Chapter

Prevention of Deviant Pathways and Rehabilitation from Criminal Activities: Social School by "O Companheiro" Providing an Alternative to the Prison System

José de Almeida Brites, Américo Baptista, Catarina Abrantes and Vanda Franco Simão

Abstract

The association "O Companheiro" is a Portuguese social solidarity institution which intends to provide an integrated response for the needs of inmates, ex-inmates, and their families. The Social School was established as part of the "O Companheiro," providing one possible alternative to the prison system. The Social School has two main aims: the prevention of deviant pathways and the rehabilitation of those who have entered into criminal activities, promoting their successful integration. Several programs were designed according to a life span perspective, which focuses on the personal development from conception to old age. A core assumption of this perspective is that maturity and development are not completed at any specific moment but result from an ongoing adaptative continuous lifelong process.

Keywords: O Companheiro, social school, crime, rehabilitation, life span

1. Introduction: the structure of Social School programs

The sparse investment in the prison system, reflected in the few psychologists and specialists working between walls, threatens the rehabilitative and reeducational role of imprisonment. Furthermore, the conventional approaches to criminology and the justice system currently underway, focused mainly on the punishment of deviant behavior, have proven to be unsatisfactory because they are associated with high recidivism rates in criminal behavior. The intervention programs developed in the Portuguese prisons do not cover most of the individuals, adding the fact that they lack a scientific validated evaluation [1]. They usually follow a cognitive behavioral theoretical basis, and the main goal is the behavior control, but they are not responsive to offenders' individual skills and interests [2, 3].

An alternative to this view could be the one proposed by positive psychology [4] adapted by criminologists as positive criminology [5]. Whereas the conventional approaches target mainly the elimination of deviant behaviors, this new approach focuses mainly on the development of a new positive lifestyle. The positive

psychology focuses on the healthy and adaptive functioning of the human being and values positive psychological traits and experiences such as optimism, satisfaction, well-being, happiness, gratitude, hope, resilience, and empathy. Therefore, positive criminology is based on the perspective that integration and positive life influences that help individuals develop personally and socially will lead to a reduced risk of criminal behavior and better recovery of offenders [6]. An example of related work is done by the Good Lives Approach to the rehabilitation of sex offenders [7, 8].

This new perspective encompasses the Social School, which is a project developed in the facilities of our institution "O Companheiro" and in some prisons. Traditionally, our institution works with ex-prisoners or inmates in a post-reclusion phase, providing various facilities (men's residence, canteen, clothing bank, legal support, and psychological support), but since the Social School was created, our work is not limited to rehabilitation, having an important role in prevention as well. The programs developed by the Social School can be an alternative to effective detention. There are many cases of individuals to whom the court proposes to attend the Social School in a pre-sentential phase as an alternative to prison. Others are released from prison before the end of the sentence (e.g., probation) because they agree to attend Social School programs. Finally, the family, especially the descendants, can integrate the Social School to prevent them from initiating a deviant pathway.

Several programs were developed targeting children and adolescents, the adult population, and the elderly. Research was conducted to establish their efficiency. The following programs were (and are) implemented, encompassing the life cycle; for children and adolescents—enjoying study, learning with sports, dating and the sexual life, and a reward program assisted by animals; for the adult population—positive parenting, anger management, learning with sports, life without drugs, pleasant and healthier marital and sexual life, and a reward program assisted by animals; and for the elderly—the well-being and happiness program.

All the programs have a similar structure composed by a specific part, unique in each program, and a general part common to all programs. In the specific part, the skills taught are those that have been assessed as deficient in each age group. For instance, children with poor learning skills or school problems are referred to the enjoying study program, adolescents charged for downloading child pornography or sexual abuse are referred to the program dating and the sexual life. Adults are referred to the positive parenting program if they report difficulties dealing with their child's behavior or if they are charged for some form of child abuse. Finally, the elderly population is referred to the well-being and happiness program to improve both their cognitive functioning and their quality of life.

The general part has four modules: emotional literacy, empathy training, virtue and strength development, and promotion of well-being and happiness. In the emotional literacy module, clients are trained on how to accurately identify and understand the functions of their expressions, as well as having them regulated. Emotions are portrayed as psychological resources that are predominantly processed automatically generating varied behaviors and decisions [9]. In the emotional literacy component, the experience of the awareness of six basic emotions, happiness, surprise, anger, disgust, fear, and sadness is addressed [10]. The same procedure is applied for raising awareness of 10 positive emotions, joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe, and love [11]. The second component, the teaching or the awareness of empathy will be described later on in this chapter. The third component involves the knowledge and the new application of character strengths and virtues. These are organized in six classes of core virtues and twenty-four-character strengths [12]. The fourth module is related

to the promotion of well-being and happiness, namely changes in focus of attention from the negative to positive events and the promotion of pro-social activities [13]. This part, common to all programs, reflects our approach on both prevention and rehabilitation. It has two simultaneous aims: decreasing the risk factors for deviant pathways and eliminating the negative characteristics. Also, it aims to develop or improve the qualities that will be helpful regarding a successful return into society.

Our program of interventions is influenced by the developments on positive psychology [4], positive clinical psychology [14], and positive criminology [5, 6]. A Positive psychology approach is taken because the "O Companheiro" association assumes that a person with a happy and meaningful life has a decreased need to resort to a deviant pathway or crime. Positive clinical psychology since our interventions aim to reduce a person's distress and the negative characteristics which led him/her to a deviant pathway. At the same time, they promote the well-being and a meaningful life. Finally, the interventions are used to assist both the prevention of entering deviant pathways and the rehabilitation and integration in society of individuals who have previously adopted deviant behaviors, as it is underlined by positive criminology.

In this sense, a person is not looked at as an individual who has a set of problems that need to be fixed and a set of risks that need to be managed, but as having qualities, strengths, or potentials yet to be developed.

2. Empathy across the life span

In our programs, empathy training follows the emotional literacy. Empathy is conceptualized as having three components: motor, cognitive, and emotional. Adequate empathy skills in children are related to social competence and popularity amongst peers [15]. Empathy deficit disorder in children is considered a risk for committing crimes [16], and children and adolescents with psychopathic traits and conduct problems showed reduced affective responses to inflicting pain in others [17].

Early manifestations of empathy were observed in infants from 8 to 16 months in response to maternal and peer distress [18]. The more children become proficient and sophisticated, with the significant help of others and contextual factors, in understanding the emotions, desires, and intentions of each one, the better they can achieve their goals and improve proper social interactions with peers and adults.

Pro-social and empathic tendencies emerge in childhood and continue to develop through adolescence. From 12 to 18 years, their presence was associated with a pro-social attitude and inversely, their absence was related to antisocial behaviors [19]. In a 23-year follow-up study, empathy assessed in adolescence, between 12 and 16 years, and when the participants were adults at 35 years, was a predictor of empathy, communication skills, social integration, relationship satisfaction, and conflicts in relationships [20]. A generalized lack of empathy is characteristic of adolescents who fulfill the category of conduct disorder with a specifier of limited pro-social emotions [21].

In adults, an adequate or high empathy facilitates social behavior, establishes priorities in social interactions, and underlies various forms of helping others or pro-social behavior. Also, it constitutes a motivation to care for the well-being of others [22]. The absence of empathy or low empathy is related to aggression tendencies and the capacity to ignore or inflict suffering on others [23–25]. Empathic adults playing economic games showed more pro-social behaviors, higher levels of cooperation, and more generosity towards their opponents and were able to treat them more fairly [26, 27]. Incarcerated individuals with high levels of psychopathy showed a stronger affective response when imagining inflicting pain in themselves,

but a smaller response when they imagined inflicting pain on others [28]. Lack of empathy is associated with narcissistic personality disorder [29] and antisocial personality disorder [30].

Empathy continuously changes through the adult years. In the elderly, empathy seems to improve, even though the nature of these changes is a matter of research. In the elderly, decreases in cognitive empathy were found whereas affective empathy increased. The age changes in affective empathy were related with the emotional valence of the stimuli used. Older participants showed more empathic concern and less personal distress in situations that presented negative emotions, whereas for situations that presented positive emotions, older participants demonstrated more empathic concern and personal distress [31]. This dissociation between cognitive aspects of others' understanding and affective aspects, in which the first showed a decrease and the second presents no change or increases with age, is confirmed in other independent studies [32, 33]; the following are some conflicting results [34, 35].

2.1 Empathy training

The empathy training in our programs is based on the three components of empathy [23, 25], the empathy model developed by Marshall et al. [36] and Marshall and Marshall [37] and the life span perspective applied to empathy [34].

Empathy encompasses a variety of processes that can be considered to be part of three categories: motor, cognitive, and emotional. Motor empathy is described by Hatfield et al. [38] as a primitive emotional contagion or perception-action. The model of empathy advanced by Preston and De Waal [39] projects the tendency to mimic or synchronize the vocalizations, the facial expressions, the postures, and movements with another person. An observer automatically imitates the facial, postural, or vocal expressions of another person. This observation activates the observer's somatic, autonomic, and motor responses, which rely on the discovery of mirror neurons, which show the same activity during the execution and the observation of an action. Rizzolatti et al. [40] demonstrated that the same neurons were activated when a monkey grasped food or when they watched an experimenter grasp food.

In a simple way, the perception of another individual's actions automatically activates similar somatic, autonomic, or motor responses in an attentive observer. Perception and action share some underlying mechanisms of representation, and the perceptual information automatically prepares for action without the need for any intervening cognitive processes. For example, if someone displays a body posture or a facial expression indicating pain, suffering, sadness, anger, or joy, the nervous structures in an observer's brain that represents these movements or postures are automatically activated, and a corresponding part of the behavior is involuntarily emitted, an overt response. This frequently happens in spectators of movie theaters or in sports arenas. For instance, videos were shown resulting in people imitating what they saw, even though they were unaware of it, for example, videos showing people laughing, which automatically induced the observers to laugh. One of the main purposes of this first step is to make people aware of this process.

Cognitive empathy is the second component of empathy training. It encompasses the capacity to take others' perspectives, allowing one to make inferences about their mental or emotional states and understanding their viewpoints or the internal states. It concedes too, the ability to imagine others' thoughts and feelings without confusing each self. Additionally, it includes also the capacity to consciously understand others' thoughts, intentions, emotions, and beliefs and predict their behavior. This is known as the theory of the mind [23, 25, 41]. These capacities allow us to adopt another person's point of view, enabling the possibility of making inferences regarding their cognitive mental states as well as affective states. Such

capacities are improved during cognitive development [42], and they involve higher cognitive functions that allow perspective taking, self-regulation, and mind perception [43, 44].

Empathy's final training component is focused on emotional empathy, the capacity to have feelings that reflect what others feel and the ability to share the emotional experiences of another person. We feel joy when our friends succeed; our own emotions are affected by the emotions of others. Consider, for instance, your emotional reaction during a horror or thrilling movie. The person's feelings evoked by the feelings of another person are considered the essence of empathy [45].

Emotional empathy has at least two components: the affective sharing, which reflects the capacity to share or become affectively activated by the emotional states of other persons, and the empathic concern, which reflects the motivation to care for another's welfare. Affective empathy was found to be the main predictor of altruistic behavior in an experimental game, the dictator game [46].

The empathy training for each of these three components follows the four steps described by Marshall et al. [36] and Marshall and Marshall [37], both for positive and negative events. Several scenarios were used, with the help of videos and written descriptions. The first scenario is to recognize others' cognitive or emotional state. The second is to be able to see things from another's perspective. The third is to be aware of his/her behavior, thoughts, and emotions, in the case of positive events of his/her joy and in the case of negative events of his/her distress and compassion. Finally, the fourth is taking steps to share the joy of success in positive events, and ameliorating others' distress and suffering, in the case of negative events.

2.2 Results of the Social School programs

Thirty-five children and adolescents, mean age 12.29 (SD = 2.79), 76 adults, mean age 36.42 (SD = 10.46), and 6 elderly, mean age 65.00 (SD = 3.09), were included in our programs. The dropout rate or program noncompleters were 22.9%, N = 8, for children and adolescents, 22.4%, N = 17, for adults, and 50%, N = 3, for the elderly.

For those who completed the program, the results were assessed by their therapists according to the following criteria: first, those who have worsened their status during the program; second, those who presented no changes; third, those who improved slightly; fourth, those who improved moderately; fifth, those who improved a lot; and finally, those who attained an excellent status and exceeded the expectations for improvement. For children and adolescent programs N = 1, 2.9% was classified as having deteriorated, N = 2, 5.7% as having no changes during the program, N = 10, 28.6% as improving slightly, N = 12, 34.3% as improving moderately, and N = 2, 5.7% as improving a lot. For adults who entered the programs N = 1, 1.3% were assessed as having deteriorated, N = 10, 13.2% presented no changes, N = 17, 22.4% improved slightly, N = 27, 35.5% improved moderately,

	Children and adolescents (%)	**Adults (%)**	**Elderly (%)**
Deterioration during the program	2.9	1.3	33.3
No changes during the program	5.7	13.2	—
Improved slightly	28.6	22.4	33.3
Improved moderately	34.3	35.5	33.3
Improved a lot	5.7	5.3	—

Table 1.
Program results.

and N = 4, 5.3% improved a lot. For the elderly we have finished one group with 3 participants classified as having deteriorated, N = 1, as improving slightly, N = 1, and as improving moderately, N = 1 (**Table 1**).

3. Conclusions

With exception of the elderly, in which we have only the results of one small group, the results showed that our interventions are effective for children, adolescents and adults. The ending status of the participants is attributed to the effects of the whole program, in which the module for empathy training is only one component. It is important, though, to reflect about the significative number of dropouts. We believe that one possible reason might be the fact that many participants are volunteers without court injunctions and free to leave the programs without any legal consequences. This is even more salient with the elderly population, some of them with mobility constraints that prevented them from continuing to go to the institution.

Due to the nature of our social solidarity institution and for ethical reasons, a control group was not included. A better understanding of our programs, set to improve efficacy and the nature of our results, could be obtained by comparing other participants in different institutions using our programs. Furthermore, the efficacy assessment of the several components of our programs (the specific part and the general part composed by the emotional literacy, the empathy, the strengths and virtues and the well-being and happiness) should be conducted.

In relation to the empathy training, improvements in empathy should not be considered equivalent to improvements in morality or pro-social behavior [47], especially in people who portrayed antisocial behaviors. Our results showed improvements in trained skills, but our goal is to prevent entry into deviant pathways and/or reduce criminal behavior recidivism rates. Larger samples and extended follow-up periods are needed in order to answer these fundamental questions.

Acknowledgements

We have written this chapter hoping that more specialists will be able to recognize our approach as a good alternative to the punitive system implemented in the Portuguese prisons. The Social School is a result of 31 years of working with inmates, ex-mates, and their families. Our first acknowledgment is to them and a very special acknowledgment to the colleagues of "O Companheiro" and all the participants who were so supportive and cooperative. Their graciousness, enthusiasm, and competence truly overwhelmed us.

Conflict of interest

The authors declare no conflicts of interest with respect to the authorship and/or publication of this chapter.

DOI: http://dx.doi.org/10.5772/intechopen.82163

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