describe them below and then estimate what percentage of the probation population is accounted for by each subtype.

<table>
<thead>
<tr>
<th>SUBTYPE NAME AND DESCRIPTION</th>
<th>% OF THE PROBATION POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

DESCRIPTION OF PROBATIONER

VERSION II

Now we would like you to focus on your conception of the typical probationer with mental illness. By typical, we mean the person that best represents probationers with mental illness as a group.

First, take a few minutes to form a mental image of the typical probationer with mental illness. Again, we don't mean to use the word “image” in a strictly visual sense—we would just like you to bring to mind as complete, detailed, and vivid a mental representation of this typical probationer as you can.

Next, describe your conception in the space provided below. There are three specific instructions:

1. Please be honest and candid in your description. Do not censor any features that are important to your conception.

2. Describe features that are common to probationers with mental illness (PMIs) as a group. Your description might include the typical PMI’s attitudes or behavior while on probation, or his/her general appearance, personality, actions, and feelings. (Note: if you list a diagnosis, please describe what you mean by that label.) These are only rough guidelines—emphasize whatever features are important to your conception.

Example descriptions are provided below. Different people have different conceptions of things, so there are no right or wrong responses.

- typical extroverted person at a party: Talkative, outgoing, loud. Attractive. Seeks people out, drinks a lot. Loves the loud party atmosphere. Pretty entertaining and easy to talk to, but sometimes dominates the conversation and boasts. Feels self-assured and comfortable. Wants others to notice and pay attention to him. Wants to have fun. Not too serious about anything.
3. Your mental image of probationers with mental illness might involve *multiple subtypes*. If your mental image involves different and distinct types of probationers with mental illness, please use a separate form to describe each type. 

*An example* of two descriptions for one category or multiple subtypes is provided below. Remember, different people have different conceptions of things, so there are no right or wrong responses.

- *typical work boot*: Black leather. Rubber sole. Steal, rounded toe. Lace up. 8-10 holes.

My conception of the *mentally ill probationer* is:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
UNDERSTANDING YOUR CONCEPTION

Call to mind the description you created and answer the following questions:

(7) Does this description represent a single type of probationer or does it include multiple subtypes? (Circle one)

SINGLE TYPE

MULTIPLE SUBTYPES

(8) If this is a single type: What proportion of the probation population is this type?

______ % of the probation population

(9) If this person represents multiple subtypes: Please name and describe them below and then estimate what percentage of the probation population is accounted for by each subtype.

<table>
<thead>
<tr>
<th>SUBTYPE NAME AND DESCRIPTION</th>
<th>% OF THE PROBATION POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E

BACKGROUND SURVEY

First, we would like some basic information about you. Please respond to the questions below.

1. Please list your age: ________ years old.

2. Please indicate your gender (circle one):
   a. Male
   b. Female

3. Please indicate your race (circle one):
   a. White
   b. Black
   c. Native American
   d. Asian
   e. Pacific Islander
   f. Other

4. Are you Spanish, Hispanic, or Latino/a? (circle one)
   a. Yes
   b. No

5. What is the highest grade you completed in school? ________ grade

6. What is the highest educational degree that you’ve earned? (circle one and specify)
   a. Less than high school
   b. High school graduate/GED
   c. Associate’s degree
   d. Bachelor’s degree in (specify major): _____________________________
   e. Master’s degree in (specify) _____________________________
   f. Doctoral/Law/Medical degree (specify) _____________________________
g. Other *(specify)*

7. Job title:

8. Years in current position:

9. Years working as a Probation Officer:

10. Do you currently work, or have you ever worked, as a *specialty* probation officer? By specialty officer, we mean a PO who has specialized training in mental health, and has a reduced-size caseload of exclusively mentally ill probationers.
   a. Yes
   b. No

11. Approximately what percent of your current caseload consists of mentally ill probationers? (0-100%): 

12. Approximately how many mentally ill probationers have you supervised?
INVITATION LETTER

December 14, 2006

Dear [Registrant Name],

Each year, a large number of individuals with mental illness are placed on probation. In order to find effective strategies for supervising these individuals, we must understand the unique challenges they present. The best way of understanding these challenges is to talk with probation officers about the differences between probationers with mental illness and traditional probationers. We originally planned to ask probation officers, like you, these questions as part their visit to APPA Winter Training Institute last February. However, we were unable to set up a meeting to talk with many probation offer attendees and were hoping that you would be willing to give us your comments via mail.

Thus, we are inviting a small group of adult probation officers to participate in a short, 20-minute mail survey. We will be attempting to contact you on the phone within the next couple of days to ask you if you are willing to complete the survey.

All participants will be compensated for their participation. Please contact us for more information regarding your $15.00 gift certificate!

Given your experience as probation officer, nobody else’s views can substitute for yours. Your help is essential to our ability to successfully represent officers’ experiences with probationers with mental illness across the nation. Please know that your survey answers will be completely confidential. Your responses will be released only as summaries in which no individual’s answers can be identified.

The results of this research will be published to inform policy and practice in supervising probationers with mental illness. We would be happy to provide you with the results. We will also make the results available to other probation officials and representatives of state government, with the help of the American Probation and Parole Association, National Association of Probation Executives, and the Council of State Governments.
If you have any questions or comments about this study, please feel free to call (702) 895-5346 or e-mail: emke@unlv.nevada.edu. Thank you very much for helping with this important study.

Sincerely,

Paula Emke-Francis, B.A.  
University of Nevada, Las Vegas

Douglas Ferraro, Ph.D.  
University of Nevada, Las Vegas
APPENDIX G

COVER LETTER

November 16, 2005

Dear Probation Officer,

Thank you again for taking time out of your busy schedule to participate in our national survey on probation and mental health. The results of this survey will be used to inform future research designed to identify “best practices” for supervising probationers with mental illness.

With your permission, we have enclosed a series of brief questionnaires designed to help us better understand probation officers’ conceptions about probationers with mental illnesses. The best way of understanding these conceptions is to talk with POs, like you, about the differences between probationers with mental illnesses and traditional probationers. One way of examining these differences is to ask PO’s about their perceptions of both traditional and mentally ill probationers. You have been randomly selected to participate in a survey designed to answer at least one of these questions.

In order to ensure that everyone completes the survey in the same way, we ask that you please complete the survey materials in the following order:

(1) First, read and sign a copy of the enclosed informed consent for participation form. There are two copies of this form, please mail one copy back and keep the other copy for your records.
(2) Next, open and complete the materials in the envelope labeled Step 1. This should take about 10-15 minutes.
(3) Then, open and complete the questionnaire enclosed in the envelope labeled Step 2.
(4) Finally, place the copy of the informed consent form and all of the materials from Step s1 & 2 into the enclosed postage paid envelope.

Please complete the questionnaires at your earliest convenience, preferably within the next two weeks. As mentioned above, we have provided a postage paid envelope for you to return the questionnaires to us. As a special thank you for taking part, you will be mailed a $15.00 gift certificate, upon receiving your completed study materials.
Again, I sincerely thank you for your involvement in this important research. If you have any questions or comments about the study in general, please do not hesitate to contact me. Our phone number is (702) 895-5346 and our e-mail address is emke@unlv.nevada.edu. Thank you very much for helping with this important study.

Sincerely,

Paula Emke-Francis, B.A.
Doctoral Candidate
University of Nevada, Las Vegas
APPENDIX H

FEATURE EXTRACTION INSTRUCTIONS

Overview of N5

You will be using the software package N5 to code data. Please familiarize yourself with this program by following the tutorial that comes with it. This should give you a good foundation for what you will be doing.

➢ Please do not code any data until you have completed the tutorial.

For questions about how to use N5:
• Check the tutorial to see if the topic you need is there.
• Check the help file.
• Please ask if there is something you don’t understand!

Coding data

This portion of the project is qualitative, and your task is to code data. The codes, as well as the data to be coded, are features.

Feature Extraction

How to decide if a word or phrase is a feature:
1. A feature is any phrase or statement which contains one idea and is descriptive of the participant’s prototype.

Ex) (A person who is sure of himself or herself) (and doesn’t like to admit he/she is wrong about something,) (They like to present themselves as always with control of themselves) in their surroundings. Some people I have had contact with this category also have (talked openly of conspiracies against them); ie. the (government is always “lurking”) or ( (government is always) “after them”). I imagine (confidence of themselves) (but skepticism [of people who represent authority] [in general] and paranoia of people who represent authority/ (either in general, or of the mentally ill individual). I don’t envision any physical characteristics/, just social ones.
APPENDIX I

FEATURE EXTRACTION PRACTICE TRANSCRIPTS

Practice Example 1
A person who cannot rationalize their crime as other criminals do. They see themselves as the victim many times and try to convince me that what they did is something other than a crime. They don’t consider themselves a risk to society. They are of a much higher rate absconders because they realize the structure of probation supervision is not something they can conform to.

Practice Example 2
Generally tends to comply with directives (not overt) abscond from supervision. Tend to be pro-socially oriented but awkward in problem-solving – their way of problem-solving may be well-intentioned but commits a criminal act to achieve ends.

Practice Example 3
Persons who fluctuates in attitudes and moods. There are times when they may seem quite normal but then may quickly change in their behaviors. This may be exhibited in being quick to anger or have a very distorted way of thinking. Many are not employable due to their mental illness and do not have employment as a tool for feeling a sense of
normalcy. Offenders with mental illness are sometimes difficult to supervise due to their distorted ideas and it takes a great amount of patience and understanding. These offenders often seem to be intelligent and capable of _____ and taking care of themselves until it surfaces that they may have some strong anti-social ideas or their mental illness takes over their understanding of right and wrong. They may indicate they would like to comply with their supervision conditions but may lapse into not feeling the rules of the road are significant or their internal feelings/beliefs overshadow their desire to comply. These with mental illness often respond more readily to acceptance rather than trying to force them into a change – especially a change that may not be possible.

Practice Example 4

Someone who is integrated in services and actively receiving treatment & medications for a mental illness diagnosis. Most of them seem to have “look” about them such as a vacant look about them. They may have a robotic look or actions. They appear to be in a drugged state. They are not at personal hygiene. Some have severe mood swings and have problems controlling their behavior. They also seem to have a nomadic behavior: they don’t have strong ties to any particular place. If the person is managed and meds are stable they are able to function somewhat in society, however they don’t really seem to understand consequences of their behavior if they go off meds etc.

Practice Example 5

Difficult. Challenging. Meds. Violation. Bipolar. Schizophrenic=violate lack of resources. Difficulty grasping terms of order; to effectively help; Exceptional amount of questioning. P.O. feeling helpless, not for sure if probation is appropriate. Great family involvement - coddling.

147
APPENDIX J

FEATURE CODING MANUAL

Instructions

In preparation for feature combination, sort the features into one of following 10 categories, which are explained in detail below:
1. Physical appearance, and self-care
2. Impressions of mental illness
3. Demographic characteristics
4. History of abuse or trauma
5. Biological impairments
6. Personality characteristics
7. Social support and other characteristics
8. Diagnostic labels/current or past mental illness
9. Current or past symptomatic
10. Mental health care or evaluation; remediability; ability to function in society
11. Criminal history and Other Bad Behavior
12. Substance Abuse
13. Miscellaneous

First, note that the categories include both positive (present) and negative (absent) features of the type that they describe. For instance, both "erratic behavior" and "acts normal most of the time" are classified under symptoms, because one describes a behavioral symptom and the other describes an absence thereof. Second, pay careful attention to the exclusionary criteria for each category. Sometimes, a feature that arguably belongs to a given category is excluded because it "fits" with features in a different category. Because our goal is to ease the task of our judges (e.g., putting together synonymous features), we must not artificially separate features that they might “put together.”
I. PHYSICAL APPEARANCE, AND SELF-CARE
Includes all features that reference how the prototype looks, including his/her facial expression and how well he/she is cared for.

Examples:
can look normal
disheveled
glasy look in his eye
lacks much movement in their face--blank, no smiles
no facial expression
flat affect
twitches; spasms
matted hair
not clean
not well cared for

II. IMPRESSIONS OF MENTAL ILLNESS
Include in this category any "feelings" that the prototype invokes in others which signify that he/she is mentally ill.

Examples:
you can tell by looking at him that he's mentally ill
gives you an uncomfortable feeling

III. DEMOGRAPHIC CHARACTERISTICS
Includes all features that reference the prototype's gender, race, employment, anything having to do with education, marital status, income, and residential status (e.g., homeless).

Examples:
not stereotyped according to gender, creed, or nationality
male
30 years old
uneducated
unstable employment history
cannot hold a job

IV. HISTORY OF ABUSE OR TRAUMA
Includes all features that reference the prototype's childhood history of physical, emotional, psychological abuse, or prior experience of some sort of psychological trauma.

Exclusion: head trauma, which should be classified under "biological impairments"

Examples:
mentally/physically abused throughout life
sees a loved one gets hurt (violence in the home, sees a beating)
born in very deprived circumstances
mom served jail sentences for child molestation
experienced some sort of trauma

V. BIOLOGICAL IMPAIRMENTS
Includes all features referencing "medical model" constructs or disorders that are often present at birth and/or are assumed to be largely genetically based (e.g., developmental disabilities).

Examples:
- chemical imbalance
- mentally retarded/mentally challenged/slow
- could have physical medical problem
- brain injured

VI. PERSONALITY CHARACTERISTICS
This is a broad category and includes all features that reference the prototype's interpersonal traits (how the prototype "seems" to or interacts with his/her world). These include: "antisocial" characteristics, general disposition, general personality characteristics and related behavior, and self-image.

Exclusions:
(1) features such as "paranoid" or "paranoid delusions" should be classified under symptomatology (however related interpersonal descriptors such as "guarded and cautious" are classified here);

Examples:
- Antisocial characteristics
  - sociopathic/antisocial
  - manipulative
  - can be very good at talking others into doing thing
  - takes advantage of people and situations
  - power-happy
  - egotist
  - selfish attitude

Early problems and general disposition
- backward nature

General personality characteristics and related behavior
- introverted/shy
doesn't say much; only looks at people
poor talker
loner
unable to communicate feelings

impulsive
flighty
overly emotional
goestogreatlengthsforattentionorsympathy

guarded and cautious*
fears others*
distrusts others*
perceives every encounter in life as serious and potentially threatening*
(*Excludes: paranoid, per se, which should be classified under symptomatology)

Self image
has always felt inferior due to his problems
poor self image

Intelligence
may be very bright/high IQ

VII. SOCIAL SUPPORT AND OTHER CHARACTERISTICS
This category includes features referencing prototypes relationships with others (e.g. "close with family", no family support") or the qualities or characteristics of friends or family.

Examples:
Friends abuse drugs
alcoholic father
not many close or long term relationships or friendships
unable to maintain normal interpersonal relationships
no family support

came from a broken home

VIII. DIAGNOSTIC LABELS/CURRENT OR PAST MENTAL ILLNESS
Includes all "DSM-like" diagnostic terms, vague labels ("psychological problems") and references to a history of mental illness. This category is distinguished from the "symptom" category by its implication that a cluster of symptoms, rather than a single symptom, are involved.

Exclusions:
(1) the term "antisocial," which should be classified under personality;
(2) vague references to childhood or adolescent "problems" which are classified under personality;
(3) descriptions of whether the mental illness can be controlled. Most of these
descriptions suggest control via treatment, and are classified under "treatment;
remediability; and ability to function."

Examples:

Diagnostic-like terms
- schizophrenic/schizophrenia
- manic/mania
- bipolar
- depressed
- demented/dementia
- delirium
- suffers from Attention Deficit Disorder
- psychotic/psychosis/psychotic episodes

Labels/history of mental illness
- mental—not stable
- history of mental illness, but not necessarily over a long period of time

IX. CURRENT OR PAST SYMPTOMATOLOGY
Includes all "DSM-like" descriptions of the prototype's symptoms or history of
symptoms. Symptoms include psychotic (delusions, incoherence, and non-command
hallucinations), cognitive (concentration, confusion), emotional (panic, depression,
anger), and behavioral (erratic, obsessive) types. Includes lack of insight or awareness
that one is mentally ill. This category is distinguished from the broad "personality trait"
category by its greater intensity or severity.

Exclusions:
(1) symptoms that reference how the prototype "looks" (e.g., flat affect, looks normal),
which are classified under "impressions of mental illness"

Examples:
Psychotic symptoms
- delusions
- paranoid (*Note: features such as "guarded and cautious" are classified under
  "personality")
- bizarre beliefs
- actively hallucinating
- hallucinates
- see and feel things that are not there
- incoherent
- out of touch with reality
Behavioral symptoms (or lack thereof)
acts normal most of the time
obsessive behavior
unpredictable
history of erratic behavior
history of inappropriate or unusual behavior
very calm at times, but can go to opposite extreme
sudden outbursts; great lengths of calm
extreme behavior

Emotional symptoms including anger and violence (toward self or others)
repeated, prolonged outbreaks of anger
uncontrollable outbreaks of anger
extreme hostility toward self or others
prone to rage
history of violence

prone to hurting self or others
may harm self
may be self abusive

severe mood swings
panics in situations that wouldn't bother a normal person

uncontrollable emotional collapse

Cognitive symptoms
history of problems in making choices
cannot make decisions
changes his mind in the matter at hand
does not fully understand things explained to him/her
confused a lot
disoriented
unable to concentrate on one thought

Impaired insight
unaware of mental imbalance

Miscellaneous
"flashbacks:" memory of previous trauma can reoccur at various times
memory of previous trauma can merge current events with the past

X. MENTAL HEALTH CARE OR EVALUATION; REMEDIABILITY; ABILITY TO FUNCTION IN SOCIETY
Includes all features that reference the prototype's history of or need for evaluation, medication, counseling, supervised living, or incarceration. This includes the prototype's
ability to function in society. It also includes features regarding whether or not his/her mental illness can be successfully treated successfully and/or whether he/she has sought treatment.

**Exclusions:**
(1) history of mental illness or symptomatology, which are coded under diagnostic labels or symptomatology, respectively;
(2) violence to self or others, which is classified under "symptomatology";
(3) self care, which is classified under "appearance"; and,
(4) family and social support, which is classified under "social support."

**Examples:**

**Medication or hospitalization**
- on medication
- not stabilized on medication
- often hospitalized for mental problems

**Clinical evaluation**
- diagnosed
- clinically certified to be mentally ill
- clinically diagnosed by a professional
- mental illness must be well documented

**Remediability**
- cannot be rehabilitated
- has taken all reasonable efforts to treat their illness
- mental problem cannot be controlled with counseling or drugs
- mental illness must not have the ability to self-correct

**Ability to function/need for supervision**
- requires constant supervision or hospitalization
- needs help at all times, even when making minor decisions
- unable to live in normal society
- unable to be social or function in a social setting
- may perform in society as completely normal

**XI. CRIMINAL HISTORY AND OTHER BAD BEHAVIOR**
Includes all characteristics or qualities that refer to the prototype's criminal history and other negative behaviors which are not necessarily criminal (e.g. problems in school).

**Examples:**

**Specific Crime**
- drug dealer
arrested for loitering

**History of Crime**

*has no record*

*in and out of jail*

*revolving door*

**Other Bad Behavior**

*brutal to animals*

*inflicts harm on surrounding people*

*constantly in trouble*

**XII. SUBSTANCE USE/ABUSE**

Includes all characteristics or qualities that refer to the prototypes history or substance use or abuse.

**Exclusion:** Specific crimes involving drugs, which are coded under criminal history (e.g. drug dealer, or arrested for possession of heroin)

**Examples:**

*alcoholic*

*addicted to crack*

*history of substance abuse*

**XIII. PO-PROBATIONER REALTIONS**

Includes all characteristics or qualities that refer to the prototypes specific involvement with probation or the probation officer explicitly. Also includes all features that describe the participant’s thoughts or feelings elicited by the prototype.

**MISCELLANEOUS**

If a feature cannot be classified in any of the other categories, include it here. Please use this category sparingly--it should contain mostly idiosyncratic responses.

**Examples:**

*childhood problems*

*had problems during adolescence*
VITA

Graduate College
University of Nevada, Las Vegas

Paula M Emke-Francis

Local Address:
8408 Starstruck Ave
Las Vegas, NV 89143

Degrees:
Bachelor of Arts, Psychology & Criminal Justice, 2002
University of Nevada, Las Vegas

Special Honors and Awards:
2005 Awarded the University of Nevada, Las Vegas Summer Scholarship ($2000.00)

Publications:


Thesis Title: Probation Officer Prototypes: Perceptions of probationers with and without mental illness

Thesis Examination Committee:
Chairperson, Dr. Douglas Ferraro, Ph. D.
Committee Member, Dr. Kim Barchard, Ph. D.
Committee Member, Dr. Karen Kemtes, Ph. D.
Graduate Faculty Representative, Dr. Joel Lieberman, Ph. D.