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CHAPTER ONE

Principles of forensic group therapy

John Woods

The place of forensic group therapy

In her landmark paper, Estela Welldon states, "Group analytic psychotherapy is frequently the best form of treatment, not only for severely disturbed perverse patients but also for sexual abusers, and sexually abused patients" (Welldon, 1996, p. 63). The experience at the Portman Clinic is that group treatment has been an effective form of psychotherapy, not for all, but perhaps the majority of our patients. The effectiveness of group treatment in general is being substantiated by empirical evidence (Burlingame, Fishman, & Mosier, 2003; Leichsenring & Leibing, 2003; Lorentzen, 2000; Taylor, 2000). In addition, at a time when cost effectiveness is ever more crucial, it is important to note that society also benefits from this treatment (Dolan, Warren, Menzies, & Norton, 1996; Hall & Mullee, 2000). Although there is much evidence for the effectiveness of the group-analytic model (Blackmore, Tantum, Parry, & Chambers, 2012), the majority of group work in many settings is highly structured, using a cognitive approach in order to correct faulty patterns of thinking and provide skills training (Saunders, 2008). This has meant that group

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process has been largely unexplored (Morgan & Flora, 2002, p. 204). The aim of this publication is to redress that balance by adding a psychodynamic perspective.

Yalom (1972) characterised the benefit of group therapy as representing the universality of experience; the individual no longer feels isolated and, therefore, stuck with his problems, but how does this sit with people who have demonstrated their rejection of social mores? Welldon goes on from the statement quoted above to show that "the group comprises three elements; the therapist, the patient, and a third element that represents society" (Welldon, 1996, p. 63). This last element has various manifestations. It exists outside the room in the form of the criminal justice system, more benignly, perhaps, in the National Health Service (NHS) that provides the treatment, or more viciously in the sometimes unthinking public media: for instance, in the demonisation of child abusers. The therapist has to think about what kind of contact is possible with statutory agencies such as the Multi Agency Public Protection Arrangements Panel, (known as MAPPA). The third point of the triangle is always there, even if only implicitly, in the group's awareness. It is represented concretely by the clinic setting, which is why such work is best undertaken in the public sector. The process of triangulation between fellow patients, therapist, and institution creates a thinking space so that each is free from what, in one-to-one treatment, might become a claustrophobic and hostile dependency. As a social form of treatment, the group provides a new experience for an individual that integrates their inner world of desires, impulses, and emotional conflicts with what before has been so mismatched: the demands of the external world.

The person presenting as a "forensic" patient has come up against society's standards in terms of legal, or morally acceptable, behaviour. They will have broken the law and/or transgressed social norms. They might not be seeking psychotherapy as others might, for some inner reason, depression, anxiety, or need for personal change, though they might admit to a need to understand the meaning of their actions. Their conflicts will have been with others rather than experienced as internal. Typically, they will have been given to action rather than thought. This particular kind of relationship with the social world needs to be accommodated in the treatment. The therapist must

pay specific attention to the external world. Indeed, the word "forensic" is derived, according to the *Oxford English Dictionary*, from the Latin "forum", the public place where judgements are made. Legal process, child protection, the risk of harm to self or others—all are very live issues and include various interested parties outside of the treatment setting. Yet, the treatment demands an investigation of a patient's innermost thoughts and feelings. How can the privacy and confidentiality upon which any psychotherapy depends be reconciled with the demands of the external world? Forensic psychotherapy has found that perpetrators are not born, but created through their experiences of having themselves been victims, though this is often split off or hidden (Welldon & Van Velsen, 1997, pp. 1–9). However, the statement "He did it because he was abused" inspires mistrust and hostility in those who expect the law to protect society. Understanding can easily be confused with permissiveness. Forensic psychotherapy, thus, holds an uncomfortable position, balancing the opposing demands of internal and external laws.

Since much group work in prisons, or by agencies such as the Probation Service, aims to manage and correct behaviour, we have to ask whether working on the causes or internal dynamics of offending are relevant, or whether they are distractions from the main task which would, for many, be defined as the prevention of reoffending. For the psychoanalytic practitioner, another question is whether analytic work is possible or even advisable for such a group. An outpatient service such as the Portman Clinic has a wider remit than, say, a Sex Offenders Treatment Programme (Brown, 2010) because our patient population includes not only those who have committed offences, but those who might be in danger of doing so, as well as those who themselves suffer the ill effects of sexual perversion. In the context of a health service setting, rather than part of the criminal justice system, the treatment is voluntary and, thus, requires the active participation of the patient. With this broader perspective comes the possibility of investigating the psychodynamics that might underlie these problematic behaviours. The aim is not only to help certain patients, but also to extend our understanding of their origin and meaning. The challenge is to ensure that this does not happen at the expense of safeguarding against further harm, whether to or by the patient.

A psychodynamic model of group therapy

"I know its no excuse, but I damn well know that if I had not been sexually abused every night in boarding school I would not have this compulsion to use prostitutes every day."

Psychoanalytic psychotherapy has come a long way from the ivory tower it was once seen to inhabit. Relational psychoanalysis is a powerful movement in the USA and the UK, (Holmes, 2011). There has been a pull away from the comfort of the private consulting room towards an engagement with wider social issues (Altman, 2009). The person of the therapist is now more acknowledged as vitally there, present, and seen by "client" or "patient", as not neutral, but as far as possible impartial, not observing an individual psyche objectively, but interacting with the other. Psychotherapy is now seen as based on intersubjectivity (Holmes, 2011, p. 309), consisting of the exchanges between the intrapsychic processes of subjective fields of consciousness. Group therapy could be the ideal form of treatment in which this process can take place. Without careful leadership, however, the group might not necessarily be that therapeutic milieu.

Bion (1961) elucidated the defensive nature of much group dynamics, arising from the conflict within each of us about our membership of any group. His description of the individual is often quoted: "... a group animal at war with his groupishness" (Garland, 2010, p. 104). Thus, a group resorts to defensive postures, designed to repudiate the threat to individual identity posed by the group. Some of these defence mechanisms become irrational and rigidified, as if psychotic processes, inhibiting any work the group may be required to do. Hume (2010) shows that Bion's was not a model for individual treatment in a group setting and that he gives little guidance as to how the therapist might work with a group. Instead, Bion remarked on how common it is that patients are convinced that the group "... is no good and cannot cure them" (Hume, 2010 p. 110). Interpretations in this model are addressed only to the group, and reflect on its method of dealing with the failure to fulfil the needs of the individual. Hume (2010) goes on to quote Sutherland as observing that Bion's group "... takes away the anchorage of the adult self-identity". However, for people who urgently need to change maladaptive forms of self identity, this disillusionment can be put to good use. Hinshelwood (2008) has suggested that the Foulkesian model and technique,

allowing, as it does, more space to the individual, is less stressful to those who might need to reorientate their relationship to what Foulkes called the "matrix" of their social world.

The "foundation matrix" is what Foulkes called the shared mental operations between people. "Dynamic matrix" refers to a more specific level, the "web of communications in the here and now within the group" (Foulkes, 1975, pp. 131-132). This is built up and developed by a process of "free group association" (Foulkes, 1975, pp. 95-96), in which each group member is encouraged to respond to each other's communications as freely as possible. This material consists, in effect, of spontaneous interpretations by the group of each other's contributions. The therapist's role is to guide, contain, and, at times, illuminate, as he or she amplifies certain features and damps down others; confusion and chaos in the group, for example, is useful only up to a certain point, beyond which the therapist needs to be more active. Foulkes draws an analogy with the conductor of an orchestra who co-ordinates the interplay of parts in order to make a coherent whole (Foulkes, 1964, p. 285). (Indeed, he preferred "conductor" to "therapist", though this is usually retained in the clinic setting.)

Interpretations about an individual's internal world are problematic in group therapy; they exclude other group members, and, if prolonged, reduce the others to an audience who must wait their turn. However, when patients are encouraged to relate to each other, there is an immediacy of therapeutic experience for group members on a collective basis. There is a far greater range of possibilities of meaning than was previously known to the individual. It is as though the unconscious emerges in the present reality rather than being sign-posted by the one "expert": "Is this how I come across to others? Perhaps this is a side of me I don't want to recognise. But in that case ... who am I really?" Increased self-knowledge can produce new identifications. Instead of denying the identity that others in the group reflect back, the person is led to accept that he may not be quite what he thought he was: for example, not the innocent victim of injustice that he had defensively maintained. Identification is a process that takes place unconsciously. Identity, on the other hand, is an attempt that each individual makes to organise conflicting identifications in order to achieve what might, after all, be no more than an illusion of unity. Questioning this destabilises a person's view of himself. Joining a group and staying with the process has to be acknowledged at

the outset as hard work, especially in order to dispel the fantasy of comfort and consolation that some might bring as their goal of treatment.

The Groups Book (Garland, 2010) shows how varying aspects of an individual's internal world are picked up on by different group members, including the therapist. "The internal world becomes visible and alive, active in the relationships lived out in the room" (p. 57). Orientated more to Bion than Foulkes, Garland and her contributors focus on the group's task, and the basic assumptions that may, or may not, unconsciously facilitate a therapeutic process (Garland, 2010, pp. 104–110). By contrast, the Portman model owes more to Foulkes, though it has been adapted, most notably by Wellton (1997, pp. 9–10). This is worthy of comment, since the emphasis on destructive group process is much less in Foulkes's theory than Bion's, even though Portman patients have been referred for predominantly destructive behaviour. It might be that the group therapy culture in the Portman clinic has been determined by a need to ensure, as far as possible, that the group remains a safe place, especially for people who have done dangerous things, despite the group also providing an exploratory, uncovering, and interpretative function.

Developing Bion's theory of the basic assumptions that inhibit the work of the group, Hopper (1997) has proposed a fourth basic assumption, "incohesion", particularly relevant to groups of people affected by trauma, and where thought and work have to be avoided because awareness is associated with too much pain. Hopper goes on to elaborate concepts of "aggregation" and "massification", two forms that operate the incohesion that itself becomes a threat to the survival of the group. In these states, role differentiation is made impossible because of envy and fear of destruction. There might be a "fantasy of perfection" that, for a paedophile group, can have sinister overtones; this is where the therapist has to provide an active form of leadership.

The group was bemoaning the impossibility of loving sexual relationships and the therapist began to feel oppressed by the repetition of these complaints. He commented that the group was bonding with an implicit idea that sexual exploitation was inevitable. Then a group member responded to someone who had been complaining that he keeps being drawn into anonymous sex: "Until I met you, I thought I was the only person who could lie so successfully to myself. Can you not see that in

going to a sauna, where you know men are going to be looking for sex, you are going to be propositioned?"

How differently this critical stance would have been perceived by the patient had it been put by an individual therapist. Perhaps a key question is that, given the background and personal histories of group members, what prevents them from becoming *en masse* perverse and/or delinquent? The rest of this chapter, and perhaps the whole book, attempts to address this issue. It is unusual for Portman groups to fall into destructive processes, because they are ever-present and always being worked with. The question will be investigated in more detail, but part of the answer arises from the valuable qualities of group therapy generally. Clearly, the power differential between client and professional is radically altered. Group therapy is fundamentally a democratic and egalitarian form of treatment. It meets a need in most people, especially those who have had severe problems in their lives, for recognition, belonging, and emotional support. This can become the basis for change. Group members report a sense of empowerment, being no longer in a passive position in relation to their therapist, but actively involved in their own and others' work. Thus, we speak of group "members", rather than "patients", and they are invited to take part, to a certain extent, in managing their own treatment setting; for example, writing to absentees, and in other ways which will be evident throughout this book. This is not to say there is no conflict or frustration at the conflicts that inevitably arise:

Exasperated by Roger's arriving again clearly intoxicated at the group session, even though he insisted he had "only a half a pint for God's sake!", the group debated whether they could take a decision demanding that he not come to the session if he has been drinking. He accepted this limit, but found it much harder to give up his other compulsion, paying for sex with "rent boys". The group would not accept his protestations that these male prostitutes were of legal age. Group members were too aware of the damage of sexual abuse, and how it is repeated in prostitution. Confronted continually with this conflict, he decided to leave, much to the chagrin of some, but relief to others. For the therapist, the sense of failure with Roger was mitigated by the sense that the group had at least confirmed their own limits to acceptable behaviour, and "who knows?" someone in the group workshop conjectured, "Roger himself may have got the message."

The peer group, siblings, and the law of the mother

"Horizontal" relationships in a group, based on equality and common purpose, rather than the "vertical" transference evoked in other therapeutic structures, facilitates independence and autonomy (Well-don, 1997, p. 17). This is a process that is particularly useful for people who have come into conflict with the authority of the law. Oedipal conflicts are mitigated by multi-dimensional sibling transferences (Well-don, 2011, pp. 126-128). This is not to deny powerful ambivalence and conflict in the group setting as well. Freud conjectured that at an early stage of cultural evolution, a "horde of brothers" banded together to murder the father, in order to have rights over the mother; they are then held together by guilt and fear of retribution (Freud, 1939a). This he regarded as fundamental to what we would now call group dynamics. Idealisation of a group leader, such as Hitler, promises relief from guilt and shame. Klein, on the other hand, commented that the bond between siblings might provide relief from parental sadism and neglect (Klein, 1927, p. 119). Wellendorf (2011, p. 4) points out the annihilation anxiety aroused by the arrival of a new sibling which, if not dealt with, is repeated in damagingly competitive relationships. Coles (2003) describes the crucial role of siblings in structuring the psyche of individual development. Joyce (2011) has shown the developmental value in managing aggression and rivalry between siblings.

The significance of siblings for the development of personality has been extensively explored by Mitchell (2003). She takes the view that psychoanalysis has focused excessively on vertical relations between parents and children, to the neglect of lateral relations and their influence on individual development, especially on relationships in later life. Sibling experience evokes existential conflicts, the trauma of being annihilated by another, and might also provide the first experience of differentiating self and other. The mother, in Mitchell's view, has a crucial role in mediating this process. The "law of the mother" introduces sharing, a concept of seriality, and mutuality, all of which militate against narcissism and omnipotence, the most blatant manifestation of which is to be seen in the incest perpetrator. Whereas breaking the barrier of incest goes against the "law of the father", albeit at the cost of entry into the symbolic (social) order (Lacan, 2007, p. 67), breaking the "law of the mother" produces primitive fantasies of power over life and death, and the pathway to adult

sexual perversion is opened up. (The clinical material about the pregnant therapist in Jessica Yakeley's chapter can be seen as a wonderful instance of re-establishing the law of the mother.)

The single therapist is often the object of a maternal transference, and it has become expected in the therapeutic culture at the Portman, following Well-don's pioneering work, that a sole female therapist may effectively work with groups of men; some may well have been violent, but come to accept the authority acknowledged her by the group (Well-don, 1997 p. 17, 2011, p. 202). Whether the solitary therapist is male or female, their nurturing and consistent role fills a gap and a need in the experience of the patients' lives. We might say that for the delinquent or offender patient, the law of the father has failed, and that sometimes a male therapist seems to evoke more aggression in the patient or group. Neither has the renunciation of a primitive union with mother happened in the development of perverse fantasy life. In group treatment, the sexually perverse patient has an opportunity to renegotiate his relationship to the social world at a profound level. A move into the social world brings the possibility of being no longer excluded from the symbolic order. What also may be supplied by a treatment that derives more from the law of the mother is a restitution of earlier pre-oedipal experience, and repair of early infantile emotional trauma.

The group is debating whether to write to Patrick, who is now absent for the third week. Martin says he does not feel like writing because Patrick did not seem motivated to change; "Quite frankly I'd prefer it if he didn't return." The group seem nonplussed by this, while the therapist is thinking about Martin recently revealing his grievance at the suicide of his brother, and being made to feel guilty for neglecting his brother's obvious mental illness. The therapist comments that it might be useful for Martin to express some of that to Patrick, since he obviously felt rather let down by him.

*How does forensic group therapy work?**Aims*

The therapist and a prospective group member formulate the aims of joining a group. These have to be realistic and achievable. Cure is a notion that usually has to be modified. The greater likelihood of gradual change, at the patient's own pace, puts the individual in a

more autonomous position. "Finding out the real reason why I compulsively exhibit myself" might be achievable, but will knowing the "real reason" enable the person to manage his life better? Above all, the group provides a forum for experiencing and, therefore, thinking about relationships. So, such a question may be reframed as, "What am I doing to people by my behaviour, and why?" Bion expressed this as a transition from "narcissism to social-ism" (Garland, 2010, pp. 34–36). The first step is for the new group member to engage with an idea that there might be a benefit to be derived from sharing their experiences with people who have "problems somewhat like" their own. The immediate result is to reduce the shame and sense of isolation with which they have been burdened, in many cases, for years. Then the work begins.

The purpose of the group

Doubts are often expressed when group treatment is recommended: "Sharing my innermost thoughts with a bunch of strangers? I've got enough problems of my own, I can't take on other people's!" The group therapist needs to have a concept, based on training and experience, of the value of taking such a leap into the unknown, but might respond with something simple: "You may learn something about yourself through sharing with others." The process is most elegantly put in a classic group analytic paper titled "Taking the non-problem seriously" Garland (1982). The presenting problem that the person brought to the group fades into the background as the foreground is occupied by those aspects of the personality and behaviour that have an impact upon other members of the group. Opening his mind to new possibilities presented by the group, an individual may be released from his repetitive and self-destructive mode of being. This is not always easy to convey to a candidate for group therapy. More readily agreed in the Portman context is the forensic focus. This has to be made explicit, since an emphasis on the presenting problem changes the traditional non-directive stance of the psychoanalytic therapist.

The forensic focus

The aims of psychodynamic group therapy are described usually in terms of self understanding and relatedness to others, (Garland, 2010,

pp. 12–13). What forensic treatment adds is twofold: (a) to develop an understanding of the offending or perverse behaviour and its unconscious determinants, and (b) a working through, as far as possible, of the trauma that is presumed to have been defended against and converted into acting out (in so far as the patient is able to do so). Once this work commences, then a shared culture develops in the group. This expectation is confirmed every time a new member joins. The convention is that pre-existing members introduce themselves, saying what brought them to the group, where they are now in their lives and in their therapy. This method of induction stabilises the newcomer and enables them to open up about what brought them here. It avoids the danger of secrecy, one that these patients are particularly prone to, having lived with shameful secrets for so long.

After hearing the others' introductions, Timothy describes his self-harming masturbation. He says, "I don't need to tell you it all but it does involve trying to strangle myself. It's too shameful to say everything." Martin says, "Well, what I do is pretty self destructive, only in a different way."

Confidentiality

A question much debated among colleagues is the question of reporting on information shared by patients, especially in relation to questions of child protection. Group members, too, will ask about what degree of confidentiality they may expect from the treatment. Clearly, the treatment will require a degree of confidentiality, but privacy, in the context of abuse, easily becomes secrecy, and patient confidentiality can be perverted into collusion. We strive as far as possible to preserve a therapeutic space, because a patient who has committed offences needs to be able to explore his thoughts and impulses before they lead to action. If, however, criminal actions are brought into the treatment, the response might have to recognise that confidentiality cannot be absolute. It is not possible to be impartial about child abuse (Woods, 2003). While we have the prerogative of clinical judgement, we also have the responsibility to support child protection and prevent child abuse. Reporting has been rare in the collective experience of Portman group work, and this largely because the sharing of such problems with colleagues has meant that a therapeutic intervention has usually managed to minimise the risk to any child connected with our patients.

The activity of the group

Interacting with others, sharing experiences, taking on their feedback and impressions produces an increased awareness of self and other, and, gradually, the interposing of thought before action. As the network of communication builds, so it becomes an experience of containment, which is eventually internalised. Confidentiality is usually taken for granted, though occasionally has to be reaffirmed. Since all are in the same boat, so to speak, there is usually an assumption that, for mutual benefit, each can count on the respect of others, though this does not preclude a degree of confrontation and conflict. It is a shock when the boundaries of trust are disrupted, when someone, for example, attempts to gossip outside the group—or worse.

Michael discloses that Larry had persuaded him to go for a drink and then suggested a sexual encounter. A row ensues, with anger from the group, outrage from Michael, denial and indignation from Larry, who then professes his loneliness and depression as excuses. It feels touch and go in the session whether the group can survive, or at least that someone has to leave. Finally, Larry accepts the group's response that he was also trying to destroy the group and with it any therapy that he and Michael might receive.

The role of the therapist

The therapist stands for reality and truth, in opposition to the illusions and deceptions of perversion, and represents something healthy in the larger social matrix, that which Foulkes called the group norm (Foulkes, 1948, p. 29). However, in so far as that has to be mediated through the individuality of the therapist, the group's functioning becomes a reflection of the person of the therapist, albeit sometimes unconsciously communicated. Positive therapeutic outcome has, in fact, been linked to the availability of the group therapist as someone with whom the group can identify (Catina & Tschuschke, 1993), but since the therapist is far from omnipotent, there will, at times, be group dynamics that cannot be controlled, perhaps only monitored, and maybe elucidated. This is not to say that that therapist attempts a "neutral" stance, though he or she needs to be impartial in dealing with the group. Evidence suggests that a non-directive approach is unproductive (Andrews, 1990). Experience provides the means to achieve a balance between how much to intervene, to maintain

boundaries and aims, and how little, to enable spontaneous expression of the individual's use of the group. Brown and Pedder (1979, p. 134) describe a "modelling function", whereby a group therapist may helpfully demonstrate actively the ways in which a group member interacts and responds to the communication of others. The aim here is to promote engagement, something that would be inhibited by interpretations about attacks on the setting.

Pines (2000) has very usefully provided a "conductor's therapeutic map", which distinguishes three aspects of the therapist's role: *dynamic administration*, which refers to selection and composition of the group and managing the setting, *boundaries*, the facilitation of group communication, and *interpretation*, which may be seen as the provision of new information to the group about the meaning of what is going on, particularly in regard to previously unconscious or transference content. At times, however, the group, especially with a new member, might launch into uncharted territory:

The therapist had recently introduced a new member, Ron, who disclosed that he had sexually abused his own son, penetrating him anally, and had served a prison sentence for it. He put this in such a way as to imply that he felt it unfair because he had "only done it once", had been drunk at the time, feeling very let down by his wife, and, in any case, he said, "it's no big deal." This was a very different version of events than he had given to the therapist at assessment, where he had expressed appropriate remorse. The group were sceptical about Ron's minimisation of his offence, but Ron was slow to take this on board. The group became despondent, feeling they could get nowhere with this. Phil began a session, saying to Ron, "I dreamt you had me gripped by the balls and were forcing something into my mouth." Ron seemed to relish this image, and wanted to explore it further, but the therapist intervened, saying that he thought the group also perhaps felt assaulted by the introduction of someone who was saying that sex between adult and child was permissible; they might even, he said, feel rather abused by the therapist. This seemed to release the group to say that Ron could only be accepted in the group if he could see the harm done to children by sexual abuse. We then heard about Ron's own experiences and the severe emotional damage that had resulted.

This was an unusual situation, unanticipated by the therapist, and the role of dynamic administrator suddenly had to be adapted to include an interpretative function. Note the need for an "analyst

centred" interpretation (Steiner, 1992), since the therapist had to accept the fact of having created the situation. To have interpreted the forbidden paedophilic impulses as belonging to the group would have undermined the therapeutic process (Alvarez, 1992, pp. 161-162).

Usually, the therapist will have formed a view from the preparatory meetings that someone is likely to engage with the group openly and honestly, at least to a degree. It should not be forgotten that for anyone it is a tall order to take the risk of revealing their innermost self to others who are, to begin with at least, total strangers. This is only possible via the therapist, who enables a transition from a one-to-one contact in assessment to the experience of being in a group. The therapist has to manage the relative loss of intimacy for the new member, creating the possibility of a shared therapeutic space. The introduction of poorly prepared patients might undermine the group, and be a repetition for the individual concerned of the injurious and traumatic events originally experienced years before. In preliminary meetings, it might be necessary to dispel the notion of the group as a kind of social club where people make friends and meet up outside sessions. There has to be a capacity at least to think about the meaning of antisocial acts, but the therapist also needs to know that an overriding tendency to action will, from time to time, reassert itself. A balance has to be achieved between knowing the individual well enough from preliminary meetings to support their joining, but not so much as to develop a dependency that would exclude the presence of others in the therapeutic space. A group therapist develops a lightness of touch through which each group member feels that they are recognised and are significant to the therapist, while also allowing space for interaction with the others.

Joe had told the therapist of his HIV positive status in a preliminary meeting, and how he had come to expect rejection, fear, and revulsion in others. He said that he could reveal this to the group. However, when he did so, there was an absentee, Mark, who, it was said by those present, would be intolerant of some one with AIDS. The therapist was slow to pick this up. Joe remained silent in subsequent sessions when Mark was present, who tended, as he always did, to dominate proceedings. The therapist drew Mark's attention to the fact, (not for the first time) that he could be intimidating, especially to a new person. "But" (and this was addressed to the group generally) "no one is going to be abused here." Mark, for his part, was saddened to think that he had been so feared, and said it was

"only" his anger about what had been done to him, and that he could let go of his prejudices when he met someone face to face and with whom he knew he shared problems.

The therapist's own reactions need to be continually monitored. Listening to traumatic experiences from group members, whether as victim or abuser, is bound to evoke painful affects. Identifying with Joe's fear in the above illustration enabled a sensitive exploration. The issue of HIV/AIDS was, of course, bound up with the traumatic experiences of child sexual abuse. Focusing upon the task, and taking care to provide a containing setting for the patient, are ways for the therapist to hold disturbing feelings in her or himself. Muddles over boundaries might threaten that the original trauma comes flooding back. Processing these feelings is a large part of the work of the therapist, trusting not only to self-knowledge derived from his own therapy, but also to the ongoing support of colleagues via the group therapy workshop. As Bion put it, the group is the container (Bion, 1961) and the therapy depends on what kind of container.

Handling boundary incidents

Following their session, the group began to hang around the steps of the clinic to smoke and chat. The therapist was unsure what to do about this, not wanting to fall into a superego role. He discussed the matter in the group workshop, where colleagues helped him deal with feelings about recent sessions, which were becoming dull, boring, and repetitive, with much lateness and absenteeism. Subsequently, the therapist took the opportunity of saying to the group that they seem to be waiting for their real session to begin at the doorstep, and "could it be there are things you don't want me to hear about?" Mick then said that he was bothered by the fact that on one such doorstep occasion he had been shown pornographic pictures by another group member. This led to some productive discussion about the corrosive effect of the "smoking" group.

Foulkes envisaged the conductor as less concerned with interpretation of meaning than with facilitating communication. The "smoking group" did not need so much to be interpreted as destructive (although, of course, it was), but to be drawn into the field of communication within the session. In Foulkes's view, there is an inherent therapeutic power of a group, which, however, has to be

mobilised to overcome symptoms of disorder, which have primarily an antisocial meaning: "[Symptoms are] . . . highly individualistic, group disruptive in essence, and genetically the result of an incompatibility between the individual and the original group, i.e. the family" (Foulkes, 1964, p. 156). To restore this connectedness with others, the conductor intrudes as little as possible, and only in so far as would enable participation, preventing anything that would deter good communication among group members. Interpretations by the conductor are less important in this model, just as the precise nature of transferences is less relevant than the relatedness of group members to each other. Reid puts it a different way when she says, "becoming a group is the therapy". Members might start out as self-centred individuals in discord with others, but move towards "a recognition of the needs, wishes and feelings of others" (Reid, 1999, p. 257).

Less extreme forms of boundary incidents may be understood as arising from members' need to be special, to be recognised and cared for. The history of neglect might have meant that this person has been treated as a part object by parents and carers, without the acknowledgement of feelings of his own or the need for safety. Although the therapist and group might not be able to provide the love that was so lacking, they could, nevertheless, provide a model of firm and caring adherence to boundaries. One is helpfully reminded at these times of the process of adolescence, where acting out under the pressure of need for change is to be expected at that stage of development. Transference, however, will dictate that there will be resistance to dependency or trust.

Graham brought in a self-help book, which he said was relevant to the problem described by another group member, Jim. When Jim hesitated, the therapist intervened and said that it would be better if, instead of reading from the book, we heard from Graham about what was stirred up in him by Jim describing his problem last week. Graham was evidently disconcerted, but Jim said later he was relieved because he could not stand self-help books but would have felt anxious about rejecting it.

Know your group

Most, if not all, forensic patients come from a background of neglect and abuse, to varying degrees. Group members will, therefore, bring

a sense of deprivation deriving from trauma directly into the treatment. The sense of grievance might stand in the way of accepting any benefit from the experience. If criminality and antisocial attitudes of arrogance have been employed by some group members to hide their shame and otherwise crippling insecurity, these defences will break down. Many will have been leading a double life, or at least one of secrecy, which will, of itself, produce an enormous emotional strain, and might, indeed, become the occasion for seeking help. The habit of (self) deception might be repeated in the treatment, sometimes with disastrous consequences. Since there is such a limited capacity for tolerating anxiety, acting out might well occur as an old and not very effective defence.

Steve informed the group, "It happened again. Some guy in a van—they think they own the road, cut in, made me slam on the brakes, so at the next lights I got alongside him, gave him the V sign, which annoyed him. OK, maybe I shouldn't have done it. He swore at me, I wound down my window and swore back. The lights changed, I drove off, he followed me. I led him a dance until there I was in a cul de sac, no way out. I got out of the car with the big spanner I keep just in case, and stood there. "Come on then," I said. That did it. He could see I meant business and so he fucked off." Leslie said, "You know, Steve, you say you shouldn't have done it but in fact you seem really happy about the whole thing and you keep the spanner there 'just in case?': Steve answered, slightly sheepishly, "OK, but there was no damage this time. No harm. I suppose there might have been. I just remember thinking, 'No one is going to mess with me'." Leslie said, "Well, your mood is certainly a lot lighter than when you were telling us about being bullied by your wife . . ."

The therapist's understanding of perversion and violence

"Perversion is a condition in which a person does not feel free to obtain sexual genital gratification through intimate contact with another person" (Welldon, 2011, p. 31). Instead of what could be regarded as healthy relationships, the person suffering from a perversion has compulsions of a more or less bizarre and asocial kind, but which always involve harm to the self or other. This is a statement not of moral condemnation, but about emotional and psychological health, and is nothing to do with sexual orientation (unless the sexual interest in children be regarded as a sexual orientation, rather than a

perversion (see Chapter Six)). What is perhaps more important than social sanction is our understanding of how the perversion might have come about. The "core complex" theory of Glasser (1964), a former director of the Portman Clinic, is a set of ideas much employed by Portman therapists. In brief, this refers to a dynamic of a certain kind of object relationship developed in early childhood and which operates as a powerful determinant of current relationships that can be described as based upon sexual perversion. As a first condition, there is a longing for fusion or merging with the maternal object, a sense of being "at one" with the object, but this gives rise to fears of annihilation of individuality. There is then a flight from the object, but in the absence of a safe place, this means, in effect, a narcissistic withdrawal. There are consequent problems of isolation and fears of abandonment, so that attempts at controlling the object are made. Aggression is used not in order to remove or destroy any realistic threat posed by the object, but to keep it at a safe distance. According to Glasser's theory, sadism and sexualisation are used in varying degrees in order to maintain an illusion of power and to triumph over, and protect against, fears of loss. This pattern is seen time and again in our patients and produces distortions in everyday relationships, which will also be evident in the group.

Michael complained of his wife's "intolerance". Upon discussion with the group, it becomes clear that he feels that she is supposed to accept his habitual use of prostitutes, instead of having a sexual relationship with him. He said how he likes the ritual of dressing up and pretend beatings that he can give the prostitute. "It's only playacting." Then he could be sexually aroused. He said he could not face his wife if he were to show her that side of his character.

From the time of Freud's (1940e) conceptualisation of fetishism, based on disavowal in the little boy of the female's lack of a penis, to Chasseguet-Smirgel's (1985) concept of the "anal universe", it has been clear that a predominating feature of perversion is the tendency to erase differences and to deny reality. This, too, will manifest itself in the group, as sometimes group members will presume a familiarity with the therapist, or claim a triumphant attitude at having all the sex they want, through pornography.

Gone are the days when homosexuality was regarded as a perversion, or, indeed, as a crime. It is now recognised that deviant

sexuality is independent of object choice and that the work of the forensic therapy group is to extricate as far as possible a healthy sexual function from the corruption of narcissism, omnipotence and destructiveness.

Frank describes how he feared his masturbation was getting more "weird". It was not enough to tie himself up; now he found himself inserting large hard objects into his anus. Group members ask if he is causing himself pain. He says, yes, but it enhances the pleasure of ejaculation. He can feel himself, he said, to be both male and female at the same time. "That is why I've never stayed with a girlfriend, even though I've had sex with them; I think they are having more pleasure than I am. I don't want to do the poking, I want to be poked."

The changing nature of the patient population

It had been thought that voyeurism was not suitably treated in group therapy since the group member would simply watch others and not be able to participate (Welldon, 2011, p. 68). However, the recent explosion of internet pornography, including the compulsion to watch illegal images of child abuse, has meant that each Portman therapy group currently has members bringing this as an ongoing problem. Perhaps this compulsion to pornography, and concomitant masturbation, differs from more traditional forms of voyeurism: it is not yet clear; theoretical research suggests that new forms of psychopathology are being created (Wood, 2007). What is certain is that our groups have adapted and provide considerable help for people to manage their addiction, to understand the underlying causes, and get the support that they need in order to change. Similarly, one group that was reserved for patients who came with contact offences against children has had to adapt to include offences of downloading illegal images of child abuse. This has helped a reconceptualisation of "paedophilia" as but one manifestation of what may be termed "paedo-sexuality" (see Chapter Six).

The inhibited capacity to mentalize and the tendency to act

The awareness of the relationship between internal and external reality is not universal; it is a developmental achievement (Fonagy &

Target, 2000), one that many forensic patients only partially attain at best, and, therefore, need to recapitulate. These authors go on to explain the need for the infant to integrate two mental states: "psychic equivalence" and the pretend mode. Psychic equivalence is shown in the above instances: Michael's frustration with his wife derives from his creation of her as the embodiment of his sexual conflict and sadism. His "playacting" with prostitutes gives him a sense of real power, just as Frank's anal penetration makes him feel that he is actually a woman. It is not enough for him to participate in a woman's pleasure; he has to possess it. In neither case is it possible for these men to appreciate symbolic reality, or to imagine that the thoughts and feelings of others are different from their own. In the ordinary social world, we do not know, or directly experience, the thoughts and feelings of others, but we can infer them, recognise them as connected to an outer reality, and use them to reflect upon our own thoughts and feelings. Opportunities for this process, which have been so lacking in the past, may be found anew in the therapy group.

Derek (challengingly to the therapist). "Sometimes I think you're disgusted with us. Actually, I think you are most of all disgusted by me. Oh, I know you don't say it, you have to be the therapist, professional and everything, but I can see it in the way you look away sometimes. Especially when I speak." The therapist remained silent, allowing the next question to be asked by Derek himself. "About what, I suppose, you would have to ask." He looked at the others appealingly, perhaps for support. They waited for him to continue. "About masturbating to children's television programmes . . . That must be the most despicable thing. Apart from abusing a child, which I would never do. I only have my fantasies. I hate myself, so why shouldn't you? And yet you go on listening to it. When is it going to change, you should ask?"

"As if I could make you change," said the therapist.

"If only you could," he said, sadly.

The question of gender

Due to the preponderance of males in forensic referral, therapy groups often find themselves single-sex, with some exceptions (see Chapters Five and Seven). Similarly, in prison, the vast majority is

male. While in some ways unfortunate in not providing a truer social experience, this feature does enable the group to engage in an intense reassessment of masculine identity. It seems, in Western culture, that masculinity is so often equated with power, especially in the area of social deviance and law-breaking. Gilligan (1999) has shown how violence, "our deadliest epidemic" (the subtitle to his book *On Violence*), is often employed by perpetrators as a solution to problems of severe low self-esteem and shame, tied especially to fears about masculinity. Violence is felt to be the solution to feelings of powerlessness. The violent patient gets rid of anxiety about his powerlessness. If a boy experiences the trauma of sexual abuse it is often felt to "feminise" him; masculinity has to be reasserted when there is an intolerance of weakness. Thus, violent males grow up unable to manage feelings of loss and more ready to resort to violence in order to restore a fragile sense of masculinity. Perelberg (1998) suggests that an extreme fluidity in masculine and feminine identifications might lead to an act of violence as an attempt to repudiate a feminine identification in favour of a more potent male identity. Women are feared, and so become the target of male violence. What lies beneath the violence is the perpetrator's fear and vulnerability, though different in each case, which needs to surface in the treatment. For men, the opportunity to explore their own vulnerability, to own projections of hostility and damage, and to question their blame of women, can lead to a new conception of themselves.

Crucial to the development of a masculine identity is the role of the father. Discussing the origins in childhood of the male tendency to violence, Fonagy and Target (1998) point to the paternal function that can facilitate separation from mother. The one-to-one mirroring between mother and child is modified by an early triangulation and a transition away from that intense relationship. Father normally enters the psychological world in the first year, and in the father the child sees a representation of himself as a psychological entity *in relation* to mother, not engulfed by her (Greenson, 1968). If the father has himself been abusive or absent, or both, this will fundamentally distort the growing boy's concept of himself in relation to the feminine. Although absent from the group, women are ever-present in the minds of the men, and may be symbolised by a maternal function that the group comes to represent, as described in the clinical illustration below.

The addiction model

The forensic group therapist needs to know about the compulsion that lies behind much sexually deviant or abusive behaviour and should not be surprised when it recurs. It is, therefore, helpful to know something of the addiction model (Carnes, 2001). This is especially useful because many "sexually addicted" patients avail themselves of the support offered by the twelve-step programme, much of which is complementary to the work of psychotherapy. Sex Addicts Anonymous (SAA) offers an opportunity to understand the triggers to acting out, and strategies for control. The experience at the Portman Clinic has been that, by and large, patients who, for example, have shown a compulsion to internet pornography, are very much helped by a combination of psychotherapy and attendance at twelve-step groups.

Nigel spoke with difficulty about his visit from the police. "I have to tell the group they found something. I had kept some images [i.e., erotic images of children] not because I was going to do anything or look at anything illegal, it was just to have them there. I even forgot about them. I was astonished when the disc was found." The group was angry about his concealment of his perverse imagery, and the therapist, too, had to think how he had been duped into a collusive belief in Nigel's avowed intention of developing "adult" sexual relationships. "You're like the alcoholic," another group member said, "you have to keep a bottle hidden, just in case . . ." Nigel bowed his head and said, "I know. I can stay away from it, but I can never not need it."

Symbolisation as a key therapeutic ingredient

When boundaries have, to some extent, been internalised by group members, and the possibility of thought rather than action becomes part of the culture of the group, then symbolisation may begin. Segal (1991 pp. 24–37) suggests that symbolisation is the creative way to deal with and process anxieties and desires. The unattainable object may be represented and internalised instead of becoming persecutory by its absence. Terrors of the past may be faced rather than avoided. Traumatic and perverse experiences are regularly presented in group treatment and, necessarily to an extent, being re-experienced, but in manageable doses.

The all-male group had been resentful and hopeless about their various failed sexual relationships. Geoff then said he wanted to talk again about something he had brought up last week. "I said what happened, like I'm supposed to, but no one understood. Well OK, there wasn't enough time." He then recounted the events that led up to his assault on his wife. At first, he presented the story angrily, with circumstances intended to minimise his responsibility, but it became clear that he had been actually unable to cope with various frustrations before the assault. "It was all to do with the bloody sink. I was trying to fix it myself. I couldn't find my tools. I'm terrible with my tools, can't organise them. I couldn't afford to call a plumber, they cost a bloody fortune! Undid the pipe. Nothing there, but still it won't drain. The wife was saying "Can't you unblock it?" I was keeping my temper and she was saying, "Don't get so upset. Leave it, if you can't manage it. We'll call someone in, if you can't do it." "I can do it," I said. So I went downstairs, undid the bloody pipes there, and out comes all this filthy water; a lot of shit flooded me, and this dirty great hairy rat-like thing, unbelievable. It was my wife's hair, and I've told her not to wash her hair in that sink, it hasn't got a proper filter, so I take it upstairs and she starts going on at me for making a mess on the carpet. "It's your fucking mess," I said. She pushes me, and I've told her not to do that . . . so I thumped her."

There is silence in the group.

Jim said, "I think it was all about control. You couldn't control the sink, you couldn't control your wife. You hit her to try and get back control. You're a control freak."

Geoff is angry: "Don't give me that bullshit! So I'm a control freak, how do you think I even survive? I control myself. Mostly. I tell you, the things I could do . . . I could have gone on hitting her. But I stopped myself. It was only the once."

Mark asks whether this has been reported, since, he reminded us, Geoff is, after all, known to the Multi Agency Protection Panel.

Geoff: "No, not this time. But, she says it's the last time. If I do it again, ever, she's had enough. She's off. She will. She's done it before."

Mark: "But she came back?"

Geoff: "I felt so awful when she wasn't there. I didn't go out. I drew the curtains. Stayed in the dark, didn't eat."

Mark: "You put yourself in prison."

Geoff: "Yes, that's where I belong. But if I went back I'd probably try to do myself in again."

Mark: "Haven't you got someone to ring if you get into that state again?"

Geoff: "Maybe I do, but I didn't think of it."

Silence. The therapist comments that Geoff seemed to feel it was only his wife who had the power to report this.

Geoff: "Well, maybe Sarah (his probation officer mentioned before) would listen. She told me I could ring anytime. But maybe I'll be recalled to prison."

Jim: "I would say mate, that's a chance you got to take."

Fred: (who had been silent up until this point) "I wouldn't tell them anything. The old bill? They'll just lock you up any chance they get."

Jim: "I think you owe it to your wife to do all you can to stop yourself doing it again."

Geoff wept and said that he could not live with himself if he hit her again. "The worst thing," he said, "is feeling that I'm no better than my Dad, who used to beat my mum all the time. Until he cleared off." As the group seemed attuned to Geoff's grief, the therapist said that something had perhaps been unblocked here, that the anger and frustration had given way to feelings of sadness at losing, or not having, the kind of relationship that was wanted. (In subsequent sessions we learnt that Geoff did report himself to the probation officer and he and his wife were able to get more support, instead of him being recalled to prison.)

It appears from this sequence of material that the group was eventually able to provide a place where Geoff could think about his violence, and the meaning of it. Initially condemnatory, this led to a more rational consideration as to whether his behaviour needed more management, and to raise the question of whether he could do something to take more responsibility. It could also be asked whether the therapist had a duty to report, and it is a matter of careful clinical judgement as to whether the patient has the capacity to keep bringing the problem and to find his own solution. In the event, the therapist had to give little more than a nudge in order to get Geoff to think about the responsibility to manage his own violence. In a different case, the therapist might be under more pressure to discuss with colleagues what the boundaries should be. As it was, the psychodynamics of the violence were presented as organised around the frustration of the blocked sink. The little boy's frustration at not coping, in the absence of

a good father, is enacted on the mother. The triangulation discussed by Welldon also symbolises an oedipal pattern and provides space for thought and the development of an identity separate from the mother, who has been created in a perverse image of fear and sexualised control (Welldon, 1997). Although it was not articulated explicitly, the metaphor of the blocked sink was very relevant to the group at this particular time, blocked as they were in terms of their emotional life and, consequently, in their relationships. As Geoff unblocks his feelings, difficult as they are, the group responds and participates in his experience; indeed, they contribute powerfully to his learning. How different would this have been if he had simply been instructed by a professional to turn himself in? He might have done so, but there would have been little therapeutic learning on his part. Alternatively, the refusal to consider the external implications of his actions would have come dangerously close to collusion. These dilemmas are less acute in the group because there is more space to think.

Conclusion

The final clinical example above shows how a mature group can reach a point where it can work to produce change. In this vignette, the foreground was occupied by one member, but clearly the other voices had their own character, and the session could be retold from an entirely different point of view with equal validity. A group session is like a constantly shifting kaleidoscope of meaning, which at times might feel chaotic, especially to those inexperienced in therapeutic groups, but which stimulates all concerned to ask questions, explore meanings, in order to produce change. The different voices responding to Geoff's situation could be seen as his own inner conflicts, sometimes feeling evasive, (Fred), accusatory (Jim), or helpful (Mark). The individual revisits his trauma, that is, both what he has done and what has been done to him. In so doing, he rewrites his own story, or reinterprets it, and the group, in a larger sense, revisits human destiny. As a microcosm of society, the group provides an opportunity for members to discover a new sense of social responsibility in a nurturing context, rather than in the blaming mode they are used to. However, that depends on probably the most significant development: the opportunity to develop a capacity for thought as opposed to action.

Freud pointed out the process of identification that operates in the formation of a group (Freud, 1921c). As an individual develops a sense of belonging, his aggression is modulated by positive feelings, which tend to foster the development of thinking. In a therapeutic mode, the group develops the capacity to understand and process violent impulses and the painful affects of fear and grievance that might underlie them. Such insights need to take place in a nurturing environment. How is this achieved, given the histories of such deprivation, in such brief sessions? While it would be unrealistic to attempt to provide the kind of love these individuals so lacked in their development, nevertheless there is available a relationship that can symbolise the sort of nurture that was absent. This experience can be seen in terms of a new attachment; some group analysts refer to attachment theory and show how a group can repair damage to previous attachment relationships (Glenn, 1987). Although the group necessarily raises the traumatic past, it also provides a positive experience: the respect each shows the other, as modelled by the therapist, being listened to and listening to others, responding genuinely; all this cumulatively leads to a belief in a non-abusive world, as each individual feels more fully known by others than elsewhere.

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