

Winter 1959

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Recommended Citation

Jack V. Wallinga, *The Probation Officer's Role in Psychiatric Cases*, 50 *J. Crim. L. & Criminology* 364 (1959-1960)

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THE PROBATION OFFICER'S ROLE IN PSYCHIATRIC CASES

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Neither the psychiatrist nor the probation officer, alone, can render the best service to delinquents
—EDITOR.

In the field of parole and probation, cases are often encountered which are believed to be of a psychiatric nature. In our consideration of the probation or parole officer's role in these cases, a problem of definition arises immediately. On the one hand we may think of all offenders as having personality or emotional problems which would entitle them to be considered psychiatric cases, very broadly speaking. At the other extreme, many people are of the opinion that few offenders or delinquents represent psychiatric or emotional problems, but rather are social problems with whom medicine or psychiatry need not be concerned. A rather pessimistic attitude by still others is that practically all delinquents or penal inmates are psychopathic personalities and thus are not responsive to any psychotherapeutic efforts.

LIMITATIONS OF THE PSYCHIATRIST AND PSYCHOLOGIST

This attitude brings us to the problem of the psychiatric diagnosis, which is the first point where the caseworker has a definite advantage in working with emotionally disturbed people. Too often the psychiatrist, and also the psychologist, allow a formal diagnosis to assume major importance in their consideration of a case, and the diagnosis subsequently interferes with treatment and strongly affects the outcome of the case. For instance, we see this occurring frequently when adolescent delinquents are labeled "psychopathic personalities", and an opinion is given that therapy has nothing to offer. This pessimism is echoed by treatment facilities which later have contact with the individual and as a consequence, too often therapy is not seriously attempted. The logical outcome is that the adolescent does not receive help, continues to act out, and subsequently becomes further involved in a delinquent pattern,

thus "proving" the initial diagnosis. When many of these youngsters do receive a thorough re-evaluation, it is often found that the initial diagnosis of psychopathic personality was erroneous.

The problem of the frequent diagnosis of acting-out adolescents as "psychopaths" or, more recently, with the euphemism "sociopathic personality", is somewhat understandable in that the teenager basically has many psychopathic-like traits in his makeup. When such an individual is examined by a psychiatrist who is not especially trained in understanding, or familiar with, defiant adolescents, this behavior pattern very closely resembles that demonstrated by the actual adult psychopath. So the adult diagnostic term, with all of its strongly pessimistic connotations, is applied to the youthful offender. Another factor is that the diagnosis of psychopath sometimes takes on an aspect of scientific name-calling. This is perhaps the most harsh label one can affix to an individual about whom one wants to convey a feeling of pessimism or hopelessness, thus the belligerent, defiant, uncooperative, often "smart-alecky" teenager who refuses to enter into a diagnostic relationship with an examiner, and who may even openly defy and antagonize the examiner, becomes the recipient of this diagnosis more as an expression of negative feeling rather than a scientific categorization. Certainly the behavior of the usual delinquent adolescent is far different from the demeanor of the adult neurotic who seeks psychiatric help because he is extremely uncomfortable with his adjustment and has some conscious awareness of a need for treatment.

It is not only in the diagnosis of psychopath that we see confusion in the use of diagnostic labels. A study of over 800 psychiatric admissions, with several diagnostic re-evaluations of the same patients within a rather brief period of time,

revealed that 65 per cent of those patients seen by more than one psychiatrist received at least two different psychiatric diagnoses.¹ There was some indication that the more psychiatrists an individual saw, the more widely differing diagnoses the patient received. Several individuals in the group received diagnoses of neurotic, psychotic and character disorder, all referring to the same psychiatric disturbance.

The use of a single psychiatric interview, or a brief period of observation in a hospital setting, does not allow sufficient time for an adequate understanding of the individual's personality. In a recent study of 200 admissions to a child psychiatric hospital unit, it was found that predictions regarding the prognosis of the patient's adjustment after leaving the hospital, without receiving substantial treatment, but only a short diagnostic study, were quite unreliable.²

It is indicated that final prognosis in any individual case will often depend not so much on what is diagnostically predicted as it will on subsequent treatment or environmental influences. The difficulty, then, is that treatment and environmental planning are based too often on a diagnosis rather than on the individual and this is where diagnosis acquires unwarranted significance.

Another factor pertinent to the probation officer's role in psychiatric cases is the extremely short supply of psychiatrists available. The particular interests and experiences that psychiatrists generally have to offer the probation officer and the offender who is referred as a patient are also important. When we lose sight of this the outcome of referrals is too often disappointing. Certainly not all psychiatrists are interested in working with the anti-social, belligerent, or even initially uncooperative patient. Many neuro-psychiatrists are primarily interested in an organic, neurological approach and demand a certain degree of cooperation from their patients. Many psychiatrists are not particularly interested in the somewhat slowly-moving hourly interview therapy approach, and certainly acting-out patients generally are not the kind to be rushed into brief interview therapy. Some psychiatrists are not sympathetic to the problems presented by

children or teenagers, nor have they had particular training in this very specialized area. There are certainly other psychiatrists who, because of their own personality makeup, do not tolerate hostility comfortably from their patients. So simply finding a psychiatrist to see an offender does not assure an objective, unbiased approach.

The central personality problem of many delinquent adolescents is basically one of defiance of authority. Psychiatry is often suggested either by the Court or by the child's parents, either of which represent strong authority figures. To maintain his adolescent pride, or to "save face", the youthful patient tries initially not to reveal any apparent anxiety or emotionality, at any cost. He resists the psychiatrist's efforts to draw him into a relationship because he knows that the weaknesses that he is trying so hard to conceal will quickly be revealed in such a relationship. So the adolescent characteristically acts sullen, belligerent, or indifferent. Unless the psychiatrist anticipates this reaction, he soon begins to feel his time is not being used to good advantage, and perhaps is even being wasted by an ungrateful patient. This frustration may be quickly replaced by covert hostility in the psychiatrist. From this frustration, or perhaps hostility, at being unable to proceed often comes the suggestion that perhaps the adolescent should be hospitalized or institutionalized for "more intensive study". What this represents to the adolescent is taking away his freedom which is treasured, and rather than gaining understanding as is hoped, this generally intensified resistance and defiance, with the result that little additional insight is gained into the patient's problems. Out of this mutually frustrating, irritating, and perhaps hostile relationship we find arising the dismal prognoses and the sweeping predictions that these individuals will "probably never be able to adjust to society and should have the benefit of long time placement in a controlled institutional setting".

The offender who even in the institution shows much anxiety and seems receptive to therapy, often quickly loses his anxiety as soon as released from the institution. Stimulating enough anxiety early in the treatment process to keep a person in therapy or stimulating such anxiety on an out-patient basis is a difficult technique, one often unfamiliar to the therapist who is more accustomed to treating patients who come with overwhelming anxiety already present.

¹ WALLINGA, J. V. *Variability of Psychiatric Diagnoses*. U. S. ARMED FORCES MEDICAL JOURNAL. Vol. VII, No. 9, pp. 1305-12, Sept. 56.

² WOLKING, W. D. ET AL. *A Follow-Up of Children Discharged from a Psychiatric Ward*. MINNESOTA MEDICINE. Vol. 40, No. 1. pp. 1-6, Jan. 1957.

We should mention on the other hand what is, theoretically at least, possible in the psychotherapy of antagonistic, hostile, delinquent individuals. Therapeutic experiences of this sort are well reported in the literature and the outcome can be very rewarding if one is willing to invest the time and effort necessary.³ Successful therapy in such cases, with the resulting therapeutic socialization of severely hostile, delinquent individuals is dependent almost entirely on the patient's developing a positive relationship with the therapist rather than the extensive interpretation of unconscious material. Such a positive relationship with its therapeutic benefits is just as possible, and usually more available, with the probation or parole officer as with a psychiatrist.

ROLE OF THE PROBATION OFFICER

Having considered what psychiatry has to offer the offender ranging from successful but generally unavailable, intensive long-term outpatient psychotherapy to repeated brief, diagnostic and often contradictory evaluations, we might think now about the probation officer's role with the offender who presents psychiatric problems. It is the probation or parole officer who actually has the offender as an assigned case. There is no problem of referral. The worker who deals with offenders is in this field because he is basically accepting in relation to delinquents and is interested in working with them. The worker is soon able to see through the defiant facade of the "tough guy" and is not quick to be angered by the hostility of the adolescent offender. The probation officer also has the flexibility which enables him to go out to the offender and to become acquainted with his home, neighborhood and gang. It is not consistent with the psychiatrist's role to pursue patients who fail appointments. Neither does the worker have the rather rigid preconceptions or expectations of how the client must react or behave in the interview situation, expectations which, as mentioned earlier, frequently hamper the psychiatrist.

The probation worker has primarily a positive relationship to offer to the emotionally disturbed offender. In addition to emotional support, very important practical support is often given as well. Such problems as employment, living quarters, marital discord are more accessible to the worker

than to the psychotherapist, for immediate relief. Help of this nature further enhances the worker-client relationship. The worker is in a position to continue some contact with the offender for an administratively determined length of time, whereas an unwilling patient can easily rid himself of a psychiatrist by simply failing appointments or being sufficiently non-productive in interviews.

The question of the danger of interpretation is often raised as an argument against the non-psychiatric treatment of emotionally conflicted people. Certainly some interpretation can be offered, particularly by the worker who has some training and skill in this approach. The danger of too much uncovering of unconscious material is fairly remote. We do not find this occurring often, and it must be weighed against the more probable danger of no help at all. Rather than too much interpretation, we too often see the opposite; workers with good insight and intuitive understanding who are hesitant to use these as tools to involve their clients in treatment.

Training is important, of course. Both formal training in the theory and techniques of working with emotionally disturbed delinquents, and continued staff training and supervised experience in treating such offenders are invaluable. Small case loads are helpful in allowing the worker to spend adequate time on difficult cases. Limited case loads may sound like unrealistic goals in our times of rising delinquency, but they are still more probable than obtaining properly qualified psychiatric services in sufficient quantity.

Good casework supervision is extremely important in working with the psychiatric case. Here the worker has an objective sounding board to test his dynamic understanding of his client, and perhaps to review tentative interpretations of unconscious or symbolic material before they are presented to the client. The psychiatrist who understands the offender and the approach of the agency may be of considerable help in a consultative role here, not by actually seeing the offender and rendering a diagnosis or judgment, but in helping the probation officer to better understand the material he has obtained and where he is going in a case.

We often see that simply preparing a case for referral for consultation provides the answers to the worker's questions. The thorough review of the case material itself clarifies the situation, but how often do we take the time to review a record

³ LIPPMAN, H. S. *TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT*, McGraw-Hill, New York, 1956, pp. 235-236.

adequately unless for some such ulterior purpose? I believe that many times a complete review for presentation to a supervisor and perhaps one or two other workers in the field provides as much diagnostic clarification as presenting the same material to the psychiatrist.

In very few instances symbolic or unconscious material is sufficiently reported in a record so that sound dynamic understanding may be obtained from consultation about the case.

In the usual situation of a poorly integrated personality functioning in a poorly socialized manner, little is accomplished by affixing a diagnostic label such as schizoid personality or ambulatory schizophrenic (suggesting he is sick but not committable), or describing him as an inadequate personality, emotional instability, passive aggressive, emotional immaturity, etc.

We might finally consider the probation officer's role in those occasional cases where psychiatric help or psychotherapy is clearly needed, and is

available. Here the mechanics of making the referral are secondary to preparing the person for being referred to a psychiatrist. Everything the probation officer can do to stimulate the offender's anxiety about his behavior, adjustment, and future, as well as to provoke an awareness of a need for therapy and a desire for such assistance, will be most rewarding in terms of the success of the referral and outcome of treatment. Before referral, the offender should be well aware of his responsibility for participation in a treatment relationship, the length of time successful treatment involves, as well as the inconvenience and actual discomfort of intensive psychotherapy.

There must, of course, be close collaboration between the psychiatrist and the probation or parole officer, especially when the offender is still on probation or parole, but generally in all cases that are to receive maximum benefit. A good psychiatric referral can never be simply a means of lightening a case load.