Psychiatry and the Penal System

J. K. W. MORRICE

A FEW YEARS ago, a member of a prison visiting committee expressed great impatience at my description of a prisoner's state of anxiety and depression. He felt that the state of mind of a prisoner was unimportant; he was a different order of being who was in prison to suffer. Happily, this attitude has already become rare among the informed public and those who have prisoners under their care. There is now general agreement that rehabilitation and guidance are necessary in prison and that a prisoner who is ill in mind should receive attention in the same way as if he were ill physically. The psychiatrist, in his role of doctor to the mentally ill, is more or less accepted therefore by prison authorities and by prisoners themselves. It is when he adopts other functions that difficulties arise.

Indeed, even when the psychiatrist confines himself to his accepted role and seeks to treat *neurotic* reactions, he may stand accused of aiding prisoners in evading unpleasant duties or consequences. He is thought of as being on the prisoner's side and a threat to the established order. This is not generally true. No psychiatrist with prison experience would try to interfere with the routine of the establishment or to protect a prisoner from his just punishment except in unusual circumstances. What governs a psychiatrist's actions, however, is his belief that neglect of a man's emotional difficulties in prison renders him more bitter and antisocial. On the other hand, to give the prisoner an opportunity to voice his complaints and worries, to give him help by talk or medicines, is to gain his goodwill and confidence. Rehabilitative measures may then stand a chance.

It is true that the treatment of emotional disorders in a penal institution (compared with outside practice) is hedged with difficulties; it requires a little more finesse to know when and how much to interfere; it is necessary to accept the restricted treatment facilities of most establishments and the artificial or stressful life that the prisoner may be leading. On the one hand, it is an unusual prison that has a therapeutic atmosphere in it, even these days. And on the other hand, the "patient" may

not be trustworthy and may seek drugs in order to peddle them. In addition, habituation to barbiturates or amphetamine preparations appears to be remarkably easy in prison and it is in prisoners that bizarre and extravagant side-effects of tranquillisers and energisers occur. There is no doubt, however, that these new drugs can be of value in the treatment of neurotic, psychotic and psychosomatic disorders in prison. Nevertheless, what I am anxious to emphasise is the atmosphere which still prevails in so many corrective institutions and which is anti-therapeutic to the extent that the psychiatrist is forced to recognise it and seek methods to counteract it.

It is not generally accepted that much of the theory and practice evolved in recent times by psychiatry is applicable also to delinquency and crime. But similarities can be shown if comparison is made between the patient in a mental hospital and the criminal in prison. For example, the factors which lead to chronicity in the psychotic inmate may be largely those which render the criminal recidivist. One may cite loss of contact with the community at large, infrequency of visits from relatives and friends, loss of independence, an authoritarian regime and so on. Until recent times the insane patient enjoyed the sequestered privilege of the mental hospital in elaborating his delusional ideas. In the same way, the prisoner today, secluded from reality and lacking active rehabilitation, surrounds himself with phantasies of the criminal life. Behind the high walls—physical and mental—that seperate him from the real world, the prisoner is set a code of behaviour and thought that is maladaptive to anything but a future career in crime. To combat this, to offer some inducement to become law-abiding, it is important to change the atmosphere of prison in the way that has proved so beneficial on the mental hospital front.

Psychiatrists and psychologists who are dealing from day to day with both the mentally ill and the criminal are aware of these parallels. My concern is to point them out to others and to plead for a greater application in the sphere of criminology and penology of what has been painfully learned in the field of mental health. Hostility towards the psychologist, sociologist or psychiatrist who dares to preach prison reform or make out a case for new methods of sentencing or after-care is voiced by a certain section of the press and the public. This is probably inevitable. It is also understandable that some magistrates, police and prison officers view the activities of the psychiatrist with some alarm. (Some of us invite disapproval by unhelpful reports or unrealistic advice; although I must say that sometimes the conditions under which we have to work give an excuse.) It is not this of which I complain but rather the acceptance of the psychiatrist in theory but not in practice.

Osler emphasised that "a judicious distrust and wise scepticism are the sinews of understanding".

It is accepted that new methods and techniques are bound to be criticised when introduced into the authoritarian regime of prison, particularly when they seek to alter that regime. One can feel sympathy with public feeling that expresses itself as anxiety over the humane policies of today, anxiety that the deterrent effect of prison sentences is weakened by them. But one grows impatient with professional penologists who pay lip-service to the new deal offered by psychiatry and social science but spend their days ignoring or obstructing it. Even in the United States, where psychiatry is a respectable calling, Abrahamsen * complains that "it is regrettable that the great strides we have made in psychoanalysis, psychiatry, sociology, anthropology, education and social work have been applied in such small measure to the actual treatment practices in the field of juvenile delinquency and crime, particularly with regard to correction".

I think that there may be public apprehension that the humane treatmant of criminals in some ways condones crime. Perhaps it is this feeling which underlies the present demand in this country for birching and capital punishment. I have thought in my own dealings with criminals how important it is for the psychiatrist to retain a sense of right and wrong. Not that he should preach or make moral judgments or even argue on moral grounds. But the prisoners (and one would hope the public) should gather implicitly from his words and actions that, although the psychiatrist is in prison to understand and help and not to judge or punish, he does not condone criminality. It might do our public relations good if psychiatrists and their colleagues were more willing to say straight out that most of us are not primarily concerned as to whether prisons are harsh or not; we offer new methods because we believe they are effective and logical. In fact the prisoner may find them a great deal more demanding and painful than merely doing his time. Moreover, the methods which psychiatry suggests, although of great importance because of the principles that underlie them, are largely modifications of the present regime. There is no reason why other methods should not continue, combined or in parallel. Personally, if I thought birching would deter hooliganism I would be all for it. I do not wish the criminal mollycoddled. I would rather his life were difficult and trying but *to some purpose*; not punishing for the sake of punishment. But this theme takes us into the realms of sentencing policy which (due though it obviously is for overhaul) is outside the scope of this paper.

One aspect of human behaviour recognised in recent years as being of importance is the influence on the individual of the group or society in which he lives. This knowledge has led psychiatrists in mental hospitals to try to structure the patient's environment in order to make his whole day a therapeutic

* Abrahamsen, D. *The Psychology of Crime.* Columbia Univ. Press 1961

experience. This is what is meant by Therapeutic Community — the deliberate employment of all the potential of both staff and patients, according to their abilities and training, in a treatment plan. To achieve this in mental hospitals necessitated a shake-up in the old authoritarian and hierarchical system. A therapeutic community cannot be imposed. It has to be seeded and cultivated. It needs certain conditions, e.g. the freeing of channels of communication; understanding as a first step in controlling aberrant behaviour; and a measure of self-determination allowed to patients. Those who have experienced the advantages of such a system would like to see it used more widely in the care of delinquents and criminals. One can visit many approved schools, borstals and prisons without meeting signs of group methods or deliberate structuring of the community. And yet, surely the day is past when we believe that to send a boy to an approved school or borstal, or a man to prison, and merely fill in his time as best we can, is rehabilitative and calculated to fit and encourage him to lead an honest life? Too often, on the contrary, these institutions are colleges of crime and turn out not honest citizens but sophisticated criminals.

It has been shown that staff in close daily contact with patients in hospital come to share a common viewpoint — what has been called the socially shared psychopathology of everyday life in hospitals. It seems to me all the more likely and dangerous that what happens in hospital also happens in prison. Against the vicious code of the prisoner what has the prison officer to offer under the old regime? He can only come in time to share the prisoner's outlook or else separate himself from any real contact with him. Neither of these attitudes can be considered useful or therapeutic.

It is against this background (illuminated by Miller*, Morris†, and others) that my colleagues and I plead for a new deal. A destuctive critic might suggest that for psychiatry to instruct penology is an example of the blind leading the blind. He might tell the psychiatrist to first put his own house in order. This criticism is not entirely unjustified. In psychiatry there are large areas of uncertainty. Even the group techniques of the therapeutic community have failed to make an impact on the prejudices and self-satisfaction of some psychiatric hospitals. But where these methods have been sincerely applied no one doubts their value. The efficacy of psychiatric treatment is not always open to convincing scientific proof. There is no conclusive evidence I know of which shows psychological methods in the treatment of criminals to be superior to others. But subjective impressions are not without validity and general considerations suggest that psychiatric techniques have some-

---

*Miller, P. R. *The Prison Code.* Am. J. Psychiat., 1958, 114, 583.

†Morris, T., Morris, P. and Biely, B. "*It's the Prisoners who run this Prison*" Prison Service Journal. Jan. 1961.

thing worthwhile to offer.

If the purpose of imprisonment is reformation not punishment then, as Fenton* points out, since more than ninety five per cent of all convicted offenders are ultimately released, logic demands that we direct our resources towards their re-education. Somewhere along the line we must try to make responsible citizens out of them. If it is also agreed that a large proportion of prisoners are emotionally disturbed, then reformation cannot be accomplished without therapy. This is particularly so when the crime consists of impulsive and repetitive behaviour derived from irrational and perhaps unconscious forces. The prisoner needs a chance to unlearn old bad habits and relearn new good ones. Now this is something that psychiatrists think they know about. We may vary in our approach from Psychoanalysis to Modern Learning Theory; but in so far as criminal behaviour is learned or acquired—like a neurotic symptom—it should be susceptible to our methods of investigation and treatment. There may be criminals who will not respond to this approach or who will not co-operate. But I am not offering psychiatry as a cure-all. Of course other methods and regimes are necessary within institutions and without. We need everything from an efficient police force to a proper after-care service. But if the powers-that-be are really anxious to combat crime and effect prison reform, then here is one promising approach that needs support. We need personnel and funds, facilities and co-operation to put our methods into practice on a reasonable scale. It would be worth while cutting through legal red-tape and prison tradition to provide controlled experiments and fundamental research. I am being clamorous about this because the time is past for polite hedging. I have stated elsewhere that "when dealing with the higher prison administration, the psychiatrist should remember that he is playing quite a small instrument in the works band." But sometimes it is valuable to give a solo trumpet performance.

Another difficulty that has to be faced is that prisons are overcrowded and under-staffed and fulfil other functions besides the custody and training of prisoners. They also act as diagnostic centres, holding units and dumping grounds. Officers spend a great deal of time checking bodies in and out to the detriment of their rehabilitative duties and their enthusiasm. Trade officers, too, feel that the task begins and ends with the fulfilling of the work contract; and the opportunity of active therapy which work affords (as demonstrated by Maxwell Jones) is neglected. But this is why the psychiatrist can be useful as consultant and adviser, as well as therapist or report writer. He does not want to make a take-over bid for the prison or borstal. But he wants recognition for his experience and an opportunity to practise his methods. I do not think he is getting this and this is why I plead, "Give the Headshrinker a chance"

* Fenton, N. *Group Counseling.* California, 1961. p. 24.