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INDIVIDUAL PSYCHOANALYTIC PSYCHOTHERAPY FOR VIOLENT PATIENTS

Violence has always been considered to be one of the more serious contraindications for psychoanalytic treatment. Conventional psychoanalytic wisdom regarding suitability for psychoanalysis teaches that a patient who has a history of violence towards self or others indicates weak ego strength and primitive defences, and so is unlikely to be able to utilise psychoanalytic therapy, which in itself may increase the risk of the patient acting violently. However, the nature of human aggression is one of the most essential themes that has interested psychoanalysis since its inception, and in its investigation, eminent psychoanalysts on both sides of the Atlantic have treated violent patients. As we have seen in the preceding chapters, violence in itself has only achieved prominence in the psychoanalytic literature within the last few decades. However, earlier generations of analysts produced creative clinicians interested in expanding the boundaries of classical psychoanalysis, such as Menninger (1938, 1942, 1963, 1968) in the United States, who saw many very serious violent cases for treatment. In the UK, the Portman Clinic in London was founded in 1931 as the Psychopathic Clinic, the clinical arm of the then Institute for the Scientific Treatment of Delinquency, by Dr Grace Pailthorpe, a psychoanalyst and psychiatrist, who enlisted the interest and support of prominent psychoanalysts such as Edward Glover and Kate Friedlander. The Clinic's first formal patient seen in 1933 was 'a woman, 47 years of age, noted as having a violent

temper, charged with assault on her woman employer' (Saville and Rumney, 1992).

Since then, the Portman Clinic has continued to treat violent, antisocial, delinquent and perverse patients with psychoanalytic psychotherapy, the clinical work inspired and research insights disseminated by psychoanalysts working there such as Glover, Glasser, Limentani and, more recently, Campbell, Dermen, Hale and Wellton. Meanwhile, other psychoanalysts have focused their interest on treating the most disturbed and violent patients held within psychiatric institutions, such as Cox, Sohn and Hyatt-Williams. These psychoanalysts working first hand with violent patients laid the foundations for the new field of forensic psychotherapy, which has rapidly expanded over the last 20 years to produce a multitude of clinicians from many different core professional backgrounds including psychiatry, psychology, social work, art and music therapy, nursing and probation, and who are treating violent individuals in psychoanalytically informed therapies in a variety of in- and out-patient settings. Parallel to and overlapping with the development of forensic psychotherapy is the recent interest in treatments and services for personality disordered patients, with the creation of specific therapies, some based on psychoanalytic concepts such as transference-focused psychotherapy (TFP) and mentalization-based treatment (MBT), for individuals with personality disorder, including those who have a propensity for violent behaviour.

In this chapter I will discuss the assessment process and treatment of violent patients with individual psychoanalytic psychotherapy, focusing in particular on some of the technical difficulties that can arise in the treatment of such patients. Following the clinical experience of other psychoanalysts I will advocate the necessity for the modification of more conventional psychoanalytic techniques in the therapeutic treatment of some of these individuals whose psychic structures and functioning are especially fragile or damaged. Although I will not be specifically discussing the psychoanalytically based therapies designed for the treatment of borderline personality disorder such as TFP and MBT, I will address some of the therapeutic strategies and techniques incorporated in these therapies that can also be usefully applied in the psychoanalytic psychotherapy of violent individuals. The discussion of the importance of attending to transference and countertransference phenomena in individual therapy is also very much of relevance in the psychoanalytic group treatment of violent patients, which will be reviewed in the next chapter.

Assessing the violent patient

There is a substantial literature on suitability for psychoanalysis (e.g. Baker, 1980; Freud, 1905b, 1912; Glover, 1954; Limentani, 1972; Shapiro, 1984) and assessment for psychoanalytic psychotherapy (e.g. Coltart, 1988a; Cooper and Alfille, 1998; Garelick, 1994; Hinshelwood, 1991), to which I will not pay full justice but will highlight the salient points relevant to assessment of the violent patient. Assessment is a multi-layered process with several functions, including diagnosis, forming a psychodynamic formulation about the patient, assessing the patient's suitability for psychoanalytic therapy and, of particular importance for the violent patient, consideration of issues regarding risk. The assessment interview may be the first exposure the patient has to a psychoanalytic way of thinking, which, for individuals who habitually act rather than think, may be a strange and threatening experience for them. How the therapist conducts these first meetings with the patient is critical for future engagement in therapy. Psychoanalytic assessment puts most emphasis on the clinical interview with the patient, rather than other methods of assessment, such as formal diagnostic psychological testing for personality traits, cognitive tests if there is suspicion of learning difficulty or structured risk assessment schedules such as the HCR-20 or PCL-R. Although these tests may be useful, the clinical meetings with the patient, attending in particular to the experience within the interviews and the nature of the relationship that emerges between patient and assessor, can yield the most meaningful information regarding the unconscious phantasies and functioning of the patient.

Selection for psychoanalytic psychotherapy traditionally aims to evaluate certain key aspects of the patient's psychological functioning and internal world, notably psychological mindedness, ego strength and defences, the capacity to form and sustain relationships and the nature of early object relations, superego factors, motivation for treatment, responses to previous therapeutic interventions and the extent of external support. However, many patients with violent tendencies will show serious deficits in these measures of psychic functioning, and the threshold for offering therapy may need to be lowered if sufficient expertise and support for the treatment is available. Coltart (1988b) enumerates the various components of psychological mindedness, which include an acknowledgement of the unconscious, awareness of emotionally significant historical events and capacity to recall memories with appropriate affect, use of imagination, capacity to dream, some signs of hope and

self-esteem, curiosity about internal reality and capacity to tolerate internal anxiety, and ability to make links between past and present. Although many violent patients who have a diminished representational capacity and deficits in symbolic thinking would not score highly on many of these criteria, they may nevertheless have some awareness that their difficulties are influenced by unconscious internal factors. The assessment process aims to ascertain whether the patient's potential for curiosity in his internal world and ownership of his difficulties can be nurtured and developed.

Ideally, the assessor should arrange to see the patient on more than one occasion, at least two or three times, and more for complex cases and if resources are available. This allows the assessor the space and freedom to address the various factors that should be examined during the assessment process, as well as the adoption of different technical stances and observation of the patient's responses, including the effect of interpretations (Garelick, 1994). This might comprise offering an initial unstructured interview to observe how the patient responds to silences, his ability to free associate, and to assess the presence and quality of emotional contact within the session and degree of access to his internal world. A more accurate appraisal of the patient's ego strength, defences and motivation for therapy is facilitated by seeing the patient several times, to discover what the patient makes of the meetings, whether the patient is capable of reflection between sessions and whether he is able to tolerate the anxiety associated with the open-ended process of psychotherapy which offers an attempt at understanding rather than immediate cure. However, many violent patients may find such an unstructured situation very anxiety provoking and persecutory, and the assessor may need to intervene sooner than with a person whose ability to tolerate anxiety is greater. The strangeness of the analytic encounter should not be underestimated, and for many of these patients, who have never developed a capacity for reflection, or have constructed life-long defensive strategies to avoid thinking and feeling, being invited to talk about their difficulties may be experienced as extremely threatening. They are likely to know very little about psychotherapy and being referred is associated with shame, failure and stigma.

In subsequent interviews, the assessor can focus on more active history-taking. This should include a detailed account of the patient's offending behaviour, including an attempt to classify the type of violence that the patient has engaged in, and to determine its precipitants in relation to the patient's objects, both internal and external,

and associated phantasies, both conscious and unconscious. The history should also give as comprehensive a picture as possible of the patient's object relations. Hinshelwood (1991) provides a useful framework for making a formulation about the patient's object relationships, by consideration of three areas – the patient's current life situation; the infantile object relations, as described in the patient's history or hypothesised from what is known; and the relationship that develops with the assessor, which is the beginning of a transference. Information from these three areas can help the assessor identify the patient's core object relationships, common themes in his object relations that run through all three areas of the patient's life.

Mr Y was referred to a specialist out-patient forensic psychotherapy clinic in another city as there were no appropriate services willing to treat him in his local area. He had spent 20 years in prison for the murder of a prostitute whilst intoxicated with alcohol. During the latter half of his sentence, Mr Y had impressed the Parole Board by his enthusiasm and motivation to engage in every therapeutic and occupational course available. At the time of his release, he had not touched alcohol for over a decade, alcohol having been pinpointed as one of the major risk factors implicated in his violence. However, his probation officer was concerned that although he had attended various anger management and victim empathy cognitive behavioural programmes, no therapeutic work had been done to address the roots of his aggression, nor had the sexual aspects of the offence been explored, so he was referred for psychoanalytic psychotherapy specifically to reduce his risk living in the community.

The therapist met with Mr Y over several sessions during the course of an extended assessment. Mr Y appeared very motivated to receive more therapy and was very willing to talk about all aspects of his life, including his previous offending. However, the therapist was struck by the one-dimensional quality of his account. His description of his childhood was brief and he appeared unable to elaborate on or describe any emotional context to significant events. He had been physically abused by both parents and spent significant periods of time in care, where he had been sexually abused in one care home. Although acknowledging that it was not a happy childhood, he felt that he somehow deserved the abuse, because he was 'born bad', and he did not think he was affected by it in later life. He dismissed the therapist's suggestion that his previous alcoholism may have been connected to his unhappiness, saying that he was genetically predisposed to alcoholism. Since his release from prison he lived an isolated life in a staffed hostel, his only social contact being the people he saw at the Alcohol Anonymous (AA) groups he attended daily, to which he attributed his continued abstinence

from alcohol. He had never had any close friends and had no contact with his family. Mr Y's account of his index offence was vague, saying he did not remember much because he was drunk, but had been angry with the prostitute because he felt she was mocking him, as he was unable to ejaculate. There had been no previous history of violence.

When the therapist tried to explore his relationship with his mother, and also when she asked him about his relationships with women, including his visiting prostitutes, she noted that Mr Y would tend to quickly change the subject. When she drew his attention to this, Mr Y appeared irritable, saying he did not think there was much to talk about, as he did not trust women and was not interested in seeing his mother again, and was very wary about starting a relationship with a woman. He added that he did not mean to cause any offence to her being a woman, as she was a professional. The therapist suggested that because she was a woman, he might feel uncomfortable and not trust her either, but Mr Y quickly dismissed this.

When the therapist saw him again, she asked whether he had had any thoughts about their last meeting. Mr Y said that if he had any thoughts he had pushed these out of his mind. The therapist enquired what these were. Mr Y admitted that thinking about his mother had upset him and she was not worth thinking about.

When the therapist saw him on the third occasion, Mr Y appeared more agitated and dishevelled. He admitted that for the first time in years he was 'desperate for a drink' and was worried he would relapse. The therapist suggested that the assessment process and discussing distressing subjects such as his mother had made him feel more disturbed. Mr Y categorically rejected this suggestion and insisted that he was upset because someone had moved into the room next door, who was noisy and rude.

On discussion of this case with other clinicians in the clinic, the therapist decided not to offer Mr Y psychodynamic psychotherapy. She thought that Mr Y did not have sufficient ego strength to withstand exploration into his internal world. It was apparent that Mr Y dealt with distressing thoughts and feelings by projection or actively pushing them out of his mind. Mr Y did not appear to be psychologically minded and was unable to make links between past experiences and present behaviour. He could not link his current anxiety to the therapist's attempts to open up his internal world, a transference experience in which the therapist was experienced as a rude and noisy intrusive object, like the neighbour, and his early experience of his mother. Any exploration of the index offence and its relation to Mr Y's rage towards his mother was impossible. In formulating his object relationships, we can see how information from each of the three areas of the patient's current life situation, the patient's description of his infantile object relations and the transference relationship with the assessor concur

to give a picture of Mr Y as having great difficulty in forming attachments at all, and how he distances himself from any emotional contact, particularly from a threatening maternal object. In view of this, the therapist concluded that Mr Y would find it difficult to form a secure enough attachment to the therapist in which 'as if' transference phenomena could be explored rather than Mr Y experiencing the relationship in a very concrete way. Moreover, in view of his limited internal capacities for mentalization, the unstructured and exploratory nature of psychodynamic psychotherapy would be likely to lead to intense persecutory anxieties that would increase his risk of alcoholic relapse and/or violence, and that he would find it difficult to tolerate weekly out-patient psychotherapy and the travelling involved to get to the clinic. She suggested that the current external supportive network surrounding Mr Y, including his probation officer, staffed hostel and structured AA meetings, appeared to be containing his anxieties and should remain in place.

Throughout the assessment, the clinician should remain cautious about asking a patient to reveal very painful memories and open up traumatised areas of his inner world to a stranger whom he may only meet on a few occasions, but to whom he may form a rapid and intense transference that may complicate the transition to another clinician for therapy. The patient may be left in an emotionally vulnerable state following assessment sessions, and if therapy is thought appropriate but is not available in the near future, there is a danger that the patient's risk of acting out will be exacerbated or that his pathological defences will harden, and he will be less emotionally available once treatment is offered. It is therefore useful at the beginning of the assessment to make clear to the patient that the assessor will not necessarily be the patient's therapist, as well as having as clear an idea as is feasible about the availability of appropriate local services or therapists qualified to take on this specialised and challenging work.

Assessment of the psychopathic individual raises particular difficulties. The patient's veracity may be in doubt and his history confabulated. Multiple interviews can identify inconsistencies in his account, and emphasis should be placed on evaluating the relationship the patient establishes with the assessor and the latter's countertransference responses, rather than the patient's account of his history. Meloy (1988) recommends that therapy will be of no benefit and should not be offered to psychopathic patients who manifest any of the following features: sadistic aggressive behaviour resulting in serious injury, complete absence of remorse or justification for

such behaviour, very superior or mildly mentally retarded intelligence, a historical absence of capacity to form emotional attachments and unexpected 'atavistic' fear felt by the experienced clinician in the patient's presence.

The setting

The setting in which the patient is first seen has an important bearing on the assessment process. If the patient is an in-patient in a secure unit, his violence is already known about and is likely to be the reason for his incarceration, although a crucial part of the psychotherapeutic assessment is to gauge how much the patient can tolerate 'knowing about' his offence and its unconscious meaning. Considerations of risk will have already been raised about the patient, although again, not necessarily from a psychoanalytic perspective. However, people may also present for the first time to counsellors or psychotherapists in primary care or private practice, and reveal a history of or continued involvement in violent activities. Hasty decisions not to continue the assessment should be carefully examined to see how much these are determined by countertransference responses in the clinician such as fear or repugnance, leading to premature conclusions about the patient's unsuitability for treatment, rather than those based on careful considerations about whether this person could use psychotherapy and what setting would be most appropriate. A person who has little external social or occupational support may find the gap between weekly sessions as an out-patient very difficult if he becomes more anxious or disturbed as a result of therapy, and may need extra external support, such as a community mental health team that could provide regular access to a psychiatrist, social worker or community psychiatric nurse. For patients who are still subject to probation, the probation officer who is monitoring the patient's risk of offending can also fulfil a helpful role in providing therapeutic support for a patient having out-patient psychotherapy. If issues regarding trust and confidentiality can be negotiated, the involvement of a third party in such cases can be felt by the patient to be a helpful parental couple working together in the patient's best interests, a novel experience for many of these patients that can be therapeutically mutative.

For a patient who is already detained in a secure hospital or prison without his consent, motivation for therapeutic treatment becomes more difficult to assess. The patient in a secure in-patient setting is less likely to request therapy himself, and unlike the out-patient,

the therapist goes to see him, rather than the patient being able to come to the therapist for his sessions (Minne, 2008). The patient may believe that agreeing to have therapy will accelerate his progress and release into the community, rather than having any genuine wish to engage in a protracted and painful process of self-awareness. This may also be true for the convicted offender who receives a non-custodial sentence with a condition for treatment. In these cases it is advisable that psychotherapy is not one of the treatment conditions, as again, the offender may have no real interest in exploring the roots of his behaviour and may not see himself as a patient in need of therapy at all. Similarly, for individuals involved in medico-legal proceedings, assessment for and treatment with psychoanalytic therapy should wait until all such proceedings have terminated.

Engaging the patient

The assessment is the initial step in engaging the patient, but difficulties in the patient's ability to establish himself in a therapeutic process may persist for a long time after treatment has been offered, so that the therapist will need to adopt a technique that is flexible and sensitively attuned to the patient's manifest and unconscious anxieties. This will involve some modification of more conventional psychoanalytic technique that may be appropriate for less disturbed patients but proves ineffective or even counter-productive in violent patients. As Minne (2003) describes, one of the tasks that the therapist has to negotiate is how to introduce the patient to the unconscious contents of his mind, without either patient or therapist becoming overwhelmed by these contents, leading to states of unbearable anxiety, psychosis or suicidal despair. This requires careful timing and continuous titration of therapeutic interventions according to the patient's affective temperature. Long silences should be avoided, as these are often experienced as persecutory by the patient, because of the projection of his aggression onto the therapist who may be pushed into an unhelpful countertransferential defensive withdrawal of silence or passivity. Indeed, the unstructured therapeutic sessions may be experienced as so unbearable that the patient cannot tolerate the full analytic hour, and it may be advisable for very severely disturbed, particularly hospitalised psychotic patients, to initially limit the length of sessions to 30 minutes, and allow the patient to leave when he wishes, without interpretations that may sound punitive or retaliatory. Similarly, the therapist may need to withstand long periods of non-attendance of patients who are being

treated as out-patients, or refusal to attend for the in-patient in therapy. The therapist's reliable availability, holding the patient in mind despite not meeting in body, may be a completely new and therapeutic experience for the patient whose body has been hijacked for violent purposes instead of being held in the mind of his original objects.

For patients with poor representational capacity and deficits in symbolic thinking, further modifications in therapeutic technique are necessary. These patient's communications are concrete and one-dimensional and they find it difficult or impossible to experience the 'as if' quality of the transference, instead identifying with the concrete content of interpretations, not their symbolic meaning (Davies, 1999). For these patients, their minds and other people's minds are experienced as concrete objects, and equated with physical reality (Fonagy, 1999). The lack of representational mediating process means that minds and bodies are experienced as equivalent, rather than having a symbolic relationship to each other, and communications can therefore only be via action rather than the symbolic activities of speech or thought. Interpretations of unconscious conflicts and phantasies are therefore not understood by the patient, and should be avoided at this stage. Instead, it is more constructive for the therapist to provide brief simple descriptive comments about the patient's state of mind (Bateman, 1999; Fonagy, 1999). This will include the therapist naming affects, putting words to the patient's concrete thoughts and feelings, and using basic metaphors to introduce him to symbolic thinking. Rather than making the unconscious conscious, the aim here is to establish and maintain emotional contact with the patient by giving the patient a clear and coherent picture of their own mind in the analyst's mind (Fonagy, 1999). This again is a novel experience for the patient whose nascent mind was not held and nurtured in the mind of his early caregivers.

Mr V was a 35-year-old man referred for psychotherapy due to severe anxiety and panic attacks that he had suffered in the past few years and which prevented him from working. He had a history of involvement in serious violent activities as a teenager and young man and had spent time in prison for armed robbery. Mr V telephoned at his appointment time saying he was lost, and eventually arrived 40 minutes late with a friend whom he wanted to bring into the assessment interview. The therapist suggested that his friend stay in the waiting room and she would see him briefly on his own. In the room, Mr V could barely speak due to anxiety. The therapist simply commented that Mr V appeared very anxious about coming to be assessed but

that he now knew the way here and she could see him again in 2 weeks time. Mr V said he thought he would be less anxious the next time. The following appointment he again arrived with the friend, but was on time and more able to talk.

This brief vignette shows how the therapist simply verbalises Mr V's affective state by commenting that he is anxious. Although it is not at all clear yet what Mr V's anxiety is about, simply naming his manifest affect appears to have been helpful as Mr V is then able to attend on time at the next appointment. The therapist's non-verbal adherence to boundaries – that she does not let the initial session over-run due to Mr V's lateness, and does not accede to his request to be seen with his friend – are communicated in a clear but non-persecutory way, to convey the experience of a containing space in which Mr V can begin to find his way.

The internalisation of a stable figure of a therapist who is consistent and boundaried, empathic and non-judgemental, but able to consider different points of view, is an important therapeutic factor. This opens up a space within the patient's mind where difference can begin to be tolerated rather than feared, an area of psychic experimentation and playfulness from which the patient can begin his journey towards mentalization. This is akin to Winnicott's transitional space (1951), which he believed was a pre-requisite for the child to develop a capacity to play, relate and be. Many of these patients exhibit profound difficulties in separation and separateness, because of their early experiences of not being conceived of as separate individuals with their own individual needs, but instead were intruded upon or treated as the narcissistic extensions of their parents. Fonagy (1999) describes the therapeutic paradox in patients who use violence to distance themselves from their objects, yet at the same time show considerable dependency on those objects, including the therapist, with difficulties tolerating breaks in therapy and expressing fears of losing their therapist. The patient needs the continuous physical presence of the object so that their internal states do not become overwhelming. Winnicott (1967) described how the caregiver needs to accept, contain and metabolise the infant's anxieties, re-introduce them in a bearable form and mirror the self-state to facilitate the development of the representation of his own internal states, rather than prematurely internalising an intrusive object that undermines the developing self and ultimately experienced as an alien being within his self-representation. The therapist must be prepared to be used in this way, as an auxiliary ego (Freud, A., 1965), for a considerable length of time before the patient's own mind feels

safe enough to rely on. The therapist will need to contain affects that are too painful for the patient to bear, as well as being used as an object that will tolerate the patient's aggressive impulses without retaliation.

For these patients whose sense of self is so precarious, and for whom the world is experienced as menacing and punitive, premature interpretations of the negative transference or attacks on the therapist will be perceived by the patient as critical, retaliatory and confirmation that the world consists of only bad objects, the therapist being no exception. In her experience of analysing a violent patient, Davies (1999) describes how it is a technical error for the therapist to attempt to return projected parts of the patient prematurely via interpretations, and that the patient needs to use the therapist as a vehicle for his projections to deny the object's separateness. The gradual awareness by the patient of the therapist's struggle with his projected hatred, and interpretation of the affect behind the patient's attacks, rather than interpretation of the manifest attack itself, are the mutative factors. The patient's expectation of the therapist's hostile reaction is not fulfilled, and the resulting dissonance between expectation and experience can lead to a change in the patient's perception.

Several authors (e.g. Bateman, 1999; Davies, 1999; Cartwright, 2002; Christie, 2006) recommend the use of 'analyst-centred interpretations' (Steiner, 1994) with violent patients. An analyst-centred interpretation is one in which the therapist attempts to clarify the patient's perception of what is going on in the therapist's mind, such as saying 'You are afraid that I am angry with you.' This conveys a sense of being understood by the therapist, which can be more containing for very anxious patients, rather than patient-centred interpretations about their own conflicts that can make the patient feel blamed. Again, being invited to observe what might be going on in the therapist's mind, which may not be what the patient fears, initiates a process of triangulation, potentially opening up a third space for thinking (Britton, 1989).

Mr V, introduced above, attended his second assessment session on time, and although less anxious, he appeared sullen, withdrawn and reluctant to talk. With prompting from the therapist, he gave an account of how he felt unfairly blamed and treated by social workers and other professionals who did not believe he was safe to be on his own with his partner's children, due to his history of violence. The therapist suggested that he was very anxious that she will be another one of the professionals who blames him and

disapproves, rather than try to understand what his violence is all about. Mr V did not directly reply to this but went on to tell her about his anxiety and how he had a panic attack when he first held his partner's new baby. Later he spoke of his father's violence towards him as a child.

In this assessment session, the therapist limits herself to making an analyst-centred interpretation about Mr V's fears that she disapproves, an attitude he expects from all professionals. The therapist's articulation of this fear in itself is a surprise for Mr V, who expects a punitive response, and the resulting dissonance between his expectation and actual response opens up a space in which Mr V is able to associate to his anxiety about holding a new-born baby. At this stage the therapist does not interpret underlying unconscious conflicts and it is only much later when Mr V is established within individual therapy that his anxiety can be linked to fears of his own aggression, and that the therapist will be unable to hold him, like the baby, and instead will attack him, as did his father. The therapist also does not interpret his lateness, wanting to bring a friend into the sessions, and his reluctance to speak, as Mr V's pre-emptive attacks on the therapeutic setting and its boundaries, but instead simply comments on his underlying anxiety.

The fostering of a positive treatment alliance, including the acknowledgement and validation by the therapist of the reality of the adversities experienced by the patient in the external world, also draws on classical psychoanalytic technique in the recognition of the real relationship that exists between patient and therapist. Both Anna Freud (1954) and Greenson (1967) proposed that the full analytic relationship was an intermingling of three levels: the transference relationship, the therapeutic relationship and the real relationship. Greenson believed that a trusting relationship with an analyst who showed ordinary human responses was essential to the development and interpretation of the transference. If the therapist can initially ally himself with more healthy aspects of the patient's ego that can be identified and nurtured, these can be used to strengthen the ego and contribute to a good working alliance or therapeutic relationship with the therapist, that will form the foundation from which insights can emerge, and that can moderate the patient's aggressive attacks on both therapist and himself, with corresponding diminution in the harshness of his superego. In his treatment of rage-offenders, Cartwright (2002) endorses some of the technical procedures advocated by Kohut (1978) by the therapist's empathic mirroring of the patient to consolidate a workable therapeutic alliance in the initial stages of treatment. Cartwright warns that if the offender's idealised

self is not initially recognised, or is prematurely challenged, interpretations of defensive structures will be unsuccessful and lead to increased defensiveness or depressive collapse.

Transference and countertransference

The therapist's attentive awareness and monitoring of the vicissitudes in transference and countertransference phenomena form an essential part of the analytic work with the violent patient, although the therapist may have to wait for some considerable time before such phenomena can be safely interpreted to the patient. The violent patient with a borderline personality organisation whose psychic world is populated by polarised extremes and who operates via primitive defence mechanisms such as splitting and projection will shape the transference into an intense experience of rapidly oscillating perspectives of the therapist between an idealised and denigrated object. Initial idealisation of the therapist may be abruptly reversed by any slight indication of perceived abandonment by the therapist, leading to catastrophic reactions in the patient and raised potential for violence. Cartwright (2002) links this with Shengold's (1989) concept of 'soul murder', in which the infant's self is smothered by his narcissistic mother's idealisations, which, once removed, leave the infant bereft and without identity, having been promised an ideal world. Again, the anxieties underlying and motivating the patient's behaviour towards the therapist and his fears of what is in the therapist's mind should be explored with the patient before interpretation about what the patient is 'doing to' the therapist.

Perelberg (1999b) distinguishes between maternal and paternal functions that co-exist and alternate within the transference. She conceptualises violence as a defence against a terrifying object, and an attempt to create a distance from which they feel neither too close and overwhelmed, nor too far away and separate. In her experience of the analysis of such patients, the analyst's interpretations, independent of their content, can be seen as introducing differentiation and separations into the interpersonal experience of the patient that is previously undifferentiated and chaotic. Thus the analyst's formulations fulfil a paternal function of intervening in and disrupting a phantasy of maternal fusion. Here again we see the process of triangulation as creating a new space within the patient's mind and in the patient-therapist dyad in which the patient can begin to symbolise his aggressive and sexual impulses through articulation of his thoughts and feelings, instead of violent discharge in an attempt to

separate from an intrusive object. This also links to Glasser's (1996a) concept of the core complex and its associated anxieties. Identification and interpretation of their emergence in the transference can help the patient understand the interpersonal triggers to his violence.

Mr R was an intelligent young man who was referred for psychotherapy due to violence towards his parents and siblings. His father had died when he was young and his mother remarried a man who was violent to her, the patient and his siblings. He felt aware of his mother's unhappiness from an early age. He was bullied at school, which he felt unable to tell anyone about, but instead coped by focusing on his studies, doing well academically. When he became a teenager he realised that he was bigger than his step-father and started to become violent towards him. His family tolerated this and sought no external intervention due to their guilt and shame, until Mr R himself requested therapy whilst at university. He was still living at home.

Mr R initially assumed an intellectually superior and contemptuous attitude towards the therapist, denigrating her qualifications and asserting that therapy was 'psychobabble pseudoscience'. Whenever the therapist tried to make an interpretation, Mr R would interrupt, his voice would become louder and he would talk over the therapist. The therapist eventually understood Mr R's behaviour as a self-preservative defensive reaction to her as a maternal transference object experienced as intrusive and overwhelming, which he had to distance himself from by not listening to and disparaging the therapist. At the same time, Mr R could not bear to hear another point of view in the therapist's interpretation (here serving a paternal function) that might be different from his own, and would disrupt his unconscious phantasy of idealised fusion with his mother. Towards the end of sessions Mr R's narrative would accelerate so that the therapist would be forced to interrupt him to announce that it was time to finish. Thus we see exhibited in Mr R's transference relationship with the therapist both sides of the core complex – fear of being overwhelmed and annihilated, and fear of abandonment, and how his aggressive response in his verbal attacks on the therapist is the enactment of self-preservative violence.

As the therapy progressed, the fluidity and confusion of Mr R's identificatory processes, in particular between male and female identifications (Perelberg, 1999b), became clearer. Understanding and empathy offered by the therapist were felt to be a dangerous seduction by an all-powerful pre-oedipal maternal therapist to whom Mr R was forced to adopt a feminised homosexual position. Mr R would defend himself against this by articulating a view of the world in which he did not care about or need anyone else and that to succeed one had to ruthlessly and even violently use other people,

in the way that his step-father had behaved. During the first break, before which erotic feelings appeared to be emerging towards the therapist, but which could not yet be verbalised, Mr R beat up his step-father for 'not sorting everything out'. Much later this violence against his step-father, whilst gratifying fantasies that avenged his father's previous violence towards him, could also be understood as protecting him from the murderous rage he felt towards his therapist/mother for not protecting him and using him for her own narcissistic needs.

Modern psychoanalytic technique places great emphasis on the transference-countertransference paradigm, the current interplay between analyst and patient, the interpretation of the transference and the centrality of the countertransference as an analytic tool. Analysis of countertransference is of no less importance for therapists working with violent patients, but the complex concept of countertransference is in danger of becoming simplified and misused as a therapeutic technique. As explained in Chapter 7, understanding of countertransference has shifted from Freud's original view that it was an impediment to treatment, to an awareness of how the patient's pathology actively affects the analyst's countertransference, the examination of which can provide clues to the patient's unconscious and internal world. However, this can lead to the mistaken belief that all of the therapist's feelings are caused by the patient's projections. This may unconsciously influence the therapist to inappropriately skew the affective tone of her interpretations so that they are experienced by the patient as persecutory and disapproving, and neglects the original understanding of countertransference as the analyst's distorted and inappropriate responses to the patient derived from her own unresolved unconscious past conflicts. For example, feelings of boredom or sleepiness in the therapist may be a response to the one-dimensional quality to the patient whose capacity for representation is limited. However, such a countertransferential response may also be the therapist's defensive reaction to unbearable thoughts of violence, and if this is not recognised and attended to, the offender's unconscious belief that bad parts of the self need to be split off and disowned will be reinforced (Cartwright, 2002).

It may be more salutary to think of a countertransferential response as an unconscious reaction in the therapist to the patient's unconscious communications of affect, defence, or internal object relations, but one which inevitably resonates with the therapist's

own unconscious configurations. Therapists who work with violent patients need to be aware of their own potential for violence and be able to tolerate their own aggressive and sexual impulses without fearing them or becoming overwhelmed. In working with violent and perverse patients the therapist may experience a range of distressing and intense countertransferential feelings such as dread, disgust, rage, terror and sexual excitement, as well as psychosomatic responses such as dissociative experiences or even temporary paralysis. It is inadvisable for clinicians to undertake intensive long-term psychotherapeutic work with such disturbed patients without having had their own experience of psychotherapy, which is of course a pre-requisite of psychoanalytic or psychotherapy training. If personal psychotherapy is unavailable, the role of supervision, consultation and reflective practice groups as discussed in previous chapters becomes essential.

In framing interpretations, the therapist can convey to the patient the idea that she may also struggle with problematical impulses and feelings, without resorting to actual self-disclosure. Again, analyst-centred interpretations such as 'You must be very worried that I may become too anxious to treat you, but if I am not anxious, you are afraid I do not understand or care about you' can be experienced as less persecutory to the patient as they acknowledge that the therapist also experiences difficult emotions and conflicts, but can tolerate and articulate them, without resorting to action such as rejection or seduction of the patient. In this way, the therapist is restored as a container, as ego rather than superego or id (Lloyd-Owen, 2007). This facilitates the strengthening of the patient's own ego, and allows him to feel that his impulses might be more acceptable (by his superego) and able to be psychically processed or mentalized, rather than discharged through violence (id-impulses).

Countertransference does not encompass the totality of the therapist's emotional reactions to the patient, as this would negate the importance of the real relationship and therapeutic alliance. However, the real relationship can be very difficult to discriminate in more psychopathic or perverse individuals who unconsciously subvert all their object-relationships. Such individuals invariably have a disturbed relationship to their superegos, which they externalise onto the relationships with their objects, including that with the therapist. It is very easy for the therapist to become unwittingly drawn into a sado-masochistic transference-countertransference enactment, which can only be recognised, understood and explored with the

patient after it has occurred. Sandler's (1976) concept of role responsiveness is again helpful in elucidating and negotiating these technical dilemmas.

Mr R, introduced in the previous clinical vignette, despite making considerable therapeutic progress, could still fill sessions with verbal attacks on the therapist's credentials and psychoanalysis as a discipline in general, and often threatened not to come as the therapy was so useless. At times, the therapist found herself explaining and defending psychoanalytic theory, and 'forgot' to tell the patient about her annual leave until a week before she was due to be away. Here, we can see how the therapist is drawn into enacting both sides of the patient's unconscious sado-masochistic role relationship in which one person is the abuser, the other the abused. Bullied by the patient, she tries to defend herself by entering into an intellectualising argument with him, and then unconsciously retaliates by omitting to warn him of her break, subjecting him to painful feelings of abandonment in her wish to get rid of him. With the help of supervision, the therapist was able to recognise and interpret the underlying fear of dependence that the patient was increasingly aware of, which he defended himself against by becoming the one who is abusive and threatens to leave. The patient was then able to admit how worried he was about losing control when he became violent and the excitement he felt whilst recently beating up his step-father – here we can see how his self-preservative violence becomes sado-masochistic, which is also exhibited in his relationship with the therapist.

The countertransference tends to be thought about when the therapist becomes aware of unusual or negative thoughts and affects towards the patient, whereas more positive feelings are often neglected or ignored. While feelings of enthusiasm, hope, warmth and concern about the patient may be a reflection of the real relationship and therapeutic progress, these feelings may also indicate an unconscious countertransference response to an idealising transference. Patients with fragile narcissistic pathology who need to eject all bad self- and object-parts from their experience may unconsciously invite the therapist to collude in the formation of an idealised relationship where patient and therapist are united in blissful union, but in which real therapeutic work, involving separation and difference, cannot take place. Cartwright (2002) warns against the therapist becoming caught up in the rage-offender's defensive system, and unconsciously imitating the patient's defensive style. Clinicians should be alert to this possibility if therapy appears to be progressing with no apparent hurdles or conflicts.

Mourning and working through

The patient and therapist who embark upon a psychotherapeutic journey together may be unprepared for its obstacles and duration. Introducing the patient to the contents of his mind, facilitating his awareness of previously repressed thoughts and feelings, encouraging him to take back projected parts of himself and exploring his unconscious phantasies comprise a huge therapeutic undertaking that may take many years to negotiate, if the task is achievable at all. The therapist may oscillate between therapeutic nihilism and therapeutic zeal, and with patients who are so seriously psychically damaged, therapeutic aims should be realistically limited to effecting small shifts in their internal world. The painful paradox that a patient has to confront in therapy is that becoming more knowledgeable about his internal world brings with it, at least temporarily, more psychic distress and anguish. If the process of self-awareness is too rapid, the patient will avert becoming overwhelmed by intolerable feelings by regressing to previous pathological but familiar and safer states of mind. Minne (2008) reminds us of the multiple traumas that these patients have to endure – the trauma of their abusive childhoods, the trauma of their offence and the trauma of discovering that their minds are disordered. She proposes that therapy can lead to the development of a post-traumatic stress-type of disorder, caused by increased awareness and understanding, which should be seen as a positive prognostic indicator. In practice, during the course of therapy, patient and therapist will need to endure many cycles of apparent progress and insight, followed by negative therapeutic reactions and regression to withdrawn, depressive states or manic, impulsive behaviour, both of which serve to obliterate self-knowledge and reflection with its associated psychic pain. The empathy and insight achieved in one session will be subverted and attacked in the next. In Kleinian terms, these cycles represent oscillation by the patient between paranoid schizoid and depressive states of mind (Bion, 1984). The former characterises the patient's familiar pathological configuration in which primitive defence mechanisms operate to keep objects split and bad parts of the self projected. If therapy is successful, the patient will gradually move towards occupying a more depressive position, in which conflictual feelings can become more integrated and directed towards the same object, ambivalence can become more tolerable, loss can be acknowledged, concern and guilt predominate over grievance and a process of mourning initiated.

However, this raises the seemingly insoluble paradox of how to mourn the loss of an object that the patient has himself destroyed, not in phantasy, but in reality. When the index offence has been extreme violence or even killing, particularly if the victim was someone close to the patient, the realisation of the consequences of the patient's actions may fill him with such despair that the only option may appear to be suicide. In the therapy of such individuals, the patient's suicide risk may be increased for long periods, and the intervention and co-operative support of other members of the multi-disciplinary team in caring for the patient during these times are paramount. Such a severe depressive state should not be confused with the patient reaching the depressive position. In suicidal states of mind, the patient remains in a paranoid schizoid state, his aggression unable to be digested psychically, but now directed towards himself. True mourning, reparation and genuine acceptance of the loss and damage he has caused may take many years and remain an incomplete process. Hyatt-Williams (1998) suggests that for pre-meditated murderous crimes, mourning has to be life-long. Like others, he underscores the necessity of the development in therapy of a mental apparatus in the patient capable of containment and reflection rather than evacuation, the growth of a psychic function that enables a detoxification process to take place in the mind.

The therapist should be wary of a 'pseudo-mourning' process that can occur in the place of true mourning. Segal (1957) refers to 'manic reparation', a glib process that evades the pain of genuine mourning and lacks the authenticity of true reparation. Cartwright (2002) warns that the therapist should not be taken in by the patient's 'pseudo-digestive' capacities, demonstrated by the patient talking about the index offence for a couple of sessions, in which apparent remorse is verbalised, but then not referred to again. Glasser (1986) describes the problems with deception in these patients, which are unconscious and not the same as malingering. He describes the defensive process of simulation that develops in some individuals, in which the person appears to comply with the demands others place upon him, but this compliance is false, albeit unconscious. Such a process, which is caused by severe early abnormalities in identificatory processes, has become part of his life-long defensive make-up and characterises his way of relating to others in general. This is akin to Winnicott's (1960) notion of the 'false self' personality and Gaddini's (1969) description of imitation as a defence. Lloyd-Owen (2007) describes patients who adopt what she calls a 'sado-masochistic compliant-defiant transference', which defends

against any real contact or relationship with their objects, which is so feared. Glasser cautions that such simulative processes may be very subtle, and often only detected via an intuitive sense that something about the offender, who appears to be making behavioural progress, does not ring quite true.

The process of mourning and working through may also be aided by certain technical interventions by the therapist. Although psychoanalytic sessions are not usually structured by the analyst but guided by the free associations of the patient which are received by the free-floating attention of the analyst, therapeutic work with offenders may need to be more directive at times. Cartwright (2002) recommends that for patients who have killed, actively bringing them back to the homicide or crime and reworking the murder scene can serve two important functions. First, this facilitates a narrative process in which the patient can locate himself at the crime scene and recognise and take responsibility for the 'bad' violent and murderous parts of himself that he has previously split off. Second, this can address the traumatisation of the offender by their offence, to begin to process the flashbacks and nightmares of their crime which these patients often suffer from. If these symptoms are not addressed and recur in unsymbolised form, this reinforces the patient's unconscious belief that such bad experiences need to remain split off and projected.

This brings us to reconstruction, a psychoanalytic technique that has been somewhat neglected or even discredited as an agent of therapeutic change in recent years with the shift towards prioritising the transference-countertransference paradigm and attention to the 'here and now'. Although entering into a historical dialogue with violent patients may be a therapeutic pitfall which can draw the therapist's attention away from addressing the patient-therapist interactions in the heat of the transference, I believe that an exploration of the patient's history is not always defensive, but forms an essential part of the therapy of the violent and perverse patient. Lloyd-Owen (2007), in her experience of treating female offenders, emphasises the importance of information-gathering and history-taking in understanding the roots of their defences, given the severe early, often pre-verbal, traumas these patients have sustained. Such history-taking should not be limited to the assessment process, but can be continued in a collaborative way as part of the flow of ongoing therapeutic work. Patients will often present with disrupted narratives of their early lives, and the reconstruction of a more coherent narrative, aided by the re-working of memories within the transference, forms a vital part of the restructuring of the patient's mind

and strengthening of his ego. In-depth understanding of the unconscious meaning of the patient's index offence is incomplete without understanding its antecedents in the patient's early object relationships, which includes ongoing appraisal and acknowledgement of the external reality of the abusive and neglectful childhoods that many of these patients have been subjected to. Such work does not ignore the inevitable distortions that the patient will apply because of his own unconscious phantasies and wishes, which are continually addressed within the transference relationship to the therapist, but the therapy is one-dimensional and limited if it occurs in a vacuum of no historical context. As Blum (2005) writes: '... reconstruction is not only reciprocal to transference interpretation in the present, but it is a complementary agent which guides and integrates interpretations and reorganizes and restores the continuity of the personality.'

Finally, the long-term nature of the therapeutic work with violent offenders should be recognised. This is unfashionable in the current era of time-limited and brief therapeutic interventions that are easier to research and market as more cost-effective than psychoanalytic therapies. However, genuine and lasting intrapsychic change, if possible at all, is likely to take years rather than weeks or months. Minne has pioneered the long-term treatment of patients through different levels of security, seeing patients initially in a high secure hospital and continuing their therapy as they progress through medium security until they can be seen as out-patients in the community. Obviously such long-term work requires not only committed and experienced clinicians, but the understanding and support of the commissioners who fund such treatment and whose opinions increasingly influence clinical decisions. I should also underline that I am not advocating individual psychoanalytic psychotherapy for all violent patients, nor that it should be their only treatment, but that for some carefully assessed individuals it will be beneficial, often in conjunction with other types of therapy and/or medication. The next chapter addresses group psychotherapy, which may be a more appropriate modality for many patients with violent tendencies. Glasser (1996b) advocates a meeting ground for psychodynamic and more structured supportive approaches in that while the former explores the roots of violence including its triggers, the latter aims to protect the patient from coming into contact with these triggers until he can be unaffected by it. Judicious time-limited use of anti-psychotic medication can also be useful in patients, who are not overtly psychotic but in whom psychotherapy raises intense psychotic anxieties (Minne, 2008). Lastly, this

intensive psychotherapeutic work should not be carried out alone. The involvement of other professionals, whether these are members of the multi-disciplinary mental health team, the probation officer, social worker or external supervisor or consultant, forms a supportive network around both patient and therapist, reducing risk and contributing essential boundaries to the containing space in which the patient's mind can begin to prosper.

Summary

- Many violent patients do not fulfil conventional suitability criteria for psychoanalytic psychotherapy such as psychological mindedness and ego strength, so the normal threshold for offering therapy may need to be lowered. Assessment should occur in a non-threatening manner and aim to ascertain whether the patient's curiosity in his inner world can be nurtured.
- The forensic psychotherapist treating violent patients should have sufficient expertise, support and supervision. The setting in which the patient is seen forms an integral part of the treatment in providing adequate containment in which the therapy can take place safely.
- Engaging very anxious patients may involve some modification of technique to foster the therapeutic alliance, such as initially giving shorter sessions, avoiding long periods of silence, using supportive techniques to build ego strength such as naming affects and using analyst-centred interpretations.
- Transference interpretations, especially those addressing the negative transference, should be avoided too early in therapy, particularly with more paranoid patients. Monitoring of the therapist's countertransference is essential to avoid being drawn into collusions or enactments with the patient.
- The therapist's expectations of therapy should be limited given the severe psychopathology of many violent patients. Therapy aims to foster the development of a psychic function in the patient's mind that can begin to experience and tolerate loss, remorse, concern and empathy. However, repeated regressions to more primitive states of mind should be expected during the long course of therapy.