Locks, Keys, and Security of Mind: Psychodynamic Approaches to Forensic Psychiatry

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In this article, we discuss psychological approaches to the understanding of acts of violence and, specifically, psychodynamic approaches to both formulation and treatment. We suggest that the key theoretical paradigm of a psychodynamic approach involves the exploration and elaboration of the meaning of a violent act for the offender and describe the relevance of this approach for both legal assessments and clinical services in secure residential care. We argue that a psychodynamic approach can improve the quality of assessments of both psychopathology and risk and inform effective therapeutic interventions in hard-to-treat patients.

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The principal model of mind that is utilized in Anglo-European mental health care systems is the cognitive model, which emphasizes conscious cognitions and their influence on feeling, choices, and behavior. In forensic clinical practice, the cognitive model has been helpful in the development of programs aimed at the reduction of offending, mainly for use in prisons.[1] In this article, we discuss the theory and practice of the psychodynamic model in forensic practice, or forensic psychotherapy.

Psychodynamic models of therapy assume the following:

> Healthy psychological function includes both conscious and unconscious processes and their meaning for the individual.
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> Psychological function is relational and includes interpersonal, intersubjective, and embodied experience of both the social world and the internal world.
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> Representations of the world are built up over time and reflect dispositions that arise from innate vulnerability and early childhood experience.
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> These representations of both the internal and external world are dynamic; they shift and change in the context of the social relationships and group settings experienced over a lifetime.
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> Therapists are affected by these processes as much as patients.

In addition to these elements, we believe that understanding is fundamental to the practice of forensic psychotherapy: understanding the reasons that the offender committed his index offense; understanding why some individuals relate to others by predominantly violent means; understanding the workings of the criminal mind and how it has been shaped by early, often adverse, experience; understanding the unconscious meaning of a person's current antisocial behavior and how it may represent a repetition of such early experience; and understanding how this behavior may be the manifestation of a mind in which negative emotions such as anxiety, humiliation, and shame become impossible to tolerate and are expressed instead by violent action toward others. This process of understanding includes attention to both conscious and unconscious processes and motivations, especially those negative emotions that in particular are often less consciously experienced as thoughts or feelings and so are less verbally accessible.[2]

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We will suggest that a psychodynamic approach is useful to both those practicing in the courtroom and those practicing clinical psychiatry with forensic patients. In the courtroom context, we describe how a psychodynamic model can assist with risk assessments and the demands of child protection work. In the therapeutic context, we describe the use of a psychodynamically based model of group therapy that can be used with antisocial patients. We also discuss how psychodynamic thinking can be used to understand how forensic institutions function as working systems and what happens when they fail to function optimally.

Psychodynamic Thinking in the Courtroom

In the past, psychodynamic approaches to testimony have been criticized as overdetermined theoretically, lacking in evidential validity, and biased in favor of the defendant.[3,4] However, we suggest that the psychodynamic model has value in the courtroom in the context of risk assessment. Actuarial models of risk assessment are ideally combined with understanding of the offender as an individual, and the psychodynamic model explores the meaning of a violent act for the individual perpetrator and treats him as an actor with choices, intentions, and agency.[5]

Several risk factors identified in the risk assessment literature have psychodynamic and relational aspects to them. Social isolation is a risk factor for violence,[6] at least in part because perpetrators of violence find relationships complicated, and they have driven away those to whom they might have become attached. They are more likely to attack people with whom they have once been close, which suggests that their attachment systems are disorganized, so that both care-giving and care-eliciting behaviors raise rather than reduce anxiety.[7] Perpetrators of violence often have derogatory attitudes toward human dependency and vulnerability,[8] which may mask their high anxiety in this context, or they experience interpersonal traumas that cause them to be hypervigilant about threats and feel persecuted.

The relationship of actuarial and clinical data to risk assessment is similar to a bicycle lock with a four-number combination. The first two numbers, or risk factors, are usually the actuarial ones, such as being male and misusing substances. The third number is mental disorders, such as antisocial personality disorder and paranoid psychoses. There may be many people who have three numbers of the combination but will never be violent, as indicated by the evidence that most of those with mental illnesses or personality disorders and substance misuse histories are not violent.

An individual offender's personal state of mind is the final number in the combination to the bicycle lock, which, when combined with other risk factors, can unlock or disable the inhibitory mechanisms that prevent the violent feelings that are held internally from exploding into the external world.[9] This fourth number is likely to be a factor unique to the individual perpetrator and to have an idiosyncratic meaning, based on the person's life history and narrative. When this number comes up, with its associated meanings and memories, the perpetrator may experience intense feelings of rage, grief, shame, or all of those together. This state of mind is typically followed by high anxiety and a dissociation process, in which neither the situation nor the perpetrator's victim seems real. This state of mind is one of maximum insecurity, and unrestrained, disorganized acts of violence are possible that may later seem incredible to both perpetrator and bystanders.

Gilligan[10] posited that violence is often precipitated by experiences that cause shame and humiliation. In these cases, such feelings trigger traumatic childhood memories of being rejected or regarded as nonexistent, which in turn generate more feelings of shame and humiliation. These emotions are too much for the affect regulation system of the offender, who then has to find a way to manage them by getting another person (the victim) to experience them, by dissociating from them, or by acting out vengefully. The shame and humiliation act as the last number of the bicycle lock's combination, releasing unconscious control of destructive rage and fear and stimulating conscious excitement or absence of concern. After the act, these perpetrators may experience a sense of relief or feelings of triumph and pride in their achievements.

Although most violence is precipitated by powerful affects, there is also a subgroup of violent individuals who describes having no thoughts or emotions during an act of violence and whose actions are better understood as predatory.[11] There is evidence to suggest that this group of perpetrators has a specific genetic and physiological profile.[12,13] They do not have a dynamic relationship with their victims, who are

merely a means to an end (commonly sadistic gratification). For these offenders, the last number in the combination may be a state of excitement that is triggered by the perception of fear or distress in a vulnerable victim.

Brewin *et al.*[14] distinguished between memories that are verbally and situationally accessible. Such memories can be triggered by aspects of the victim's perceived appearance or behavior, which in the perpetrator's mind mirrors either his real experience or fantasy life and thereby stimulates unconscious distress and rage.[15,16] Traumatic memories that are evoked in this way can generate emotional arousal and distress with little warning and present-tense intensity, as if the past were happening now.[17] The violence may literally be an acting out of a previous traumatic experience, which is compulsively repeated every time the memory is triggered. However, the offender may not understand the cause, because affect and meaning are split by the dissociative process.[18]

We do not argue that all violence is unconsciously motivated or that the unconscious re-enacting of traumatic events outweighs personal responsibility and agency. We do suggest, however, that in many cases, there is a level of meaning to the violence that may not be immediately apparent and may be hidden by oversimplification and myth, such as that all men are violent or that victims can provoke violence. Without an understanding of the personal meaning to the individual of the last number (risk factor) in the combination to the lock of psychological security, it may be impossible to obtain anything but a most general assessment of the extent and risk of reoffending.

We suggest that such a psychodynamic approach to risk assessment has particular salience in regard to family violence and especially the risk to children of abusive parents. An understanding of a parent's own attachment history as a child can provide detailed understanding of how and why abusive parents get into hostile and helpless states of mind with respect to dependent children in their care.[19] Such an understanding may provide an insight into the last number in the combination to the mental lock that maintains psychological security and the kind of stressor that disengages the internal security system. In child protection cases, this insight has considerable implications for risk assessment in relation to other siblings and future children.

Case 1

The following case is fictitious but includes clinical features from real medicolegal cases known to the authors.

Dr. Arnold was asked to see Miss Jamison, a young woman who was facing criminal charges of cruelty to her infant child. Social services wanted an opinion about the continuing risk she posed and whether there was any therapy that might reduce the risk so that she could keep her child. She did not show any of the actuarial risk factors that are known to be associated with an increased risk of violence, such as an antisocial personality disorder, a history of substance misuse, or psychotic illness. She had no history of psychiatric disorder or contact with health, social, or criminal justice services. She had become pregnant unexpectedly, but she said that the pregnancy was welcome, and the child was born healthy at full term. She gave a history of an unhappy childhood, during which she was exposed to physical and sexual abuse by a stepfather and a lack of support when she told her mother about the abuse. She said that she had coped with the adversity by spending as much time at school as possible and concentrating on her schoolwork.

Miss Jamison did not deny hurting her child. However, she was vague and gave minimal details when asked to recall the offense, and while she accepted that she had committed the act and expressed regret, she could not explain why it had happened. She seemed to be a warm and likeable young woman who did not score high on measures of psychopathology or risk assessment tools. Although her vagueness about the offense may suggest dissociation, there were no other active symptoms of mental illness, and the principal evidence of personal dysfunction was the offense itself, an opening for Dr. Arnold to opine that there was no role for mental health services to play. She might even have taken the (erroneous) view that Miss Jamison had a personality disorder, based on the history of the offense alone.

In addition, Dr. Arnold took a detailed history of Miss Jamison's attachment experiences (i.e., her experience of being cared for in childhood when distressed or frightened). When Dr. Arnold asked about her relationship with her mother, she replied, "There's something between us that isn't there."

Close attention to this statement suggests a paradoxical aspect to the maternal attachment relationship in Miss Jamison's mind. In the relationship,

there is something both there and not there, which could be positive, negative, or possibly both. The wording linguistically hints at an oscillating, insecure state of mind. Such a remark, combined with the established history of abuse (confirmed by contemporaneous external records), indicated to Dr. Arnold that Miss Jamison might well have a highly ambivalent state of mind toward her infant son and his need for care. Any demand for care (of the type that any normal 10-month-old child might make) could trigger an oscillating state of arousal and distress in his mother's mind. A period of therapy and further assessment would allow the risk to be managed and more to be discovered about Miss Jamison's experience as a child.

Dr. Arnold worked with social services and the lawyers handling both Miss Jamison's criminal case and the child protection hearing, to ensure that Miss Jamison received a probation order with a condition of psychiatric treatment that involved both standard psychiatric treatment and psychological therapy, including dialectical behavioral therapy and reflective work. As the work unfolded, Miss Jamison became more aware of her own disturbance and distress and her mixed feelings about being a mother. The psychiatrist and therapist understood how dysregulated Miss Jamison's affect and arousal systems were, in fact, and helped her to understand how angry she had been with her child when he cried. She was able to remember in greater detail (and with greater distress and remorse) how she had broken her child's arm by twisting it, an injury that involved active force and intention. This information aided in the risk management planning process, and gave both Miss Jamison and her supervising team a language to discuss her risk.

For Dr. Arnold, attachment theory provided a clear and understandable language to describe to the court the complexities of the relationships between mothers and their infants and the effects of trauma on those relationships. The psychodynamic approach did not seek to excuse or even mitigate Miss Jamison's actions, but to provide a useful explanatory paradigm for the family court that explained her capacity for violence and provided a framework for managing the future risk. An approach based simply on current risk assessment tools or a diagnosis/no-diagnosis heuristic would not have assisted the court in the provision of protection for the most vulnerable people in this story, namely Miss Jamison's children, present and future.

In the United Kingdom, forensic psychotherapists and psychodynamically trained psychiatrists are progressively becoming more involved in appearing as expert witnesses in both the criminal and family courts, and judges appear to welcome more sophisticated psychological explanations of the violent and antisocial behavior of offenders. However, psychodynamic concepts (for example, unconscious mechanisms) have to be conveyed in terminology comprehensible to a layman. Juries may need convincing that investigation and discussion of an offender's past is not intended as exculpatory, but is necessary to understand and predict future risk of offending. This necessity exposes a tension in the courtroom in conveying conceptualizations to do with emotions and feelings in a legal arena that demands evidence and facts.[20]

Treatment for Disorganized Minds

The ultimate aim of forensic psychotherapy is like any other psychological intervention for offenders: to help the offender accept responsibility for his offense and, by acknowledging both agency and ownership of the offense, reduce the risk of future violent acts.[21] The most effective psychological therapies are associated with increased agency and more coherent self-narratives,[22] and in the forensic context, with the recovery of mental health combined with ownership and responsibility for risk to others.

Early psychoanalytic theorists argued that psychoanalysis could not be used to help violent and antisocial people. However, a few early notable psychoanalysts in both the United States and the United Kingdom, such as Karl Menninger and Edward Glover, were interested in applying psychoanalytic theory to understanding and treating such individuals, leading to the development in both countries of clinics that addressed both the psychodynamic assessment and treatment of forensic patients. Some (like the Portman Clinic in London and the Menninger Clinic in Houston) continue to provide a service to patients who can be treated outside of secure conditions.

The psychodynamic approach then began to be extended to work with prisoners and patients in secure residential settings.[23,24] Practitioners offered group and individual work with men and women who not only had histories of offending but also had

mental illnesses and severe personality disorders, patients again not traditionally offered psychodynamic therapy. These practitioners noted the technical challenges to psychodynamic work, and the complexities of managing professional boundaries within closed custodial institutions.

The International Association for Forensic Psychotherapy was founded in 1991, and forensic psychotherapy became a formal subspecialty within British psychiatric training in 1999. Since then, the field of forensic psychotherapy has flourished in Europe, but is rarely practiced outside publicly funded forensic facilities.[25] In the United States, forensic psychotherapy is not widely recognized or practiced, perhaps because of the identification of the term forensic with expert testimony, the diminishing availability of psychodynamic training for psychiatrists in this cognitive era, and the traditional understanding of psychotherapy as a private transaction between a therapist and a patient.

In contrast, forensic psychotherapy takes place in the space between the patient and therapist and the society whose rules the offender has broken. Third parties, such as courts or custodial services, are nearly always involved in the treatment of the offender-patient, so that forensic psychotherapists have to learn how to negotiate complex boundaries around the work. There may be inevitable conflicts of value and ethics in relation to preservation of confidences, the need to disclose information in the absence of consent, and the duty of care to others.[26]

A recent technical development in forensic psychotherapy is the use of mentalization-based therapy (MBT). Mentalization is the capacity to reflect and think about one's mental states, including thoughts, beliefs, desires and affects; to be able to distinguish one's own mental states from those of others; and to be able to interpret the actions and behavior of oneself and others as meaningful and based on intentional mental states.[27] Mentalization, by integrating psychoanalytic thinking with research findings from neuroscience and developmental attachment studies, functions as a coherent and empirically supported heuristic of personality, especially the regulation of negative thoughts and feelings, such as anger, fear, and shame. On this account, mentalization is a process, not a capacity, which operates continuously in healthy people to allow us to manage affects and arousal in our social worlds, both at home and in the wider community. Mentalization includes a variety of meta-level operations of mind such as empathy, theory of mind, mindfulness, emotional recognition, meta-cognition and self-reflective function.[28]

The normal development of mentalization processes is dependent on a secure attachment relationship between a child and his caregiver. A secure attachment allows the child to become aware of his mind and the minds of others[29] and is associated with a secure and coherent narrative of the self and others, both in childhood and in adulthood, that has been called autobiographical competence.[30,31] Mentalization processes and the capacity for self-reflective function is also critical to being prosocial, because insecure minds are likely to lack curiosity in or empathy for other individuals' minds.[32]

Poor mentalizing is associated with insecure attachment, usually as a result of early childhood adversity. Children of frightened or frightening mothers are at risk of growing up with a disorganized attachment system, with adverse effects on arousal and affect regulation and psychological health.[33,34] Domestic violence, child abuse, and neglect are all situations in which a developing child is likely to experience fear and disorganized security. Without a secure base and attachment system, the child may fail to develop the capacity to feel safe about what others think of him or may fail to see others as thinking beings at all. If he is unable to see others as having mental states separate from his own, he will interpret others as being angry and destructive when he is angry and destructive. If he does not see the others as being thinking beings at all, he will not feel empathy with them.

First attempts to offer mentalization-based therapy (MBT) have been applied to people with borderline personality disorder, with good results.[35–37] Combining individual and group techniques, MBT has been shown to be effective in reducing self-harming behavior and increasing self-reflective function.[38]

Theoretically, impaired mentalization processes will be evident in those who have insecure attachment histories and may be manifest as poor self-integration, poor affect regulation, and negative feelings acted out in unpredictable ways. If failure to mentalize is relevant to impulsive acting out toward the self, then it also may be the last number in the combination that unlocks the potential for violence. Forensic patients may be expected to have poor mentalizing function because they are more likely than nonviolent individuals to have been exposed to abuse

and neglect in childhood and to have experienced insecure attachment experiences.[39] Histories of abuse and neglect are found in 60 to 70 percent of persons in forensic populations, compared with the 30 percent typically reported in general populations internationally.[40,41]

Both the authors have had experience in testing MBT in forensic populations. Adshead *et al.*[42] carried out a pilot MBT group treatment in an extended-stay residential unit in a high-security hospital for six forensic patients who had struggled with frequent episodic violence throughout their lives. The aim of the intervention was to improve the patients' capacity to manage negative affect and to improve reality testing and perspective taking in their day-to-day lives. A variety of interventions aimed at improving mentalizing function[27] were used within the groups, as well as psychoeducational sessions, the use of film clips, and individual reflective sessions.

Of the six men in the pilot program, three have left the hospital and two were in the process of discharge at this writing. This outcome is noteworthy because the average number of years of detention of the men before the program was approximately 10 years (i.e., they had failed to make progress before the MBT program). The last group member is not being discharged, but has been able to discuss his index offense with professionals, which he could not do before.

Yakeley and her colleagues are conducting a pilot study investigating whether violence and aggression will decrease in male patients with a diagnosis of antisocial personality disorder (ASPD; Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision[43]) receiving MBT in an outpatient forensic psychotherapy setting over the course of 18 months. Preliminary results show that all the patients who started treatment rated their aggression toward others and themselves as decreasing in severity over the first six months of treatment, and all group members also showed a reduction in subjective distress.[44]

These are pilot studies only, and it is as yet too early to tell whether MBT in antisocial men will be as effective as it has been in people with borderline psychopathology. Indeed, one might predict that antisocial individuals with high levels of psychopathy already have an enhanced capacity for mentalization in their ability to deceive and manipulate others, and so any further training in mentalization would risk making them better psychopaths. However, their apparently highly tuned capacity to mentalize is actually very restricted and rarely generalizable to complex interpersonal situations.[45] Psychopathy can be thought of as exemplifying a partial but fundamental impairment of mentalizing, described by Baron-Cohen[46] as mind-reading without empathizing. Individuals with Asperger's disorder and autistic spectrum disorders also show deficits in mentalization or theory of mind in which their inability to read interpersonal cues and lack of consideration of social consequences may increase their tendency to commit offenses.[47]

Given the current lack of effective psychological treatments for antisocial men and women, it is encouraging that forensic patients have been motivated to engage and work in such programs. It also supports the notions that complex disorders require highly technical and specific therapies, delivered by trained therapists, if good outcomes are to be achieved and that the psychodynamic model is both relevant and complementary to other offender treatment models.

The Dynamics of Clinical Forensic Systems

The role of the forensic psychotherapist is not confined to treating patients, but extends to thinking about and working psychodynamically with the wider structures and agencies that seek to contain the offender patient. Violent and antisocial individuals who habitually act in predominantly destructive ways toward others may do so because they have great difficulty in tolerating negative feelings within their minds, particularly those associated with vulnerability, such as anxiety, shame, and humiliation, and they will attempt to rid their minds of such unbearable feelings by discharging them in violent acts. This process can contribute to complex feelings (or countertransference reactions) in the professionals who are attempting to provide care and containment for offenders. Countertransference responses, which include potentially damaging defensive processes such as denial or projection of anger, are unconsciously mobilized within the staff group as a result of the emotional impact of the patients' disturbance on the institution.

If these feelings go unrecognized and unexplored, then they may interfere with therapeutic care. Consideration of such feelings may be facilitated by reflective practice in which such emotional responses

in staff members are recognized and explored. An important role for the forensic psychotherapist is the facilitation of multidisciplinary work discussion, staff support, and reflective practice groups in which the staff involved in the care and management of mentally disordered offenders come together to explore the emotional impact of such work. In reflective practice, the forensic psychotherapist also assists the staff in understanding how the psychopathology of the patient or offender may be re-enacted in the institution. Such behavior may cause divisions among the staff and result in paralysis of therapeutic functioning (for example, staff burnout, boundary violations, breaches of security, or an emotionally toxic staff culture). Lowdell and Adshead[48] and Gordon and Kirtchuk[49] described reflective practice in forensic institutions as a way of exploring staff countertransference as the staff member's basic relational potential.

A further use of the forensic psychotherapeutic approach in secure services is in considering how professionals' unconscious subjective responses or countertransference may affect their assessment of risk.[50,51] This evaluation is of crucial importance when making decisions about discharge or transfer.

Conclusion

Forensic psychotherapists are psychiatrists who are trained in the use of psychodynamic approaches to assessment and treatment of individuals who break the law and have been frightening and dangerous to others when mentally disturbed. The psychodynamic approach is not the only psychological framework that is valuable in forensic practice, but it is an approach that we argue has particular value in forensic practice because of its emphasis on relationships, experience, and meaning. We suggest that risk assessment in particular should include some account of the meaning of the offense to the offender in terms of personal history and narrative of experience. We also suggest that it is not possible to manage secure residential services safely without forensic psychotherapists who can provide reflective opportunities to explore the impact of work with very disturbed patients on professionals and the reactions and responses of staff.

Perhaps the most important added value of forensic psychotherapy to forensic practice is its person-centered approach, in the sense that the forensic psychotherapist meets each new patient or evaluee as a human being who lives in a world full of meaning. It may not be a meaning shared by many others; it may be unspeakable or even unthinkable. Forensic psychotherapists commit themselves to discerning that meaning and giving it a voice and, in so doing, offer an enhanced understanding of risk and the potential for bringing about change for the better.

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