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Thoughts from consulting in secure settings: do forensic institutions need psychotherapy?

Stanley Ruszczynski

4.2.26. Three matters concerned the team ... The focus of clinical discussion and decision-making was predominantly on social behaviour and administrative and risk issues, rather than on seeking a psychological understanding of the patient ... Whilst the assessment was good, there were shortcomings in the application of those assessments to help understand the offending behaviour and to design an appropriate treatment programme: "... What is needed is a clear and shared understanding of the patients' psychopathology, the reasons for their offending, psychologically, and to keep those in mind as targets of treatment and to monitor how treatment progresses."

4.2.28. Second, arrangements for the clinical supervision of ward-based staff did not appear to be sufficiently systematic and well organised. Such supervision is particularly important in the context of work with personality disordered patients.

4.2.29. Third, the Unit lacked highly experienced psychodynamic contributions to the assessment and treatment of its patients. This would complement the other approaches to

assessment and would help a vigilant awareness of the depth of the patients' psychopathology.

4.4.23. Dr O ... gave evidence ... on behalf of the Royal Collage of Psychiatrists ... He invited us to pay regard to what he regarded as the "toxic emotional processes" in Special Hospitals: "We are dealing with the most disturbed individuals in society, incarcerated with each other for a very long period of time, working with staff groups who are also there for a very long period of time, and there is a corrosive effect on the staff group unless in fact management is aware of this, unless all the staff groups are in touch with this." [Ashworth Special Hospital: Report of the Committee of Inquiry, Vol. 1, January 1999, pp. 318, 324]

These quotes from the Fallon Report could be read as offering a criticism of the functioning of Ashworth Hospital in the mid-1990s. There is little doubt that it was warranted at that time. Institutions which have the remit for working with the most difficult mental health patients in our society will inevitably struggle in their duty of care, and they will arouse the concern of fellow professionals, politicians and the public. All high- and medium-secure hospital and prison settings will, from time to time, raise this concern. However, to read the comments simply as criticisms is a mistake. What these comments also point to is, I believe, a development in the ways forensic and personality disorder services need to be thought about. This development is the product of our growing understanding of the nature of these patients and the type of care, containment and treatment they require (Hinshelwood, 2001; Newrith, Meux & Taylor, 2006).

The Fallon report is wide-ranging, but the quotes given above represent a discernible approach in the document which regularly refers to shared understandings, clinical supervision of ward-based staff, different contributions complementing each other, toxic processes in special hospitals, the patient group, the staff group and management. In other words, what are being addressed, not surprisingly, are the various relationships and systems which make up the *institution* within which the patients are offered and staff attempt to

provide containment and treatment. The significance of this perspective is my starting point.

In this chapter I will focus on those patients who are contained in institutions such as prisons and medium- and high-secure hospitals. I take it as given that some of the patients whom we encounter in the forensic and personality disorder services, whose disturbance and dangerousness as expressed through their criminal, perverse or violent actions are a central factor, may have the potential to benefit from one or more of a variety of individual and/or group therapeutic interventions, be that as inpatients or in the community. However, I will argue that for such patients the institution as a whole offers the most significant possibility for treatment and is in essence the primary therapeutic agent.

Hence I take the question in my title literally and answer it in the affirmative. I outline a view that, quite appropriately and necessarily, the institution itself, the institution as a group of clinical staff and of supporting administrative, security and management staff, all with the shared task of containing and managing the patients, benefits from the opportunity to reflect on, think about and try to understand the nature of its work with its patients. I base my thinking on my experience of consulting to a wide range of forensic institutions. I am not denying, of course, that the patients' states of mind and behaviours also need careful and considered attention (Cartwright, 2002; Morgan & Ruszczyński, 2007; Perelberg, 1999).

The therapeutic function I want to discuss is informed by psychoanalytic principles. Central to this is the capacity to observe, think about and try to understand the multiple dynamic interactions between the patients, between the staff, and between the staff and patients. Referring to interactions I am thinking not only of behaviour but also of attitudes, perspectives and emotional states. Further, there is the crucial issue of how this understanding is communicated to the patients so that they might assimilate not only some understanding of the ways in which they function, but also some of this capacity to try to reflect and think about emotions, impulses and experiences rather than act them out. And further, there is the question of how this is done alongside the necessity for the physical security of the staff and the physical containment of these dangerous patients (Parker, 2007; Pfäfflin & Adshead, 2004).

This stance, of course, is the clinical stance taken by the practitioner informed by psychoanalytic principles, and one within which the dynamics of the transference-countertransference relationship is central. It is taken as read that the nature of the relationship between the patient and the clinician will be informed by the patient's internal object relationships—his or her patterns of expectations, assumptions, fears and hopes born out of life experiences (actual and emotional). This will be paralleled by the nature of the patient's relationship to multiple others, to groups and to the institution as a whole. Who and what is the other (be that individual, group or institution) in the patient's conscious and unconscious mind? Striving to address this question requires careful attention to the details of the ways in which patients and staff interact with each other at a conscious and an unconscious level. The clinician's affective response and reaction to the patient—the countertransference—becomes a rich source of understanding of the patient when it is considered alongside knowledge of the patient's history, the nature of their offending behaviour and the ways in which they relate to those around them.

A central clinical and management fact about forensic patients, as with psychotic and borderline patients, is that they act upon their environment—both physically, whereby they can be hostile, aggressive, violent, unreachable, seductive, sexually perverse or violent, and also psychically, whereby they can generate states of mind in those around them which are disturbing and militate against reflection and thought. Difficult patients are difficult because they generate difficult feelings in us (Hinshelwood, 1999).

Forensic patients, by definition, also invade, corrupt, attack and damage the institutions which hold them. This is not said as a criticism but as a description of the psychological functioning of the patients we are referring to. They are forensic patients exactly because they have in some form or other imposed themselves onto others, whether violently or criminally or sexually. This acting upon the world does not cease because they have now been institutionalised. It continues because for these patients it cannot easily be otherwise, though it may now often be more subtle: seduction rather than sexual abuse, bullying rather than violence, passively aggressive rather than overtly controlling, inevitably pulling staff into more subtle as well as more obvious responses. This means that forensic institutions may

benefit from, arguably require, access to a resource—one could say, to a mind—that is less disrupted by these dynamics and can continue to function thoughtfully on behalf of the mind, or minds, that have been disturbed. This role might be that taken up by the clinical and institutional consultant.

One of the functions most vehemently attacked by forensic patients, and hence most difficult to sustain, is thinking and reflective capacity. This may not be so difficult to understand if we think about some of the unthinkable acts of violence or perversion both perpetrated by and usually suffered by some of these patients or prisoners. We are describing patients who might be defined by their incapacity to manage their impulses and emotions psychologically, but rather to express them through the use of their own body or that of their victim. I can say that I am angry with you because I have a capacity to mentalize my emotions—to convert them into psychological states of mind which I can symbolically represent with words (Fonagy, Gergely, Jurist & Target, 2002). If I did not have this capacity, as many of our patients do not, then it is likely that the only way that I might have of expressing this same emotion and, in doing so, communicating this fact to you, is to use my body and hit you, or alternatively to harm myself and so indirectly attack you by shocking you or frightening you or distressing you. Whatever the concrete physical behaviour might be, it is its impact on the mind of the other that requires attention—something very difficult to achieve if the concrete behaviour has been particularly brutal or destructive.

One of the most extremely difficult tasks we have in working in forensic settings with very disturbed, disturbing and dangerous patients is to try to hold in mind that this acting upon others, or upon themselves, might possibly be a very primitive communication with others. In such settings, ordinary communication often fails and staff have the dual function of controlling the patient's behaviours, physical and emotional, but also taking in the emotional impact of these actions and thinking of them as potentially having symbolic meaning. If this is not kept in balance—easier said than done—there is then the danger of an oscillation between mindless and sometimes harsh discipline and control on the one hand and equally mindless sentimental sympathy and collusion on the other hand.

So what is the "psychotherapy" that might be offered to a forensic institution? Working from a psychoanalytic perspective, where we are primarily interested in unconscious processes and dynamics, our stance is that of receptive listener, curious to learn about our patient or about the work of the staff or staff group we are consulting to, and being prepared to be surprised and, with forensic patients, being prepared to be shocked, disgusted, outraged and frightened, or excited, seduced, and feeling sorry for the person. Having a conceptual framework and therapeutic model provides us with some scaffolding upon which we can locate our experiences, thoughts and feelings, as a result of which we might begin to make links and connections as we listen to and are affected by the staff describing their work with patients and with each other. Below I refer to some such scaffolding.

It is fundamental to the task of being able to manage one's emotional responses to forensic patients to have an idea about the differences in functioning between the non-psychotic and the psychotic, borderline and perverse mind. This is relevant both to an understanding of the patient's history and index offence or perversion and also to how the patient will most likely function in his or her setting.

In ordinary development, the early, unintegrated experiences and states of the infant's body and mind are gradually processed and integrated as a result of the receptive and containing relationships with primary carers. The internalisation of this good containing experience gradually leads the infant to develop his own capacity to reflect and think, to feel a sense of security, and to begin to differentiate self and other. This leads to the possibility of a sense of morality, a value system and the development of relationships (Hinshelwood, 2004).

However, if something goes wrong in this process, for example if there is insufficient or abusive or absent early parental care (containment), or if there is something inherent in the infant's predisposition so that he is not able to make use of or even rebuffs his caregivers, the capacity for containment will not be internalized. Consequently, more primitive mental processes, including splitting and projection, will remain as primary aspects of the internal world, and these will influence the person's experiences and relationships. The result is that in the emerging adult there will be little capacity

for an awareness of a separate other, and therefore neither a capacity for concern for the other nor a sense of morality or a value system. In Kleinian terminology, the person remains in the paranoid schizoid way of functioning rather than having developed a capacity for more depressive position functioning. The likelihood of developing ordinary relationships is negligible.

Without the primary experience of containment, no development of a psychological self can take place, of a self that can process and think about impulses, experiences and psychological states, because such development requires the primary experience and perception of oneself, in another person's mind, as thinking and feeling (Fonagy et al, 2002). The incapacity to reflect on and integrate mental experiences results in only the body and bodily experiences being available to be used to provide a sense of relief, release or consolidation. It is not unfamiliar to hear from borderline patients about their profound sense of relief and peace following an act of violence or a suicide attempt.

The patients we are referring to are usually diagnosed as displaying severe personality disorder, psychosis or psychopathy. They have great difficulty in engaging and sustaining relationships (including therapeutic relationships). This is not so much because they don't have relationships, but more that their way of relating is to encroach on others psychologically, affecting the balance of the minds of both, for example, through physical action or violence, sexually perverse behaviour or self-harm. Whether it is any of these actions or even if it is only words that are used, the function of this is to act upon the other's mind in an intrusive way.

The more disturbed patient, therefore, is very likely to be relating in a manner which includes the greater use of powerful processes of splitting (more accurately, fragmentation) and projection, and other primitive processes. As a result, he is likely to unconsciously use people around him, patients and staff, through processes of projection, to represent parts of his disturbed and disturbing internal world, if not actually to act it out. It can be said that borderline, personality disordered and perverse patients act on their environment as a way of expelling parts of their unbearable internal world. This results in the recreation in the current situation of dynamics and interactions similar to those experienced in earlier childhood.

If the patient has not ever been the object in the mind of another (a carer or parent), then he does not have a sense of a space in his own mind which he can occupy and use to think in. As a result, he is likely to project different parts of his mind into whatever space he is in and affect those around him who are also occupying that space. This is the way in which forensic patients impact in gross or more subtle ways on those around them. However, this creates the possibility for the practitioner to understand aspects of the patient's internal world, if we can be receptive enough to their projections, come to recognise them in ourselves and in our colleagues and in our interactions, and be capable of reflecting on their nature and functioning. The enormous problem, though, is that the splitting and fragmentation requires an acute capacity by the staff to relate to and—crucially—link up the various aspects of the patient's presentation. Working from their own experiences of the patient, both as an individual and as a member of the ward he is in, is essential in forensic settings. The role of the consultant is to try to create the space to do this and to begin to see the possible links and connections.

It is very useful to have the concept of what we might think of as a vertical split in the personality of a perverse and violent patient, a split which differentiates the more violent and perverse part of the personality from the non-perverse part (Chasseguet-Smirgel, 1985). This vertical structure can be thought of as if superimposed on the more familiar horizontal structure differentiating neurotic from borderline and from psychotic parts of the personality. One of the important ways in which this is useful is to remind us that some patients who are diagnosed with psychiatric illness might well be aided by the use of anti-psychotic medication and significantly reduce their psychotic presentation and ideation, but there will probably remain in place a disordered personality which was responsible for the index offence and which has probably been traumatized by the fact of committing that offence.

In thinking about forensic patients it is very useful to have in mind what is fundamental about forensic patients—to recognise the aggression, hostility and malevolence inherent in their offending behaviours. This is obvious with overtly violent patients, but it is equally true of patients who act out in sexually perverse and sado-masochistic ways. The apparently sexual behavior is recruited in the service of aggression, and the patients themselves, as well as the

victims, are affected by this violence and hostility, certainly in their minds and, in the case of masochistic or suicidal patients, sometimes in their bodies. Robert Stoller, an American psychiatrist and psychoanalyst, refers to sexual perversion as the "erotic form of hatred" (1975).

Understanding this hostility and violence is fundamental to understanding the forensic patient. One of the central ways in which this hostility is enacted, other than physically upon others, is in its impact on the patient's capacity to use his mind, and especially the destruction of the capacity to think and be sensitive to others. The fundamental task, in my view, of the mental health institutions is to take very great care of the mental states of the mental health staff. This requires a sophisticated but essential understanding of the nature of work with forensic and personality disordered patients which is not always present in our contemporary institutions. Hinshelwood discusses this very powerfully in his book *Suffering Insanity* (2004).

If the original family environment was one in which attachment figures expressed depressive or narcissistic anxiety, or aggression, or sexual or physical abuse towards the child, the child would not only have been deprived of the caregiver's reflective and thinking mind as a model for developing his own, but may have learned to actively avoid thinking about his own and/or others' experiences because they were disturbing or violent. As a consequence, there is little likelihood of the development of a sense of a real other person, and therefore no system of values or moral code. Callousness will emerge as a way of functioning, an apparently total lack of sensitivity which is actually rooted in anxiety. Only a sense of triumph or dominance over the external world or the immediate attention or unquestioning admiration of others provides any sense of safety or relief (Hinshelwood, 2004). Intermingled with this there is likely to be the disrupting core complex anxiety about both closeness (which results in feelings of claustrophobia) and separateness (which results in feelings of agoraphobia), and a resultant sense of agitation which can be very disturbing both to the individual himself and to those around him (Glasser, 1984).

Patients in a high-security setting, usually because of the nature of their developmental history and experiences, are likely to have a very disordered reaction to care. Such patients are characterised by

constant attacks on and often defeat of help. This defeat may be by aggressively dismissive means or, more often, by corrupting the help. This is likely to be based in part on their personal experience of caregivers being abusive and violent or sexually perverse. This often results in one of the most difficult aspects of what is required by the practitioner in a forensic setting. The sense of good work and of the patient "getting better", probably desired by all clinicians, is often absent for long periods of time, and if this is not understood as being part of the patient's symptoms then it can be very demoralising.

For the patient who has little if any trust in others, identification with the aggressor becomes a likely defensive posture. This is an especially acute issue when, by definition, a secure institution is struggling to provide both care and custody. There may be unconscious pressure for both care and control to be corrupted—care might become indulgence and complacency and control might become mindless and sadistic—or alternatively, the difficult tension of care or the control is lost, with the result of perversely providing just one or the other (Hinshelwood, 2004). It is interesting to speculate whether this is in part an enactment of the patient's earlier relationships to the parental couple, who were experienced as narcissistic, perverse and corrupt, or as violent (or both), or as lacking a capacity for co-operation and not displaying a mix of maternal and paternal functions.

As well as enacting these functions of care and control of the patients, forensic institutions might also inadvertently institutionalise their patient. The long-term care of forensic patients in medium and high security, for example, may not infrequently result in their desocialisation—a type of "social illness" emerges (Main, 1989), resulting from their dependency not only on the doctors and nurses but less consciously on the structures, boundaries and containment offered by being within the physical and emotional framework of the institution. Adaptation to the particular nature of the hospital regime and the hospital staff may be counterproductive as far as learning to live in lower security or outside the hospital is concerned. Hence, part of the task of the staff is paradoxically to protect their patients from the hospital system itself. This is, however, no easy task, as the staff themselves are also likely to be dependent to a certain degree on a parallel set of physical and emotional safeguards

which, quite properly, they require to support and sustain themselves in their work.

The fate of those working with violent patients is to feel frightened or violated or sadistic; the fate of those working with sexually perverse patients is to feel corrupted and seduced or disgusted; the fate of those working with personality disordered patients is to feel abused or omnipotently indulgent or hostile and dismissive. Staff in high-security settings work with a range of patients who are likely to be all of the above: violent, sexually perverse and personality disordered. As a result, the institution is likely to be flooded, and the staff overwhelmed, by fear, violation, corruption, seduction and abuse. Or—usually and—they may feel defensively sadistic, dismissively disgusted and abusive (directly or indirectly by, for example, being unrealistically/omnipotently indulgent and hence "betraying" the patient). Without the opportunity to reflect on these inevitable and very difficult experiences, the staff working in forensic institutions are destined to repeat the early corrupt, mindless and depriving experiences that most forensic patients had in their beginnings. If staff can sustain a thinking capacity, then in doing so they provide a psychological setting within which some patients might be able to take the first tentative steps from acting out their internal worlds to beginning to be able to reflect on themselves and on their relating to others, and so to begin to develop a less disturbed and disturbing way of functioning.

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