The Institutional Treatment of Delinquents

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THIS ARTICLE BEGAN as a review of a book entitled *Reality Therapy: A New Approach to Psychiatry* by William Glasser, M.D. (published by Harper & Row, New York, $3.95) but has, it seems to me, become something more than that. Many readers of the PRISON SERVICE JOURNAL may wonder why they should concern themselves about psychiatry, and I urge them, if they have such feelings, not to be put off by the title. Nor should they anticipate that the book is laden with psychiatric jargon, because it is not. Although Dr. Glasser is concerned with the treatment of psychiatric patients, our interest is claimed because this book is also about the institutional treatment of delinquents. The reasons for these activities coming under the same heading of psychiatry in an American book will, I hope, become clear.

Mentioning the title of the book to a member of our Service provoked the instant retort that it involved a contradiction in terms. In part, of course, his reaction was meant to be facetious, he is one of the Service's cynical wits and may well be missing a fortune as a superior Celtic comic, but there is a great deal in what he says and which reflects Service thinking. His experience with institutional treatment of delinquents has brought him into contact with many of the grosser difficulties involved in the attempt to produce more acceptable attitudes in personalities which any society will have difficulty in absorbing, even supposing they had no criminal tendencies. No doubt he has seen the delinquent approached from all angles of the therapeutic compass, from simple but rigorous, institutional discipline, on the one hand, to the ultimate permissiveness of the Freudian psychiatrist on the other hand. My Celtic colleague is confused in this situation, I believe that I am also confused and I suspect that the whole of the Prison Department, not to mention the Home Office and society in general, is equally confused. Perhaps we could spare

a passing thought for the state of the delinquent, who can only be either blinking in bewilderment at the receiving end of whatever this confusion produces, or happily (and more healthily) standing aside and allowing us to get on with it. In either case, there is a reasonable assumption that, in general, the people who most need our help, from either their own or society's point of view, will not get it.

It is, surely, about time that we engaged ourselves in a debate intended to reach agreement on the answers to some fundamental questions. The questions which seem to be most urgent are these connected with the characteristics and motives of delinquents (adolescent or adult) and those connected with the aims and methods of our treatments.

The Personalities of Institutionalised Criminals

There are many arguments in which we are still involved which have their origin in the contrast between sinful and virtuous behaviour and the absolute standards of behaviour which can be derived from these contrasts. It is doubtful whether these absolute standards have ever been completely adhered to. Sinful behaviour can often be justified, in personal terms or more generally, however specious or genuine the justification may be. Similarly, virtuous behaviour can be reduced in value, the saint is made that way and the rich man is rarely tempted to steal bread. Perhaps the most significant departure from absolute standards has occurred following the increase of knowledge of human personality which has flowed from psychological investigation and experiment during the past 70 or more years. Crudely speaking, there has been an increasing tendency to clarify as "mad", those who in former times might simply have been thought to be "bad".

But not, of course, completely mad. No one here has argued for a long time that there is no distinction to be drawn between the average criminal and the average patient of the chronic ward of the mental hospital. And the stigma attached to mental illness is rather different from that attached to the prisoner or ex-prisoner. Would our problems be fewer in number, more susceptible to identification and some formal resolution, if the opposite had been true? In that case we might have handed over our work to the psychiatrists who, no doubt, would have tested out their traditional solutions of a pill, an electric shock, a rollicking or an involvement in a therapeutic process, according to which school of psychiatry claimed their allegiance. To a certain extent this hand-over seems to have happened in America where, as far as a British layman can judge, the emphasis in psychiatry is heavily placed on the psychoanalytic approach to most problems of deviant behaviour, whether criminal or otherwise.

Consequently, a British reader of this book must bear in mind that it is written against a background which is foreign to us. As indeed, are the various articles by other American psychiatrists on the same topic, such as those by Melitta Schmideberg, one of which appears in this issue of the PRISON SERVICE JOURNAL.

To be able to look at someone else's controversy about a problem with which we are thoroughly familiar ought to provide us with opportunities to examine our own position. Perhaps such an examination would help us to make up our minds about what we really think of the characteristics and motives of our charges. Do we, or do we not, accept a straightforward, black or white, division between sin and virtue? Do we, or do we not, believe that the average criminal can be usefully described as "mad", or "bad", or do we think that he comes somewhere in between the two?

If we ask the questions in terms of why people commit crimes rather than ask questions about motives, the answers are likely to amount to a collection of factors which probably contributed to the onset and establishment of delinquency. The tendency is for this to be a hotchpotch of historical factors which can range from the statistically significant to the generally accepted fantasy. For example, from the influence of the urban environment to the supposed necessary connection between divorce and delinquency in the children of divorced parents. One of the connecting threads between these factors is that they are all in the past of the offender and, therefore, irreversible. The problem facing those who wish to attempt treatment of the delinquent condition is largely centred round this, but the confusion of the problem may well arise because we are unable to distinguish the historical conditions such as these from current motivation. There is an apparent contradiction involved in the attempt to juxtapose statements like:

(a) X is delinquent now because of the effect which certain (specified?) environmental pressures have had on him. This suggests helplessness and inevitability rather than positive motivation.

(b) X committed this particular crime for a particular reason (perhaps avarice, wickedness or lust). This suggests positive motivation which can be controlled by the criminal.

Our approach to X and our attitude towards him is likely to be substantially determined by whichever of these viewpoints we adopt and, of course, if our adoption is a consistent one. But since both of these alternatives is likely to have elements which appeal to us at different times our approach may not be consistent. Furthermore we

must regularly face the irreversibility of the factors in (a) and the ineffectiveness of simple reactions to (b) such as punishment, intellectual argument or advice.

Institutional Treatment

Because of our persistent failure to deal satisfactorily with recidivists we have long been forced to accept that there is nothing in simple imprisonment which will necessarily bring about changes in criminals towards more acceptable behaviour. This is not to say, that society at large does not derive some satisfactions from the knowledge that criminals are punished for their crimes. But we are committed to the provision of custodial treatment and this implies much more than punishment. For 70 years the basis of treatment has been influencing the criminal away from his former pattern of behaviour and the system has concerned itself with discovering the means of exercising such influence. Increasingly, the importance of relationships, as the means through which influence can be focussed, has been emphasised and after many false starts it is probably accepted now that there can be no grade of staff which can specialize in treatment. All staff are involved in treatment and to the extent that this is not true attempts at treatment may be ineffective.

The need to establish good relationships with individual inmates is inevitably obstructed by the need to maintain authority in the institutional situation. Other social agencies dealing with respectable citizens and their problems do not have the authority difficulty in such an acute form and can evade the issue in many ways not open to us. We have tended to try to use treatment techniques developed in these other spheres and to adapt them to our circumstances. Casework, for instance, is described in general social work as a problem-solving process for those in social distress. Certainly the inmates of prisons, etc. have no shortage of problems and are often in considerable social distress. Therefore, if casework is useful in the one situation it ought to be useful in the other. But casework, and also group counselling, are said to necessitate a certain set of attitudes on the part of the practitioner which are loosely described as permissive and these are often felt to be incompatible with the authority inherent in the whole notion of imprisonment. Both techniques also seem to depend on the development of the self awareness of the inmate as to his real motives for criminal behaviour, the assumption being, presumably, that awareness of deeper motives will set a criminal free from the need to act out former conflicts symbolically in current behaviour. This approach is linked with Freudian concepts about human psychology and the methods which can be used to alter individual personality where it is deemed to be necessary.

It is a feature of such treatment

that it can only begin when the patient (or the caseworker's client) wants it to do so. When he has no motive to change there will be no effective treatment, because he will not make a genuine effort to search within as in (a) above (for the deeper reasons for his criminal behaviour). On the other hand when he has the motive to change the layman will want to say that he can do so, that is, that he is not compelled to behave criminally. In other words, his motives are not linked to the past but to the particular criminal act (as in (b) above).

A growing body of opinion is prepared to assert that there is no similarity between those who are susceptible to treatment of the insight-developing kind, i.e. the neurotic who needs deep therapy, and those whose acts, criminal or not, can be described as impulsive and linked with present situations. The full differentiation between these two groups means that the impulsive behaviour problem is not even developed as a human being sufficiently to be a neurotic, but is suffering from what is termed a character disorder.

In prisons, and residential penal establishments generally, are the inmates neurotic or suffering from character disorders? The answer we give to this question should, if the latest theoretical developments are correct, determine our approach to treatment. Are we to go on floundering, some of us attempting a technique based on Freudian assumptions about criminal character and treatment, some of us resisting this for one reason or another but not proposing any alternative? Those who attempt the Freudian techniques inevitably face problems about their own authority and also the inmate's lack of desire to change. Those who attempt nothing but the transmission of *ad hoc* advice find that this is a futile process and not helped in any way by having simple power to enforce sanctions.

Reality Therapy

Dr. Glasser appears to have become dissatisfied with the American methods of psychiatric treatment almost before he had completed his training. Readers in this country should be careful not to assume that what is American psychiatric good practice is accepted here. The opposite is more probably true and psycho-analytic methods in wide use in America are only used here by a minority of psychiatrists. In his reaction away from these methods he has developed not a variation but something totally different. He makes this quite clear by setting down what he considers to be the six essential convictions upon which the treatments of classical American psychiatry are based, as follows:

1. Mental illness exists, can be classified and treatment can be provided according to the classification.
2. Essential treatment is the investigation of past life,

i.e., searching for the psychological roots of a patient's problems. The idea is that the patient's understanding of these roots will enable him to change attitudes and develop more effective patterns of living.

3. Part of the process of understanding entails the transference by the patient to the psychiatrist of attitudes which were developed in relation to people in the patient's past life who were important. This leads to interpretations by the psychiatrist which will increase the patient's insight.
4. Unconscious mental conflicts are considered more important than conscious problems, and awareness of these is essential for successful treatment.
5. Morality is irrelevant in the treatment process and the conventional psychiatrist avoids any pronouncement on right or wrong behaviour. This follows from the assertion that mental illness produces deviant behaviour.
6. Teaching people to behave better is not important, better behaviour follows from understanding historical and unconscious sources.

"Using these six essential convictions as a basis for both pychiatric theory and practice, conventional psychiatry may appear in many forms from simple counselling through non-directive therapy to orthodox psychoanalysis, but in every situation almost everyone who does therapy in the United States and Canada would concur with these six criteria. Although some people might place more emphasis upon one than another usually they stand unchallenged." (*Reality Therapy*, page 43.)

One may underline two relevant facts here. Although these basic facts may seem to be concerned with the treatment of mentally sick people, the psychoanalyst's definition of mental illness is so broad as to include anyone who behaves in a manner which deviates from the normal, and this includes criminals. Although Dr. Glasser is primarily talking about trained psychiatrists he is also asserting that what he says applies equally well to any way of treating deviance which is derived from psychoanalytic knowledge, that is, it includes caseworkers and group counsellors.

The purpose of stating these basic conditions of classical American psychiatry is to reject them completely and in detail, in theory and in practice. The book is an account of the treatment of psychotic soldiers in a military chronic mental hospital, delinquent older girls in a large correctional establishment, preventive treatment in an ordinary school, and private practice treatment of what would usually be called neurotic

patients, on principles which can be formed when the six essentials listed above are rejected.

People must be regarded, says Dr. Glasser, as either responsible or irresponsible, and the concept of responsibility is defined as "the ability to fulfil one's needs and to do so in a way that does not deprive others of the ability to fulfil their needs". Psychiatry is concerned with two basic psychological needs (there are other needs), namely, the need to love and be loved and the need to feel that we are worthwhile to ourselves and to others. In the normal way the ability to meet these needs is acquired through involvement at an early age with important people like loving parents, but there are situations in which this does not happen or, if it does, development or alteration in life may make the learning inadequate, and further learning may be necessary. In any case, this can only take place through involvement with people who are themselves firmly in touch with reality. At any time when problems arise which can be termed psychiatric or psychological it is to be assumed that part of the problem is a lack of involvement and the consequent inability to satisfy psychological needs.

Involvement

Involvement is essential to reality therapy but Dr. Glasser clearly is thinking in different terms to others who use the same word. He means something much closer to ordinary involvement, which does not set out to be uncritical and entirely accepting on the one hand, or reserved and professionally remote on the other hand. Reality, as he sees it, demands something different and, he would say, more genuine.

"The ability of the therapist to get involved is the major skill of doing reality therapy, but it is most difficult to describe. How does one put into words the building of a strong emotional relationship quickly between two relative strangers? And when the patient does not want to be in therapy—as often occurs with delinquents—or does not even know that he is in therapy—as sometimes occurs with severely withdrawn patients in a mental hospital—the task is particularly difficult.

"One way to attempt an understanding of how involvement occurs is to describe the qualities necessary to the therapist. The more a person has these qualities, the better able he will be to use the principles of reality therapy to develop the proper involvement.

"The therapist must be a very responsible person—tough, interested, human and sensitive. He must be able to fulfil his own needs and he must be willing to discuss some of his own struggles so that the patient can see that acting responsibly is possible though sometimes difficult. Neither aloof, superior nor sacrosanct, he must never imply that what he does, what he stands for, or what he values is unimportant. He must

have the strength to become involved, to have his values tested by the patient and to withstand intense criticism by the person he is trying to help. Every fault and defect may be picked apart by the patient. Willing to admit that, like the patient, he is far from perfect, the therapist, must, nevertheless, show that a person can act responsibly even if it takes great effort.

"The therapist must always be strong, never expedient. He must withstand the patient's requests for sympathy, for an excess of sedatives, for justification of his actions no matter how the patient pleads or threatens. Never condoning an irresponsible action on the patient's part, he must be willing to watch the patient suffer if that helps him towards responsibility. Therefore, to practise reality therapy takes strength, not only the strength of a therapist to lead a responsible life himself, but also the added strength to stand up steadily to patients who wish him to accede to their irresponsibility and to continue to point out reality to them no matter how hard they struggle against it."

This, it seems to me, is a relationship of a different category to any which follows from the current tenets of psychoanalysis, whether applied in full by a trained psychoanalyst or in part by a caseworker or group counsellor. As indicated here, it is likely to be much more demanding on the worker since he is compelled to contribute himself as a real person with the ability to fulfil his own needs in a realistic way. He is at once a challenge, particularly to the delinquent, to be tested by attack, and an example of responsible behaviour.

The Teaching of Responsibility

In the normal situation children learn what responsibility is through the care of their parents. They do not learn easily and part of the process is the testing out of the reality of their parents' care by irresponsibility. This should attract discipline, which is, therefore the expression of parents' care just as much as more pleasing demonstrations of love may be. The child needs responsible parents who will undertake this and parents must realise that taking responsible action will never permanently alienate the child. Stated like this, Dr. Glasser's views may seem incontrovertible and, indeed, it is probably only in extreme cases that the apparent opposite has ever been attempted, either from theoretical conviction or parental inadequacy.

Perhaps it can be said, however, that even in this country we are apparently changing towards children and, what may be more important to us, have already given up the idea that more adult people can be dealt with in a similar way. In the latter case it often seems that we are in the position either of providing the discipline without the purposeful involvement, or we become involved and cease to see a function for a discipline, thus, in

Dr. Glasser's terms, stamping the involvement as unrealistic. From our point of view the chapter on the treatment of delinquent girls in the Ventura school has particular interest, because Dr. Glasser's claim is that treatment in residential conditions is more effectively carried out than in the outside environment. Again, one should note that this is the opposite of what is usually believed about institutions.

When I first read this chapter, my immediate reaction was that this might very well be a sort of rationalisation that one could produce very easily when working in an institution geared to deal with indeterminate sentences. In these circumstances, it is all too easy to talk about qualifying by responsible behaviour for advancement in grade, etc., but meaning very little more than keeping a clean bed space and a civil tongue. I hope Ventura is different and that when planning and programming is talked about it is with recognition of the fullest implication.

"The school programme consists of three main parts:

1. The custody programme is administered by warm and skilful counsellors who use the principles of reality therapy. The girl's knowledge that she is in an institution from which she cannot escape is basic to the programme. With the guidance of the staff, she is forced to take responsibility for her behaviour in a total situation where responsibility is continually stressed.
2. The treatment programme is administered by a group of competent psychologists, social workers, and a consulting psychiatrist. The treatment personnel not only work with the girls directly, but they continually work with the custody staff to help them treat the girls according to the principles of reality therapy.
3. The school programme consists of both academic and vocational courses taught by qualified teachers. All girls have a full daily schedule taking either an academic or a vocational course, or sometimes both. Those who enter the Ventura school with sufficient credits and stay long enough and complete enough work to graduate receive a regular graduation certificate which does not indicate that it comes from a correctional institution."

Each part of the programme is as important as any other and each inmate goes through the whole process, e.g. no one is given a special psychiatric treatment programme. Students are held fully responsible for their behaviour no matter what their state of psychiatric health may have been said to be in the past, and exclusion from

the treatment means that no progress is made towards release. Unlike in our own methods, exclusion means total exclusion, living separately, though not necessarily alone, and not having an entirely easy return to processes of treatment.

Standards are high because, as Dr. Glasser puts it: "We have discovered that unless we have high standards, the students conclude that we are 'phony' and don't really care for them".

An initial success rate of 80 per cent is claimed in the treatment of these girls who are described as very sophisticated in their own mileau and poorly motivated for change towards a more responsible life. Many have had psychotherapy as a condition of probation; all have been in juvenile halls, some for many months. Profiting little from this treatment, they have continued to break the law. Finally sent to the Ventura school, the last stop before adult prison, they are confined, in most cases, for six to eight months for rehabilitation.

What is the Treatment?

Both individual and group methods are used, although Dr. Glasser has an obvious preference for group methods for reasons which he gives. In both cases the emphasis is on present behaviour and responsibility. A further indication of how far Dr. Glasser has parted from the psychoanalyst is his insistence that dwelling on the past of patients is useless. Finding the psychological root of present behaviour, he would say, does nothing to control the behaviour and it is this with which we are concerned. The psychiatrist or counsellor spends no time on this but insists on examining current realities and future possibilities. The adult person who attempts to achieve his basic psychological ends by bad behaviour has become involved in a self-defeating process since respect and love are given to those whose behaviour attracts it. This they need to learn immediately and to be able eventually to be similarly successful in the future. Incentives, rewards, punishments (however disguised) and restrictions come into this learning process and all is focussed through the relationships in which staff are involved. There is no easy way out for staff here, because to provide less than is necessary in any sphere is to nullify the treatment. One part of the staff cannot see itself as concerned with treatment and leaving the custody to others, or vice versa. We would have a very long way to go before we could claim to have devised anything resembling the Ventura system, if it is as described, and in many areas we have not yet begun.

This book ought to be read by everyone concerned with the custodial treatment of delinquents and it has the distinct advantage of being quite easily readable. It will satisfy no one who wishes to become better acquainted with the causes of delinquency, because it

does not make this attempt in any detail. For those who need this kind of justification, it seems to me that Dr. Glasser's method could be easily related to the theories being developed about character disorders and the use of authority rather than passivity in their treatment, but this would only be in the area of delinquency. What the reactions of psychiatrists may be to the denial of the basis of their expertise, i.e. by the assertion that patients are not mentally ill but merely irresponsible, is more than I can say. But here also Dr. Glasser's claims to have successfully treated so many patients, formerly classified as chronic and untreatable, to the point where they could be successfully released from the closed wards of mental hospitals, are too formidable to be ignored.

Nor, of course, is this a book without faults, even if one recognises that it is a description of a treatment system rather than a comprehensive study of the personalities of criminals and psychotics. Dr. Glasser makes a point very strongly about the superiority of group treatment over individual treatment, but his case histories are presented in a way which reverses this emphasis. His treatment programme for Ventura clearly depends upon the full participation of all staff in custody, treatment and education, but for our purposes there is too little detail about the achievement of this advanced co-operation. To say that the treatment staff work with custody staff to enable this to come about will not satisfy us. Perhaps, now that the claims for the primary aim of the treatment have been made, we can look forward to further enlightenment on staff training at all levels. In the last analysis, this sort of development of his theme will prove to be the most important aspect of his new approach. As it stands, where the publication of this book leaves it, there is much in the system that can be dangerously misinterpreted. On the one hand, the caseworker or group counsellor who has long feared that he is more authoritarian in his relationships than he ought to be, may find comfort and self justification without accepting the responsibilities of working for the wider participation by others in his work. On the other hand, those who unwillingly accept their department's primary task of treatment may equate "reality" with discipline and regimentation without making any move towards personal involvement. Notwithstanding these criticisms and dangers, I repeat my recommendation that the book should be widely read by all ranks and grades in this Service. If we have the intelligence and the wish to do the work well, as I believe we have, we shall survive the dangers. The result may be that, even if we never wholly accept the method and its implications, we will benefit from the arguments which this book ought to raise.