

Contribution of forensic psychotherapy to the care of forensic patients

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Abstract This article outlines the current provision and describes the role of forensic psychotherapy in the management of forensic patients. The authors maintain that the contribution of forensic psychotherapy is not limited solely to treatment provision. The forensic psychotherapist has a supervisory role, which can help staff and institutions to understand the dynamic processes that arise from the effects of managing forensic patients. The article outlines how forensic psychotherapy can contribute towards risk assessment and highlights some particular areas of concern for the forensic psychotherapist.

Used generically, the phrase ‘forensic psychotherapy’ describes the application of psychological therapies to the management and treatment of mentally disordered offenders. The main modalities used are the psychodynamic, cognitive and systemic. However, in current UK practice, the phrase is often used more specifically to refer to the application of psychodynamic principles and treatment in the service of understanding and managing the forensic patient (Welldon, 1994). In this usage, the development of forensic psychotherapy arises predominantly from psychoanalytical and psychodynamic roots. In other words, forensic psychotherapists not only provide treatment but also apply psychodynamic thinking to the complexities and dynamics within staff teams and institutions treating this patient group. For the purposes of this article, ‘forensic psychotherapy’ should be read as ‘psychodynamic forensic psychotherapy’ unless otherwise specified.

Forensic patients frequently employ primitive unconscious defence mechanisms. Overreliance on or the inappropriate use of these distorts the patients’ perceptions and if these perceptions are acted upon, incongruous or dangerous behaviour may result (Bateman, 1996a). Particularly in forensic settings, these processes evoke reactions in the staff and the institution that arise either from the unconscious response of staff to the projected aspects of their patients’ internal world or from mobilisation of the unconscious defence mechanisms of the staff and

the institution to reduce internal anxiety. If left unattended, these processes diminish the therapeutic potential of the environment and decrease the effectiveness of the particular therapeutic task, irrespective of whether this is one of containment, assessment or treatment.

This article reviews the contribution that forensic psychotherapy can make to the management and treatment of forensic patients across a range of settings, outlines current provision and comments on developments that it is hoped will happen in the future.

The position of forensic psychotherapy

Although the past decade has seen interest in forensic psychotherapy rise considerably, it is still a developing speciality (Norton & McGauley, 2000). Forensic patients have complex and enduring mental health problems that require a wide range of treatment interventions. Forensic psychotherapists need to work closely with forensic psychiatrists, general and community psychiatrists or be part of their clinical teams. Forensic psychotherapists must also work alongside other professionals delivering psychological interventions. When considering treatment interventions for forensic patients who are severely disturbed and have complex needs, clinical discussion must be guided by assessment

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of their therapeutic needs. However, the dynamic understanding that forensic psychotherapy can provide regarding the patient's past experience and current mental state can help decision-making.

Provision of forensic psychotherapy services

Although interest in forensic psychotherapy has developed across a range of settings (Box 1), provision is thinly spread. Resources available in secure settings are inadequate so that, even if a forensic psychotherapist is available, he or she can meet only a small proportion of treatment and supervision requests.

The concept of continuity of treatment by a psychotherapist is at the core of psychodynamic psychotherapy. However, the configuration of forensic services and demands made of them often introduce delays and discontinuities into a patient's treatment. Frequently, this occurs when patients transfer between institutions and between levels of security, from high to medium and minimum security, through to non-secure forensic services and then to generic services and the community.

Provision in the prison service is often limited to particular units or institutions that function as democratic therapeutic communities (e.g. Her Majesty's Prison Grendon Underwood in Buckinghamshire). Therapeutic community approaches have also been shown to be beneficial in high security (Reiss *et al*, 1996) but the role of the forensic psychotherapist in these units is often limited by available resources. Ideally, the forensic psychotherapist would be part of the multi-disciplinary staff team offering a comprehensive assessment, treatment and supervision service, integrated within the framework of the community.

Box 1 The settings for forensic psychotherapy

High security – hospitals, prisons (including secure therapeutic communities)

Medium security – regional/medium secure units

Minimum security – local forensic units

Non-secure in-patient units – residential therapeutic communities and specialist in-patient units

Non-secure out-patient units – non-residential therapeutic communities, day hospitals and specialist centres

Community – patients managed by community forensic teams

Well-established residential non-secure democratic therapeutic communities offer integrated programmes to patients with personality disorder. The importance of these communities and day hospitals for forensic patients is two-fold. First, some forensic patients with personality disorder are able to tolerate the structure and to benefit from treatment; others may use such resources when they are well enough to be discharged from secure care. Second, the experimental and quasi-experimental designs of some studies (Bateman & Fonagy, 1999, 2001; Chiesa & Fonagy, 2000) provide high-quality evidence for the effectiveness of these treatment programmes for specific groups of patients with personality disorder. These studies raise a pressing research question about the generalisability of such treatment regimes to the group of forensic patients with personality disorder in secure environments.

Although forensic psychotherapy is most often found in in-patient settings, out-patient treatment is available in specialist centres such as the Portman Clinic in London, which was founded to offer help to offenders and which also provides psychodynamic psychotherapy to patients with paraphilias and gender identity disorders.

The patients

The particular setting in which the forensic psychotherapist works will influence the type and severity of the clinical problems referred. At the upper end of the security gradient, in high and medium secure settings and prisons, the forensic psychotherapist will be working with those, mainly men, with complex and disturbing levels of psychopathology who have committed violent and aggressive acts on others and on themselves. The majority will have suffered deprived and abusive childhoods within the context of dysfunctional families or 'care' systems where parenting has been, at best, inadequate and, at worst, neglectful and abusive.

Although much of the recent impetus behind service and training developments in forensic psychotherapy has come from recognition of the value of the speciality in the management of personality disorder (Department of Health, 1994; Royal College of Psychiatrists, 1999), secure forensic psychiatry deals predominantly with offenders with psychotic illnesses. Although such patients are not traditionally regarded as the preserve of general psychotherapy, they are very much within the remit of forensic psychotherapy. McGauley (2002) discusses how the application of psychodynamic thinking with or about patients with psychotic illnesses can contribute to their clinical and risk management.

The majority of patients at higher security levels have high levels of comorbidity, both within and between DSM-IV Axis I and Axis II (American Psychiatric Association, 1994). Patients with personality disorder who are detained in high and medium security are vulnerable to psychotic episodes. Even if they do not become frankly psychotic, the cognitive processes of their internal world can become dominated by concretised, psychotic thinking (a rigid, psychotic organisation of thinking). In addition, effective treatment of patients with a psychotic illness often unmasks an underlying personality disorder.

At lower levels of security or in non-secure or out-patient settings, the forensic psychotherapist may well see patients who have a lower compulsion to act out dangerously. In general, the degree to which frank psychotic thinking can be directly linked to aggressive behaviour, is lower but the patient's psychopathology may be no less complex.

The role of forensic psychotherapy

Forensic psychotherapy may be thought of as encompassing four main types of work (Box 2). Although these functions apply to the range of settings in which a forensic psychotherapist might work, the nature of the setting and the particular role of the therapist will determine the contribution of each component. For example, forensic psychotherapists working in high and medium secure settings may find themselves heavily involved in assessment and supervision work, whereas those working in therapeutic communities or specialist out-patient units may dedicate a greater proportion of their time to treatment work.

Box 2 The role of forensic psychotherapy

Direct clinical work – provided from within an institution or service, offering assessment and treatment of patients individually, in groups or in specialist treatment regimes

Supervisory work – of psychotherapists or trainees undertaking direct clinical work; of other forensic mental health professionals; or with respect to the psychodynamic processes in an institution

Clinical meetings – case conferences, clinical team meetings, patient reviews

Consultation or 'institutional supervision' – psychodynamically informed consultation provided to an institution from outside

Box 3 Functions of assessment

To assess the patient's potential to participate in treatment

To contribute to multi-disciplinary management of the case

To make sense of less-conscious affects and beliefs that drive behaviour in interpersonal relationships

To describe the patient's unconscious defence mechanisms

To reveal unconscious thoughts and fantasies with respect to offending behaviour

Direct clinical work

Direct clinical work is provided from within an institution or service and it comprises the assessment and treatment of patients individually, in groups or in specialist treatment regimes such as therapeutic communities.

Assessment work

Although the severity of their psychopathology precludes many forensic patients from formal psychodynamic psychotherapy, it is still valuable to have a psychodynamically informed assessment (Box 3). An assessment can address the contribution that a psychodynamic approach might make to the multi-disciplinary understanding and management of the case as well as the patient's potential to participate in treatment.

More specifically, an assessment can shed light on the nature of the unconscious impulses and beliefs that were, and are currently, expressed in the patient's behaviour and interactions and on the configuration of the patient's defence mechanisms. It can also provide information about the patient's ability to tolerate uncomfortable affective states and on the extent to which these are projected into the external environment, resulting in unthinking and aggressive actions.

One of the distinguishing characteristics of a forensic psychotherapist's patient is that he or she has committed an index offence, and assessment can reveal the historical and current state of mind with respect to the thoughts and fantasies surrounding that offence. In this way, forensic psychotherapy can contribute to decisions by the multi-disciplinary team about treatability, management and risk assessment.

With patients who are severely ill and disturbed, the request for an assessment may not always be linked to a request for treatment intervention. At

lower levels of security or in non-secure settings, the focus of the assessment may be the patient's capacity to participate in treatment, either as an individual or within a group or therapeutic community. One of the key questions to be addressed in any assessment is whether the patient is able to be curious about and interested in who he or she was and is, so increasing self-understanding.

The process of assessment will also vary with the setting, the type of treatment available and the nature of the patient's difficulties. Sometimes, the forensic psychotherapist is asked to assess a potential admission. An arrangement where the treating and receiving clinical teams and the forensic psychotherapist discuss a patient before admission or transfer is a valuable exercise. In high and medium secure settings, either the complex nature of the patient's difficulties or the fact that the patient is too unwell to withstand a single long assessment can necessitate an assessment stretching over several weeks, with appointments tailored to the patient's capacity to sustain contact. If a patient is being assessed for a therapeutic community then the process can include assessment by a group of community members (staff and patients) to determine whether the patient is suitable to join the group.

Treatment

A major task of treatment is to enable patients to develop an awareness of their mind and its functions. Through treatment, they can acquire an awareness of who they are, what they have done and the impact of this on their own minds and the minds of others. In providing patients with an understanding of their own mind, the forensic psychotherapist aims to increase patients' capacity to contain unpalatable thoughts and emotional states rather than impulsively acting on them. Benefits for the patients may include a more realistic perception of their self-worth, a firmer sense of identity and a decrease in psychotic and paranoid anxieties. Patients' capacity to make and sustain more-mature interpersonal relationships may also improve as their view of the external world becomes more realistic and less distorted by the configuration of their internal world. The benefits for society may include a decrease in damaging and criminal behaviour and a more-appropriate access to health and other resources by the patient.

Patients may be treated in individual therapy, in group therapy or through treatment programmes in therapeutic communities and day hospitals that incorporate these and other psychological treatment modalities (Bateman, 1996*b*; Norton, 1996). Wellدون (1993, 1996) describes the contribution of group-analytical psychotherapy for forensic patients in an

out-patient setting. Cox (1976) describes the group in secure settings, emphasising its role in both facilitating disclosure and monitoring the nature of patients' behaviour and experiences. Sohn (2000) describes how the individual treatment of patients who have psychotic illnesses elucidates the relationship between their psychotic state of mind and violent behaviour and how the victim and the attacker can be psychotically linked in the attacker's mind.

The nature of the environment also affects the process and delivery of therapy. For forensic psychotherapists working in secure settings, issues of security are omnipresent and, at times, are in tension with the task of delivering treatment. The forensic psychotherapist has an important contribution to make in considering how to manage such situations. With the multi-disciplinary team, the forensic psychotherapist needs to differentiate between the patient who has made significant psychological progress and could move to a less-secure environment, the patient whose level of illness remains severe and the one who falsely believes himself or herself to be better and engages in either a conscious deception or an unconscious pseudo-compliance.

What forensic patients have done and are capable of doing must never be forgotten. However, in secure environments the availability of nursing staff to maintain a watchful presence, together with physical security aids such as emergency buttons and personal alarms, protect forensic psychotherapists when seeing patients. In non-secure environments, the task of the forensic psychotherapist can be made more difficult when there is poor-quality or ambiguous information about the patient's behaviour between therapy sessions. In these settings, the forensic psychotherapist must more frequently assess whether the total treatment available has been enough to prevent destructive acting out.

Supervision

The forensic psychotherapist not only is involved in supervising therapists and trainees undertaking direct clinical work but also frequently provides supervision to other forensic mental health professionals who may be using a different treatment modality. At times, a psychodynamic view of the case, often in terms of transference and counter-transference phenomena, can be helpful to the ongoing treatment.

The nature of the internal world of a patient who is severely disturbed means that there is always a degree of enactment. This may be manifest mainly within the therapy, for example in the development of a delusional transference or the patient's abrupt

termination of treatment. Alternatively, it may be acted out within the forensic setting, for example in the development of an erotomanic delusional attachment to another member of staff or in a serious assault. At these times, events cannot wait for the next scheduled supervision and 'emergency supervision' is required.

Therapists are supervised on an individual or group basis. Group supervision affords teaching and training opportunities for both psychiatrists-in-training and other multi-disciplinary staff. It is vital in settings such as therapeutic communities and day hospitals, where an understanding of the dynamics of the various therapeutic groups is a key component of treatment. Group supervision of the therapists working with a particular patient group ensures that knowledge about the psychotherapeutic work and the mental state of the patients is available to clinical colleagues. In secure institutions, the forensic psychotherapists are periodically absent; the patients are always there. A patient's mental state and behaviour may deteriorate, and at such times, knowledge about the patient and the therapeutic work made available through group supervision is vital and allows others to give the patient temporary support, with the clinical team being kept informed, until the patient's therapist is available.

Crucially, supervision and staff-support groups can pay attention to, and help staff understand, the psychodynamic processes in the forensic setting that arise from the effects of managing and treating forensic patients. These can be provided either from within the service or by visiting professionals on a consultation basis.

Clinical meetings

As Hook (2001) notes, attendance at case conferences, case reviews and clinical team meetings can be mutually educational and allow the formation of a working relationship that mitigates against the holding distorted and prejudicial views by different professionals. These clinical forums allow the forensic psychotherapist to report directly to the clinical team on assessment and treatment work. The therapist must pay attention both to what must be

discussed with their patients in therapy prior to the meeting and to maintaining an appropriate balance between informing the team and ensuring an adequate level of confidentiality in the therapeutic process. Through clinical meetings, the therapist may also learn about aspects of patients' behaviour, achievements and difficulties that they have been unable to bring into the therapy.

Consultation or 'institutional supervision'

This consists of psychodynamically informed consultation to the institution or service, which, of necessity, is provided from outside. In the light of recent inquiries, there is a greater awareness of the need to understand how the psychopathology of patients affects an institution at all levels. Consequently, for institutional supervision to be effective in forensic settings, it needs to be available for the full range of staff, from the auxiliary nurse to the chief executive.

Institutional supervision can provide interventions that operate at three levels (Box 4). First, supervision of clinical work with patients. This is shared with other staff in general terms or when it is judged that there is a danger to others or to the patient. Second, helping staff to understand patients in the context of the ward on which they live and their interaction with other patients and with staff. Third, institutional supervision may address how patients' psychopathologies unconsciously influence the system that contains them, on the ward level and in the institution as a whole. The boundaries governing the exchange of information are such that the flow of information from the first to the second level of intervention should be less than that from the second back up to the first.

One of the aims of institutional supervision is to understand how the patient's psychopathologies can be enacted and become incorporated into particular aspects of institutional functioning. This is especially important when the forensic setting cares for patients with perverse psychopathology that induces the institution to react by collusion, cynicism or violence. Institutional supervision can also explore and illuminate the related area of the nature of the social defence system of the institution. Hinshelwood (1993), basing his studies on the work of Menzies (1959) and Spillius (1990), describes a particular contradiction for forensic institutions, namely that, as the forensic patient and society are in conflict and the institution serves both, the institution faces an intrinsic conflict. For prisons (and secure forensic institutions), Hinshelwood describes this conflict as being between the institution's custodial function, as the representative of an

Box 4 Levels of institutional supervision

Psychodynamic supervision of staff happens with regard to:

- 1 confidential clinical work
- 2 the patient in the context of the ward
- 3 the patient in the context of the institution as a whole

endangered society, and its caring, treating and rehabilitative function towards its inmates or patients. If this conflict exists within and between staff then a 'care v. toughness' culture clash emerges within the institution. In forensic institutions, the particular personal anxieties against which a psychological defence is raised are fear of destruction or corruption. The nature of this defence can take the form of staff 'forgetting' the index offence or the patient's violent behaviour and unconsciously adopting an attitude of 'pseudo-caring'. The message communicated about the patient may be that he or she is quiet and therefore no problem on the ward. If the wider institution also colludes unthinkingly, the patient or prisoner may be prematurely discharged or paroled.

Alternatively, in an attempt to control their own internal fears about a patient's violence or corrupt criminality, staff can unconsciously adopt a tough, controlling stance. The consequences of such a culture becoming predominant in an institution have been described in several inquiry reports (Health Advisory Service, 1988; Department of Health, 1992).

Particular areas of concern for the forensic psychotherapist

Risk assessment

The forensic psychotherapist can contribute to the assessment and management of risk by consideration of the often disturbed internal world of the patient, its reaction with the external world and the mixing of the internal worlds of the patients and their carers (McGauley, 1997). As well as using psychodynamic principles and working to understand the unconscious meaning of the forensic act in the patient's mind, forensic psychotherapy may provide information relevant to several other areas of risk management. For example, consideration of the patient's unconscious view of his or her institution can be important, especially if a transfer is planned. The patient's unconscious construction of the meaning of taking medication is also relevant where non-compliance may result in the return of active psychotic symptoms and a consequent increased risk of violence (Taylor, 1985). In these areas, a psychodynamic perspective adds to the range of dynamic risk factors that augment the static factors and actuarial elements of risk assessment.

Chronicity and continuity

For offenders whose incarceration is lengthy, Cox (1976) argued for the provision of forensic psychotherapy on humanitarian grounds so that they can

make the best possible psychological adjustment to their detention. For some patients, treatment may be more palliative (in terms of the effects of the institution on them) than mutative (in terms of their own internal world). Irrespective of the shape of future service provision, there will always be forensic patients who are severely disturbed, with multi-disciplinary staff working alongside them. Consequently, there will always be a need for staff to understand the less-conscious and more-bizarre communications of their patients. In addition, staff often need support because of the high demands of working with patients with severe personality disorder and psychosis, who frequently attempt to distort accepted frames of reference for interactions (e.g. staff/patient or patient/patient boundaries).

The forensic psychotherapist may also provide supervision to support the staff working with patients who are chronically ill and dependent, whose prognosis is poor and who will never be safe enough to be released.

In community settings, forensic patients often need long-term support that may include periodic in-patient admission. Stein & Adshead (1999) stress that forensic patients who are chronically ill can stimulate feelings of anger, frustration and hopelessness in professionals. Unless such reactions can be understood, these feelings may be unconsciously enacted within the therapeutic relationship. The relationship may then be distorted, becoming abusive or neglecting or, alternatively, the patient may be treated dismissively or contemptuously.

Confidentiality

Forensic psychotherapists are often involved in multi-disciplinary, interagency and medico-legal work as well as working in settings such as prisons, where they have dual obligations both to their patients and to their employing authority. Such situations can give rise to conflict with respect to confidentiality. Cordess (2001) discusses the recent trend towards providing rather than protecting information and the increasing expectation that information will be shared with other professionals who may have different roles or duties.

The traditionally confidential relationship between the patient and the psychotherapist comes under closer scrutiny during the work of a forensic psychotherapist. It can be argued that within secure settings, the nature of the institution means, in general, that there is a lower threshold of disclosure. However, the tension experienced by the forensic psychotherapist with regard to the extent that clinical work is reported to other professionals may be heightened if, as Kaul (2001) points out, the institution reacts with a punitive response, for

example automatically segregating a prisoner on disclosure of sadistic fantasies. Institutions can make alternative responses to similar situations. For example, when a psychotherapist reported the intensity and psychotic nature of a patient's erotomanic fantasies about a member of staff, the team's response resulted in the patient receiving more-intensive nursing and more psychotherapy sessions.

On a day-to-day level, the forensic psychotherapist is often concerned with deciding the extent and level of detail of the clinical work that should be reported to the clinical team. Scant communication carries the risk that therapy will become a marginalised activity. This can mean that clinical decisions, for example ward moves or discharge plans, are taken without reference to the therapeutic work. The forensic psychotherapist needs to keep the clinical team informed, in general terms, about the nature of the patient's internal world and how this affects his or her mental state and external behaviour.

Conclusions

This article has described the particular contribution that forensic psychotherapists can make to the treatment and management of forensic patients and other mentally disordered offenders. Their role is not limited to the provision of treatment or the supervision of psychodynamic work. Indeed, many forensic patients in secure settings may be too ill or disturbed to benefit from direct treatment.

The forensic psychotherapist has a valuable role in supervising therapists who offer other psychological treatments and mental health professionals, primarily nurses, whose role brings them into prolonged contact with patients who are disturbed and disturbing. The forensic psychotherapist can also contribute within the wider institution by providing institutional supervision and advising on psychotherapeutic issues that need to be considered with reference to service development and on areas of clinical governance relevant to the delivery of psychodynamic work.

The majority of forensic patients do not remain in forensic institutions or services indefinitely. Outside of forensic settings, where there is less back-up from physical security, it can be argued that risk management relies more heavily on dynamic knowledge of the patient. In addition, compliance with treatment regimes and therapeutic progress require the patient to be engaged and a therapeutic alliance to be sustained without the props provided by physical and procedural security and, at times, without the framework of mental health legislation. Forensic psychotherapy can impart skills and develop competencies to enhance the ability of professionals

to cope with these situations. However, such an endeavour requires ongoing dialogue, not only between forensic psychiatry and psychotherapy, but also between these disciplines and other relevant specialities.

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Multiple choice questions

1 Forensic psychotherapy:

- a involves the treatment of patients solely in long-term psychotherapy
- b does not contribute to overall clinical management
- c must keep all clinical information confidential to the patient–therapist relationship
- d is not provided in the prison service
- e can be provided only by professionals working in the patient’s institution.

2 A consultant forensic psychotherapist:

- a must be a psychoanalyst
- b would work only in secure settings
- c might have accreditation in psychotherapy and forensic psychiatry
- d could not manage forensic in-patient beds
- e should not work on an on-call consultant rota.

3 Forensic patients:

- a rely heavily on primitive defence mechanisms
- b have only DSM–IV Axis II psychopathology
- c do not act out once psychotherapeutic treatment has begun
- d evoke unconscious defence mechanisms in staff
- e do not form transference relationships.

4 A forensic psychotherapist:

- a works independently of other disciplines
- b offers a way of understanding psychotic thinking
- c rarely explores the patient’s index offence
- d may explore the social defence system of the institution
- e aims to reduce the patient’s ability to tolerate affective states of mind.

5 Reasons for making a referral to forensic psychotherapy include:

- a wanting an assessment with respect to treatment suitability
- b wanting advice on management of a particular patient for the team caring for him or her
- c wanting information to augment clinical risk management
- d mitigating against the effect of long-term incarceration
- e wanting advice on drug regimes.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a T
b F	b T	b F	b T	b T
c F	c T	c F	c F	c T
d F	d F	d T	d T	d T
e F	e F	e F	e F	e F