# Permissiveness: Good, Bad, or Indifferent

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PERMISSIVENESS is part of the brand image of modern psychology. It is nevertheless a much abused term. Parents bringing up children, case-workers relating to clients and therapists leading group meetings are all urged to be permissive. But just what the word means is not clear.

One reads continually in the public Press criticism of what is felt to be the fruits of the "new psychology". Illegitimate babies, disobedient children, delinquent juveniles, and young adults with venereal disease and no standards —these phenomena (it is alleged) are being stimulated by dangerous people (like psychiatrists and psychologists) who have abandoned normal sanctions and safeguards. Society is not evolving naturally so much as being guided to its destruction by airy-fairy theorists. In penology their influence is even more malignant.

It is possible to examine these views more closely and use-fully in the microcosm of the therapeutic community where psy-chiatrist and psychologists hold sway. A psychiatric hospital run as a therapeutic community employs consciously all staff and patients in the treatment programme, each person being involved according to his capacities and training. Permis-siveness is one of the main characteristics of the culture and yet, at the same time, some attempt is made to follow as closely as possible the ordinary realities of life. In such a setting, what does permissiveness mean and how does it work?

In the therapeutic community permissiveness implies the tolera-tion of deviant behaviour, a willingness to accept activities generally thought to be unaccep-table outside. This does not mean, however, that such behaviour is ignored. On the contrary, suppres-sion by decree is avoided to allow the behaviour to be examined. In this way, deviations and difficulties are exposed for investigation and discussion in the hope that causes will be uncovered and insight and control achieved.

Permissiveness encourages a sparing use of restrictions and

sanctions. These exist, but take their force from the agreement and expectation of the whole group. Patients are expected to accept responsibility for themselves and the group in which they live and work. Of course the responsibilities so given are modified according to circumstances. The doctor and nurse does not relinquish ultimate authority which remains to be invoked if and when necessary. But what a patient is capable of doing is expected of him. If he fails—if the principle of freedom with responsibility is abused, as it must be from time to time—the whole situation is examined by those concerned in the hope of learning and improving. Sometimes an individual's failure is recognized to be the group's failure. Permissiveness and democratic organization go hand in hand.

The full application of this principle calls for skill and experience. If permissiveness is mistakenly equated with indifference or lack of leadership then a group, a ward, a hospital, or a family can drift on a sea of missed opportunities. It has been said that consumer participation is no guarantee of consumer satisfaction. The co-operative store, for example, is not noticeably more efficient than the capitalistic supermarket. Presumably, however, it could be if it learned its lessons.

The value of permissiveness was shown by psychoanalysis. But the psychoanalyst chooses with care the sort of patient he treats and the setting in which he treats him. The situation may be very different in a psychiatric hospital and even more in a penal establishment. Nevertheless, the model has been taken over and modified for use in the therapeutic community. Patients are encouraged to communicate their thoughts and feelings. Group meetings occur, in some cases daily, in order that patients can express themselves and examine their day-to-day living problems. The role of the therapist who acts as leader of the group is important. He allows individuals in the group to be themselves, to say what they have to say in their own way and in their own time, speaks himself only when it is constructive to do so, avoids sermonizing, is tolerant, kindly, neutral and yet positive, teaching by example rather than by precept. In short his role is well-nigh impossible. The situation is a perpetual challenge to his capacity for permissiveness, raises his anxieties and tends to provoke the exercise of authority. It is well to remember that to treat people permissively is to invite behaviour designed to avoid responsibility and calculated to test limits. In practice permissiveness often fails in the face of such difficulties. It seems to me that too little has been said and written about these difficulties and the less welcome consequences of permissiveness.

That the novice can get confused is illustrated by the child psychologist who asked in all seriousness whether she was allowed to duck when an aggressive

and disturbed child aimed the water-hose at her in the playroom! Permissiveness of this sort is absurd or obviously self-defeating, as in Heller's novel, *Catch* 22, when Milo Minderbinder is encouraged to bomb his own airstrip. In the treatment of delinquent patients with character disorder, or criminals in prison, other factors may conflict with the principle of permissiveness and the therapist may have to adopt a frankly realistic and restrictive role at times.

The idea that a therapist should not use his authority coercively may also raise difficulties in administration. A permissive policy implies great flexibility in social organization and this in turn leads to inevitable dilemmas. In some cases to act permissively is to deny another principle which may be just as important. Which principle is sacrificed?

The more obvious examples of conflict of principles occur in the field of morals and ethics—mainly sexual. For example, two patients, male and female, both long-term, form a liaison with the risk of pregnancy. They ignore all pressures and advice and continue to meet. Sexual intimacy confessedly takes place. What do the staff do? Does the psychiatrist discharge one, or both, or provide contraception, or lock them up? It is clear that the psychiatrist may be involved in conflict over his duty to an individual patient and his own moral and ethical standards as well as those of the outside community. Or staff may disagree fundamentally among themselves or with the patient group. In such cases, reality factors (e.g. the need for the hospital to maintain its good reputation in the community) may set limits to permissiveness; and these are ignored at peril.

A hospital that bases its practice on permissiveness (along with other principles like democratization) exposes itself to criticism. There are always people eager to react to new or liberal ideas by pointing out their failures and weaknesses. Disagreement is not unhealthy if it leads to the development of opinion and practice that discards the exaggeration and excess of both sides. But new ideas and methods, like young children, need protecting in order that they may survive into healthy maturity.

What then are the lessons for those who are concerned with the custody, treatment and rehabilitation of delinquents and prisoners? How far can a permissive approach be adopted by prison officer, probation officer, or approved school headmaster?

There are no easy answers to such questions; and no one with first-hand experience of delinquents will hasten to give dogmatic advice. Much depends on the circumstances and the personalities of those involved. What is possible in a small approved school might be foolhardy in a large prison. It has been suggested that prison as we now know it must disappear before realistic treatment of the

criminal is possible. Merely to graft on to the traditional prison structure a treatment ideology that involves a permissive approach is to beg for disaster. And yet, without permissiveness, it seems unlikely that deviant behaviour can really be examined or treated constructively.

If one follows this argument to its logical conclusion, what emerges is the recognition that the social structure of an institution determines what kind of regime is possible. Even more, the social organization of a prison, borstal, or corrective institution constitutes in itself a method of treatment. What happens to the inmate day by day, in his work, in his leisure contacts, in his relationships with staff and other inmates—it is here that permissiveness begins. Is he allowed to reveal his problems in his behaviour or is he merely punished according to a fixed set of rules? A hierarchical, bureaucratic organization, built and run to contain and control, cannot be at the same time an effective machine for the treatment and rehabilitation of people with character disorders or those showing anti-social conduct.

One must begin from where one is. My own experience at Edinburgh Prison has revealed what is possible with very small resources but much good will and motivation on the part of the prison officers concerned. Therapy in penal institutions is very much the art of the practicable. Limitations set by lack of time, shortage of professional help and the creaking machinery of prison administration have to be accepted. This can be extremely frustrating; but the atmosphere is changing gradually and more understanding and commitment to rehabilitation is now apparent in the penal institutions in Scotland and, one believes, elsewhere in Britain. And yet a conceptual framework is lacking. Preoccupations with better living conditions, more satisfactory work situations, higher wages, religious instruction and so on, ignore the fact that making a penal establishment more humanitarian may have little to do with changing the criminal's criminality. If our society means what it says when it sends a boy to borstal, puts a youth on probation, or sentences a man to prison, if the final goal is really to welcome him back to his role in the community, then we must mould our correctional methods with this in view. The criminal must have the opportunity to unlearn old, bad habits of feeling and behaving and learn new, better ones. And how does such learning occur?

This is not an easy question to answer either and much has been written about it. It seems likely, however, that a greater control over aggression, sexual needs, greed for material possessions and so on, is something which is learnt through relationships and social interaction, much in the way a "normal" person gains such controls by growing up in a family who care

for him and exert discipline upon him. The therapeutic community concept is based on such ideas. The neurotic patient—like many prisoners and delinquents—has to learn new habits of feeling and behaving towards others. Hence the use of group methods, the sharing of responsibilities, and the need for permissiveness. Prisons and borstals are not psychiatric hospitals; prisoners are not, in the main, mentally ill nor are custodial staff trained therapists. But the lessons that have been learned in the treatment of the mentally ill and their rehabilitation in the outside community have relevance in the field of corrections. (I have already made a plea along these lines in "Psychiatry and the Penal System" in the *Prison Service Journal* of July, 1962.)

Permissiveness is not mollycoddling and it is not indifference. It is not letting the prisoner off nor ignoring reasonable rules and regulations. It is, on the contrary, a characteristic of a culture where responsibility is shared, where deviant behaviour is allowed expression *in order* that it be examined and corrected, where social learning in fact is encouraged. And that, after all, is what correctional agencies are for.

# CONTRIBUTORS

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