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Definition of Forensic Psychotherapy and its Aims

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ABSTRACT

In this paper the author shall try to illuminate the advantages of using a psychoanalytical model in our understanding of the forensic patient. There is the problem that sometimes the judicial and psychoanalytic approaches appear to be incompatible, though both are inherently intertwined with societal mores through the nature of anti-social, delinquent actions usually associated with such cases. Many of the ideas at the root of this paper are from Karl Menninger, with whom the author trained in the early 1960s. Copyright © 2015 John Wiley & Sons, Ltd.

Key words: perversions, crime, psychodynamic

Forensic psychotherapy creates a bridge between traditional forensic psychiatry with its main focus on illness and risk, and psychoanalytical psychotherapy that helps to understand the forensic/offender patient. We need to understand not only the crime in detail, but also the individual as a whole person, within his environment. Sometimes the two disciplines may seem antithetical, but this paper addresses the contributions specialist forensic psychotherapy can make to the rigorous discipline of forensic psychiatry and the related field of criminal justice. We will also tackle a number of misconceptions along the way.

There are at least three different "cultures" involved: of learning, of concern and of blaming. As a caring society we should be regulated by a culture of learning, although this is generally absent when dealing with offenders who blatantly break the law. Unfortunately the culture of concern is almost exclusively left to clinicians, health workers, and the judiciary. The culture of blaming is left to the lay public and society at large. The titillating front pages of tabloid newspapers make it very difficult if not impossible to understand the inner world of the offender or the motivations for their crimes.

Forensic psychotherapy involves demonstrating the unconscious motivations that underpin specific offending behaviors. In terms of management and risk this will include the triggers to and timing of the antisocial act. One misconception is that we focus only on the early months of life. The aim of forensic

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psychotherapy is to foster psychodynamic understanding of the offender and contribute to his or her consequent treatment. It does *not* seek to condone the crime or to excuse the criminal. On the contrary, the object is to help the offender to acknowledge responsibility for his/her acts and thereby helps to protect the offender and society from the perpetration of further crimes (Welldon, 1994). Taking responsibility and understanding what you did, and why, is more than simply saying you regret it: getting there takes hard work from both patient and therapist(s).

Sometimes it is (again erroneously) thought that such insights require a high level of intelligence. Except for a few pioneers, psychotherapists do not traditionally work with people with intellectual difficulties, even less so when they show offending behavior. Alan Corbett (an earlier International Association for Forensic Psychotherapy [IAFP] Board member) has carefully designed a specific treatment along psychodynamic lines for the previously so-called handicapped children and adults with intellectual disabilities (Corbett, 2014). The psychodynamic approach involves working with both hope and expertise.

A crucial point about the discipline of forensic psychotherapy is that it is usually a team effort with a wide range of people inescapably involved. Successful treatment rests not only with the specialist psychoanalytical psychotherapist from a number of core professions such as psychiatry, psychology, nursing, social work or creative arts, but also with a team of helpers, including managers, administration and clerical staff who get involved with the patient at all levels and in different settings. Music therapy and art therapy in prisons and other safety places for offenders have been used with success (Compton Dickinson, Odell-Miller, & Adlam, 2012).

Forensic psychotherapy may involve group work, therapeutic communities, family work and work with victims as well as individual offenders, all within an informed and (hopefully) supportive institutional base.

Resistances to making use of psychodynamic principles in judicial contexts remain among even distinguished clinicians. For example, my American colleague Altshul (2013), in reviewing Yakeley and Adshead (2013), describes his reservations about the applicability of psychodynamic principles to judicial and legal processes, but goes on to say "They describe a humane, sophisticated, and civilized position, and they describe it in a thoughtful and scholarly manner. A large part of me hopes they can prove me wrong. (p. 48)" We will.

There is a prejudice among some clinicians that judges are not ready to listen about unconscious motivations and what they would perceive as maneuvering legal processes to diminish the guilt of the accused. On the contrary we have found that they are open and ready to learn and felt better prepared to face their own work. Forensic psychotherapists have to work to influence the broader system.

As a matter of fact we have to acknowledge that our own expert colleagues can share, unconsciously, the same prejudices. For example it is revealing that the DSM-III-R (American Psychiatric Association (APA), 1987) listing of

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paraphilias omits both zoophilia (bestialism) and necrophilia. This may denote a trait associated with the "culture of complaint" (Hughes, 1993) in that the omissions may have to do with the inability of victims to voice having been abused!

The United Kingdom (UK) was at the forefront of the development of forensic psychotherapy when in 1931 people from the Portman Clinic in London formed what was later called the Association for the Scientific Treatment of Delinquency and Crime, in order to promote a better way of dealing with criminals than putting them in prison. The eminent psychoanalyst, Dr Edward Glover, a co-founder of the Portman Clinic became its first chairman (Cordess & Cox, 1992)

This work continued slowly over the next 60 years. In 1991, while attending a conference of Law and Psychiatry in Leuven (Belgium), myself and a few colleagues of like mind discussed how we could foster an understanding of what psychotherapy had to offer to the forensic field. We felt rather neglected and prejudiced against, given the small allocation of time we had been given to present our ideas! I got agreement with colleagues from the Netherlands, UK and Switzerland to create our own group, the International Association for Forensic Psychotherapy (IAFP), which adapted the original aims of the English organization. IAFP is still going strong and our 25th Annual Conference in 2016 will be held at Ghent, Belgium. This year's meeting at Yale University in the Unites States attracted people from nine countries.

One of the problems in developing this field is that the offender attacks the *outside* world (society) through his actions and hence concerns become rarely focused on the *internal* world of the offender.

Crimes are viewed as directed against individuals and society, which then judges. It is unfortunate that the focus of attention most times is placed exclusively on the offence and on the punishment of the offender. Any attempt at psychodynamic understanding of the offender and of the delinquent actions resulting from his own self-destructive internal and compulsive needs is usually equated by society with condoning it. This is an understandable but serious error.

The common retaliatory responses to violence are characterized by splitting and projective mechanisms that see people as "good" or "bad" in a black and white way, which is itself similar to the non-thinking, acting-out way of the perpetrators. "Good" people need to safeguard their own goodness by locating badness in others. This is the universally employed mechanism of defense known as projective identification, described by Melanie Klein (1946). Thinking and learning is needed to integrate these perspectives. Once again, we need to stress this does not mean "letting people off", although this is often challenged and psychodynamic approaches are vilified.

This makes our work extremely difficult: we have to cope with the burden of these projections as well as facing derogatory attacks from our patients. Part of a holistic psychoanalytical approach is to make sense of these reactions.

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For example, in the UK in the wake of the appalling tragedy brought about by the disappearance and death of an eight year old girl in 2000, the first reaction was one of a systematic, public revenge by "naming and shaming" paedophiles, which led to miscarriages of justice and suicides. It became a witch-hunt, spurred on by the media, where irrationality, mindlessness and extreme violence were the rule. A psychodynamic formulation is not difficult. Such behaviors help to avoid facing up to the fact that domestic violence and physical and sexual abuse to children are sadly much more common occurrences in our own homes than those carried out by strangers. Yet it is the outsider deviants that we fear.

The treatment and support of victims is encouraged (although still may be inadequate), but the same does not apply to the perpetrators, who are believed to be evil, and thus deserve only punishment. This issue adds to the fraught and difficult task for a forensic psychotherapist, who is trying to help his/her patient and also play a part in elucidating some of the painful problems with which society struggles.

To help understand the perpetrators' situation consider Akhtar's (2014, p. 144) concept of the mental pain of the minorities: "In terms of being perceived by the majority, the minority feels both the anguish of invisibility and the torment of hyper-visibility … . If one is not wanted but does exist, then what is one to do with one's existence?"

Most of these people have felt completely unwanted from the beginnings of their lives and their early upbringing is characterized by a lack of love, much neglect and at times abuse. No wonder some want to make a "big splash" to make sure they do exist.

While it is acknowledged that victims may sometimes become perpetrators, this is uncomfortable to face and it is easier to stick to the clarity that victims are innocent and perpetrators are bad. The first group is assumed to be devoid of any negative, hostile feelings and the second group as filled only with hatred. This is a primitive splitting response. Both victims and perpetrators are left without the benefit of a full understanding.

A similar stereotype is that women are seen as victims and men as perpetrators. When men are sexual abusers different agencies may intervene and call the police in. In contrast, the female abuser is relatively ignored (Welldon, 1988/2004). Nobody wants to hear about her predicament, and nobody takes her too seriously.

This can happen even in group therapy when she finds that other patients minimize her problems. Such a reaction is anti-therapeutic, and if the therapist is not ready to interpret this total denial the women will never gain any insight into their problems, let alone be able to change themselves. The difficulties in acknowledging a woman's abuse of power in motherhood ("they don't do those awful things") could be the result of massive denial as a way of dealing with this unpalatable truth. Until recently a lack of legislation on female perversion reflected society's total denial of it. The woman is thereby

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seen as a part-object, or just a receptacle of a man's perverse designs. The apparent idealization of mothers prevalent in society contains a denigrating counterpart.

The theme of female sexual perversion is explored in two case examples later.

The overall difficulty in recognizing flaws in idealized people is visible again through the long delays before the public acknowledged sexual abuse in clergy (priests *and* nuns), teachers (male and female), or high profile figures in the entertainment industry. It is not just "them" of course – therapists can be abusers ourselves.

These are amongst the reasons that society has been slow to recognize the limited but significant contribution, which forensic psychotherapists can make to the achievement of a dynamic understanding of the causes of delinquent and criminal behavior and of how we cope with it.

Let us consider how these psychoanalytic insights might help. The more we understand the criminal mind, the more we can take positive preventive action and the more we are also able to cope with our counter-transference responses. This in turn, can lead to better management and the implementation of more cost effective treatment of patients (Welldon, 1994).

In this regard we find it extremely helpful to refer back to James Gilligan's (1996) assertion that any acts of violence, especially those considered to be "irrational" are invariably preceded by a subjective feeling of being humiliated.

According to Reena Kapoor and Andrew Williams (2012, p. 460) "We simply believe that thinking through the possible unconscious forces at play in a forensic case adds a layer of richness that would otherwise be lost. (p. 309)"

According to Dr Donald Winnicott (1956, 1975), an influential pediatrician and psychoanalyst: "The antisocial tendency (in adolescence) implies hope and it is characterised by an element in it which compels the environment to be important". Although this appears to be paradoxical, the axiom means we need to understand that these incidents can be symbolizations of the need for love, which has been expressed by transient delinquent behavior. We could equate delinquent acts as a form of adjustment, a way of managing otherwise unmanageable emotional conflict. Delinquent acts may keep a balance for somebody who feels non-existent.

Not every offender warrants psychotherapy, not everyone wants it and not everyone benefits. Sometimes the offending behavior is associated with professional, careerist criminality, where criminology and sociology will play the major role in learning.

In order to assess whether psychotherapy might help an offender we must modify terms and concepts from those used in assessing neurotic patients. For example, when the criminal action is committed clumsily, the person is especially susceptible to detection. What does this mean? The poorly carried out criminal action has perhaps become the equivalent of the neurotic symptom. The offender may express fears of a custodial sentence, understandable in many ways, but one possibility is that this may also denote some motivation

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for treatment, however much under implied duress. He is now ready to own his psychopathology and this may signify an incipient sense of capacity for insight.

From this therapeutic standpoint, it is not unfortunate that a patient has to face prosecution, but what is unfortunate is that just when he is ready for treatment he may instead have to face punishment. The patient may actually acquire a criminal record for the first time while in treatment or on the waiting list. Ironically, the very success of our treatment may produce this result. It is when the patient who has hitherto escaped detection starts to acquire some insight into himself that he becomes clumsy and is detected.

An important characteristic in determining the prognosis and motivation for treatment is an intense sense of shame and despondency, commensurate with the societal condemnation. This is not always immediately evident as sometimes the feelings are disguised by a manic defense, created to mask chronic depression. The criminal action appears understandable as an action against society and yet at the same time, it is a self-destructive act, with harmful effects for the offender also. The aspect of criminality associated with unconscious guilt has been examined by several authors including Freud (1915); Glover (1960) and Tuovinen (1973) amongst others.

The criminal action is the central fact. Unfortunately mistaken psychotherapeutic approaches can seem to be a "soft" option, justifying and rationalizing behavior – "false understanding". Our forensic patients use similar mechanisms to conceal their "real selves" resulting in encapsulation of the offending behavior and keeping it hidden or minimized. An effective collusion between society and offenders is at work.

Some sexual offences are identified through criminal activities, but some people who indulge in similar actions may never be caught. This is a secret or secretive population who apparently lead normal lives, sometimes in both work and domestic situations. There can be severe pathology which is secretive, encapsulated and split from the rest of the patient's personality, possibly acting as a defense against a psychotic illness (Hopper, 1991). The sudden and unexpected "disclosure" of the encapsulation in what appears superficially to be a normal person is so shocking that our first reaction is to dissociate ourselves, followed by a suspension in our ability to think. This is analogous to the criminal behavior in that it is impossible to intersperse thought before action.

The forensic patient is unable to think before the action occurs because he is not mentally equipped to make the necessary links (Bion, 1959). His thinking process is not functioning in his particular area of perversity, which is often encapsulated from the rest of his personality. This therefore is the work of therapy, but at times the patient's tendency to make sadistic attacks on his own capacity for thought and reflection is projected and directed against the therapist's capacity to think and reflect. It is then that the therapist feels confused, numbed and unable to make any useful interpretations.

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Most forensic patients have deeply disturbed backgrounds. Some have criminal records and very low self-esteem that is often covered by a facade of cockiness and arrogance. Their impulse control is minimal and they are suspicious and filled with hate towards people in authority. Some rebellious and violent ex-convicts have long histories of crime against property and persons.

Other people may refer themselves for help and are often insecure, inadequate and ashamed people. They enact their pathological sexual deviancy, such as exhibitionism, pedophilia or voyeurism, in a very secretive manner so that only their victims know about their behavior. Some patients have a great capacity for expressing anger, yet seem shy and awkward in showing tenderness or love to anybody.

Forensic patients generally are often deviant both sexually and socially. However, the links between criminal actions such as "breaking and entering" and sexual deviations are not always obvious, at least not until the unconscious motivation is revealed.

We will illustrate some of the themes that we have raised in this paper through two case histories that relate to a research interest into women with forensic issues. This theme has been further reviewed and researched by an ex-student and friend Anna Motz in her books about violence in women (Motz, 2001, 2009, 2014). The first example is of a patient I had a long way back and to whom I owe much of my own clarity and expertise in this field.

She was a practicing prostitute who was referred for a psychiatric assessment because of violent behavior directed towards her second child. She had been a victim of paternal sexual abuse. Her first pregnancy came as a surprise to her. Still, she felt the need to go ahead with it, because in this way she was taking out insurance against a dread of being alone. The child could become utterly dependent on her and totally under her control. When this first child arrived, she was overcome by feelings of repulsion and revulsion against her baby. She felt ready to kick it, and after reflection she decided that in order to overcome these horrid feelings she would fix in her mind the idea of the baby being part of herself. Some days she would choose her right arm as being the baby, and at other times it would be one of her legs. In this way she felt able to master her impulses to beat up her first child. Later with her second baby she asserted, "There is no more room in my body for a second one. All has been used up by the first one."

The main difference between a male and female perverse action lies in the aim. Whereas in men the act is aimed at an outside part-object, in women it is usually against themselves, either against their bodies or against objects which they see as their own creations, that is, their babies. In both cases, bodies and babies are treated as part-objects (Welldon, 1988/2004). The second example demonstrates the main differences between male and female perversion. A woman patient was referred because of exhibitionism. She told me that her compulsion to "flash" occurred when she became attached to a person whom she invested with idealized "maternal" qualities. She wanted to get closer, to be noticed and to be taken care of by that particular person but she also wanted a shocked

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response from her "victims". She carefully planned the "appropriate" clothing to wear when she was to meet her. Usually she wore an overcoat covering only a little vest in order to respond readily to her urges. She knew this was wrong and that she would be rejected but she could not stop herself.

She had a most deprived early history of being sexually abused by her mother and her siblings. It is interesting to note that, even when her exhibitionism could superficially appear to be the equivalent of her male counterparts, this is not so. It is a well-known fact that male exhibitionists have the compulsion "to flash" only to women – and women who are unknown to them – while my patient had suffered from this compulsion only with other women with whom she felt a close attachment. This is yet another clear difference between the genders.

Looking at forensic psychotherapy from my own personal professional perspective over 40 years, it is clear that the understanding of human behavior has deepened beyond recognition in the last half century. I want to acknowledge the seminal work of two pioneers in the field of forensic psychotherapy, who I was fortunate to work with and who influenced my future career.

After completing medical school in Argentina I studied at the Menninger School of Psychiatry in Topeka, Kansas. Dr Karl Menninger believed that punishment neither helps the criminal nor protects society. "Regardless of its futility and expense, punishing criminals gratifies, comforts, and even delights the general public: sadistic attacks in the name of righteousness deal with the public's unconscious guilt about their projective identifications, having conveniently located their aggressive impulses in the criminal, the 'other" (Menninger, 1967, p. 333).

At the time of the assassination of President Kennedy, Menninger had been paying all his attention to the neglected "weaker fellowman". In this instance it was Oswald, the man responsible for President Kennedy's assassination. Menninger stated: "Thwarted in repeated efforts to have someone pay attention to his puffed up insignificance, this nonentity had concealed himself in a warehouse whence he could overlook thousands of his despised fellow citizens. Far below him they were singing hosannas to their radiant, beloved young leader … The little man in the warehouse was no longer anonymous" (Menninger, 1967, p. 334).

Menninger's understanding of the single, insignificant man and his position in a society where he was despised and ignored, was not shared by the rest of the population. They were (and are) ready to blame almost everything else and to speculate on extremely complicated international political conspiracies. As Menninger (1967) wrote: "No one blamed the system. (p. 333)"

When I left Topeka in 1964 and went to the UK I worked in one of the most exciting and revolutionary clinical institutions: the Henderson Hospital in London. Dr Maxwell Jones had founded this residential unit, or "therapeutic community", with the aim of treating people with severe personality disorders, then called psychopaths.

The enormous challenge of their treatment was met by a sound and adequate structure of democracy and division of labor in which everyone, patients and

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staff, shared not only the burden of their treatment but also the administration of the hospital. Admission and discharge procedures were only a part of the philosophy of the place in which patients had not only their say, but also could make decisions regarding the discharge of patients.

I subsequently obtained a position at the Portman Clinic where I worked until my retirement, 30 years later. I was able to conceptualize my clinical findings about the main characteristics of perversions and was able to focus on the still unreported cases of maternal abuse towards their children. I am very grateful to all those who taught me, especially including my patients.

In conclusion, there is an important place for psychoanalytic approaches to working with offenders. Given resource implications this cannot be in terms of intensive individual work except for a few. Perhaps our major clinical role is in supervising, educating and supporting others including such techniques as "reflective practice". The increasing development of "mentalization" approaches, where patients are helped in a group context to develop the capacity to think before acting, is proving a good psychodynamically-based approach.

As importantly, there is a task for forensic psychotherapists to join in a cross-disciplinary approach to understand and help eradicate some of the more correctable reasons for crime in our society. This involves action by political scientists, sociologists, community leaders, forensic workers – and (importantly) offenders. An imaginative effort is required to promote discussion and to educate the general public, the media and politicians. Forensic psychotherapists can and must play a crucial role in this.

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