Progression in forensic psychiatry

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Progression in Forensic Psychiatry
About Boundaries

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Foreword

As this is a rapidly changing world, in which globalization has become an important factor both in medical science and law, we would like to draw your attention to the Tilburg collection 2012, *Progression in Forensic Psychiatry: About Boundaries*. This collection is part of the series on Forensic Psychiatry which, starting 1997, has been published every three years by Tilburg University. The rationale of this series is the belief that Forensic Psychiatry consists of a number of fundamental disciplines such as law, medical science and psycho-social disciplines, such as forensic psychology, victimology and criminology, but is also founded on disciplines like philosophy, ethics, and history.

We have been happy to receive contributions from various quarters, also from abroad. There is a number of contributions dealing with diagnosis and psychopathology, in individuals and in management systems, with accountability, victimology, and medico-ethical matters and with new subjects, such as old age crime, process management in a forensic psychiatric centre, youth crime, TBS, Prison Mental Health and suchlike. We have been happy to welcome not only Dutch contributions but also a considerable number of foreign contributions. This shows that Dutch Forensic Psychiatry has a considerable say in the international forum. It is on account of the many contributions from colleagues here and yon that we can confidently offer this first English-language Tilburg collection of Forensic Psychiatric subjects to a wide international public. A public consisting of colleagues and readers in a range of disciplines, the kind of public we have always favoured. In our view Forensic Psychiatry is not an isolated field of study, but one of cooperation between experts representing behavioural sciences and law.

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PART I: ABOUT BOUNDARIES IN THEORY

The Diagnosis of Psychopathology: Improving Reliability and Validity in Forensic Examinations†

*Alan R. Felthous**

"Certainty generally is illusion,
and repose is not the destiny of man ..."

Oliver Wendell Holmes, Jr.

Abstract

Critical to accurate diagnosis of mental disorders for forensic purposes is attention to improved reliability and validity. After reviewing the centuries-long process of developing and improving approaches to the classification of nature in general, viz., plants and animals, and mental disease in particular, the critical role of reliability and validity in the still ongoing process of improving the Diagnostic and Statistical Manual of Mental Disorders through subsequent editions is addressed. Conscientious adherence to the current DSM should enhance the reliability of diagnostic findings, but not per se their validity as appreciated by the evaluator. Here it is argued that in addition to methodical compliance with DSM criteria and method, thoughtful application of the validity criteria of Robbins and Guze will enhance the evaluator's appreciation of the relative validity or lack thereof of diagnostic conclusions.

Introduction

The judicial system finds psychiatry and psychology, despite their limitations, to be relevant and useful, even indispensable, in a variety of legal issues for which an individual's mental functioning is relevant. The law does not require people to do what they cannot do and in some cases, certain occupations for example, people should not be permitted to do what they cannot do: Hence the variety of civil and criminal competencies and disabilities with legal significance. The search for causes of dysfunction, at least in terms of mental disorders, provides some validity and explanation of the apparent dysfunction and further strengthens the need for mental evaluation by professionals.

Chief Justice Bazelon in *Washington v. U.S.* (1) pointed out that the introduction of the term "disease of the mind" (p. 445-446) in the M'Naghten insanity standard (2) "firmly established the relevance of medical testimony" (p. 445-446) in criminal trials where the defense is insanity. Similarly psychiatric and psychological testimonies are sought for other types of mental incapacity and disability.

Courts have recurrently expressed their view that psychiatric testimony is of poor reliability. In *Solesbee v. Balkcom* (3) and again in *Ford v. Wainwright* (4), the U.S. Supreme Court stated that a determination of execution competence is "... in the present state of the mental sciences . . . at best a hazardous guess however conscientious." In *Ake v. Oklahoma* (5) and again in *Ford* the Supreme Court stated, "... . psychiatrists disagree widely and frequently on what constitutes mental illness [and] on the appropriate diagnosis to be attached to given behavior and symptoms."

Forensic psychiatry and forensic psychology are referred to as "soft sciences" for which satisfying levels of reliability and validity of findings are suspect. More accurately expressed, forensic psychiatry is a discipline and subspecialty of psychiatry that is an art which draws from various scientific fields, and yet respects the humanity and individuality of each person. Perhaps the most "scientific" function of a forensic psychiatrist is arriving at a diagnosis of psychopathology, a function that itself is properly subject to question and challenge. Thus, it behooves the forensic psychiatrist to strive continuously for diagnostic findings that are as reliable and valid as currently accepted methodology allows. This article is written in an attempt to assist the practitioner if not the field in the furtherance of this effort.

Only physics, among the natural sciences has been described as a "pure science of laws" (Henning (6) citing Hartmann, *Allegemein Biologie*). Physics is most purely nomothetic, allowing accurate predictions based upon the laws of physics and mathematical computations. Others (Windeband and Rickett cited without reference by Henning (6)) distinguish the cultural and mental sciences as being more ideographic than nomothetic, and therefore as not belonging to the more nomothetic natural sciences. This present review will compare the development of classifications of life forms with classifications of mental disorders. Both pursuits began as primarily descriptive, but are evolving into more theory driven. Still, compared with chemistry, for example, the classification of mental disorders and the diagnosis of such disorders is basically descriptive. Nonetheless, even with recognized limitations, forensic psychiatrists can take additional measures to reduce bias, increase objectivity and enhance the reliability and validity of their diagnostic conclusions.

Empirical studies in contrast to opinion demonstrate better than expected reliability between forensic evaluators in establishing diagnoses of mental disorders. Recently published studies in Australia (7), where the DSM is used, found "good agreement in diagnosis of acquired brain injury, schizophrenia-spectrum psychoses, depressive disorders, intellectual disability, substance

abuse, and personality disorders; fair agreement on substance-induced psychotic disorder; and poor agreement on the presence of anxiety disorders"(7) in diagnosis for criminal issues. "Overall, there was moderate agreement between experts and treating practitioners on the principal Axis I disorder, and the evidence for psychiatric diagnoses presented by treating practitioners in criminal cases was found to be generally reliable" (Ibid.) When diagnoses of experts only, and no treaters, were compared, in criminal cases, they found "very good inter-rater agreement on the diagnosis of acquired brain injury, schizophrenia-spectrum psychosis, substance-induced psychotic disorder, and intellectual disability," ". . . moderate agreement on the diagnosis of depressive and personality disorders" and poor agreement on anxiety disorders, especially post-traumatic stress disorder (8). "Agreement on the principle Axis I diagnosis was moderate, and there was a similar probability of agreement within pairs of experts engaged by the same side and those of the opposite sides" (Ibid, p. 516).

While the inter-rater reliability between psychological and psychiatric experts was better than commonly assumed for diagnosis in criminal cases, it was poor for civil cases involving the question of psychiatric injury (7). "Reports written by experts engaged by the same adversarial side had good agreement about the presence of a mental disorder (K=.74) but had only fair agreement about the specific psychiatric diagnosis (average K=.31). Reports written by experts engaged by opposing adversarial sides had poor agreement about the presence of any mental disorder and also the specific psychiatric diagnosis" (Ibid, p. 515).

Comparable, contemporary research on inter-rater reliability between psychological and psychiatric experts in arriving at diagnoses in forensic contexts is needed in the United States. Of particular concern is the possibility of adversarial bias in civil cases where there is question of psychiatric injury. Of special interest is possible variation in fidelity to diagnostic criteria and methodology of the current Diagnostic and Statistical Manual of Mental Disorders (9).

The first step towards improved reliability and validity in psychopathological diagnosis is conceptual clarity beginning with the four relevant types of validity, the most critical yet elusive of which is construct validity. Secondly is an appreciation of the development of the currently used diagnostic system, the assumptions and purposes upon which the system is based, and how to use the system within forensic contexts. Beyond appreciation of ancient and contemporary attempts to classify and understand nature and specifically psychopathology, classification as continuous improvement process indicates the relevance of futuristic directions including the dimensional approach to assessing psychopathology, the exploration of anomalies and defects in neurocircuity, and molecular neuroscientific investigational approaches such as methylomics.

The DSM I (10) provided a nomenclature that was generally well accepted and widely used in the United States. The changes introduced in DSM III (11) should result in greater reliability if proper diagnostic method is followed. More elusive but no less important is the matter of validity. As neuroscientific research

improves understanding of the brain in health and disease, improved validity in future DSMs should result. Hopeful future research developments in this regard are the psychological dimensions, neurocircuity functions of the brain and methylomics. With the absence of a unified theory of the mind, the general systems theory can usefully incorporate other aspects of mental health and disease not included by these specific approaches. With the exception of the dimensional approach, these current and future directions in research are not likely to change the next edition of the DSM. Thus, the forensic practitioner is left with the open question as to how to best improve the validity of diagnosis in conducting forensic assessments.

The widely accepted maxim to follow the criteria and method of the DSM should ensure maximum diagnostic reliability. Following the DSM alone, however, does not ensure an appreciation of the validity, or lack thereof, of disorders identified in the DSM taxonomy and of their application to an individual forensic evaluee. A potentially useful method of improving validity in diagnosis is the application of the diagnostic validity criteria of Robins and Guze (12), which may allow the evaluator to more meaningfully understand and explain the relative validity of diagnostic conclusions. Application of these validity criteria to forensic evaluation are discussed, with an eye towards improved validity in forensic practice.

Validity in Diagnosis of Psychopathology

Before examining the development of the DSM and the effort to enhance validity of forensic diagnosis in pathology, a brief review of the types of validity and their relationship to the diagnosis of psychopathology is helpful. Basically the four types of validity most relevant to the nomenclatures of mental disorders are face, descriptive, predictive and construct validity respectively (13). Face validity is simply the recognizability of a disorder, which for the DSMs, has been established by expert consensus regarding the disorder's description. Descriptive validity, beyond the disorder's recognizable description, is the disorder's uniqueness due to characteristics that set the disorder apart from other disorders. Mania and dementia, for example, each have features that distinguish these conditions from other abnormalities, whereas the features of inadequate personality in DSM II (14), are common to various personalities, whether disordered or not. Both face and descriptive validity serve the purpose of communication, allowing clinicians and researchers to meaningfully discuss and write about known disorders. Predictive validity serves the purpose of control, because the ability to predict the course of a disorder informs decisions regarding effective treatment and safe management. A known course of a disorder further defines it and sets it apart from other disorders. An early example is Kraepelin's famous distinction between manic depressive psychosis (now termed bipolar disorder)

and dementia praecox (schizophrenia) by the progressive, ineluctable deterioration of the latter. Another type of evidence in support of predictive validity is differential treatment response, an excellent example being the favorable response of bipolar disorder, and not unipolar disorder, to lithium (13).

Most highly desired but largely absent for mental disorders is construct validity, identification of the disorder itself including its cause, not just its manifestations and course. The purpose is to comprehend the nature of the disorder which hopefully can contribute to the development of effective preventive and treatment measures. The best examples can be borrowed from neurology. Tubercular meningitis can present with altered mentation and increasing drowsiness together with increasing intracranial pressure. The diagnosis is established by identification of the tubercle bacilli on CSF acid-fast bacilli (15). Of greater relevance to psychiatry is neurosyphilis which can present with an astounding array of mental changes and is known to be caused by a specific spirochete, *treponema pallidum*. Although several laboratory tests are helpful, most mental disorders are not diagnosable with a test of sufficient specificity and sensitivity (16). Alas, the cause of most mental disorders is unknown, and relative construct validity, manifested by evidence for a theory of pathogenesis, is sought, such as evidence that certain genetic alterations (e.g., schizophrenia) or stressful events (e.g., post-traumatic stress disorder) are associated with a disorder (13).

Early History: Etiology v. Phenomenology

Today the causes of most psychopathological conditions are unknown (17). This has long bedeviled the field, as known causation would add construct validity to pathological conditions with the hope of arriving at well reasoned and efficacious preventive and treatment strategies. For millennia nomenclatures with and without postulated or received etiologies have been proposed and used. Some Greco-Roman classifications of mental conditions were atheoretical and descriptive, whereas others were tied to assumed etiologies such as the humoral theory of Hippocrates and Galen which would profoundly influence Western medical thought and practice for centuries.

Ancient Classifications

Ancient and modern attempts to classify nature in general have influenced approaches to the classification of mental disorders. Ethnographic and anthropologic studies (18, pp. 108-109), provide evidence that for spiritual, social, cultural, bio-economic, and other reasons, pre-industrial societies developed folk

taxonomies (19) but the taxons, roughly corresponding to specific or generic names, were limited to several hundred, e.g., 900 (19, 20).

Known as the "founding father" of systematic zoology and medicine (20), Aristotle first introduced a hierarchical classification about 2,300 years ago (20, 21). Utilizing the observations of earlier Greek writers such as Homer, living animals and preserved specimens in the then contemporary *Alexander Muséon*, which was both a zoo and a museum (20), Aristotle recognized about 520 animal species (21), explaining diverse taxonomic characteristics including morphologies, based upon an "essence" unique to each species (20, 22). Through reasoned processes, Aristotle for the first time reclassified dolphins as warm-blooded animals rather than fishes (20, 23). Identifying animal types such as lion, dog, or horse, using the Greek term *eidos*, a particular form, derived from the Platonic concept of essential forms, and *genos*, or class to which a particular type of animal belongs, Aristotle identified about 520 animals (24) and established a hierarchical, system of classification that continues to be used today.

By the fourteenth century, improved preservation methods enabled the massive collection of plants and animals in museums (25). The *Musée d'Histoire Naturelle* in Paris, for example, houses about 60 million specimens and an estimated 2.5 billion specimens are preserved throughout the world (26). This allowed a "museological" approach to the study of plants and animals, i.e., the ability to test and challenge named biological concepts using material evidence (24).

Carlos Linnaeus: The Foremost Classifier

For the study of nature in particular the Linnaean binomial classification of plants and animals supported the first steps of the Baconian and scientific methods in the study of nature. Developed by Carlos Linnaeus, Swedish botanist and explorer in the 18th century, in this system of classification plants and animals were organized, grouped, subgrouped, and given Latin binomial genera and species names based on their morphology. The Linnaean classification was remarkably similar to later classifications of mental disorders, including the binomial nomenclature (e.g., schizophrenia, paranoid type) and the DSM in particular. Less well known than his classification of plants and animals, Linnaeus also developed classification of minerals and human disease (27). The Linnaean classification proved useful in development of concepts and theories that advanced the study of plants and animals, and yet, as Linnaeus himself recognized, the system was artificial. Currently long assumed relationships between various life forms are being confirmed or revised through the superior technologies of molecular genetics such as DNA barcoding. The remarkable similarities between the Linnaean taxonomies and those of the DSM have not been lost to critics of the DSM approach (e.g., Blashfield, 1984) (28). (See Table 1)

Table 1. Similarities in the Linnean Classification of Plants and Animals and the Classification of Mental Disorders in the DSM III (29) and subsequent editions.

Hierachical
Binomial
Polythetic
Quaisi-natural
Temporal
Practical

A fundamental difference between the Linnaean and American Psychiatric Association's approaches to classification is that Linnaeus attempted to categorize all plants and animals and every organism was assigned to a specific species. Modern DSM editions in contrast allow for the commonly observed occurrence that a disorder cannot be assigned to a known diagnostic entity and is designated as "other" (e.g., Psychosis, not otherwise specified). This can be regarded as a weakness of the DSM. Conversely, the all encompassing Linnaean classification system can be viewed as even more artificial in comparison. Distinctions between variations, races and species can be subtle and more continuous than absolute. Nonetheless, the Linnaean method has immensely advanced the study of nature. A comparable approach to human disease, whether of the body or brain, could not be avoided.

Classification of Nature beyond Appearance

Phylogenetic Systematics

As we recognize the remarkable parallelism between the Linnaean descriptive classification of life forms and modern neo-Kraepelinian descriptive classification of mental disorders, we might examine as well continuing parallelism. The classification of both mental disorders and of life forms will become less purely descriptive as theory supported by empiricism leads to new premises for classification. After publishing his theory of evolution, Charles Darwin (30) and other biologists proposed that organisms be classified by their phylogenetic relationships (31).

Phylogenetic relationships were long assumed to be evidenced by common traits such as similar morphologies and behavioral patterns. Also assumed long before Hennig's morphophyletic method of classification was the evolutionary concept of convergence. Similar traits can evolve independently, resulting in false impressions of close genealogical relatedness (31).

Willi Hennig (1913-1976), whom Ronquist (31) considers "perhaps the most influential systematist of all time," (p. 632) argued that plants and animals should not simply be classified based upon similar morphologies, but on their phylogenetic or evolutionary relationships (32). Hennig was the first to develop a complete theory of phylogenetic reconstruction with principles for phylogeny-based classification

(6, 30, 31). Hennig attempted to unravel the problem of false relatedness through convergence by distinguishing between "shared derived traits" (synaptomorphies) and "shared primitive traits" (plesiomorphies). As Ronquist (31) illustrates, humans, chimpanzees, dogs and lizards cannot be grouped together based upon the plesiomorphy of sharing a tail inherited from a common ancestor. The synopomorphy of missing a tail, however, is a trait that supports the classification of humans and chimpanzees in a common monophytic group or clade (31). Thus according to Hennig, "all named taxa must be monophyletic groups" (31, p. 633).

If the descriptive approach of Linnaeus was unifying, the morphophletic approach of Hennig ignited controversy and stimulated the development of competing theoretical models: Classifications were proffered that were based upon overall similarity alone "phenetics" (33), both overall similarly and evolutionary relationship, "evolutionary systematics" (34); and parsimony of data (35). Hennig's theory of phylogenetic systematics (6, 31) continues to be debated today and a consistent Hennigian classification has not been widely adopted due to persistence of familiar conceptual categories such as invertebrates, gymnosperms and protozoans and due to the sketchiness of current knowledge about phylogeny. Nonetheless, the principles proposed by Hennig are today "almost universally accepted" (31, p. 633).

Molecular Phylogenetics

Today analysis of molecular data is resulting in significant revisions in assumed phylogenetic relationships between organisms. For example, hemichordates, previously thought to be the closest relatives to chordates, are now grouped with echinoderms (starfish and sea urchins) to the exclusion of chordates (36). This constitutes a substantial adjustment of the classification of animals and in the theoretical evolution of vertebrates. Evolutionary history, and therefore phylogenetic relatedness is reconstructed by molecular analysis of the sequence of nucleotides (phosphate, amino acid base and pentose sugar) in the DNA and of amino acids in the encoded proteins (37, p. 150). The greater the similarity in such comparisons, the greater the assumed relatedness. For many species full genomes have been sequenced (p. 143). The three methods of reconstructing evolutionary history and phylogenetic relatedness are distancing, parsimony and likelihood (pp. 139-143).

In contrast to the strong similarities between the Linnaean descriptive classification of life forms and modern neo-Kraepelinian classification of mental disorders, mental disorders are not classified based on underlying molecular similarities in genetic material. Even where the precise molecular genetic cause of the disorder is known, as in Huntington's disease, the disorder is simply grouped with other conditions resulting from organic etiology and resulting in dementia (Dementia Due to Other General Medical Conditions) (9, p. 168).

The diverse pathomorphological conditions of lissencephaly, schizencephaly and polymicrogyria, thought to be different entities, were grouped based upon

common morphological abnormalities, i.e., disorders of sulcation (38) and of embryonic neurodevelopment (39). Whole exon sequencing recently demonstrated that all three of these disorders are caused by (the same) mutation in a single gene (40).

The Neuropsychiatry of Griesinger

Equivalency of diagnosable mental disorders and diseases of the brain was propounded by the German physician Wilhelm Griesinger in the nineteenth century. Although he held the unitary concept of psychosis (41), his assumption that all brain disease could be demonstrated by autopsy findings, (42, 43) and genetic histories would influence Kraepelin's classification of mental disorders and their presumed manifestation of mental (or brain) disease (28, 44). Early findings of specific organic etiologies were critical medical discoveries (e.g., tuberculosis, syphilis, alcoholism). The early assumption about the morphological and genetic basis of psychopathology continues to have strong influence on current DSM classifications and investigative directions for future changes in official nomenclatures.

Kraepelin: The Preeminent Trailblazer in the Classification of Mental Disorders

In the development of modern classifications of mental disorders, the influence of Emil Kraepelin on modern classifications of mental disorders cannot be overemphasized. In the introduction to the second volume of his textbook on psychiatry in which he presents his taxonomy of mental disorders, he at the same time acknowledges the trailblazing Linnaean model of classifying plant and animal forms, and the value of rational classification in constraining preconceived opinions:

> If we therefore now must foresee a smooth organization of mental disorders, somewhat in the sense of Linnaeus, from a list of soundly established types for all times, thereby supporting the current practical need for at least a general grouping of the raw material of experience, which will possess enduring worth, the less it is influenced through preconceived opinions in the sober processing of the facts (44, p. 2)

In the Griesinger tradition of assuming psychopathology to have organic causes, Kraepelin applied the practice of carefully analyzing and describing behaviors based upon observation to the study of psychopathology. Blashfield (28) suggests that Kraepelin's description of mental disorders compares with the Platonic concept of "ideal types" to which actual clinical cases with psychopathology of undetermined etiology may not invariably correspond in all respects.

Emil Kraepelin, a contemporary of Sigmund Freud, developed a most influential classification of mental disorders that famously distinguished dementia praecox from manic-depressive illness, based upon course of the illness. Not to be overlooked was this German physician's search for etiology and emphasis on course of illness. In 1882 Koch conclusively demonstrated before the Physiological Society in Berlin that tuberculosis was bacterially caused (45). Influenced by this finding, Kraepelin developed a nosology that attempted to predict prognosis from presenting signs and symptoms (45).

Kraepelinian Influence on Precursors of the DSM

As early as 1917 a U.S. classification of mental disorders included the Kraepelinian concepts of paranoia, manic depressive disorder and dementia praecox. This taxonomy distinguished neurotic/character disorders, functional psychoses, and organic brain syndromes respectively (28, 46). In 1933 the American Psychiatric Association adopted a classification in which 19 of 24 major categories came from Kraepelin's classification (28, 44, 47, 48). The remarkable correspondence between the 1933 APA and Kraepelinian taxonomies are illustrated for dementia praecox (schizophrenia) and manic depressive illness. (See Table 2)

Table 2. Comparison of Kraepelinian and early APA taxonomies for dementia praecox and manic depressive illness

Kraepelinian (1899)	APA (1933)
Dementia praecox	Dementia praecox/schizophrenia
Hebephrenic forum	Hebephrenic type
Catatonic forum	Catatonic type
Paranoid forum	Paranoid type
	Simple type
	Other types
Manic-depressive psychosis	Manic-depressive psychosis
Manic conditions	Manic type
Depress conditions	Depressive type
Mixed conditions	Mixed type
	Circular type
	Perplexed type
	Stuperous type
	Other types

American psychiatry essentially adopted and added to the Kraepelinian taxonomy. Incidentally, the original Kraepelinian disorders more than the APA additional disorders have endured today.

Although Menninger (45) observed that the APA's earliest classification had little influence, the evolution of the DSM was and is profoundly influenced by the pioneering work of Kraepelin. Not without reason, the APA approach to the classification of psychopathology is described as "neo-Kraepelinian" (28).

U.S. Nosology before the DSM

Nineteenth century American psychiatric nosology was influenced by three currents: 1) classification based upon signs and symptoms, 2) the search for etiology, and 3) organizing and gathering statistics for public policies (48). These three currents, classification for social purposes, search for etiology, and population statistics, led to the evolution of classification of mental disorders. The decennial United States census in 1840 was the first official system for tabulating mental disorder in the United States (13), but the methodology did not enable classification (48) and the only category registered was "idiocy" which included "insanity" (13). Forty years later the 1880 census included seven categories of mental disorder which incorporated Esquirol's concept of monomania (49, 50). Benedict A. Morel in 1857 (51) in France attributed mental illness to degenerative factors, a view based more on philosophical and religious assumptions than scientific observations, (50) yet his named disorders are familiar. The classification developed at the International Congress of Mental Science in Paris, 1889, adopted the eleven disorders of Morel's taxonomy (13).

In France Jean Etienne Esquirol's (1772-1848) classic textbook *Des maladies mentales* published in 1837 (50) categorized mental disorders based upon their predominant behavioral manifestations (51, 52). The monomanias of homicidal mania, pyromania, kleptomania, etc. contributed to the concept of moral insanity, the emerging field of forensic psychiatry, and classifications of mental disorders. Isaac Ray, the leading 19th century American forensic psychiatrist, for example, in his classic text, "A Treatise on the Medical Jurisprudence of Insanity" (53), followed the classification proposed by Esquirol.

The third current was based upon the assumption that the federal census could provide statistical descriptions that could in turn inform attempts to address social problems (48). This outside influence from the social sciences and the census process itself spurred psychiatry to develop a classification of mental disorders. Beyond the obviously useful aims of improved understanding the causes of morbidity, mortality and "dependence", the census process itself emphasized social and demographic factors and early in the 20th century led to

eugenic practices to solve or prevent social and mental ills (48), which would eventually be discredited.

The First DSM: Towards a Common Nosology

The first Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association in 1952 (10) was intended to influence psychiatrists and other mental health professionals to follow the same diagnostic nomenclature. This effort toward a uniform nomenclature of diseases was started several decades earlier by the New York Academy of Medicine which recognized that large centers for medical education developed their own nomenclatures, not just for mental disorders but for all pathological conditions, and which "resulted [in] a polyglot of diagnostic labels and systems, effectively blocking communication and the collection of medical statistics" (10, p. v).

In 1933 the effort initiated by the New York Academy of Medicine in 1927 culminated in publication of the first official edition of the Standard Classified Nomenclature of Disease (48). By 1948, this effort was nearly derailed by the development and use of other nomenclatures, such as those of the Armed Forces and the Veterans Administration, and one of these corresponded with the contemporary "International Statistical Classification" (10, p. vii). The first DSM in 1952 then was the section of the Fourth Edition of the Standard Nomenclature of Diseases and Operation titled "Diseases of the Psychobiological Unit" (p. v).

Adolf Meyer and the First DSM

That Swiss and British educated Adolf Meyer would become the single most influential figure in the development of the first DSM is ironic given his open antipathy against the classification of mental disorders. Because of the great variations between individuals, he recommended that psychiatrists relinquish the effort to classify people "as we do plants" (54, p. 105). His theory of psychobiology was neither a purely biological nor a psychoanalytic explanation of psychopathology, the two predominant competing psychiatric epistemologies in the first half of the 20th century. His psychobiological theory of psychopathology, which incorporated concepts from biology, physiology, psychology and sociology (55), was more unifying and less polarizing than either of the other two approaches would have been for the first DSM. Unification was needed, if a single classification were for the first time to achieve common usage among U.S. psychiatrists. His disease-reaction to stress model of mental illness anticipated the later stress-diathesis theory of psychological symptoms.

With the exception of post-traumatic stress disorder, stress and reaction to stress were discarded in psychiatric nomenclatures of subsequent DSM editions, except as the item on Axis IV of the multiaxial system. Kraepelin had already recognized PTSD essentially, and termed it "fright neurosis" ("*Schreckennerose*") (42).

Throughout the first half of the twentieth century the two major etiological theories of mental illness in the United States had been basically neurological and psychodynamic. The psychodynamic and psychosocial views became resurgent immediately after World Ward II. With the aim of achieving wide acceptance and usage among practitioners, the first DSM relied upon the psychobiological theoretical framework of Adolf Meyer, as a compromise orientation that allowed for both biological and environmental contributions to psychopathology, an approach that is akin to today's stress-diathesis concept of psychopathology. Accordingly many of the conditions described in the first DSM were termed "reactions." An example is the description of "antisocial reaction."

> This term refers to chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. They are frequently callous and hedonistic, showing marked emotional immaturity, with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behavior so that it appears warranted, reasonable, and justified.
>
> The term includes cases previously classified as 'constitutional psychopathic state' and 'psychopathic personality.' As defined here the term is more limited, as well as more specific in its application (10, p. 38).

This and descriptions of other "reactions" attempted to concisely summarize the conceptions of pathological conditions as presented in the professional literature. Because such descriptions seemed to allow a diagnosis based upon various unspecified combinations of features of the condition, the evaluator could exercise considerable discretion. The first DSM was successful in that it was more widely used than previous attempts at a standardized nomenclature, but it was not invariably used in the same way. Studies both before and after publication of the first DSM indicated unacceptable discordance between diagnosticians (56). Greater reliability between large diagnostic categories in contrast to subtypes or more specific disorders favored a Linnaean[1] model of classification (57) which the first DSM had already adopted. Also comparable to evolving nosologies of mental disorders, Linnaeus had recognized his classification as a temporary convenience that would be modified with improved knowledge of the relationships between species, as eventually occurred with its

1 The hierarchical classification of plants and animals by Carolus Linnaeus (1707-78) is well known with large categories (kingdoms) divided into subcategories (phyla) which in turn are further subdivided and so on. His binomial nomenclature of plant and animal types (genus and species) compares with the binomial terminology for mental disorders that has existed throughout all DSM editions.

influence on evolutionary theory, improved comparative morphological analysis, and is currently taking place through DNA barcoding (58). The concern then was insufficient reliability in psychiatric diagnosis, a concern which would eventually drive the shaping of the third edition of the DSM.

The DSM III: Towards a Reliable Nomenclature

The second edition of the Diagnostic and Statistical Manual published in 1968 (14) was not much different from the first. The third edition, however, was radically different, mainly because of the increased emphasis on establishing reliability of diagnosis. The earlier versions of the DSM, and the Meyerian psychosocial model upon which they were based, was criticized on various grounds, not the least of which was the want of greater reliability in the diagnosis of psychopathology (59). Publications beginning before the first DSM (60) and continuing into the 1970s (61-64) suggested that the likelihood of two psychiatrists agreeing on the diagnosis of a patient was little more than chance.

The core of interest and productivity that would contribute to the methodology and emphasis on reliability and thereby shape the DSM III, was the research group at Washington University headed by Robins and Guze (12). This group recognized the need for explicit, descriptive, rule driven criteria, in diagnosis, if mental disorders were to be subject to quality scientific research (59). The well known Feighner criteria for 14 psychiatric syndromes (28, 63) were explicitly, substantially validated based upon the five validity factors of Robins and Guze (12) to be described below. Follow up and family studies in particular served to validate these syndromes, not a committee's "best clinical judgment and experience" (63). Even while proposing these 14 syndromes to be more validly established than the disorders of the DSM II, the authors recognized the development of a valid taxonomy to be an evolving process that should progressively improve the diagnostic classification. Their work resulted in the Research Diagnostic Criteria (64) which in turn would serve as the template for the DSM III (59).

The Feigner taxonomy was polythetic, allowing diagnosis of a disorder to be made with different combinations of signs and symptoms from a list of manifestations, and it included thresholds. For example, symptoms of schizophrenia must have existed for at least six months before the diagnosis can be applied. The more clearly the criteria for a disorder are specified and the more structured the interview in eliciting the criteria, the better the inter-rater reliability which is essential in achieving improved reliability. However, narrowed, formulaic diagnoses do not always contribute toward increased construct validity, which should be the ultimate goal. A consequence of the

Feighner-RDC-DSM approach was the creation of "undiagnosed" or "nonspecified" disorders, already in 1974 reported for "20-30 percent of newly-admitted inpatients" (62, p. 346). For the many forensic evaluees whose findings would fall into such a category, the possibility of malingering must be given even greater attention than for the diagnosis of a clearly defined disorder.

As noted by Saß (65), the DSM III descriptions of personality disorders were essentially modified versions of the personality disorders described in 1950 by Kurt Schneider (66). The DSM III was intended to result in increased reliability in diagnosis of mental disorders, if diagnosis is based upon the requisite criteria. In clinical practice, situational difficulties can comprise appropriate use of the DSM III and the DSM IV and DSM IV-TR (9) that followed. In clinics, hospitals, jails and other settings, psychiatrists face large volumes of patients, and have limited time for assessment. Patients are hospitalized only so long as they risk harming themselves or others, not necessarily until an accurate, thorough, evidence based diagnosis is established. A working diagnosis is typically required for payment of service, even when service is first administered. Initiation of treatment is not to be temporized, but treatment requires a diagnosis. Given time constraints and the pressure to arrive at an early diagnosis, clinicians may rely on the diagnosis previously applied by another evaluator or settle on a diagnosis that is easily and quickly established such as "psychosis not otherwise specified," "mood disorder not otherwise specified" or "substance induced mood disorder," i.e., disorders that are relatively non-definitional. Presumably if the clinician had taken more time and care in the evaluation, he or she would have arrived at an accurate diagnosis of a disorder that is well recognized. Forensic evaluators, too, are not immune from pressures of limited time in which to complete evaluations. Court schedules sometimes seem to dictate expedited evaluations. Compensation mechanisms are variable and some disincentivise the clinician from taking the time needed for comprehensive, accurate diagnostic assessment.

Assuming that adequate time and care are given to following the rules and criteria of DSM III and arriving at an accurate diagnosis, the question remains whether the diagnosis is valid, whether it corresponds to a specific disorder. We are reminded that the DSM III was developed through a process of consensus building and consensus is not equivalent to "truth" (67, p. xiii). Although clearly established etiology for mental disorders would contribute to their construct validity, the DSM III strives to be purged of etiological assumptions that can polarize, so as to achieve consensus and "buy in" by those who would use the diagnostic manual. Yet, as becomes clearer in DSM-IV-TR (9), etiological assumptions are not completely absent, with family studies, for example, suggesting a genetic link between schizophrenia and schizotypal personality disorder, and psychoanalytic theory contributing to the conception of narcissistic personality disorder (67). The "truth" derived from science itself evolves over time, and the consensual process of updating and refining the DSM adds another dimension to the manual's continued "provisional" nature.

DSM V and Beyond: Towards a Valid Nomenclature

Dimensions

The next version of the DSM, DSM-V, is in the making and now expected to be completed by 2013. As prior DSM's have been shaped by the push to achieve conceptual consensus and therefore, hopefully, widespread acceptance and use, and improved reliability, the next version might give greater attention to construct validity, though actual validity is difficult to disentangle from consensual agreement. Existing clusters will be grouped into larger structures, the clustering referred to as "meta-structure," and reliability may be sacrificed in the interest of achieving greater validity and clinical usefulness (68).

To be given greater emphasis is the dimensional, in contrast to categorical, approach to disorders. Studies using psychological testing suggest that some, perhaps many, psychopathological manifestations of psychological suffering and dysfunction, represent continuously distributed traits within the population, rather than discrete and well demarcated disorders. In general medicine, examples of categorical disorders are specific cancers or infections, whereas hypertension would in contrast represent the dimensional approach that is increasingly influencing conceptions of psychopathology, especially character pathology. The designation of hypertension also depends on a consensual process but explicitly takes into account scientific findings that suggests a significant increase in risk of myocardial infarction or stroke at a given threshold level of blood pressure readings above (the norm). (http://www.nhlbi.nih.gov/guidelines/hypertension/incintro.htm>) (67). In this sense even a dimensional approach can become categorical and allow for dichotomous decision making as to whether or not to treat the condition. With either model, categorical or dimensional, clinical decisions will have to be made as to whether a presenting condition is sufficiently severe to warrant treatment, in terms of health care, or some legal allowance, in forensic or judicial contexts.

Although not generally characterized as such, the polythetic method of the DSM III and later editions was something of a hybrid between the "hard core" categorization of a nomenclature with diagnostic criteria all of which must be met to establish a diagnosis and dimensional assessment. The multiaxial system and allowance of mixed conditions and traits further recognized that individual psychopathological conditions cannot always be pigeonholed into discrete categories.

Nonetheless, to the extent that the DSM approach has been categorical, this seems to support various levels of diagnostic certainty that are relevant to forensic evaluations. For example, if a forensic evaluee fully satisfies criteria of schizophrenia, paranoid type, the level of certainty that the individual has a thought disorder characterized by psychotic dysfunction, is substantially greater than if the individual does not satisfy criteria for a well defined disorder and is diagnosed with an exclusionary condition such as "psychosis not otherwise specified."

In forensic evaluation the possibility of deception must always be considered. This possibility becomes an even more serious consideration where the evaluee's condition does not correspond to well defined and recognized diagnostic category. The DSM is singularly useless in guiding the detection of deception. If the DSM did provide a similarly concrete and formulaic approach to the detection of various types of deception concerning specific DSM disorders, this could conceivably confound the effort because of the universal availability and growing popularity among laypersons of the current DSM. A potential difficulty with the categorical approach to differentiating authenticity from deception in the current "information age" is that anyone can learn the criteria for categorical diagnoses by obtaining the latest edition of the DSM from the nearest popular bookstore or by accessing relevant information on the Internet. Attempting to outwit psychological tests for dissimilation, exaggeration, etc., should be more difficult, but this too can be accomplished and tests are not designed to detect all forms of deception and are not standardized for all populations.

Neurocircuity Domains

Useful as the DSM has been in gaining widespread use with improved reliability, it has not incorporated recent discoveries in genomics and neuroscience and has failed to explain the underlying mechanisms of dysfunction (69). The National Institute of Mental Health is now about to begin the Research Domain Criteria (RDoC) project to focus study on pathophysiology is intended to inform future classifications. This project rests on three assumptions: 1) Psychopathology is caused by disorders of brain circuits which correspond to behavioral domains such as fear/extinction, reward, impulse control and executive function. 2) Neuroscientific procedures can be employed to identify dysfunctional neurocircuits, 3) Such study will discover biosignatures or biomarkers which, together with symptoms, will improve the validity of nomenclature and classification of psychopathology. A classification based not only on symptoms, but also biomarkers that correspond to the causative pathophysiology will lead to more productive research, more efficacious treatments, and more accurate prognoses (69). This could add the precision that the field needs for forensic evaluations, at least in providing greater construct validity for diagnostic findings. Such clarity and certainty seems a long way off at present.

Research into neurocircuity domains offers hope but not promise. Hope should be tempered with a caveat against phrenological-like reductionism. Some circuits may correlate strongly with specific disorders but not to be overlooked are: 1) the cortical and nucleic endpoints of circuits, 2) the counterbalancing of opposing circuits and potential for variable combinations of circuits accounting for similar manifestations, 3) brain placticity, 4) pleomorphic, chameleonic mental conditions and behaviors despite "hard wired" circuits, and 5) impact of environmental events, such a stress and personal relationships on the functioning of the circuits in questions as well as other regions of the brain.

A research consortium headed by Washington University and University of Minnesota but including Saint Louis University and nine institutions altogether will conduct a study, Connectone, over the next five years designed to map the connecting tracks first in healthy brains and then in the brains of individuals afflicted with psychopathology. It is hoped that this study will provide missing links in understanding brain-based disorders such as alcoholism, autism and schizophrenia (70). Ultimately a more complete understanding of how the entire brain, including connecting tracts, functions in health and disease will result, thereby adding to construct validity in classification and diagnosis.

Research Domain Criteria may transform conceptualizations and classifications of psychopathology, but not DSM V, and not the practice of forensic assessments in the near future. Nonetheless, it behooves forensic evaluators to become familiar with this direction in research into psychopathology and diagnostic classification, and biomarkers that already have demonstrated correlation with specific disorders, such as the low pulse of the psychopath (71), but without attaching undue significance to such signs.

Methylomics

Methylomics, the science of the uses of methyl groups for physiological functions, brings the study of brain circuits to the molecular level (72). Classical genetics is concerned with the inheritance of DNA sequences which can be transcribed into specific sequences of RNA which in turn carry the potential for transcription into specific proteins. A parallel system that determines whether given genes are activated or inactivated, i.e., whether they actually produce their corresponding protein, is the focus of epigenetics (73). Genes can be turned off by methylation of DNA or chromatin, or turned on by demethylation of DNA or chromatin. DNA methyltransferase regulates methylation of DNA whereas DNA demethylase removes the methyl group (CH_3) from DNA (72).

DNA and its associated proteins – chromatin – must be tightly packaged for the DNA, which if stretched out would be two meters long, into a space in the cell nucleus that is less than a few micrometers in diameter. The chromatin proteins or histones, in groups of eight, nucleosomes, keep the DNA wrapped tightly around them. Only when a DNA gene is unfolded can transcription factors promote the goal of transcribing the RNA that produces the protein. Gene activation is accomplished by removing methyl groups with the help of histone demethylase, and inactivation by methylation catalyzed by histone methyltransferase. Not only methylation, but also acetylation, phosphorylation and other chemical processes can also affect gene expression (72).

Methylomics, implicated in neurotransmitter function and psychopathology, is not independent of environmental contributions to mental functions. Nutritional deficiencies can contribute to insufficiencies in folate, L-methylfolate, and methyl donors (72). Good and bad experiences can affect production of methyl "marks" (72) leading to correspondingly enhanced good and bad memories. In

experimental animals methylomics has been shown to be involved in the acquisition and extinction of learned fear (74).

Whole-Exome Sequencing

A methodology that could improve construct validity to mental and brain disorders is whole-exome sequencing. By this technique the sequence of an entire portion of a section of DNA, that codes for a section of messenger RNA from the DNA that will eventually be translated into a specific protein at the ribsome, is determined. The application of whole exome sequencing to the study of genetically shaped mental and developmental disorders, as mentioned above, recently demonstrated that mutation in a single gene can result in a wide variety of cerebral cortical malformations and debunked the assumption that such divergent patho-morphological conditions such as lissencephaly, i.e. agyria; schizencephaly, i.e. abnormal clefting of brain substance; and polymicrogyria, i.e. excessively numerous and abnormally small gyri, are different entities with distinct genetic contribution (39). This finding exemplifies that mental/brain disorder classification based more on etiology than morphology or dysfunction can result in clustering or lumping rather than splitting pathological taxons.

Like the study of neurocircuits, epigenetics and molecular genetics will hopefully increase our understanding of psychopathology and construct validity of pathological conditions. It will not have much if any impact on the practice of evidence based forensic psychiatry in the near future, however. Moreover, from the purely scientific viewpoint, epigenetics does not encompass all relevant fields of knowledge for understanding the wide variations in psychopathology and their change over time. For this one might turn to the general systems model.

General Systems Model

The goal of developing a unified field theory of psychopathology remains highly desired but terribly elusive. It seems overly reductionistic to expect that one theoretical framework will explain all aspects of a mental disorder. Likewise a single perspective of psychopathology may not be the most valid, even if that perspective has the best scientifically demonstrated validity. A more comprehensive and in this sense more accurate accounting of psychopathology is the general systems model which has been applied to defining personality states/traits. Barratt and colleagues (75, 76) modified the Ashby model as described by Diamond, Balvin and Diamond (77) and influenced by Lazare (78). Barratt and colleagues then applied this general systems closed feedback model to collect and organize multidisciplinary data and to guide their research. Four classes of constructs were biological, behavioral, environmental (including both physical and social stimuli), and cognitive or thought processes (76). Concepts and measurements within each of these four categories interrelate to various degrees and their relationships can change over time. Although initially applied to

personality traits and ability (76, 79), this model can serve as a useful model for synthesizing data on psychopathology in general, especially if chronic.

Even though the theoretical underpinning of each category are different and not integrated one with the other, this model can also usefully ensure that the forensic examiner has attended to the major relevant fields of data in conducting a forensic evaluation and establishing valid diagnostic findings through convergence of disparate types of data.

The Robins and Guze Criteria for Recognizing a Mental Disorder

The categorical approach in psychopathology has been influenced but not dictated by the method of Robins and Guze (12), developed forty years ago for establishing the validity of a psychiatric disorder. Their five criteria for recognizing the validity of a disorder are: 1) a defining clinical description, 2) consistently supportive laboratory studies and psychological test results, 3) exclusionary criteria that delimit the disorder from other disorders ensuring a homologous condition, 4) determination through follow up studies that the proposed disorder does not evolve into another condition that would explain the findings and 5) evidence for familial/genetic inheritance.

As an example with forensic relevance, Felthous and Barratt (79) argued that using the Robins and Guze method serves to confirm the construct validity of impulsive aggression as a mental disorder, which is similar to intermittent explosive disorder of the DSM. Unlike the purely categorical approach to IED, impulsive aggression can usefully be considered as a dimension as well as a disorder once threshold criteria are satisfied. In some conditions such as the manic phase of bipolar disorder, impulsive aggression represents a manifestation of mania. In other conditions, such as antisocial personality disorder, the question rises as to whether the impulsive aggression is further manifestation of the character pathology, or a separate but co-morbid condition that can be effectively treated (76, 79, 80, 81), regardless the relative lack of proven amenability of the core defect in psychopathy to treatment (82).

The consistent therapeutic response of impulsive aggression, sufficiently defined and diagnosed, suggests a sixth optional criterion for recognition of a disorder: demonstrated and consistent therapeutic response to a specific treatment, anticonvulsive or mood stabilizing pharmacotherapy in the case of impulsive aggression (81). Many examples of specific responses that can serve to confirm the diagnosis could be cited in psychiatry, neurology and medicine in general. For infectious disease this response is sought before specific antibiotic medicine is prescribed: Culture and sensitivity testing at the same time identifies the etiology and the most effective treatment, both serving to establish or confirm the diagnosis. Unfortunately treatments in psychopathology are relatively

non-specific, curb symptoms rather than the underlying disorder, and may not result in improvement until six weeks after initiation of treatment.

The outpatient forensic evaluator typically does not have the option of initiating treatment and observing for a favorable response over time, although prior treatment response, as noted through mental health and medical records, should be noted. Moreover, forensic ethics (83) advises against the forensic examiner also serving as the evaluee's treating physician. Treating psychiatrists, more than forensic evaluators, have direct opportunity to observe for the expected response to specific pharmacotherapy. Inpatient psychiatrists who treat forensic evaluees in extended inpatient treatment can observe for improvement using objective parameters. The ethical caveat against dual roles notwithstanding, the aim of the inpatient forensic psychiatrist in treating an incompetent-to-stand trial defendant should be to restore competence. This can be done most efficiently if the treating psychiatrist is addressing and monitoring the incompetence and its restoration, not just symptoms of mental illness. At the same time, she must look for symptom response to treatment to inform the ongoing diagnostic assessment and treatment strategy.

Limitations in the Classification of Psychopathology

As the publication of the DSM V is awaited, forensic evaluators can appreciate strengths and weaknesses in the current DSM and anticipate such strengths and weaknesses in the next version. Specific tests and procedures used in arriving at a diagnosis will have published reliability and validity figures, but the DSM itself is unlikely to contain this information about specific diagnoses. If the DSM V incorporates more of a dimensional approach without relinquishing its categorical framework, this could more accurately register current scientific understanding of psychopathology, but this is likely to complicate the forensic evaluator's attempt to qualify the level of certainty attached to his diagnosis. The forensic evaluator will not know from the DSM itself how strongly the validity of a given diagnosis is supported by the Robins and Guze criteria.

At least the forensic evaluator should be able to *comment* on the extent to which a given DSM diagnosis once established may or may not be supported by the Robins and Guze criteria for assessment of validity. Here we review these criteria with an eye towards sensitizing forensic evaluators in particular to the relevance of these criteria to the application of the DSM nomenclature to the diagnostic assessment.

Description of the Disorder/Dimension

If not obvious from the forensic report, the evaluator should be prepared to explain the nature of the description and to what extent the clinical diagnosis actually corresponds to the DSM description. Is the description of the disorder nomothetic, polythetic and/or dimensional? It is recommended that the evaluator who finds that the evaluee meets more than the requisite optional criteria for a given diagnosis, lists not just enough criteria to establish the diagnosis, but all of the optional criteria that are satisfied and describe how each of these criteria is evidenced.

The method of establishing presence of descriptive criteria is as important as the criteria themselves. By asking questions that essentially reveal the criteria, the evaluator invites answers that support a given diagnosis. In the interest of time and completeness, some leading or close ended questions may be necessary. Diagnostic criteria that are identified through the evaluee's spontaneous descriptions of his subjective symptoms, dysfunctions, and presenting history are as a rule less suspect than those elicited by pointed questioning (84). Criteria that are similarly more or less spontaneously generated and derived from independent collateral sources can enhance the level of certainty of one's findings. The forensic evaluator must attempt to assess whether expressed criteria are feigned, exaggerated, authentic or minimized. In this effort it becomes critical to obtain a description that is maximally detailed (85, 86). To simply report whether auditory hallucinations are present or absent, for example, is to offer an unsupported pathological interpretation that could be misleading. Far more useful in achieving a valid diagnosis is a detailed description of what the evaluee reports as "voices".

Diagnostic and Supportive Tests

Beyond a description of experiences and events, tests and procedures provide objective findings that can contribute to the core description of pathological condition, support a given, disorder dimension, or disconfirm specific diagnostic considerations. Although not subject to qualitative determination of reliability and validity, the mental status examination is critically important in forensic evaluation, as it serves to identify areas of psychological function and dysfunction. Through the mental tasks and direct observations of the mental status examination, evidence for and against presence of a thought disorder can be demonstrated. If, for example, the evaluee provides abstract interpretation of proverbs, this demonstrates some ability to think abstractly that would not have been feigned by the evaluee who tries to appear psychotic but is unaware of the diagnostic significance of this particular exercise.

The Mini-Mental State Examination

The Mini-Mental State Examination (87) can be used as an initial test of cognitive abnormalities and to monitor cognitive changes over time (88). The Mini-Mental State Examination is quick, simple and, unlike most mental status examinations, *standardized*. It is widely used in clinical psychiatry and neurology and is available for use in forensic evaluations.

With a cut off score of 23 out of a total of 30 scored points, the MMSE has a sensitivity of 86 percent and a specificity of 91 percent in identifying dementia in the community (89). Cut off scores should take into account age and education level for which normative data demonstrate variations according to these variables (90), although it is doubted that most practitioners reference these published benchmarks.

Because of its wide popularity and greater scientific foundation in comparison with traditional mental status outlines, the significance of the MMSE can be overvalued. Items of the MMSE can be administered in nonstandardized ways and "ceiling effect" can obscure cognitive impairments in individuals who function at a high level (91). Such problems with the MMSE can be minimized or overcome by following standardized scoring instructions (91) or by using the Modified Mini-Mental State Examination for which age and educational-corrected normative data exist (92).

Of equal concern, because of its popular and scientific basis, the MMSE is used in place of a traditional mental status examination. Although less scientifically rigorous, not standardized and typically lacking normative data that allow for accurate scoring with known sensitivity and specificity values, the traditional mental status examination is more useful in the majority of forensic assessments. The MMSE's value is best established for assessing dementia such as in Alzheimer's disease, but it does not identify the impaired abstraction ability that is characteristic of the thought disorder in schizophrenia (93).

Laboratory Tests

Would that a laboratory test could specifically and categorically establish the diagnosis of a mental disorder. Actually there exists a diagnostic test for Huntington's disease, a severely disabling illness with a poor prognosis. Historically the diagnosis was established from its clinical features and hereditary passage from parent to child. Neuroimaging shows characteristic striatal atrophy but this finding is nonspecific. Somato-sensory evoked potentials are abnormal in 94 percent of Huntington's cases.

A significant cause of dementia, Huntington's disease is not only a severe and progressive movement disorder; afflicted individuals have high rates of suicide

and alcoholism (94). Pathology includes selective destruction of the caudate and putamen and markedly reduced GABA concentrations in the caudate nuclei (95). Highly specific and sensitive is the test for the Huntington disease gene, expanded CAG repeats (96), a gene on chromosome 4, which is associated with the formation of the Huntington protein (16, 97). Genetic testing for Huntington 's disease is not only exceptionally accurate in establishing the diagnosis, it allows the "diagnosis" to be made before the clinical features of the disorder appear, even prenatally. Because of the certainty of diagnosis and concern for not only the grave prognosis of this untreatable condition, but also dire social consequences such as denial of insurance or occupational discrimination, suspected carriers of the gene avoid testing and testing itself is a matter for medical ethics.

Disorders that can be treated with a favorable prognosis are also diagnosable with laboratory testing. Wilson's disease or hepatolenticular degeneration, can present with various mental disturbances including dementia, psychosis and disturbances of thought, mood and personality (97). This inherited autosomal recessive condition with markedly low levels of serum ceruloplasmin (97), a Γ-globulin needed for copper transport and regulation, results in excessive levels of copper in the blood, and copper deposition in the brain can lead to a variety of mental and neurological symptoms. Slit lamp ophthalmologic exams demonstrate with high sensitivity deposition of copper in the Descements membrane, known as Kayser-Fleischer rings, and sunflower cataracts are common. A number of characteristic laboratory studies as well as neuroimaging studies can support the diagnosis. Most specific and sensitive in diagnosing Wilson's disease however is, together with Kayser-Fleischer rings, the findings of low serum ceruloplasmin, elevated copper excretion, and elevated hepatic copper confirm the diagnosis (96).

Numerous examples could be given in which laboratory tests are diagnostically useful if not diagnostic themselves in identifying the disorder. Delirium or acute confusional state, has a recognizable clinical presentation but can be the result of various pathological conditions best determined by laboratory testing. Useful tests in delirium include serum electrolytes, complete blood count, blood urea nitrogen, glucose, transaminases, creatinine, ammonia, thyroid function tests, arterial blood gases, urinalysis, and urine drug screens (97), as delirium can result from intoxication or withdrawal from either illicit or prescribed drugs.

For most outpatient forensic mental examinations, laboratory tests are not obtained because of the increased cost, time and effort, and because they are unlikely to contribute to establishing the diagnosis except by excluding unlikely anomalous possibilities. When laboratory studies are used, typically more information is available about the reliability of such tests than for aspects of the mental status examination. Although not made known to the forensic evaluator, information exists about the sensitivity and specificity with which a given test corresponds to various disorders. The evaluator must utilize test

results in a way that maximizes their accuracy and diagnostic meaningfulness. Because of the possibility of analytic error or brief physiologic variations, for example, the significance of borderline determinations can be difficult to interpret (98). Variations in test results can be due to differences in laboratory techniques, methodology, and instrumentation. Pre-analytic but non-pathological factors can also yield different results: characteristics of the test population, age, sex, dietary and medication effects, position of the patient/evaluee (e.g., upright or supine) and other conditions of the evaluee (e.g., fasting or post-prandial) (98). The forensic evaluator is advised to use reference ranges from the laboratory that is conducting the tests. The significance of many tests depends on knowledge as to when the sample was taken, for example, whether the urinary drug screen was obtained before of after the evaluee was thought to have ingested illicit drugs. Correlation of laboratory values with the evaluee's mental and medical condition and with relevant literature in clinical pathology is critical. The evaluator should have had a purpose in mind when ordering any laboratory test, a diagnostic purpose that he can explain later. Because of the potential complexity of interpreting laboratory tests, the evaluator should make use of an appropriate manual and consult with the testing laboratory and other specialists where questions and uncertainties exist.

Most outpatient forensic examinations are conducted without laboratory tests. Most DSM disorders are diagnosed without laboratory tests and most forensic evaluees do not have a mental disorder that is diagnosable with a laboratory test. More routinely and without specific indication, certain laboratory tests like the CBC and urinalysis are done routinely on hospital admission. Where clinical indications exist, more specific laboratory testing can be critical for a proper diagnosis the results of which are needed for specific and effective treatment.

Exclusionary Criteria

Exclusionary criteria, more consistently introduced in the DSM III (28), serve to distinguish mental disorders one from the other in support of descriptive validity. While following the exclusionary criteria of the current DSM, forensic psychiatrists must not overlook the possibilities of co-morbidities, traits and dimensions, and co-occurrence of feigning/malingering together with authentic psychopathology. Importantly, the consideration of alternative diagnoses, rather than simply marshalling all data to support the suspected diagnosis, helps to diminish confirmatory bias.

Consistency when Reassessed

This criterion of Robins and Guze, which supports predictive validity and temporal or "test-retest reliability," adds to the value of interviewing a forensic evaluee more than once, so as to assess the evaluee's condition at several points in time. A therapist or treater who follows a patient over the course of years will have better opportunity to assess directly the changes and stability of the individual's condition over time, in comparison with a forensic evaluator who typically sees the individual only a few times. Mental health records and interviews with collateral sources, such as family members, can enhance the evaluator's knowledge of the course of the evaluee's condition over time.

Family/Genetic Inheritance

Perhaps one day genetic testing or biological markers will become sufficiently specific, sensitive, and practical so as to be effectively relied upon in forensic assessments. For now family history of mental illness, with attention given not only to diagnosis and treatment but also importantly, to the extent such information is available, the phenomenology, or signs and symptoms of mental disorders in family members, can provide useful diagnostically supportive information. Absence of such history alone does not however rule out the diagnosis of a given mental disorder.

Expected Response to Specific Treatments

Like consistency when reassessed, those who treat mentally disordered individuals over the course of time should be in a better position to assess response to specific treatments than non-treating forensic psychiatrists. Nonetheless, forensic evaluators can and should look for response to specific treatments as can be ascertained from history through interviewing the evaluee and collateral sources. Also not to be overlooked are medical and mental health records. It is a mistake to look only for diagnosis without also looking for the documented data in support, or not in support, of the diagnosis. Also critical is noting how substantiating evidence in support of the diagnosis was collected. Reports of improvements in specific signs and symptoms of the disorder are as contributory as general comments about diminished suffering and enhanced functioning.

The Forensic Examination

The forensic psychiatrist's search for diagnostic truth should be an attempt to glean and weigh the validity of relevant data, an attempt for which reference to the four types of validity and the time tested criteria of Robins and Guze should be useful. Within this more purposeful approach to the assessment, the basic approach and structure of the report need not be much different than is customarily recommended.

Richard Rosner (99) has identified the following four points of a forensic psychiatric examination:

1. What is the specific psychiatric-legal issue?
2. What are the legal criteria that determine the issue?
3. What are the relevant psychiatric-legal data?
4. What is the reasoning process used to reach a conclusion?

These elements having been addressed in the examination, must also be clear and transparent in the forensic report. For our efforts to enhance the reliability and validity of forensic examinations, the following two Schneiderian steps (100) must be especially explicit (65): First, diagnose mental disorder(s) and assess for psychological dysfunction, and second, relate any relevant dysfunction to the legal standard, including the legal definition of legally relevant conditions (65) as well as the functional component of the standard. Of critical and fundamental importance, yet understressed or neglected, in discussions guiding forensic assessments is the two step process of diagnosis and assessment of function followed by relating dysfunction to the legal standard.

Two misleading assumptions may actually tempt the evaluator to place the cart before the horse. 1) By addressing first direct evidence that the evaluee satisfies or not the legal standard, the diagnostic and general functional assessment can be focused, efficient and cost effective, benefits of which retaining attorneys and courts can appreciate. 2) It is stated that the law in addressing individual responsibility, psychological harm and the many competencies is only interested in function, not causation.

The classical and most logical approach, however, is to first identify whether a problem exists and the nature of the problem before attempting to relate dysfunctions resulting from the problematic disease or defect to the legal standard. If only the criteria of the requisite legal standard were demonstrably lacking and no basis for the deficiency is found, the validity of the deficiency itself might rightfully be challenged. Even without a clear understanding of the "ultimate" cause of a mental disorder, mental defect, or pathological dimention, recognition of the pathological problem for which the dysfunction is secondary, when the problem itself is scientifically grounded, is as important to presenting this relevant "truth" as the dysfunction itself.

Beyond the logic of first identifying the problem, viz psychopathology, before suggesting how the problem affects the functional criteria of the relevant standard, this approach also serves to limit confirmatory bias (101). If the dysfunction is "identified" first, the evaluator may in effect seek support for the dysfunction through diagnosis of a consistent diagnosis. If the psychopathology is first diagnosed, this first step should not be influenced by the final opinion to come later, as to whether the specific dysfunction exists.

Conclusions

To strengthen the scientific basis for forensic assessment, report and consultation, it is incumbent upon the forensic psychiatrist to be familiar with the development of the standard nomenclature of psychopathology and with current efforts towards achieving valid understanding of psychopathology and corresponding nomenclature. The evaluating psychiatrist is advised to adhere to the current DSM with transparency of method, relevant data, and logic of conclusions. Adherence to the DSM, following acceptable standards, consideration of methods for assessing validity, and consistent self-vigilance should serve the evaluator in guarding against confirmatory bias. Finally, the forensic psychiatrist must always be prepared to acknowledge limitations in findings, methods, and the diagnostic classification itself.

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The Disease Concept in Psychiatry

– Basic and Ideal Values, Qualitative and Quantitative Dysfunction –

W.H. Lionarons

Introduction

Different disease concepts have been proposed (1, 2). Which one should be preferred? Wakefield's (3-6) analysis may serve as a starting point. The body has many internal mechanisms, and in disease one of these internal mechanisms fails to perform the function for which it is biologically designed. This dysfunction causes harm to well-being. Harm is a value concept, referring to effects the dysfunction has on the person, effects which we evaluate negatively, on the basis of sociocultural values. In short: disease is harmful dysfunction.

As I see it, the deeper structure of both the value aspect and the dysfunction aspect has to be specified. This may be shown using an example with which Wakefield illustrates his analysis. In neurosis as defined by Freud the dysfunction is a failure of the defense mechanism of repression; it doesn't do that for which it has been designed. This causes the harm of 'painful' anxiety. However, I add, not anything a person can do or which may happen inside a person counts as a natural function. Repression can only count as a natural function when an internal mechanism has been specified with repression as its function. Such a specification, be it provisional or even primitive, we may call a hypothesis about deeper structure. In the case of repression, a hypothesis is required about the structure of anxiety and ways of coping with anxiety.

The repression example shows that the value aspect too has to be specified with respect to its deeper structure. All anxieties cannot count as harmful in the same way and to the same extent. That is why Wakefield speaks of 'painful' anxiety. We have to distinguish between harmful or painful anxieties on the one hand, and normal anxieties on the other hand, with normal triggers and of normal intensity, duration etc. We also have to distinguish between different types of painful anxiety. Psychotic anxiety, like when someone wants to jump out of the window because he hallucinates that killers are hunting him down, is fundamentally different from phobic anxiety, when someone avoids situations in which he fears he will be evaluated. It is a difference between harm to *basic values* versus harm to *ideal values*. In psychotic anxiety basic values are harmed, such as the value of a minimally adequate sense of reality. In phobic anxiety there is mostly harm to ideal values such as self-realization.

Basic and ideal values

The distinction between basic and ideal values has been elaborated by Moore (7), among others. He speaks, with respect to basic values, of a 'thin theory of the good', and with respect to ideal values of a 'full theory of the good'. In case of disease someone is not able to perform basic activities which are necessary for anyone's conception of the good life. These activities we should be able to perform according to a thin theory of the good. There is great diversity in conceptions of the good life, but there is agreement on the necessary or basic capacities we need to have at a minimum. When we call someone ill we make a limited value-judgment: he lacks a capacity which is necessary for any good life whatsoever.

The idea of full and thin theories of the good seems to originate with Rawls (8, 9). According to him, a full theory of the good defines what are 'beneficent and supererogatory acts', and what moral worth is; it is about 'final ends'. A thin theory on the other hand defines 'primary goods', 'things which any rational person wants, whatever else he wants'. Among these primary goods Rawls counts 'health and vigor, intelligence and imagination'; Moore adds 'a body that is relatively free from pain, that allows one to move about, and the like, is part of such a thin theory because all persons would value such a body as necessary to whatever else they want. Likewise, a mind that is relatively free from elementary logical errors, that by and large forms factual beliefs in proportion to the evidence available, that has capacities of imagination, and so on, is also part of such a thin theory of the good.'

Many others have investigated basic values; I mention Gewirth (10, 11), Feinberg (12), and Fuller (13). Gewirth argues that everyone has to regard some conditions as necessarily good. These are 'basic goods', such as 'life and physical integrity (including such of their means as food, clothing, and shelter), mental equilibrium and a feeling of confidence as to the general possibility of attaining one's goals.' Without basic goods we can attain our goals hardly, or not at all. A lack of basic goods is called basic harm. Basic harm is objective, because everyone needs basic goods, however diverse our values may be.

Feinberg theorizes about 'welfare interests', interests in 'conditions that are generalized means to a great variety of possible goals, and whose joint realization, in the absence of very special circumstances, is necessary for the achievement of more ultimate aims.' Welfare interests include interests in achieving and maintaining the minimum level of bodily and psychological health, material resources, economic means and political freedom, which is necessary 'if we are to have any chance at all of achieving our higher good or well-being, as determined by our more ulterior goals.' There is harm to welfare interests only if they are satisfied at a lower than 'tolerable' minimum level.

According to Feinberg, welfare interests include the interest in continuance of our life 'for a foreseeable interval', interests in physical health and energy, in the integrity and normal functioning of our body, in being free of pain and suffering which totally preoccupies us, being free of grotesque disfigurement. Furthermore, interests in minimal intellectual acuity, emotional stability, being free of unmotivated anxiety and anger, in the capacity for normal social interaction and friendship, in minimal income and financial security, a tolerable social and physical environment, a minimal freedom from obstruction and coercion.

There is evidently much agreement between the basic values discussed by Moore, Rawls, Gewirth and Feinberg. We may summarize them in a list of basic values which are relevant for psychiatry:

- Life
- Minimal bodily integrity, i.a. being free of grotesque disfigurement
- Minimal bodily functioning: this includes being free of pain and suffering which completely preoccupies us, and being able to move about.
- Minimal psychological functioning: intellect, logical thinking, testing beliefs, imagination, self-confidence and emotional stability; all at a tolerable minimum level. Being free of emotional pain and suffering which completely preoccupies us, and being free of unmotivated emotions.
- Minimal social functioning: attachment and social interaction, both at a tolerable minimum level.

Fuller deserves our attention especially for his ideas about ideal values. He distinguishes a 'morality of duty' and a 'morality of aspiration'; these show some overlap with the Rawlsian thin versus full theory of the good. The morality of duty concerns basic demands of social life, rules without which an ordered society is impossible. Everyone has a duty to submit to these rules and is punished on transgression.

The morality of aspiration however, concerns 'the Good Life', excellence, the fullest realization of human powers, behavior fitting a person who functions at his best. Whoever fails according to the morality of aspiration cannot be punished, but can meet disapproval, because he has not used the opportunity to realize his capacities to the full. In these higher regions of human endeavor there is always great diversity, individual differences abound. We can only be persuaded, not coerced, to strive towards ideals of the Good Life.

I propose, with respect to the value aspect of disease, that we should distinguish between a *narrow* disease concept, according to which there should always be harm to basic values in disease; and a *broad* disease concept, according to which disease may also involve harm only to ideal values.

A structural model of dysfunction

As mentioned earlier, according to Wakefield's analysis disease is harmful dysfunction. I will argue now that a condition should count as disease only if the dysfunction aspect can be specified properly. Take as an example a person A who uses a street drug which may damage the liver. Physician B takes this fact in itself as enough proof that A is ill. B reasons that A has a dysfunction of internal mechanisms which evaluate risks of drugs. It is a harmful dysfunction, because the drug is harmful.

What are we to think of this? With such reasoning every behavior that is evaluated negatively would count as proof of disease, for we may always ad hoc construct some dysfunction. This implies that a dysfunction may only be validly asserted in case we have some hypothesis, however provisional or even primitive, about its deeper structure; a hypothesis which fits in a larger body of knowledge for which we have some evidence. Which internal mechanism are involved, what functions do they have, and what type of failure is there?

How are we to go about in formulating such hypotheses? We may distinguish between models proposing how disease in general is structured, and specific hypotheses, about the structure of a specific disease. In a general model we may find some guidance on how to construct specific hypotheses. I will now describe what we may call the classical structural model of psychiatric disease. It has been developed in the 'classical' age of psychiatry, between 1890 and 1940. Birnbaum (14) has been the first to give a systematic discussion of this model, but many others, among whom Hoche (15), Kraepelin (16-18), Kleist (19-21) and Schneider (22-24) have contributed.

According to this structural model psychiatric symptoms develop in the following way. There is

- a *predisposition*, out of which via
- an *etiological process*, triggered by *etiological factors*,
- a *cerebral disorder* develops, with which
- an *underlying psychological disorder* is associated which, via processes of becoming conscious, manifests itself at the conscious level in
- *primary symptoms*, and which via
- *plastic processes*, triggered by *plastic factors*, leads to the
- *final symptoms* of the disease.

Simplified as causal chain:

cerebral ↔ psychological

predisposition

↓ etiological process

cerebral disorder ↔ underlying disorder

↓(process of becoming conscious)

primary symptoms

↓ ↓ plastic process

final symptoms

Underlying disorder, qualitative and quantitative

I elaborate on this model, starting with the underlying psychological disorder, which has been called 'Grundstörung', and also 'Basisstörung' (25-28). With the underlying disorder a cerebral disorder is associated. An example, from Cloninger's theory of personality disorders (29, 30): in antisocial personality one of the underlying disorders may be a strong tendency towards exploration of new stimuli ('novelty seeking', NS).

In one disease there are mostly several underlying disorders, and different diseases may overlap partly with respect to underlying disorders.

An underlying disorder lies on the psychological level, but it cannot be experienced consciously, according to Huber. Via a process in which the underlying disorder becomes conscious, primary symptoms are derived from it; these are the first manifestations of the underlying disorder which the patient experiences consciously. For example, according to Huber in schizophrenia one of the primary symptoms – he calls them 'Basissymptome' – may be micropsia, seeing objects smaller. Another example: Cloninger proposes that in high NS impulsivity and high distractibility are primary symptoms.

We have to distinguish between qualitative and quantitative underlying disorders, according to Schneider. A disease is a qualitative deviation from the norm, and as such has to be distinguished from an abnormal variation which is a quantitative deviation. Schneider is a proponent of the classical view that a disease has no analogue in either normality or abnormal variations. Psychiatric

disease is not motivated by external events, its existence is not understandable, but only its individual content is understandable.

In psychiatric disease there is a qualitative underlying psychological disorder, which cannot be attributed to normal-psychological processes, but which is instead associated with a cerebral disorder that is also qualitatively abnormal. Plastic processes give individual content to this qualitative underlying disorder, and in this way final symptoms result. The individual content is normal-psychological and in that sense understandable. The qualitative underlying disorder can be masked by a diversity of normal-psychological, motivated contents which differ only quantitatively between patients. At the level of final symptoms we then don't see the qualitative differences anymore.[1]

Other elements of the model

Before the underlying disorder starts there may be a predisposition, which I localize in cerebral structures and processes. These are characteristics of the relevant structures and processes which increase the probability of a cerebral disorder. The (cerebral) predispositions may be associated in some cases with psychological characteristics; we may then call those characteristics psychological predispositions.

Etiology is shorthand for events (which may also be stressful life events) that activate the neurobiological processes resulting in the cerebral disorder. Associated with this cerebral disorder the underlying psychological disorder will develop.

From the underlying disorder there is a complicated path towards the final symptoms. This path is determined by plastic factors. Birnbaum has put it thus: plasticity gives content, color and individual form to the underlying disorder. In many psychiatric disorders plasticity may contribute more to the final symptomatology than the underlying disorders do.

1 Is the qualitative-quantitative distinction valid? We may imagine a quantitative underlying disorder which approaches a qualitative one ever more closely. But does such a counter-argument make sense? These transitionality problems also exist in e.g. ethics. Feinberg (12) says: 'It is reasonable to impose a duty to walk one step to warn [a traveler against a swollen river], then surely it is reasonable to require two steps. The difference between two steps and one is insignificant morally [..] Similarly insignificant is the difference between three steps and four, or between [..] 999 and 1,000. So there will be no place to draw the line, the argument goes, that will not mark an arbitrary difference between those made liable and those exempted. Clearly something has gone wrong with the argument. There may be no morally relevant difference between any two adjacent places on the spectrum, but there is a very clear difference between widely separated ones. It would be inconsistent to exempt one bad Samaritan for failing to take two steps while convicting another for failure to take one, but there would be no inconsistency in convicting one for failure to take half a dozen steps, while exempting another for failure to run two miles.'

To Feinberg's considerations I add: while we may *imagine* that of 100 Samaritans the first walks 1 meter, the second 2, and so on till 5000, but in reality bad Samaritans probably walk at most a few meters and good Samaritans at least hundreds of meters. In reality there is polarization and discontinuity. Guze (31) cites Sokal: 'Uniform continuous change is [..] not very frequent in nature. Centrifugal forces frequently hold together a certain structure over a given domain and loosen their control only in zones of rapid intergradation.'

Plasticity determines not only final symptoms, but also normal psychological phenomena. An example of a normal plastic process is the 'emotional labor' described by Hochschild (32). We induce or suppress feelings 'in order to sustain the outward countenance that produces the proper state of mind in others'. We don't do this arbitrarily, but apply unconscious feeling rules. Thus, emotional labor as a plastic process determines the development of basic emotions into the emotions which we experience and observe.

Plasticity is also at work in somatic symptoms. Cassell (33) reminds us that in physical diseases the abstract pathophysiology is modified in the individual patient by interpretations. 'Thinking about symptoms, attaching meanings to them, searching for explanations, are as much a part of the illness as are its physical expressions.' 'Illness is a combination of bodily symptom plus meaning.'

Because of plasticity, the same underlying disorder may result in very different final symptoms in different patients, and different underlying disorders may result in the same final symptoms. Kraepelin (17) stated this as follows: 'Die klinischen Krankheitszeichen sind trügerisch, weil sie sich in ähnlicher Weise bei verschiedenen Leiden wiederholen und bei demselben Falle vielfach wechseln können. Für ihre Gestaltung fällt warscheinlich oft auch die persönliche Veranlagung wesentlich ins Gewicht.' And: 'Zunächst wird es darauf ankommen, in den Krankheitsbildern die wesentlichen und kennzeichnenden Züge von den zufälligen und nebensächlichen Beimischungen zu trennen. Dabei wird sich vielfach herausstellen, das äusserlich anscheinend ganz gleiche Krankheitszeichen doch in ihrem Zustandekommen und damit in ihrem Wesen verschieden sein können.'

As a consequence, when developing hypotheses about diseases we should focus on underlying disorders, although this is a daunting task indeed.[2]

Emergence and integration of the elementary by culture

In what way are underlying psychological disorder and cerebral disorder associated? And in what way does the underlying disorder lead to primary symptoms? Some answers are suggested by Sperry (35-7) and Luria (38, 39). According to Sperry psychological functions emerge from processes in cerebral systems. Psychological functions are emergent, pattern or configurational properties of the brain in action. They interact with the cerebral processes, direct the cerebral processes, and are determined by them. They are dynamic

2 An ethical argument for focusing on underlying disorders can be derived from Stone (34). 'Social and racial bias' are unavoidable consequences of diagnosis which focuses on behavioral manifestations. For example, when antisocial personality is defined on the behavioral level, it is diagnosed much more frequently in the 'urban poor and racial minorities' than in the affluent and white.

system-processes that control their neural and chemical components. They consist of neural events, but cannot be reduced to those.

Sperry regards mind and consciousness as 'real causal agents, having an important place in the causal sequence and chain of control in brain events. They give the orders, and they push and haul around the physiological and the physical and chemical processes'. Something similar we see with atoms and electrons, which are 'hauled and forced about in chemical interactions by the overall configurational properties of the whole molecule.' In the brain 'the electric, atomic, molecular, and cellular forces and laws, though still present and operating, have been superseded by the configurational forces of higher-level mechanisms.'

Psychological processes supervene (as opposed to intervene) in cerebral physiology. Sperry gives the example of a TV program supervening in the electronic processes of the TV set. Supervenience is also termed downward causation, whereby higher-level, in this case psychological, processes exercise downward influence on lower-level, in this case the cerebral, processes.

One of Luria's contributions is that psychological functions are at first 'elementary', and that from these elementary functions higher functions develop, in interpersonal interactions which are structured by culture. Through these interactions elementary functions are selected and linked, becoming components of complex functional systems. By this integration of elementary functions higher functions are installed. After installation the higher functions can be activated internally, by the person himself, but they continue to need support and fine-tuning from the person's culture.

In these ideas Luria is following his mentor Vygotsky, as is apparent from Kozulin's (40) discussion of Vygotsky's theory: 'higher mental functions must be viewed as products of mediated activity. The role of mediator is played by psychological tools and means of interpersonal communication.' Psychological tools, e.g. sign systems, transform natural capacities into higher mental functions. 'Vygotsky thus made a principal distinction between "lower", natural mental functions, such as elementary perception, memory, attention, and will, and the "higher", or cultural, functions, which are specifically human and appear gradually in the course of radical transformation of the lower functions. The lower functions do not disappear in a mature psyche, but they are structured and organized according to specifically human social goals and means of conduct.'

We may conclude about the underlying psychological disorder, first, that it emerges from a cerebral disorder. Second, that it is a disorder of an elementary psychological function. This disordered elementary function is integrated, through what has been called, by a prominent sociologist, microlevel dynamics (41), into a disordered higher function. While being integrated, we may note, the function is also becoming conscious. These integrative and coming to consciousness processes result in primary symptoms, the first conscious elements of the classical structural model.

An example of an elementary function may be found in a model of the visual system, proposed by Kosslyn and Koenig (42). This model consists of many subsystems, each of which performs a specific input-output transformation. It explains micropsia – which is, as mentioned earlier, according to Huber one of the primary symptoms in schizophrenia – as caused by a dysfunction of a spatiotopic mapping subsystem localized in the parietal lobe. This subsystem transforms information arriving from the visual buffer in such a way that its spatial organization comes to conform better to the state of affairs in the external world. This transformation is an elementary function, and in micropsia the underlying disorder might be a failure of this function.

With respect to the quantitative-qualitative distinction we may hypothesize that in a *quantitative* underlying disorder the infrastructure of input-output transformations has not changed significantly. In the relevant cerebral system the normal transformations are performed on the input, only more per unit of time (in hyperfunction) or less (in hypofunction). In a *qualitative* underlying disorder however, the infrastructure is changed; there is loss or disintegration of the elementary function.

Comparison with modern models

Is the classical structural model which we have discussed obsolete? I don't think so: in models of modern theoreticians many classical elements can be recognized.

I give some examples. The vulnerability-stress model of Zubin and Spring (43) is still influential. They see vulnerability as a relatively permanent individual characteristic that is determined by many, hereditary and acquired factors. Acquired factors may be perinatal complications, traumas, disease processes and negative family events. Everyone has a degree of vulnerability, a sensitivity to disturbances of equilibria, and also a degree of resilience, the capacity to restore disturbed equilibria. When stressors such as life events disturb an equilibrium in such a way that it cannot be restored, a disease episode is triggered.

So far the elements of predisposition and etiologic factors are evident. The underlying disorder is with some effort recognizable in the disturbance of equilibrium, also called 'strain'. Next, coping strategies are mobilized, in order to restore the equilibrium, to compensate for, or to adapt to the disturbance. On the other hand, restoration of the equilibrium may be opposed by factors such as institutionalization and stigmatization. These are indeed important types of plasticity. Weak points of the Zubin and Spring model is that the underlying disorder is left vague, as are the relationships between the elements of the model. Also, the idea that through plastic processes a diversity of final symptoms may develop remains implicit.

A second example is the model proposed by Van Praag (44, 45). He sees psychiatric disorders as responses to noxious stimuli; these responses will show great variability interindividually, and in the temporal dimension also intraindividually, with respect to symptomatology, and their course and prognosis are unpredictable. The noxious stimuli will disturb a diversity of neuronal circuits and thereby also a diversity of psychological systems. The degree to which different neuronal circuits are disturbed varies interindividually, and is dependent on, on the one hand, neuronal plasticity and, on the other hand, personality factors which determine psychological resilience. Symptoms which are related directly to the neurobiological substrate of the disorder may be called primary, and symptoms derived from these secondary. Van Praag notes that a symptom as revealed to an observer, and as experienced by the patient, is an 'image' of the underlying psychological dysfunction. On these psychological dysfunctions, and not on the symptoms, psychopathological research should focus.

Van Praag describes, as an illustration of his model, the 'seca' ('stressor-precipitated, cortisol-induced, 5-HT-related, anxiety/aggression driven') depression, a depression subtype characterized by dysregulation of anxiety and aggression as primary symptoms, and by the lowering of mood as a secondary symptom. The patient may have a genetically determined abnormality in the sensitivity of the 5-HT1A and/or 5-HT2 receptor-systems, causing these systems to function marginally under normal circumstances. When he is exposed to stressful events, hormonal processes are activated, leading to a failure of the 5-HT receptor-systems and an increase in anxiety and aggression. Chronically high anxiety and aggression levels finally induce a depressive mood.

The similarities between Van Praag's model and the classical model are striking. Predisposition, etiologic factors, cerebral disorder, underlying psychological disorder, primary symptoms, and final symptoms are all directly recognizable. That final symptoms may vary greatly has been mentioned as a classical theme.

I note that the classics also assume that specific predispositions and etiologic factors have predilections for specific neuronal circuits. A biological etiologic factor, an infection for example, has an affinity for, say, a specific cell protein, and this protein is has a distribution which causes some circuits to be damaged more than others. The important point is that the cerebral disorder, when defined neurobiologically, for example as stemming from an abnormal gene, will always be associated with a diversity of underlying psychological disorders, which emerge from neuropsychologically defined systems. So there will be some overlap between a research strategy that starts with elementary psychological functions, and a strategy that starts with neurobiology, especially genetics, but this overlap will be rather weak. This point seems to be ignored as yet in the research strategy now favored by psychiatric genetics (46, 47), but hopefully it will be taken into account soon.

For example, suppose there is in schizophrenia an abnormality in a gene that encodes a morphoregulatory protein which regulates neuronal migration in a specific phase of embryonic development, and in a specific sector of the embryonic brain (48). Abnormalities will result in the distribution and connectivity of neurons in the brain areas that grow out of this sector. Of course, these abnormalities will not be limited to one neuropsychologically defined system, but all those systems will dysfunction which are localized to an important extent in the brain areas affected.

The same goes for Van Praag's seca-depression. 5HT1A and 5-HT2 receptor-systems don't coincide with a single cerebral system out of which an elementary psychological function emerges, but these receptors are distributed over many neuropsychologically defined systems. An abnormality in a specific receptor-system will affect all the neuropsychological systems with a high density of these receptors. Van Praag hypothesizes that the elementary functions affected by an abnormality in 5-HT1A and/or 5-HT2 receptor-systems are important for the regulation of anxiety and aggression.

Some conclusions

We have already distinguished concepts of disease which are narrow versus broad with respect to the value aspect: narrow in case basic values are harmed, broad when there is only harm to ideal values. The same distinction may be drawn with respect to the dysfunction aspect. In a *narrow* disease concept it should be plausible that there is a qualitative underlying disorder. In a *broad* disease concept there may be only quantitative underlying disorders.

Disease which is narrow with respect to both the value and the dysfunction aspect may be called *disease in the narrow sense*. If there is only quantitative underlying disorder, and it is left open whether there is harm to basic or rather ideal values, then this is *disease in a broad sense*. A disease concept in which only disease in the narrow sense counts is *restrictive*. Other disease concepts are *permissive*.

A final remark: we have to consider the context in which a disease concept is used. In one context arguments in favor of a restrictive disease concept may be stronger, or put otherwise a restrictive concept may be preferred, and in another context a permissive concept. For example, in the context of health insurance we may prefer a permissive disease concept, at least in times of affluence. In the context of involuntary commitment a restrictive disease concept will be preferred.

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Boundaries: Applying Understanding of and Insight into Human Nature and Political Violence

Terry R. Bard

Most healing professions enjoy a rich legacy of both implicit and explicit values and directives inherent to the role and relationship between the healer and the person seeking healing. Vaidya's Oath (Indian) dating from the fifteenth century BCE states that healers should care for their patients "as if they were your own relatives". Ten centuries later, Hippocrates' (Greece) well-known oath *primum non nocere,* (first, do no harm) became an underlying approach that remains a core contemporary value. "Do not divulge the secret of a man who has trusted you" and "Do not take any reward to destroy and to ruin" encase values attributed to Asaph and Yohanan (Jewish) in the sixth century of this era. One of the seventeen rules of Enjuin (Japanese) from the sixteenth century adjures "Rescue even patients who you dislike or hate". These snippets represent a tiny fraction of the many values by varying cultures and traditions inherent to the caregiver and recipient relationship.

Nonetheless, human history is replete with many very perplexing and troubling occasions during which healers adopted competing values that trumped the more irenic approaches enshrined by these traditions. Accounting for these variances has become an important focus of 20th and 21st century historians, ethicists, and caregivers. The founder of the field of psycho-history, Prof. Robert Jay Lifton, *The Nazi Doctors,* offered a powerful report and analysis of the atrocities perpetrated by physicians during the Third Reich. The Nuremberg Code and its subsequent iterations sought to protect human research subjects, and its stipulations have informed current values for patient care worldwide.

The fact that healers can become aggressors and brutalizers raises fundamental questions about human nature. Western traditions, based upon a Christian understanding of the biblical story of Adam and Eve, propose that, at base, humans are plagued by their curiosity and arrogance. Accordingly, Adam's grab for the apple against divine prohibition constituted a fundamental flaw characterized by a sinful nature. Even though Jewish tradition did not embrace this notion of innate human sinfulness, both traditions acknowledged that one component of the human predicament includes a continual struggle between

opposing forces, good and bad — even evil. Many nineteenth and 20th century philosophers, anthropologists, theologians, and caregivers struggled with this dilemma. At base, is human nature competitive and aggressive or cooperative and reflective? Thinkers such as Sigmund Freud and Konrad Lorenz embraced the former, while others such as Erich Fromm, Jean Paul Scott, and Howard Zinn opted for the latter.

These approaches to this question are not only theoretical musings. They have practical implications, particularly in the realm of managing the competitive and aggressive aspects of human nature that manifest themselves in destructive ways in order to foster the competitive human features for love and connection. Are these elements immutable, genetically built-into the human genome, consistent with the model of "original sin", are they learned, adopted by social and environmental interactions, or are they epigenetic, an amalgamation of biology and all other factors that humans encounter?

Such considerations are not simply theoretical; they inform societies, cultures, and individuals. For caregivers, it makes a difference whether one considers humans flawed or a *tablulae rasa* from the outset. Therapeutic roles and goals can become defined by such basic notions and can inform actions taken by caregivers that could be contrived in such a way as to reject a number of fundamental caregiver-patient values in favor other values imposed from without that could challenge their loyalties and their professional roles.

Such challenges have too often marked this value shift, especially in the political arena. Human history is replete with experiences characterized by human violence, particularly in war. Aggressive wars include fundamental issues of power, economic, and territorial control. These issues become natural corporate extensions of basic human drives. Devising "just war" theories to support such aggressiveness externalize these drives that help individuals to dissociate from their own more prurient instincts. Defensive wars are equally complex and equally compelling for those engaged in the conflicts. Such wars need not be military though they often are. They can be ideological. Revolutions, terrorism, martyrdom are all different modes of aggressive expression.

The professional values of healers, caregivers, physicians can become challenged in the face of greater, more corporate expressions of aggression, sometimes converted to justify human and professional aggression and the commission of atrocity. Under uniformly accepted international code, medics are protected in combat to preserve the professional distinction between the caregiver and the warrior. But there are other ways by which healers' values can be co-opted such as the so-called Nazi physician "experiments" on their "victims". Currently, this problem arose when American psychologists participated in the torture and

"water-boarding" of war prisoners in Guantanamo, Cuba generating a rift between the American Psychiatric Association and the American Psychological Association.

Such experiences raise the question about the role of healers, particularly physicians and psychologists, in managing perpetrators and victims of political violence. Clearly, such circumstances bring together the correlation between environment and cultures in relationship to human nature. The skills of psychological professionals have been used for "information seeking". They would either participate in or provide statistically tested and validated instruments for questioning, interrogating, and persuading others in order to gain information for the professionals' country. Even models of torture have been guided by such individuals. Similarly, psychological professionals have been instrumental in developing punishments for others, including determination of criminalization, incarceration, relocation, trials, and even capital punishment.

What values ought to be the guiding principles for such psychologically informed professionals? What modes should inform them? How ought basic understandings about the fundamentals of human nature inform their management stratagems?

Current thinking supports a more epigenetic model and characterizes interventional therapeutic models. The traditional medical model of the therapeutic dyad and the behavior management model were, at one time, viewed as antithetical. Increasingly, they are frequently viewed and used collaboratively. Foremost, psychologically informed caregivers who become involved in providing services in arenas of political violence ought to know the details of their professional codes of ethics. Additionally, they ought to have reflected about their role in relationship to their profession irrespective of any stated or presumed expectations external authorities calling them into such service. Struggling with the potential ethical conflicts that could arise as well as the challenges to manifest and hidden loyalties is imperative. Such professionals should be professionally trained in decision-making in the context of complexity, and they should maintain their own authority to make personal, professional decisions irrespective of any external pressures imposed upon them. From time to time, doing so may include choosing to become a conscientious objector. Professional insights about both mental health and mental infirmity coupled with behavioral insights and therapeutic methods remain the most important and invaluable tools for professional assessment and intervention. Utilizing these tools ought to be the sole purpose of psychological assessments and interventions. Utilizing them otherwise should be evaluated in the context only of the therapeutic values that undergird their professional roles.

In this context, the management of professional boundaries becomes central. Professional healers are to consider professional boundaries, organizational boundaries, as well as personal boundaries. Professional and organizational boundaries are usually clearly stated, regulated, and monitored. Personal boundaries are not, and these may be informed by personal definitions of human nature as described above. Personal boundaries are usually informed by both utilitarian as well as deontological models, though most people normatively lean toward one or the other of these two competitive models. Clinicians tend to choose more utilitarian models. However, in making such professional value choices, Immanuel Kant's deontological imperative enhanced by philosopher Hermann Cohen serves well: treat others not only as means but always also as ends in themselves.

Clearly, as with all values, the professional value choices remain individual to the caregiver. Such choices are profound and have profound ramifications. Preserving and practicing the fundamental models valued through the millennia still provide a firm base from which mental health professionals and all healers can proceed.

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Theory and Diagnostics of the Conscience

Frans Schalkwijk

Introduction

In my capacity as a psychoanalyst and a forensic psychologist, the conscience has my undivided attention. In my psychoanalytic practice, I see patients who suffer greatly from a harsh conscience, condemning themselves for being overly egoistic. For them, their conscience has become an incubator of horrible emotions, rather than a source of soothing, reassuring feeling of inner control. In our sessions, I see the hampering psychodynamics of intense shame and guilt, and diagnose 'a harsh superego' or 'a masochistic superego'. My patients sometimes suffer more from their shame about being ashamed than from what they actually feel ashamed about. In my other work, in which I conduct psychological evaluations of young delinquents, I meet boys who, without batting an eyelid, tell me about ransacking a store or beating an old man. What on earth were they thinking and feeling when planning the raid or after the battering? Why do they commit a criminal act when they know there is a law against it? Forensic evaluators refer to this in diagnostic terms as a 'lacunar superego'. In both my psychoanalytic treatment and forensic work, I am often dumbstruck: how does the conscience work?

In this chapter, I will summarise the theory of the conscience I developed and discussed at greater length in my book *Emoties bij jongeren. Theorie en diagnostiek van het geweten*.[i] The question at hand is finding an accurate language for describing the functioning of the conscience. Although this functioning is a major focus of forensic evaluation, a clear conceptual framework has so far been lacking. In this chapter, I will provide an outline for such a framework. First, I will briefly treat the traditional psychoanalytic theories of the superego, which I will then leave aside in favor of a model of the conscience as a regulatory function of self-conscious emotions. In the next section, an introduction for diagnostics of the conscience will be sketched by describing the functioning of some of its constituents: empathy, shame and guilt.

A brief sketch of the superego

Having been trained as a classical psychoanalyst, I first approached the working of the conscience from Freud's structural theory of the superego.[ii] In classical

psychoanalysis and ego psychology, the superego is a dynamic structure in the mind which offers the ego guidelines for the regulation of the drives. The superego contains the capacity for self-observation, moral values and the ideal ego. The actual regulation is performed by the ego, be it consciously or unconsciously, by means of defense mechanisms. The superego develops as a result of the child internalizing the criticism and punishment meted out by parents during the oedipal developmental phase. The workings of the superego can be seen for example when guilt arises from a conflict between the desire for drive fulfillment and the fear of destroying the other, or when shame is felt about thoughts or fantasies. In early psychoanalytic theory, the harshness of the superego, activated by the fear of loss of love, dominates.

The object relational psychoanalyst Sandler, among others, added a benign aspect to the harshness of the superego which develops out of internalizing encouragement and support of the parents.[iii] Sandler writes about the superego as 'an enduring organization, which may or may not be involved in current mental processes to a significant extent, but which nevertheless remains capable of being brought into use when appropriate' [op. cit., p. 165]. With respect to the observational function of the superego, Bollas depicts it as 'the part of the mind that speaks to oneself as its object. This intrasubjective relationship will change according to the person's state of mind (...). Perhaps the most important object relationship is that relation that each person has to the self as an object of perception, facilitation, and object presenting.'[iv] [o.c., p. 42]. As I see it, Bollas views the superego as reflecting a form of self management during which the self is objectified by reflecting on the question 'Who am I, if I do/think/fantasize this?' As it is, the person is taking the position as 'a third' while looking upon himself. In addition, Bollas states that relations between individuals always also imply a relation to the self as an object, that is, when in communicative interplay, a person always also looks upon himself as the person who is communicating.

In psychoanalytic theory, the birth of the superego is located in infancy and early childhood. From early childhood onwards, the superego is an *intra*psychic regulation function for balancing self-evaluation as well as an *inter*psychic regulation function for balancing attachment and reciprocity. Consecutive developmental phases contribute to different components of its functioning. In the preverbal phase, the emotional qualities of the attachment relationship are internalized and form the background against which benign aspects of the superego exist.[v] In an insecurely attached child, the benign aspect will be more or less lacking. After the age of 18 to 24 months, the superego expands with a growing sense of self, leading to the internalization of essentially conscious benign qualities in the superego. Stapert argues that observation of young children shows that, at an early age, the toddler strives to maintain a positive emotional balance.[vi] Acting in a morally just way gives pleasure. This is also true in a relational sense: to give the other what is good or to withhold what is not so good

gives pleasure. In the oedipal phase, the development of the 'paternal' aspects of the superego dominates out of fear of punishment or loss of love. As the child's symbolic capacities begin to expand enormously around at the age of seven, the role of thinking and abstract ideas of morality come more to the fore.

To me, Sandler's conception of the superego as 'an enduring organization, which may or may not be involved in current mental processes to a significant extent', seems important. This wording opens up a means of attributing conscious, dynamically unconscious and non-conscious aspects to the superego. Bollas emphasises the function of the superego as a form of self-management.

Personally, I no longer subscribe to the metaphor of drive theory, so I will have to attempt to reformulate the accumulated knowledge of classical and object relational theory in a new theoretical framework. This should make it easier to integrate non-analytic theories and have a scientific discourse, which would include research into the functioning of the superego. As the concept of the superego is loaded with associations to drive theory, I will leave it out of the discussion for the time being. This makes it easier to 'think outside the box', i.e. not being hindered by the thought 'But that's not what the superego is about!' Instead, I will use the concept of 'conscience' and, as the reader will see, my thinking will frequently fall in line with what is written from the perspective of drive and object relational perspective. In the next section, I will address three questions: What does the conscience regulate, when does the conscience develop and when and how does the conscience work?

The conscience as a regulatory function

What does the conscience regulate?

Psychoanalysts Lichtenberg, Lachmann & Fosshage (2011)[1] state that people are motivated by emotions: the moment we experience an emotion, we have to act on it.[vii] This reaction itself is a new emotion, perhaps transformed by a defensive mechanism, to which we also have to react. Sometimes we react with factual behavior but, all too frequently, inner behavior is the result, such as the experience of a self-evaluation: 'I did that well' or 'I feel ashamed'. From the earliest forms of mother-child emotion regulation to the highly complex self-evaluation of the adult, our psychic life is one big stream of emotions, which motivate us ceaselessly. Some of these regulation mechanisms have never been conscious and operate in implicit memory, others come into awareness when attention turns to them and yet others have become conflictual and, as a result of defense mechanisms, dynamically unconscious. Aggression and sexuality are emotions, as are fear, enjoyment, surprise and many others. Although an emotion can be defined in many different

1 I will not go into the specific emotion theory these authors have developed.

ways, most psychological theories agree that it contains a physical, cognitive (thinking) and feeling (awareness) component. Any of the three aspects may dominate the other two or they may all be equally present in the felt or warded off emotion. The metaphor of drives is thus replaced by referral to concrete psychical and physical activities, while the classical theory that feelings and ideas are the two psychical representatives of the drives remains incorporated.

When conceptualizing the conscience, the differentiation between basic and self-conscious emotions is important.[viii] In early development, basic emotions such as hunger, enjoyment, surprise, fear or rage dominate. In the process of emotion regulation and marked mirroring, preferred emotional patterns, such as attachment styles, develop and become part and parcel of implicit or procedural memory.[ix] In the course of early development, they are or become more or less biologically enhanced action tendencies for processing emotions, with a neurobiological substrate located in two different brain circuits. Most of the basic emotions have specific, universal patterns of physical features such as muscle tone, facial expression, level of arousal and active brain patterns.

The conscience, however, is hardly connected with basic emotions, but rather with self-conscious emotions, such as pride, shame, guilt or embarrassment. 'Self-conscious' means 'pertaining to the self' here, whether or not dynamically conscious or unconscious. The experience of self-conscious emotions presupposes the existence of stable self and object representations, theory of mind and a reflective capacity: The infant cannot speak to oneself as its object, unless it has the capacity to experience itself as an object. We now enter Bollas's world, when he writes that the superego is the 'part of the mind that speaks to oneself as its object', and touch upon Sandler's theory, when he writes that the superego is 'an enduring organization, which may or may not be involved in current mental processes to a significant extent.' Self-conscious emotions are not biologically bestowed, but they develop out of the experience of speaking to oneself as its object. Self-conscious experiences can be related to evaluations of the strict self-representations, but they may also be related to representations of the relational, social or cultural context.[2] Like Sandler, I think that self-conscious emotions can play a role in psychic life at any time alongside basic emotions: 'How does what happens relate to who I am?' 'What happens' can be an external situation as well as an internal one, such as fantasies or thoughts. Fantasies and thoughts compel us to react as much as external conditions do – or even more, a psychoanalyst would say. And, once more, this evaluative process can take place consciously or unconsciously as well.

Why is it that these self-conscious emotions have to be regulated? Through their self-evaluative character, they touch on the self, identity, ego or personality of

2 In the same vein, Modell (1993) differentiates between the private and the public self.

the subject.[3] And the self is itself emotion-based. Thus, if they are not warded off by a defense mechanism, self-conscious emotions like shame, pride or guilt are 'Ich-nah', or pertaining to the self. What we experience is what and who we are. By conceptualizing the conscience as a regulation mechanism of self-conscious emotions, a language for conceptualizing what we experience when the conscience works becomes available; the conscience is functioning when we experience shame, pride, guilt, embarrassment, etc.

It would be a mistake not to devote attention to morality when theorizing about the conscience. Forensic psychologists tend to stay away from moral judgments in their evaluations, and are probably right to do so, but their clients do have moral beliefs which play a role in evaluation of the self. It is tempting to restrict the moral domain to abstract thinking, but the moment moral is related to 'Who am I?' feelings also come to the fore. This is especially the case when the acute awareness of 'Who am I?' stands in contrast to what 'I' thought myself to be (the ideal self). In the course of its cognitive development, the child acquires a wide range of social and moral norms. According to cognitive and social psychology, these transcend the strictly individual, being relational, social and cultural.[x] A psychoanalyst would object that they are actually also individual, as the emotions the subject has towards these social and moral norms are strictly individual. The norms have been internalized in the subject's unique identity, supported by his unique way of applying meaning and tied to self-esteem. In the same vein, the social and moral norms can be part of a psychic conflict.

When does the conscience develop?

As written above, the developing functioning of the conscience is indicated by the emergence of self-conscious emotions, which takes place after the infant has developed the necessary basic mental prerequisites such as a theory of mind, stable self and object representations, the capacity for mentalization and reflection. Cognitive psychology postulates, however, that precursors of the conscience develop through conditioning at an earlier age. In the emotion regulation processes, the infant learns what is unwanted from withdrawal of the mother. The mother, working in the kitchen, hears her toddler walking in the living room, saying 'No, no. Don't! No, no…' and, seconds later, she hears the television being switched on. But, as reflection on the self is probably not at stake here but only the memory of prohibitions, I would say this is not the working of the conscience itself. Ideally, a secure attachment style has developed thanks to the internalization of positively loaded object relations. All these psychic achievements are basic to a healthy functioning of the conscience.

Thus, we would expect the functioning of the conscience to appear in the second half of the second year.[4] By internalizing emotion regulation processes, the toddler

3 The theoretical difference between self and the character of personality is not the issue here. I personally prefer speaking about the self in its experiential connotation.

4 In this section, Erikson's developmental psychology is sketched.

has developed the capacity to recognize its own emotions and tune in to the emotions of others.[xi] It is able think symbolically and make inner representations. Now that the child can reflect on itself, it is also able to reflect on the inner world of others. If all these capacities have been well developed, the child is capable of empathy. The toddler, the child of the separation-individuation phase, is preoccupied with finding a balance between autonomy and conquering the world versus feeling small and impotent. Success and massive parental admiration lead to pride, while failing and feeling small leads inevitably to shame. Accordingly, pride and shame are the dominant self-conscious emotions in this phase of life. Some years later, the oedipal pre-schooler's cognitive and motor capacities have expanded, and so has the possibility of symbolic play and fantasy. The child must find a balance between the desire to take the initiative and be competitive, on the one hand, and the feelings resulting from going one's own way and being egocentric, on the other hand. At this age, the social aspect of the conscience, in particular, develops and, with it, the concomitant self-conscious emotion of guilt. From the seventh year onwards, due to its still increasing capacity for abstract reasoning, the latency child takes a bird eye's view of itself and experiences the self-conscious emotions as part and parcel of its identity. Up until this point, most children do not see themselves as someone who tends to be ashamed, guilty or proud. Now, however, the child may say: 'I'm somebody who often reacts in a proud/shameful/guilty/embarrassed way.' With the increasing capacity for abstract reasoning, there also is a strong development of the capacity for moral reasoning. Then, until puberty, the empathic capacity and the impact of self-conscious emotions remain relatively unaltered, although self-conscious emotions about being part of a cultural group may come to the fore more consciously.[xii] In puberty and adolescence, the functioning of the conscience may come under pressure and accordingly may be slightly reorganized.

When and how does the conscience work?

The conscience is therefore not a stable psychic structure that starts operating in reaction to external or internal situations, but it is a continually active regulation function: one self-conscious emotion leads to another self-conscious emotion, which motivates another appraisal of the situation with another concomitant emotion, etc. Concomitantly, basic emotions might be evoked and experienced. In a healthy individual, and under normal circumstances, this function cannot be switched on and off as the subject pleases. As long as the self is in a relatively stable state, self-conscious emotions operate in the background to enhance the stability of the self smoothly, almost at a non-conscious level. But, as soon as the appraisal of a situation, action, thought or fantasy threatens the stability of the ongoing self-evaluation, self-conscious emotions come to the fore and, with them, almost invariantly, defense mechanisms.[xiii]

For those not familiar with theories of emotion regulation, 'regulation' is used here as describing the psychodynamics through which the subject modulates his emotions. As in the classical theories under the influence of the reality principle,

the ego and superego are supposed to regulate the drives. In the same vein, the subject strives for an emotional equilibrium between all his emotions. For a long time, only Anna Freud's[xiv] theory of the defense mechanisms was available to describe these psychodynamics, but recent theories on attachment[xv] and mentalization[xvi] have added important psychodynamic insights as well. In Fonagy's theory, emotion regulation is followed developmentally by mentalization and, from then on, thinking about mental states greatly influences self-evaluation. So again, thinking and feeling comprise regulation of the self-conscious emotions.

Now, a second feature of self-conscious emotions comes to the fore: self-conscious emotions depend greatly on appraisal. The situation, action, thought or fantasy itself does not make one shameful, guilty or proud, but it seems so in the eye of the beholder. It is the subject imparting meaning, a psychoanalyst would say, or the subject's appraisal, a cognitive psychologist would say, which leads to awareness of a self-conscious emotion. The blueprint of the internalized self and object representations form the backdrop against which these evaluations are made, as if when the inner third speaks to oneself. And, as neuroscience shows, this process of imparting meaning can occur via the dynamic unconscious or the non-conscious, as it is in the course of our development that we generate preferential emotional reaction patterns which become part and parcel of our self-concept or identity.[xvii] Now it is possible to understand that the conscience is a psychic function whose level of functioning fluctuates under the influence of many variables. In some situations, the subject might be harsh in his self-evaluations and engage in self-punishment while, under different circumstances, he seems to evaluate himself in a neutral or even positive way. Intoxication due to drugs or alcohol alters functioning, as do important life events such as divorce, the birth of a child or mourning for a lost parent. Some individuals genuinely lack any self-consciousness, which is a sign of pathology, while others are excessively prone to experiencing guilt or shame and suffer greatly from their conscience.

The conscience at work

In the section above, empathy, shame and guilt were labeled as the markers of the functioning of the conscience. Empathy is an important contributor to concern for others (and oneself), while shame and guilt are two prominent self-conscious emotions. Now, in this section, I will comment briefly on the theory of these components. There is a wealth of analytic and non-psychoanalytic literature on these topics, which I describe at length elsewhere.[xviii] In this chapter, I will only make reference to some of this.

Empathy

Empathy is, to a greater or lesser extent, dominated by cognitions or feelings, depending on many variables.[xix] Psychoanalyst Aragno[xx] sums up three important aspects of empathy.

First, the ability to be empathic is a capacity that depends on the accomplishments of the development up to 18th-24th months. Sometimes, cognitive comprehension helps us understand what is going on in another's mind, while other times we just sense what the other is feeling without purposeful thinking. More often, it is a mixture of the two. Empathy is intimately connected with emotion regulation: being empathic toward the other changes one's own emotional state, which, as we saw in the emotion theory above, elicits a response: do I want to come closer or stay at a distance? So, empathy leads to an interpsychic and intrapsychic evaluation: Who am I in relation to the other (interpsychic evaluation) and how do I relate to the emotion the other feels (interpsychic evaluation)?' Empathy is accompanied by an increase in heart rate and breathing and the activation of specific brain circuits. Mirror neurons are being hyped as *the* neural substrate of empathy, but Gallese,[xxi] among others, strongly warns against this, stating that it is still much too difficult to explain empathy based on the functioning of mirror neurons. Empathy is not an emotion: empathy is the psychic activity of connecting with the other's emotion.

The second important aspect of empathy, according to Aragno, is its two intertwined goals: regulating emotions and facilitating social interactions. The concept of empathy should be restricted to the phenomenon of being able to adequately experience the emotion of the other as something separate from one's own emotions.[xxii] Thus, conceptually, empathy differs fundamentally from sympathy, temporary identification or projective identification, as in empathic processes the separation between subject and object remains intact. Empathy is not the same as concern for others: through empathy the child can understand the other, but he still has the choice to act upon this knowledge. However, concern for others does improve the quality of the empathic activity. In an insightful article on projective identification, Meissner argues that the metaphor of the analyst being able to unconsciously pick up and identify with the other's unconscious is way beyond reality.[xxiii] We can only know the other within the boundaries of our own emotional life and as much as the other allows him or herself to be known (albeit non-consciously, i.e. through non-verbal cues or messages). Empathic knowledge of the other cannot be but intersubjectively based, fuelled by the vague empathic arousal experienced by the person who is being empathic.

Thirdly, Aragno argues that empathy is a temporary phenomenon, an intrapsychic function in which we turn our attention towards an (imaginary) other. In a more or less conscious way, the empathic capacity can be switched on and off or function in in-between states. The functioning of empathy is highly influenced by a wide array of variables, such as the closeness of the other (family, partner, friend, acquaintance, belonging to the same religious group, race), the likeability of the other, the state of being under the influence of alcohol or

drugs, etc. These variables have been studied extensively in social and cognitive psychology, and Watt[xxiv] describes neurobiological substrates of contagious variables. Shame undermines empathic activity, as shame is directed inward whereas empathy is directed outward, towards others. In our work, we see patients who have developed an empathic wall to protect themselves from being overwhelmed by others' emotions, or patients who suffer from empathic anger, feeling and acting based on the anger felt by a 'victim'.[xxv]

Shame

Of the self-conscious emotions, shame is the most hindering one, because it directly questions one's own identity: '*Who am I*, if I do/think/fantasize this?'.[xxvi] Therefore, in general, shame asks for much more recalibration of the self esteem than guilt. Shame catches one off guard and makes one want to give anything to be invisible at that moment, because one feels looked at, humiliated or rejected.[xxvii] It can be a temporary, fleeting feeling (the so-called 'bypassed shame'), but also a stable emotion that as a character trait evaluates the identity in a chronically negative way. Contrary to what is usually assumed, shame does not arise when the 'high' values of the conscience do their work. Shame is the feeling that accompanies a person when he realizes who he 'really' is compared to the ideals of the ideal-self. The feeling component of the emotion is the realization of one's smallness or badness in reality or fantasy: with respect to most shameful situations or thoughts, it isn't so much the real or objective situation which makes one feel shame, but the meaning given to it. The appearance of shame is labeled cognitively afterwards: 'Of course I'm feeling down, I don't live up to my ideal-self'. From attribution theory we learn that a situation, thought or fantasy is shameful if it is evaluated in terms of inner, stable, uncontrollable and broad attributions: 'I am a stupid person'.[xxviii] Suddenly ('uncontrollable'), for the umpteenth time ('stable and chronic'), you find yourself in a shameful state. There is no place for shades of gray, such as the uniqueness of the gravity of the situation, and black and white thinking dominates ('broad'). The subject adheres to 'pars pro toto' thoughts: one bad thought implies a completely bad person. People do not differ much across culture or religion in their proneness to feeling ashamed, but individual differences in shame-proneness are enormous.[xxix]

In research into self-conscious emotions, there is a recent trend of distinguishing between intrapersonal and interpersonal self-conscious emotions. Intrapersonal shame is characterized by feelings of helplessness and powerlessness, and the subject suffers from the shame evoking situation.[xxx] In interpersonal shame, the subject feels looked at; he wants to disappear and hide from the situation.

Guilt

Contrary to shame, guilt is a self-conscious feeling that can strengthen self-esteem. Guilt ordinarily offers the possibility of repair, as it is strongly connected

to the evaluation of one's doing instead of one's being: 'Who am I, if I *do/think/fantasize this*?'[xxxi] Accordingly, it is usually easier to endure guilt than shame. Although the English Freudians and Kleinians differed on the origin of guilt, both groups attributed guilt to innate aggressive and sexual drives (Hughes, 2008). Modell, influenced by Mahler, introduced the concept of separation guilt, which is based on a child's belief that growing up and separating from the mother, and later from the father, will damage or even destroy it. Nowadays, concepts such as unconscious guilt, survivor guilt and crime out of longing for punishment are used to impart meaning to otherwise incomprehensible feelings, thought or behaviors.[xxxii] It would be interesting to theorize about whether these are different kinds of guilt or whether these concepts refer to different situations in which exactly the same guilt dynamic is active. In clinical practice, it is often seen that the painful shame is warded off with more tolerable guilt.

Cognitive psychology complements psychoanalytic thinking in that it maintains that guilt functions to generate empathic messages geared towards repairing and regulating behavior and mentalizing vague inner agitation.[xxxiii] Attribution theory explains that guilt results when one makes inner, labile and controllable attributions: 'I (an inner attribution) failed my exam (a labile attribution, as it is situational), because I didn't study enough (a controllable attribution, as this could have been otherwise). Remember, shame results from inner, stabile and uncontrollable attributions.

In intrapersonal guilt, the trespassing of inner norms and values leads to a negative self-evaluation.[xxxiv] The person longs, as it were, for punishment in order to be relieved of feelings of guilt and promises to change. Interpersonal guilt leads to the desire to take care of the other person and undo what one has done to the other person. Of course, in daily life, social, interpersonal and strictly individual intrapersonal aspects of guilt are interconnected and thus cannot be separated clearly. On the other hand, this differentiation is of great interest to psychoanalysts, as it allows them to listen more keenly to the other telling about his guilt: are both aspects mentioned or is one missing, and is this a characteristic of the other's psychodynamic way of giving meaning to what he has done, thought or fantasized, consciously or unconsciously?

Forensic evaluation of the conscience

Now that I have outlined the functioning of the conscience, we can take a first glance at the diagnostic framework for the evaluation of the conscience. Ideally, the evaluator would first establish the person's capacity for mentalization, his attachment style, the quality of the object relations and the coherence of the identity or self. He would then address the specific functioning of empathy, shame and guilt. The evaluator should naturally also address pride or other self-conscious emotions, but I will leave these out of the discussion in this chapter.

Empathy

For diagnosing empathic capacity, the evaluator should first try to establish if there is any capacity for empathy. It is sometimes lacking due to a defect in the person's personality structure or neurobiological make-up, while sometimes the person has created an empathic wall, preventing reciprocity with others.[xxxv] Another possibility is that the person has emotional conflicts over empathy, hindering him from being empathic. For example, someone might be afraid that being empathic leads to closeness, which would then activate the fear of intimacy. In the same vein, someone might want to keep empathic distress at bay in order to prevent having to act on it by, for example, having to comfort the other. In an interesting article, De Waal offers an alternative hypothesis for seemingly altruistic, helping behaviors in animals. The behavior of an encaged rat who gives up his own possibility for reward by relieving the misery of another rat could well be instigated by the wish to relieve his own distress, caused by having to observe and undergo the distress of his congener.[xxxvi] In a study involving youngsters diagnosed with behavior disorders, children with ODD seemed to lack empathic capacity, while failure in the empathic reactions of children with behavior disorder without the antisocial trait seemed to be governed by the social or individual context.[xxxvii] In them, empathic capacity seems to be selectively active.

When using the MMPI for diagnostic evaluation, good empathic capacities can be indicated by a high score on the K-scale, which unfortunately can also indicate the negative capacity for keeping up social appearances.[xxxviii] A lack of empathic capacities is indicated by a higher score on the L-scale; these are people who present themselves as too good to be true, that is, they lack the capacity to understand that others will see through this presentation. Lastly, high scores on the subscales of Social Imperturbability (Pd3) and Imperturbability (Ma3) can indicate poor empathic capacities; these are people who do not take others into account, as is the case with people with narcissistic disturbances.

In Exner's Comprehensive System, the appearance of two or more 'M-' scores indicates poor empathic capacities due to misperception of others. Also, a high egocentricity index points to a lack of empathy as well as relatively low H scores, which indicates poor internalized object representations.

Shame

For diagnosing shame, the evaluator should keep in mind that shame is almost always present in the interview, sometimes even as an equivalent of signal anxiety: the person is shamefully anxious that he will feel shame in the interview ('signal shame'). Having to submit to a forensic evaluation and answer the evaluator's questions can easily be experienced as humiliating. The opposite is also possible: some people really do not consciously experience shame at all; rather, they defend themselves against a potentially shameful experience by attacking the evaluator by questioning his method and professional experience. A young juvenile delinquent shouted at me: 'Who do you think you are, asking me questions like this! You are

not even a proper evaluator and your questionnaires are bullshit.' As many violators or delinquents were once victimized or traumatized themselves, it is important to realize that being victimized or traumatized can lead to intense feelings of shame. Thus, it might be that today's delinquent who humiliates his victim is defending himself against shameful experiences in his past, thus unconsciously turning passive into active: 'I am doing to you what they did to me.'

When using Exner's Comprehensive System, the Vista score can indicate shame, as this score reflects negative self-criticism. If the Vista score coincides with a reflection response or a high level on the egocentricity index, it is reasonable to expect that the person sees himself in a painful negative way. This is especially the case when the MOR scores are high as well. Shame is also associated with the cooling down of relationships, so the lack of any texture response, like 'The deerskin is raw' or 'The water in the fountain is cold', might indicate higher shame proneness, although no link has been found in research yet.

In the MMPI, higher shame proneness is expected with increased scores on Low Self-Esteem (LSE) and Shyness/Self-consciousness (Si3). High scores point to a negative self image, feelings of being a failure and a lack of sturdiness. In a pilot study involving delinquent juveniles, I found a correlation between a very low score on LSE (indicating an extremely positive self-esteem) and a high score on shame proneness, as measured with the Test of Self Conscious Affects-Adolescents.[xxxix] The absence of shame is expected in people who exploit or manipulate others, revealed by high scores on Psychopathic Deviation and Mania, in combination with high scores on Antisocial Practices (ASP), Naivete (Pa3), Amorality (Ma1), Ego Inflation (Ma4), Social Imperturbability (Pd3) and Imperturbability (Ma3). These scores are usually associated with narcissistic personality disorders.

In a study involving juvenile delinquents yet to be published, I will describe the use of questionnaires such as the Test of Self Conscious Affects[xl] and the Compass of Shame Scale.[xli] The latter questionnaire is of particular interest, as it identifies four styles for reducing, ignoring or magnifying a shame experience. These styles function as a defense mechanism, in that they work largely out of consciousness. The four scripts include withdrawal, turning the evoked aggression against the self, turning the aggression against another and avoiding the shame evoking situation.

Guilt

For diagnosing guilt, it is important to realize that for most people, guilt proneness might be a personality trait, but the actual feeling of guilt fluctuates due to specific circumstances. In forensic evaluation, it is important to establish whether the person takes responsibility for his actions and not only for the consequences. Guilt results from the former, while regret or remorse results from the latter. Among the criteria for the antisocial personality disorder listed in the DSM-IV is an absence of feelings of regret, indicated by being insensitive towards or rationalizing the fact of

having hurt, mistreated or stolen from others. As answers from the subject are highly prone to social desirability in forensic evaluation, the evaluator should look for signs of guilt without mentioning the word itself, and should also explore the capacity to experience guilt outside the forensic situation, inquiring about potential feelings of guilt in relation to relatives, friends or pets in the present or the past. In forensic evaluation, neurotic guilt is not to be expected; research has indicated over and over that neurotic levels of guilt proneness are associated with a low probability of crime. There are, however, some rare instances of 'crime motivated by unconscious guilt', in which unconscious guilt motivates the person to act destructively.[xlii] Nevertheless, a conclusion about a crime as motivated by unconscious guilt can only be made when numerous emotional patterns point in the direction of unconscious guilt.

Absence of guilt is to be expected in the case of strong psychopathic and narcissistic traits. The person is totally occupied with his own needs and wishes, and others do not come alive as separate individuals for whom he is responsible. In the evaluation, the assessor should evaluate whether the person is capable of experiencing feelings at all, whether he has the capacity for mentalization and thus is capable of experiencing guilt. If so, is the person able to reason about the consequences of his behavior on others (the cognitive aspect of the emotion), feel guilt the moment he trespasses (the feeling aspect of the emotion) and/or think in abstract moral terms about his behavior?

In the MMPI, Ganellen finds that guilt is related to high scores on scales 2 and 7, on Subjective Depression (D1), Brooding (D5), Self-Alienation (Pd5) and low Ego Inflation (Ma4).[xliii]

When using Exner's Comprehensive System, an 'FV+' score points to the ability to accept guilt.[xliv] The capacity for experiencing guilt is associated with the capacity for introspection, for objectifying oneself. In the Exner system, these qualities are associated with FD and V scores. When there are more than one V scores, the interpreter must look first for recent events, which might understandably lead to a feeling of guilt. If this is not the case, the high V score might indicate negative self-esteem. According to Ganellen, guilt is indicated when there is positive score on FV, VF or V.

Concluding remarks

Describing the conscience has long been problematic in forensic evaluation. Diagnosing a lacunar superego or the lack of feelings of guilt or remorse is almost practice as usual. Although I do not pretend to have *the* answer to the difficult question of diagnosing the level of functioning of the conscience, I do think that the new approach I am taking is fruitful. It conceptualizes the conscience as a psychic function, aimed at balancing the self. When in a proper

balance, little work has to be done, but when there is a danger of misbalance, self-conscious emotions and concomitant defense mechanisms come to the fore. By describing the conscience as a psychic function, the description of its physical elements can correspond to current theories about the functioning of the brain. By choosing to rewrite the functioning of the conscience in concepts taken from motivation theory, the outdated metaphor of drive theory can be replaced by concepts which are more open to experimental research and questionnaire methods for its measurement in forensic evaluation.

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PERSONAL AUTONOMY, GOOD CARE, INFORMED CONSENT AND HUMAN DIGNITY SOME REFLECTIONS FROM A EUROPEAN PERSPECTIVE

Aart Hendriks

Abstract
Respecting and protecting personal autonomy requires that autonomy is interpreted in conjunction with the principle of good care in a way consistent with (the aspirations enshrined in) human dignity. This leads to a principled and relational approach towards personal autonomy. This implies an active role of health care providers, as councillors of patients, and a personalised way of obtaining informed consent, to maximally ensure the enjoying personal autonomy.

Key words: personal autonomy, good care, human dignity and informed consent

1 Introduction

The principle of informed consent is generally considered to embody the most fundamental right of patients towards health care providers. It combines the right to be informed about one's health status and treatment options and the right to consent or to withhold consent to proposed medical interventions that by definition invade the physical and mental integrity (henceforth: privacy) of a patient.[1] Respect for this principle in the health care sector and upholding the corresponding patients' rights reflect the importance attached to the idea that individuals are entitled to determine their own course of life in accordance with a self-chosen plan.[2] This notion is better known as 'personal autonomy',[3] an important ethical and legal principle that underlies, according to the European Court of Human Rights (ECrtHR), the interpretation of various guarantees laid down in the European Convention on Human Rights, notably the right to private life.[4] Autonomy was recently explicitly recognised by the Court to constitute a

1 Cf. ECrtHR 9 March 2004, *Glass v. the United Kingdom*, no. 61827/00 and ECrtHR 5 October 2006, *Trocellier v. France* (dec.), no. 75725/01.
2 T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics* (sixth edition), New York, NY – Oxford: Oxford University Press, 2009, p. 99.
3 Cf. ECrtHR 17 February 2005, *K.A. & A.D. v. Belgium*, no. 42758/98 & 45558/99, § 83: 'The right of autonomy over one's own body, an integral part of the notion of personal autonomy, which could be construed in the sense of the right to make choices about one's own body'.
4 ECrtHR 29 April 2002, *Pretty v. the United Kingdom*, no. 2346/02, § 61.

right in its own.[5] National judges should therefore, according to the European Court, take the autonomous will of individuals with mental illness into account when deciding on applications to deprive a person of his legal capacity or to subject him to restrictions of liberty or forced treatment.[6]

Personal autonomy is mostly understood as a warrant for individuals to make their own decisions, also with respect to the provision of health care, and as a deterrent for the State and others to interfere with individual wills and actions. Personal autonomy, thus perceived, corresponds with negative liberty, the absence of constraints ('the freedom from'). However, disease and infirmity imply per definition that an individual's capacity for self-determination is impaired. By providing good care,[7] after obtaining the individual's informed consent, these restrictions may be overcome and personal autonomy can be strengthened, if not restored.

This raises the question to what extent, if at all, personal autonomy or human rights in general also entail an entitlement to positive liberty, to good care, to enable individuals to be truly in control of their lives.[8] It is argued here, building on the case law of the European Court of Human Rights and other (mainly) European experiences and insights, that personal autonomy and human rights should not merely be interpreted as an individualistic and negative right radically opposed to any form of outside intervention with personal liberty, but that there is a need for a more principled[9] and relational approach towards personal autonomy and human rights, with due attention being paid to the 'freedom to' and the provision of good care. The principle of informed consent in the health care sector should be interpreted in a commensurate way to ensure that its application is in line with the basic principles underlying human rights law.

2 Human dignity

For an accurate understanding of the concepts of personal autonomy and good care, it is important to recall that human dignity is the basic principle underlying human rights law. Or, in the words of the European Committee of Social Rights (ECSR), 'Human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention on Human rights', adding that 'health care is a

5 ECrtHR 20 March 2007, *Tysiąc v. Poland*, no. 5410/03, § 107; ECrtHR 10 April 2007, *Evans v. the United Kingdom* (GC), no. 6339/05, § 71.
6 ECrtHR 27 March 2008, *Shtukaturov v. Russia*, no. 44009/05,
7 B.J.M. Frederiks, 'The Rights of People with an Intellectual Disability in the Netherlands: from Restriction to Development', *European Journal of Health Law* 2007, p. 1-15.
8 Cf. ECrtHR 8 January 2009, *Schumpf v. Switzerland*, no. 29002/06. Here the restriction of health insurance costs was considered a violation of the applicant's private life.
9 Term coined by the philosopher Onora O'Neill.

prerequisite for the preservation of human dignity'.[10] This is not to suggest that it is easy to define human dignity.[11] According to the European Court of Human Rights it concerns 'a particularly vague concept, and one subject to random interpretation'.[12] Human dignity is, according to Advocate General Six Hackl of the Luxembourg-based European Court of Justice (ECJ), 'an expression of the respect and value to be attributed to each human being on account of his or her humanity. It concerns the protection of and respect for the essence or nature of the human being per se – that is to say, the "substance" of mankind.'[13]

Human dignity is commonly interpreted in different ways. In 2001, Beyleveld and Brownword made a distinction between human dignity as 'empowerment' and human dignity as 'constraint'.[14] The former interpretation offers a foundational concept, reinforcing the claim that personal autonomy should be respected.[15] In this view, the emphasis is on free choice, autonomous decisions making and non-interference. The existence of human dignity gives rise to human rights that seek to respect and protect the inviolability and integrity of human beings, notably the non-interference with fundamental human attributes.[16] Or, according to Dieter Hart, 'The term dignity describes the protection of objectives of dignity and privacy, of respect and trust, of autonomy and non-discrimination.'[17] Conversely, human dignity as 'constraint' is above all concerned with human duties, in terms of the limits of human conduct and behaviour to ensure that dignity (*dignitas*) is not affected. Human dignity as constraint entails not only a duty to act in a way that is compatible with respect for the vision of human dignity that gives a particular community its distinctive cultural identity, but also a duty not to compromise one's own dignity.[18] Dignity as constraint is also sometimes interpreted as imposing duties on individuals towards other members of the community, to ensure that everyone can lead a dignified life.

It follows that proponents of human dignity as empowerment conceptualise human rights, above all or exclusively, as negative, non-interference rights. In this perception, human dignity entails the right to be different and to make non-rational ('unwise') decisions. 'If I want to smoke, I have the right to smoke'. 'If I refuse medical treatment, no one should subject me to such treatment'. The

10 ECSR 7 November 2004, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint no. 14/2003, § 31.
11 R.E. Ashcroft, 'Making Sense of Dignity', *Journal of Medical Ethics* 2005, p. 679-682.
12 ECrtHR 26 July 2005, *Siliadin v. France*, no. 73316/01, § 101: 'concept particulièrement imprécis et sujet à des interprétations aléatoires.'
13 Advocate General Stix-Hackl 18 March 2004, case C-36/02 *(Omega)*, § 75.
14 D. Byleveld & R. Brownsword, *Human Dignity in Bioethics and Biolaw*, Oxford: Oxford University Press 2001, p. 1.
15 R. Macklin, 'Dignity is a useless concept', *British Medical Journal* 2003, p. 1419-1420.
16 Cf. Supreme Court of Canada 3 October 1996, *Quebec (Public Curator) v. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 S.C.R. 211, § 105.
17 D. Hart, 'Patients' Rights and Patients' Participation. Individual and Collective Involvement: Partnership and Participation in Health Law', *European Journal of Health Law* 2004, p. 17-28 at 19.
18 D. Byleveld & R. Brownsword, *Human Dignity in Bioethics and Biolaw*, Oxford: Oxford University Press 2001, p. 1.

individual's consent is crucially important to allow others, such as health care providers, to interfere with the personal autonomy of the individual concerned. This is not to suggest that human dignity as empowerment allows for unrestricted use of individual freedom; restrictions on freedom are generally justified, if not required, in case the use of corresponding rights and freedoms interferes with the (negative) rights and freedoms of other persons.

The adherents of human dignity as constraint perceive the notion of human dignity, first of all, as a justification for interference with personal autonomy: an individual shall neither impair the dignity of others, nor of his or her own, and shall not involve in activities – such as certain forms of stem cell research and human cloning – that are considered incompatible with human dignity. An example of the latter concerns the selling of organs for commercial gains; whereas the not-for-profit donation of organs is deemed acceptable, it is perceived objectionable if people decide to sell their organs to make financial profit out of them. In addition to these restrictions on individual freedom, the State and other members of the community are called upon, by the 'human dignity as constraint' adherents, to actively protect vulnerable members of society and to ensure the preconditions to enable everyone to live a human and dignified life (positive and interference rights). The primordial importance courts attach to the 'child's best interests', sometimes prevailing over the rights of parents and the child 'to be left alone', is a clear example of the latter. Human dignity as constraint also implies a duty to care for individuals. The deprivation of necessary care can lead to situations that are incompatible with respect for human dignity. Therefore, in many European countries health providers are obliged to provide necessary care, independent of the financial position of the person in need, and forbidden to leave a person in a desperate position.

When studying human rights, health law documents and authoritative interpretations one will notice that references to human dignity are made in various ways, interchangeably using this concept to empower or to restrict individual autonomy. The 'purpose and object' of Council of Europe's Convention on Human Rights and Biomedicine[19] is to protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine (Article 1). This goal is clearly inspired by advocates of human dignity as empowerment. At the same time, however, this Convention contains various provisions that restrict the autonomy of individuals for the sake of his or her dignity. This notion of dignity not only transpires in such provisions as Article 21, stipulating that 'The human body and its parts shall not, as such, give rise to financial gain', but also underlies the restrictions of bio-medical research, interventions and tests, independent of the consent of the individual concerned (see for example Articles 12-16). It should be noticed here

19 CETS No. 164.

that these (and my) interpretations are not always fully consistent with the inspiring framework designed by Byleveld and Brownsword, who have argued that all human dignity underlies all human rights and duties, entailing both positive and negative elements.[20]

3 Personal autonomy, good care and informed consent

Personal autonomy and good care are often thought to reflect incompatible ethical and legal principles. The implicit assumption then seems to be that personal autonomy equals negative freedom and that everybody has the capacity of self-determination, unless independently and reliably shown otherwise. In this view, personal autonomy presupposes freedom of choice. Individuals have the right, if not the duty, to make choices in life. When doing so, individuals are only accountable towards themselves. If it is their choice not to be treated or when they prefer a second-best treatment option, this choice has to be respected by others, including care providers and relatives.

This individualistic concept of personal autonomy is increasingly being criticised by medical ethicists and health lawyers alike as being too narrow-minded, lacking contents and out of touch with the underlying principle of human dignity. This concept of personal autonomy suggests that freedom, individuality, rationality and independence are the most important values for each and every human being. Moreover, the implicit assumption is that everybody is in the (personal, social and financial) position to fully enjoy these values. The fact that people with health impairments are often vulnerable and dependent on others is seemingly – and maybe conveniently – neglected. However, dependence on care diminishes the possibilities to freely determine one's wills and actions. But not only patients, most if not all human beings are at most partially autonomous.[21] A patient is not a free decision-maker and a health care provider is not a neutral service provider who offers, in a non-directive way, a couple of treatment options from which the patient can independently choose. The patient often needs – and wants – others to assist him in making such decisions, also taking into account the effects of choices on his or her relations with others. For example, hospitalisation implies a physical separation from those who are most dear to him or her. And undergoing a genetic test may imply that information is revealed that may also impact on the life and well-being of relatives. Most individuals take this social / relational aspect into account when taking health care decisions.

The latter requires that health care providers do not merely provide care, and neutrally give information in view of obtaining the individual's consent; a health

20 D. Byleveld & R. Brownsword, *Human Dignity in Bioethics and Biolaw*, Oxford: Oxford University Press 2001, p. 68.
21 O. O'Neill, *Autonomy and Trust in Bioethics*, Cambridge: Cambridge University Press 2002.

care provider should act as a councillor to – and almost personal coach of - the patient, respecting the patient's personality, wishes and desires. This requires a slightly broader vision on (negative) personal autonomy. In fact, this presupposes a principled view on autonomy, where dignity as constraint and dignity as empowerment strengthen each other. This perception on personal autonomy rightly takes into account that human beings are interdependent and relational, and most often only partially autonomous when it comes to medical decision making. Thus, justice is done to human dignity, as described above.

Personal autonomy should therefore, to ensure its conformity with the ample concept of human dignity, been seen and interpreted in conjunction with the concept of good care. In fact, providing good care could, in view of the concept of dignity as a constraint, be perceived as a duty resting on health care providers towards other members of the community, to ensure that everyone can lead a dignified life. By providing good, personalised care to individuals, the personal autonomy of the patient is best conserved and protected. Good care therefore presupposes an active duty on health care providers to provide care to people in need, instead of waiting for individuals to turn to the health care sector for assistance. This positive obligation is both enshrined in the right to health and in classical human rights, notably the right to life, the prohibition of torture and inhuman or degrading treatment or punishment and the right to privacy.[22] These rights and corresponding State obligations are in many respects a precondition for personal autonomy and human dignity.

The duty to protect human dignity requires States to set standards with respect to health care, environmental pollution, labour conditions, the quality of food and drinking water, housing etc.,[23] and to impose duties of care to protect vulnerable persons,[24] to the extent that all necessary and reasonable steps should be taken to prevent harm to the health, safety and life of individuals.[25] The provision of adequate, personalised and understandable information, to allow people to best protect themselves and their health, is instrumental in this respect.[26]

The above is not to suggest that a State can arbitrarily use the notion of human dignity to restrict the autonomy of individuals in the interest of (care for)

22 A.C. Hendriks, 'The close connection between classical rights and the right to health, with special reference to the right to sexual and reproductive health', *Medicine and Law* 1999, p. 225-242.

23 ECrtHR 28 October 1998, *Osman v. the United Kingdom* (GC), no. 23452/94; ECrtHR 30 November 2004, *Öneryildiz v. Turkey* (GC), no. 48939/99 and ECrtHR 27 January 2009, *Tatar v. Romania*, no. 67021/01. See also V. Derckx & H.D.C. Roscam Abbing, 'Patients' Right to Health Protection and Safety of Blood (Products)', *European Journal of Health Law* 2005, p. 153-166.

24 ECrtHR 15 March 2005, *Kilinc v. Turkey*, no. 48083/99 and ECrtHR 20 January 2009, *Slawomir Musial v. Poland*, no. 28300/06.

25 ECrtHR 1 March 2005, *Bone v. France* (dec.), no. 69869/01 and ECrtHR 18 December 2008, *Saviny v. Ukraine*, no. 39948/06.

26 ECrtHR 29 October 1992, *Open Door and Dublin Well Woman v. Ireland*, nos. 14234/88 and 14235/88, ECrtHR 19 February 1998, *Guerra and others v. Italy*, no. 14967/89, ECrtHR 9 June 1998, *McGinley and Egan v. the United Kingdom*, nos. 21825/93 and 23414/94, ECrtHR 9 June 1998, *L.C.B. v. the United Kingdom*, no. 23413/94; ECrtHR 19 October 2005, *Roche v. the United Kingdom* (GC), no. 32555/96 and ECrtHR 3 February 2009, *Women on Waves et all v. Portugal*, nr. 31276/05.

health. As a rule, this requires a medical or therapeutic necessity.[27] The European Court of Human Right has repeatedly considered that a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot, in principle, be regarded as inhuman and degrading or to violate the right to private life.[28] The notion of medical or therapeutic necessity is, nevertheless, to be interpreted narrowly is it not to undermine the very principle of autonomy.

4 Conclusion

To sum up, non-interference with personal autonomy should be combined with offering active support and protection to individuals to strengthen their personal autonomy, to maximally respect the (freedom) rights and dignity of the individual concerned. Good care also assumes a fiduciary relationship between a patient and a care provider. The care provider discusses with the patient what type of care best matches the patient's wishes and needs. Building on the latter, the care provider starts offering information on treatment options, not necessarily in a neutral way.

The latter implies that obtaining the patient's informed consent is not a mechanical process, but presupposes that the information is tailored to the needs and capacities of the patient concerned, taking into account the personal, social and financial position in which the patient finds him or herself. Thus seen, informed consent and the provision of good care can maximally contribute to personal autonomy and human dignity, both in terms of 'empowerment' and in terms of 'constraint'.

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27 See for example European Commission of Human Rights 25 February 1997, *Buckley v. the United Kingdom*, no. 28323/95, ECrtHR 5 October 2000, *Varbanov v. Bulgarije*, no. 31365/96; ECrtHR 22 July 2003, *Y. F .v. Turkey*, no. 24209/94 and ECrtHR 28 February 2006, *Wilkinson v. the United Kingdom* (dec.), no. 14659/02.

28 ECrtHR 24 September 1992, *Herczegfalvy v. Austria*, no. 10533/83, § 82; ECrtHR 10 February 2004, *Naoumenko v. Ukraine*, no. 42023/98, § 112; ECrtHR 11 July 2006, *Jalloh v. Germany* (GC), no. 54810/00 and ECrtHR 7 October 2008, *Bogumil v. Portugal*, no. 35228/03.

Ethical Dilemmas in Structured Professional Judgements

Ethical Issues in Risk Assessments in Forensic Psychiatry: What does a Prediction based on Group Data say about an Individual in his Specific Context?

Swanny Kremer, Harry Beintema, Marinus Spreen

The narrative constructs the identity of a character, what can be called his or her narrative identity, in constructing that of the story told. It is the identity of the story that makes the identity of the character.
Paul Ricoeur

1 Introduction

Discussions about the quality of care in forensic psychiatry often concern the quality of risk assessment decisions in relation to the safety of society. In the Netherlands forced detention in a psychiatric hospital, i.e. ter beschikkingstelling (TBS), is focused on treating inpatients who have committed serious crimes (1, 2). In this treatment each patient is offered an 'opportunity' to learn from his past, to change his risk behaviours and to return to society if his or her risk behavior has been evaluated by forensic professionals as reduced sufficiently. Dilemmas for forensic professionals are: Which forensic inpatient (TBS'er) is competent enough to permit leave? Whom should the hospital order be extended to and who can rehabilitate? It is therefore important to accurately assess risk behaviors of patients to get an estimate of the potential danger to society.

In forensic psychiatry, it is crucial to weight 'all' interests concerning such safety questions. It is (at least) about the interest of the patient and the interests of society, including victims and their family members. Obviously interests of the patient and society may conflict. An ongoing ethical dilemma for a professional is: what do you consider as more important in your decisions, the safety of society or the liberty of a person? And how can one assess whether someone is (still) dangerous? Making assessments in terms of possible future violent behavior entails a great responsibility.

In forensic psychiatry there are several procedures to achieve accurate assessments of possible criminal behaviour, but it remains difficult to predict a possible new offence (3). A distinction is usually made between an unstructured clinical evaluation, an actuarial or statistical prediction and a structured

professional judgement (4). The quality of risk assessment is not only in the interest of a safe society, but also in the interest of the patient whose freedom is being curtailed.

In this essay we explore to what extent these different risk assessment methods have positive and negative 'side effects' and discuss whether a narrative approach may contribute to cope with these side effects. To explore the extent to which a narrative approach may contribute to risk assessments, current risk assessment methods are described in section two. Section three deals with mistakes that can be made in predicting risk behavior by applying group data on individuals. This section includes a discussion about misclassifications like false-negative and false-positive decisions. The fourth section is about the role of narrative identity in structured professional judgements. The goal is to try to understand the patient in a more individual, contextual way. The last section contains some conclusions of this essay. It is about the question how to deal with the dilemma that risk assessment instruments are scientifically validated, but also lead to a certain amount of misclassifications in terms of risk at the individual level. We argue that structured professional judgements may be improved by also focussing on the narratives of a patient.

This essay is not specifically about absolute levels of predictive values of current risk assessments. It is necessary to explore a view about how to deal with risk assessments, because it is important to reflect on methods practitioners apply to decide about freedom of patients. Making choices about leave or no leave, rehabilitation or not, should concern us.

2 Risk assessment methods in TBS

Risk assessment methods are elaborated to support assessments on the probability of criminal behavior in the unknown future. In the Netherlands TBS is one of the most freedom constraining measures in the penal code. A person is literally separated from society to undergo treatment. But, unlike imprisonment, it is uncertain how long this separation will last. Basically, every two years the court decides whether the TBS-measure for a patient should be extended or not (5). The opinion of the court is for a (large) part based on the advice of the hospital/institution and their risk assessment (6). This section briefly discusses the different methods in forensic psychiatry to evaluate potential future criminal behavior of patients.

2.1 CLINICAL PREDICTION

A clinical prediction of future criminal behavior is solely based on a clinical assessment by a practitioner in forensic psychiatry (7). This prediction is based on the treatment relation with the patient, combined with theoretical and

practical background of the practitioner. On an individual level this type of prediction of risk-behaviour takes typical aspects of the person of its own specific context into account. However, clinical predictions lead to questions as 'how unprejudiced is a practitioner'? Is a clinical prediction not too much influenced by the personal biases of the practitioner, and might another practitioner have another opinion on that same patient? Clinical assessment has repeatedly made mistakes and appears less reliable than actuarial risk assessment (8). One could say that a clinical prediction is tailor made, but has no benefits from scientific developments. Because of this unreliability of clinical assessment, practitioners increasingly make use of other risk assessment methods.

2.2 ACTUARIAL- OR STATISTICAL PREDICTION

Methods that are based on solely statistical data and used in risk assessment are called actuarial valuations, like the STATIC99 (9). In this method the practitioner values some well defined risk indicators, which are known to correlate at a group- or category level with risk. By applying a predefined counting rule (most times the sum score of the items) the practitioner gets an indication of the degree of dangerousness of the patient. This implies that at the individual level the dangerousness of a patient is expressed by a number which stems from group level norms. Other possible relevant aspects of this patient are ignored. As an example consider patient William for whom some scientifically validated actuarial instrument has been completed. William has sexually abused several underage boys before his detention. Suppose all items indicate no risk except the item sexual preoccupation. Nowadays William tells his psychologist that he still dreams about immature boys which makes him sexually arroused. It will be obvious that the total sum of the actuarial instrument will be low, leading to a conclusion of low risk, while the dreams of William can be understood as a high risk. In other words the fact that William dreams about little boys does not influence his final risk actuarial assessment judgement. Actuarial methods are based on static indicators such as past detentions and a psychiatric history (10). An actuarial- or statistical prediction concerning William generates a low risk (with all risks that entails this). So an actuarial based prediction has benefits of science, but the specificity of the individual case is ignored.

2.3 STRUCTURED CLINICAL ASSESSMENT OR A STRUCTURED PROFESSIONAL JUDGEMENT

A third method is called structured clinical assessment or structured professional judgement (SPJ). This is a hybrid of actuarial- and clinical assessment (11). There is a scientific consensus that structured professional judgements are the golden standard for risk assessments. In this method a practitioner has to value a set of risk indicators of which correlations with future criminal behaviors are known

from earlier studies. The set of risk indicators concern historical but also dynamic and future indicators. Dynamic indicators are usually defined as risk behaviors in the last 12 months for the evaluation moment. Future indicators are defined as possible risk behaviours or social contexts which the patient will meet in the future. In the structured professional judgment method the practitioner must base his final risk judgement by weighing the available information with the typicality of the individual case. The final judgement is usually categorized as low, middle or high risk on future criminal behaviour.

In the Netherlands structured professional judgement methods are imposed by the Department of Justice. For instance, at FPC Dr. S. van Mesdag a practitioner as well as an independent researcher completes independently of each other the risk assessment. After a discussion on each indicator, they try to reach a consensus score, on each item based on arguments. Following this discussion, they will reach an overall consensus conclusion on the risk for recidivism, on a five-point scale that runs from low to high. Although one works with a standardized list of risk factors, the final assessment is a clinical assessment in the sense that it is not a sum of the items. For example, a score of 40 points on the HKT-30 might imply a low risk on recidivism for one patient and a high risk for another, i.e, a score of 40 for William whom is still dreaming about underaged boys must be interpreted different than a score of 40 for Peter who has a job and a supportive network (12). For each individual patient there is a "sauce" of individual perception placed on the outcome of the group data. An advantage of using the SPJ method is the structuring of thoughts and arguments to reach the best possible insight into the possibility of reoffending. Often there is a lot of information about a patient and such a procedure helps to organize this information. A restriction of the SPJ method is that the dynamic items are bound to behaviors the last twelve months.

3 Undesirable situations

Information extracted from group data is obviously useful for risk assessments procedures because it gives the practitioner insight into scientific knowledge. For example, from literature it is known that about 70% of people with a first psychosis will experience more psychotic episodes during their lifetime (13). But how to decide whether the patient sitting in front of you belongs to the 70% that become psychotic again, or to the 30% that do not? One may argue that this decision is basically a random judgement because no one can predict the future. Applying structured professional judgements methods may support such decisions because it is a combination of actuarial knowledge, the individual risk behaviors of a patient the last twelve months and the professionalism of the practitioner. It remains unknown which specific part of information of the SPJ is

most influential in the final decision. Theoretically in a group study with an SPJ instrument the total sum of the items of the instrument (actuarial data) must correlate with recidivism. One can define some cut-off point in order to make individual decisions. However whatever level of cut-off point is chosen in actuarial data, there will always be patients who are classified as non-risk but turn out to be recidivist (a false-negative decision) or classified as risk but turn out to be a non-recidivist (a false-positive decision). Weighing the other two parts (individual risk behaviors and professionalism) in the decision must theoretically lead to a reduction of the amount of false-positive and false- negative decisions.

The process of combining actuarial data with individual risk decisions leads to a number of ethical dilemmas such as: how to weigh the fact someone uses his medication as prescribed in the TBS-setting, or the fact that someone has a partner that offers social and emotional support. Such circumstances can easily change as the TBS measure is ended.

Practically in decisions about granting freedom to TBS detainees the dilemma is how influential the role of statistics should be. While it appears to be difficult to estimate the recurrence risk for a patient, this prediction is very important to the judge or the ministry, as they need to decide whether an individual is allowed to have (un)supervised leave or to rehabilitate. Two misclassifications can be made in decisions of risk. It is possible that a patient is mistakenly granted leave (false-negative decision), and it is possible that a patient is mistakenly not granted leave (false-positive decision). It is clear that both errors produce undesirable situations. The ethical question is whether you have a preference to reduce false-negative or a false-positive errors. Should our primary concern go out to welfare of an individual, or should our first concern be about the safety of society? What does one want to emphasize? What error do we 'prefer'? A false negative prediction is a prediction that behavioural scientists and researchers want to avoid because it has a direct negative impact on society; it concerns a new offence. A false negative prediction also may have a negative impact on the patient. It is known that after a relapse a patient is placed back in another treatment phase and therefore his treatment will last longer.

On the other hand, a false positive prediction may result in limiting a patient's freedom which is not justifiable. One could argue that keeping people locked up inside a psychiatric clinic simply because they do belong to a risk group is a frightening idea. Going on leave is an essential part of TBS treatment because the aim of TBS is to return to society after a sufficient reduction of risk. Leave is required in order to practice new behavior in the 'outside world'. The patient may show, first under guidance, to what extent he can apply what he has learnt. Is he able to display acceptable behavior? Thus, leave is important for both, the patient and society. When no 'freedom' is allowed, which might be the case when one is overly afraid of making false-positive errors, one negatively influences the patient's present situation as well as his future. In summary, although the SPJ methods are the golden standard in risk assessments and the instruments are

scientifically validated, the dilemma remains that a certain amount of false decisions are made. In order to improve the SPJ method we argue that adding a more narrative approach may lead to better risk assessments.

4 The role of narrative identity in structured professional judgment

Practitioners in forensic care need to formulate a view on how to deal with SPJ procedures. In a SPJ procedure one must also pay more attention to ethical issues, like the identity of a single person, his life story and his individual contexts. In other words, the person must also be understood in a narrative way (14). Attention to the other one is needed if we want to try to understand the other in a concrete way. A constructionist approach to narrative sees it as a key organizing principle, helping us to make sense of events and people (15).

When applying the narrative approach on a patient one takes his individual life story into account. By recognising the other, by having 'an eye' for the other, by being attentive, one does more justice to the unique other. The narrative identity of a patient, both; embodied and socially embedded, is recognised. Having attention for the concrete, individual life story that 'runs like a red thread straight through the patient', might help in the final SPJ decision on risk. In this sense a narrative can be helpful to understand an individual. The narrative approach helps to theorize how social formations and personal biography interact (16). Attentiveness to the individual is a central value and narratives also help to identify the other as a specific individual. In practice, this means that a risk assessment should not only reflect a patient's behavior of the last 12 months. The assessment should be rather seen as a part of the life of an individual, as a part of the 'theme running straight through the patient.'

An example of a narrative based method to improve the quality of SPJ decisions is the Forensic Social Network Analysis (FSNA), which is described in another contribution in this book (17). In the FSNA method the network of a patient is analysed in terms of protective and risk relations and understand in relation to the patient's life history. This way another piece of information to support the SPJ decision is added in which the patient is seen as a person influenced by the codes of his social network.

5 Conclusion: we should have to care about our care

Clinical assessment has repeatedly resulted in mistakes and appears to be not very reliable. Methods that are based solely on statistical data like the actuarial- or statistical prediction have some benefits of science, but the individualised view is

ignored. Structured professional judgements have benefits of science and the individualised view, but still have some ethical dilemmas. Although actuarial and SPJ methods are scientifically validated, these dilemmas remain. A possible approach to better cope with these dilemmas might be using narrative approaches in the SPJ procedures.

Narrative based methods, like Forensic Social Network Analysis, provide practitioners in forensic care with other information about an individual patient. Interestingly, narrative approaches to support SPJ decisions reflect a direction in ethics that focuses on good care, which is ethics of care or relational ethics. According to Paul Ricoeur it is the task of ethics to ensure 'le meilleur humain possible'. Being attentive to the narrative identity of a singular person more justice is done to a patient than only using group and treatment data. The significance of identifying narratives lies on their direct and indirect effects on a person and how that person might act. Narratives might help to 'explain' a person, and also to 'predict' certain behavior of an individual person.

SPJ based decisions are the best validated decisions that can be made when deciding about and for the future of a patient. However, by taking a closer look by the use of a narrative approach one may gain a lot. Not only does one more justice to another person, it also helps to fine-tune the results of a risk assessment. To turn a workplace into a better workplace, it is necessary to make use of new developments, so this new knowledge may lead to reflection on the practice of treatment evaluation. And as statistician Dr. W. Edwards Deming said: 'It is important that an aim is never defined in terms of activity or methods. It must always relate directly to how life is better for everyone...'

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The Trias Psychiatrica

The Connection between Law and Care, as seen through the Eyes of a Senior Medical Director

A.J.K. Hondius

Introduction

The connection between law and care has been sure to create tension since the start of the 19th century. This tension is most apparent where coercion and pressure is being practiced. Here it concerns tension between protecting society on the one hand and striving to provide quality care and treatment on the other. There is also the question of with whom lies the decision-making concerning application of coercion, the judge or the physician?

On the basis of three (composed) cases from the practice of the Dutch Psychiatric (Compulsory Admission) Hospitals Act (Bopz-law) these tensions are being discussed. This touches on reasoning and decisions concerning a forced discharge, a denied request for admission and abrogating of a Provisional detention.

The position of senior medical director exists because of the Psychiatric Hospitals (Compulsory Admissions) Act (in Dutch 'the Bopz-law'). Although there are many different ways in which this function is being interpreted in The Netherlands, all senior medical directors deal with tension between the law, care and safety. They are often a kind of oracle for colleagues and advise with complex and legal issues, besides monitoring careful decision-making concerning the application of coercion.

Naturally no solution can be offered for the existing tensions, but there are a number of different ways to handle them. It is important who plays what role and that a balance remains between the varying interests.

Historical tensions

In the 18th century and early 19th century the Enlightenment and the French Revolution brought new notions[1] (1). 'Insanity that was before seen as demonic possession, a result of sin and guilt, was increasingly seen as an illness'. 'Madness was an erroneous processing of impressions and incorrect associations of the senses and deserved a humane and therapeutic approach, geared toward re-education, self-control and sense of responsibility'. For this a leader of high

1 In this section there is a number of quotations from Oosterhuis, but for readability reasons not in each case exactly referred to per sentence. It concerns referrals to pages 29, p 43, p 158, p 319, p 545.

moral fiber was needed. The physician was seen as such and medicalization got under way. During the so-called 1st Psychiatric revolution legislation came about which focuses on protection of society on the one hand, on the other hand aimed at the interests of the individual citizen and the sanctioning of the role of the physician in a mental institution, the so-called Asylum-doctors. The latter were responsible that patients were not only locked up and were subjected to constraint by (untrained) keepers, but could also benefit from new and hygienic medical notions (moral therapy and non-restraint). This caused tension between care, law and the safety of society. Are people admitted against ones will to protect society or to be treated?

From the French Revolution on the principle of freedom of the individual had become an important aspect. A reason to only want to arrange deprivation of liberty through the courts. Physicians advocated making faster asylum admission possible in the lunatic's best interest. To regulate the tensions, among decision makers and others, legal or medical, the legislature created laws (1, p 43). Certain things were regulated according to the French Code Civiel (1811: adults in continuous state of insanity were put under guardianship) followed first by royal decrees (King Willem I). In 1814 the decree stated that non-chronic sufferers, although dangerous or troublesome to society, could be compulsorily admitted for one year at most. In 1816 at the request of Willem I an investigation was initiated and a new royal decree followed, the so-called "humane decree". In there it was determined that healing should be the main concern.

Still many "senseless" in mid 19th century Holland remained in guesthouses, houses of correction, poorhouses and jails, as local authorities decided on the detainment. In these places of custody there was hardly any medical care given.

In 1841 the first Lunacy Act was implemented, in which admission and discharge were regulated and a distinction is made between places of treatment and detention; the latter had to be of medical use.

The Lunacy Act had two objectives: the primary goal was to lock up the insane and the secondary goal was to apply the new hygienic notions. There were provisions against the insane to protect society and in favor of the insane to protect his individual rights. Also there were regulations to improve the quality of care. Inspectors were appointed (doctors Feith and Schroeder van der Kolk) to monitor the situation. The roles of judge and physician were once again confirmed: the physician makes a medical statement about the lunacy, the judge -as guardian of civil law- made the decision about hospitalization but also about prolongation of coercion.

Doctor Donkersloot asked the question at the realization of the second Lunacy Act if interference by a judge was really necessary. The judicial primacy remained when in 1884 the second Lunacy Act became applicable.

Houses of correction were shut down, but also the mental institutions that did not meet the legal requirements. De Meerenberg was the first institution where coercive measures were abolished.

A second tension occurred concerning the discussion about responsibilities and power of authorization. Who defines policy in the asylum, the physician or the board?

In 1869 Doctor Ramaer put forward that the physician must be the director of all aspects of mental home existence, because only then proper mental care can take place.

In 1887 a large dispute took place at the asylum in Vught as first physician Tellegen clashed with the board over competences. Tellegen wanted to relieve the Brother Superior of his duties. When that did not happen Tellegen and two colleagues resigned (1,2).

Ultimately about 1930 the physician formally became the director responsible for the policy of the asylum, and for its personnel, the medical director (1, p 319). After the second world war it became more common to have an economic director (1, p 545) alongside the medical director. In recent decades (3) all sorts of constructions were brought about in which the Governing Council could be responsible for offering of responsible care, also without a physician (conform law of Quality of Care).

With the advent of the Psychiatric Hospitals (Compulsory Admissions) Act (1994) a definition was given of a senior Medical Director (art 1 lid 3): "also include a physycian who, although he does not occupy the position of director, is charged with the general medical operation of a psychiatric hospital." This was a function, as a public body, to monitor qualitative aspects of the coercion according with the 'Bopz-Law'. Herewith it was taken into account the tension between governing executive interests and quality of coercive application and monitoring thereof.

From the historical perspective one can formulate a number of tensions between law, care and safety, like the tension between:

1. the legislative branch and the executive branch (politics create laws, physicians implement them; discussion during the coming about of two Lunacy Laws and Bopz-law)
2. the judiciary branch (testing jurisdiction) and the executive branch (where lies primacy for ordering coercion, with the judge or with the physician?)
3. the executive branches, board and physicians: who is responsible for policy?
4. the judiciary branch (testing jurisdiction) and the executive branch (the institute-board and internal and external testing of coercion, by the senior medical director respectively Inspection)

Cases

1. a 44 year old man suffering from Asperger is voluntarily committed to an institution of psychiatry because of depression during alcohol abuse on account of the separation from his wife. After he has on several occasions

vigorously interfered with other patients and ward-policy, has been warned a few times to cease, he is dismissed from the clinic. He appeals to the senior medical director against the dismissal. He agrees with patients appeal and tension arises between the nurses and physicians and the board of the institute on one side, and the senior medical director on the other.

2. A 39 year old man with schizophrenia is after being admitted against his will dismissed under certain conditions. He does not abide by these conditions (among others taking medication and allowing monitoring), but lets it be known to the attending psychiatrist that he wants to harm his family, with whom he is furious. He is known to use violence against the nurses staff during admissions, for that reason the psychiatrist in charge of the admissions department would rather not admit him (or immediately into seclusion upon admission); the psychiatrist in charge of ambulatory care on the contrary wants a readmission, fearful of a 'family drama'. The senior medical director decides to not admit him against his will, but to arrange consultation between the parties to reach agreement about direction and actions. He finds it too early to report to the public prosecutor (disproportionate).
3. A 29 year old woman with borderline personality disorder is readmitted with a Provisional Detention after she stepped off a railway platform onto the tracks while drunk, witnessed by numerous travelers. The question to the police was if this constituted a criminal offence. They however referred to the psychiatry; the next morning the psychiatrist of the ward wants to discontinue the Provisional Detention and offer ambulatory continuous care. The mother calls to pass on that her daughter called her, is threatening suicide and beseeches the psychiatrist not to discontinue the Provisional Detention. The attending psychiatrist asks the senior medical director for his opinion. After he has made an inventory of all legal provisions and care factors, it is decided to discontinue the Provisional Detention. Furthermore management is advised to review such decisions with the police (admission to in-patient psychiatry, quick discharge).

Connection law, care and safety

These three cases show that the law has a controlling and structural influence on care giving. The law offers support when weighing principles and therefore also defines a rational boundary to the care giving process. Moreover ethical principles are implicitly absorbed in the decision making process. From the law administrative principles are implemented, like 'no arbitrariness, correct treatment, hear both sides, right of petition and clear written motivation (for instance case 1).

General principles of justice are applied as well, in fact those of proportionality, subsidiarity and efficiency (for example case 2).

From care giving various quality principles have been considered, namely prevention of coercion, to assess risk-and protective factors, arranging of basic (after)care and adjusting of the direction and responsibility in the care chain (for example case 3).

Out of safety it was decided in case 2 to not (yet) resort to reporting of danger to the Public Prosecutor. This did not (yet) constitute a conflict of duties between professional confidentiality and reporting a possibility of a 'family drama'. In case 3 the police could have decided this was a 'culpa in causa' situation, after all when one drinks excessively you know you can exhibit dangerous behavior for which one can be held accountable. Case 3 would have then spent a night in jail and this situation could have been reviewed by the public prosecutor.

At this time social tension exists during which pressure is exerted on the medical confidentiality to report any chance of (social) harm to judicial authorities to minimize safety risks as much as possible. In doing so the psychiatry is pressured to admit those people who pose such a safety risk, while admission against one's will is only allowed if there exists a causal connection between the disorder and the risk. A better transition between civil law and criminal law would be desirable to stave off risk; if it stems from the disorder refer to the psychiatry (Bopz law), if it does not, to criminal justice. A flexible transition to and fro could remedy the situation.

Roles

The tensions between law and care dominate when it comes to coercion in care giving (15%). These tensions can be traced back to three interests or powers. These three each play a role in the care process and coercion and balance each other. It involves the well-known triad:

1. legislative power (legislature branch)
2. executive power
3. judiciary power (testing jurisdiction)

The legislative power constitutes politics, which decides when, which, how much and by whom coercion in care giving can be applied. For that purpose laws are made that fit the paradigm of the times and that generally codify existing practices. Proposed legislation exists to replace the Bopz law (law on commitment psychiatry, forensic care law, care and coercion law). Even though several parties are involved with these proposals becoming a reality, determining the law remains a political act.

The executive power is, among others, the Mental Health Care Institution. These institutions are tied to quality legislation (Quality Act, law BIG) and to

professional standards. The treatment of a disorder is done according to directives borne out by evidence based findings.

The executive branch has the responsibility for the quality of care as well as for business policy, or the finances, personnel, safety and such. Therein policy choices are made, where care and possibilities are balanced.

The judiciary power/testing jurisdiction deals with the constitutional rights of the public and monitors if the law is applied correctly. Consequently the judge decides on the external legal position (Admission against one's will, discharge), monitors the Inspection for Health the internal legal position (compulsory treatment, necessity) and monitors the senior medical director the internal and external legal position (formal aspects of application of coercion, sustained coercion, request for discharge with an authorization of the judge) and in a number of institutes the individual quality of care as well.

Because these three powers/ branches have been placed with several players, the necessary tension between law and care is built and maintained by a separation of roles. In the GGZ these are the executive and the controlling roles. By analogy with the trias politica – separation and balance of powers – one could speak of a 'Trias Psychiatrica'.

Finally

The tension between law and care cannot be resolved, indeed they are valid and perhaps even necessary. The tension can be structured through legislation that fits the period and by properly allocate roles and formally position those within an organization. Therefore it is right to build an executive branche as well as a judiciary/controlling power within the GGZ-organization and maintain the Trias Psychiatrica.

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Pathways in Forensic Care: The Dutch Legislation of Diversion

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Summary

The Dutch criminal justice system (CJS) and the mental health system (MHS) have been standing alongside of each other for many years because in the Dutch criminal law legal provisions for psychiatric care are arranged in the MHS. Nowadays the prison services are aware of the possibilities of forensic treatment to prevent recidivism. As the mental health services could not fulfil their role as a psychiatric institution for all the mentally disordered offenders, more emphasis has been laid by the criminal justice system on the diversion of these offenders over differentiated units within the CJS itself. New developments are the purchasing by the CJS of forensic psychiatric care in the MHS, but paid by the system itself and under its own safety conditions.

Keywords: mentally disordered offenders, diversion, forensic care, equivalence of care, penal measures, TBS.

Introduction

Since no country escapes the reality of mentally disordered citizens committing offences, questions concerning 'decriminalizing the mentally ill' and special prevention have to be faced. In different countries the criminal justice systems have found different solutions depending on their criminal law codes and their view on the relationship between mental disorder and the responsibility for a crime. There is general agreement that patients diagnosed with some form of psychosis, e.g. schizophrenia, and who manifest symptoms of loss of their sense of reality while delusions and hallucinations constitute their motives for committing a crime, are not to be held responsible for their actions and should be transferred to secure facilities of the mental health services immediately. Offenders with a mental disorder who remain in the prison system pose new challenges in implementing contemporary principles of provision of care in the least restrictive environment and access to adequate treatment facilities. Hence, a balance has to be found between security of staff and psychiatric patients' rights. And also the character of their sentence should be visible all the time ('a prison is

not a hospital') for the satisfaction of the community as a reaction to the offence itself.

The discussion about this balance between 'mad' and 'bad' has led to the establishment of mental health courts in North America, while other countries, like the Netherlands, rely on modifications of their criminal justice system and the mental health services connected with it. In this article we will discuss the ideas behind the recent emergence of a type of 'diversion' in the Netherlands in the form of forensic referral options graded to needs and risks. While there are no Mental Health Courts in the Netherlands, the forensic referral system reflects similar objectives and philosophies. The Dutch system provides equivalent outcomes to U.S. or other specialist mental health court models, through options for track switching within trials, various 'transfer' options for inmates/patients, and a combination of prosecutorial powers.

In this article we will discuss the forensic referral option within the Dutch system. We will first introduce the 'purest' form of diversion: the '*Rechterlijke Machtiging*' (court order) from Private Law in case of dangerousness for self and others, meaning there is no charge and an offender gets treatment within the general mental health system, or under special circumstances in a maximum security hospital under the criminal justice system. The prosecution has a discretionary competence with regard to the choice which offences or offenders not to prosecute. We will also introduce the possibility of having mentally disordered offenders committed to a psychiatric hospital by Criminal Law. These offenders are charged and convicted, but not judged responsible for the committed crimes. Then we will discuss forensic care in prison and options for track switching and transfers. We will discuss forensic care and important principles. We will then discuss the possibilities of securing treatment by prosecutorial powers, i.e. the TBS-treatment and other treatment possibilities after conviction.

Diversion in the Dutch System

Using a provisional 'judicial authorisation' a person can be forced to be admitted in a psychiatric hospital, if he is a 'risk' for himself or for others. This is called civil commitment, the *Rechterlijke Machtiging (RM),* i.e., a court order. A 'judicial authorisation' may be requested by direct family members, the patient or the public prosecutor. The judge imposes a 'judicial authorisation' if the person concerned poses a risk caused by a disorder of the mental capacities and this risk cannot be averted by intervention by persons or institutions outside the psychiatric hospital. A causal relationship between the mental disorder and the perceived risk is necessary for implementation of this private law court order.

The criminal prosecution expires when placement in a psychiatric hospital has been realized. With petty crimes and misdemeanours by mentally ill patients most is expected of this treatment, and also in the realm of prevention of repeated offences as the aftercare to out-patient treatment is more easily established. Therefore, the 'judicial authorisation' offers the public prosecutor the possibility of applying diversion in the Dutch law. It resembles the idea of decriminalization in Mental Health Courts as diversion can occur prior to the accused's initial court Appearance.[1]

Another way of enabling that a mentally disordered offender is almost directly admitted in a psychiatric hospital is posed by Article 37 Dutch Criminal Code. This Article can be considered as a measure resembling the aim(s) of Mental Health Courts. The offence is not attributed to the convicted person, meaning that the criminal responsibility is absent. There is a conviction, but the convicted person is released from punishment, i.e. a prison sentence. This construction is possible because of the responsibility-doctrine. Article 39 of the Dutch Criminal Code (DCC) outlines the principle as follows: *A person who commits an offence for which he cannot be held responsible due to impaired development of mind or mental disorder is not criminally liable*. Note that the Dutch claim of irresponsibility is not an acquittal but an excuse, which means that there actually and legally is an offence, but there is no attribution of guilt. Since in the Netherlands *actus reus* and *mens rea* are to be established at the same trial, assessment of responsibility may be ordered before the trial. While the Dutch criterion for lifting intent is narrow, the criterion for the absence of responsibility has been broadened in the doctrine into a graded concept. The Dutch criterion may be called 'percentage responsibility',[2] which means that it is based on the proportion of the crime that can be explained by the disorder (based on the degree of freedom of the willingness to act), regardless of the individual's other (cognitive) capacities. As a result, five degrees of criminal accountability (which can be translated into terms of responsibility) are acknowledged in literature and practice (although they are not mentioned in the law). These are 1) accountable, 2) slightly diminished accountable), 3) diminished accountable, 4) marked diminished accountable, and 5) not accountable. Also personality disorders can be the basis for finding diminished or non-responsibility if they match the criteria of a mental disorder or mental impairment. It should be mentioned here that Dutch criminal law does not exclude any psychiatric disorder or patient within the formulation of these criteria for a diminished or absent responsibility.[3] There is an ongoing discussion about the empirical underpinnings of these degrees of responsibility; the Guidelines for forensic psychiatric examination point recently at three: accountable, diminished accountable and not accountable.

Article 37 Dutch Criminal Code implies that the convicted person is not accountable according to art. 39 DCC and can therefore not be held responsible.

The convicted person is placed in a psychiatric hospital for a period not longer than one year. After a year, a new court decision has to be made if continuation is required under private law. Conditions for imposing this sentence are also that the convicted person is a risk to himself, to others or to safety in general of persons and/or goods. If one year of treatment is not sufficient, then the treatment can be continued with a civil 'judicial authorisation' as mentioned above. The difference with working with only the 'judicial authorisation' is that this one-year-treatment is a sanction – more specifically: a measure – imposed by the criminal court itself, meaning that the accused has been prosecuted and convicted, but has had no prison sentence since he was forced to treatment in a closed ward in a general psychiatric hospital.

Forensic Care

In Europe and the United States the humanitarian view exists that health services within the prison system should be on the same level as in society, particularly because the conditions in prisons do not comply with treatment conditions.[4-5] Next to the necessary treatment of mental disorders in the prison services, mental harm reduction and mental health promotion are strongly recommended in prisons by the World Health Organisation consensus statement of 1999. This means that there is agreement that further treatment can take place outside the prison. There are juridical and diagnostic criteria to outplace a prisoner from a hospital. Some of the prison population, such as psychotic patients or addicts, need transfer to specialised institutions because adequate treatment with medication and activation cannot be given in a prison setting. Others, like people with depressive and anxiety disorders, need assistance by health care services visiting the prisons. Another group with problems related to the detention situation, will benefit most from mental health promotion within the prison system. The last group also includes the prisoners who have adjustment disorders with the prison system. One might say, they are reacting normal on an abnormal situation.[5] These kinds of treatments are possible in the Netherlands in several ways. Some prisoners get treatment while they are in prison or while they are transferred to a hospital because of their medical conditions and other criteria. To other prisoners sentences have been imposed that force them to go to some clinic as a result of a judge's decision made during the criminal procedure and by verdict in court. All together, with every step in the process of prosecution, passing judgement, imprisonment and conditional leave there are possibilities in the Dutch criminal law system to divert a psychiatric patient to the Mental Health Service or to security hospital provisions owned by the Ministry of Justice. Vegter[6] mentions the possibilities there are for treatment. In his view a conditional sentence offers time and possibilities to arrange treatment for prisoners. But this is not the only

way to arrange treatment for prisoners. As Vegter describes, forensic care in prison to treat inmates is also very important and in this way more convicts should be treated in prison. It is possible to get psychiatrists and psychologists to work in prison and this should happen more often and more embedded in the process.

Nowadays a utilitarian view exists on the prison sentence of offenders. In this view the detention situation can be used as a starting point for changing behaviour, i.e. the prevention of criminal activities. In this way, every detainee can be subjected to forensic care. This is different from regular basic health care in prison, which can also be called 'forensic' because of the setting in which it takes place. Thus, prisoners do not only get forensic care. When they are ill, both physically and mentally, they get treatment from doctors, psychiatrists and psychologists within the prison.

Forensic care encompasses medical care, as it concerns also social and criminogenic factors, and not only mental and personality aspects of the offender. This is forensic care in prison in which regular medical care is only taken into account if there is a certain patient's need for it. In the Netherlands the method for applying forensic care is to use a (defined) combination of (1.) a particular indication for care, depending on a psychiatric diagnosis, in combination with (2.) a particular circumscribed state of the art or – better – evidence-based treatment, written down in a protocol and certified by the professional domain, and (3.) the degree of security which is needed to realise the treatment. If needed because of severe behavioural problems, the degree of security for the staff has to be adjusted to the treatment setting, e.g. by diverting a patient to a more controlled or secured environment, or – in absence of risks of renewed violence – to stick to a conditional ambulatory treatment. The determination of a treatment protocol also enables attributing a certain amount of money to this forensic treatment. This has become common practice for all prisons and there is agreement about the time needed and the professional skills involved. Then the combination of a particular diagnosis with a certain professional action is a financial unit (Diagnosis – Security – Treatment – Combination; in Dutch: DBBC). Every detainee can be assessed on his risk factors by risk-assessment procedures and when these risk factors can be controlled for or cured by certain psychosocial interventions, forensic care is started. This means that for detainees whose status does not give some opportunity for change on the psychological or social level, diversion to another institute cannot be realised as there are no indications for a decreased level of risk for society.

According to forensic ethics, forensic care has to fulfil four medical and ethical conditions. It has to be in accordance with:

1. the prisoners' needs and their vulnerability (evidence based care);

2. the state of the art in public mental health services (equality of care);
3. medical ethics and human rights jurisprudence (proportionality, coercion);
4. there has to be a possibility of continuation of care after detention.

These basic conditions have been supported by the Dutch Council for Penitentiary Practice and Youth Protection ('Raad voor Strafrechttoepassing en Jeugdbescherming') in their latest report (2008) with regard to forensic care. The forensic medical care has to have a qualified status described and agreed upon in protocols. This will be formalised by the upcoming Renovation of Forensic Care Act (now in the Parliament). This will require describing the quality of care to defend the rights of detainees. The following conditions for forensic care by quality management are important as a benchmark: equality or equivalence in care, continuation in care, and coercion within the care, including which possibilities exist within the Dutch system for forensic care.

Equivalence of care means that within the criminal justice system mental health provisions are on the same level as within society. Still we have to recognize that the setting of a prison system is not comparable with living in the free society, in which people can choose or can be referred to different levels of special medical care and diagnostics. Psychiatric health care in prison is the responsibility of the Ministry of Justice.[7] The Dutch Forensic Psychiatric Institute (*Nederlands Instituut voor Forensische Psychiatrie en Psychologie, NIFP)* has psychiatrists working in the prisons. These psychiatrists cooperate with the so-called Psycho-Medical Consultation team (*Psychomedisch overleg:* PMO) in the prison. This is a multidisciplinary advisory board with a psychologist as the chair and the prison doctor, the NIFP psychiatrist, the nurses and the social worker as members. Each of them is entitled to raise cases in this weekly consultation. The purpose of the consultation is to assign these cases to a certain level of care. The more psychiatric problems are involved, the more the psychiatrist can advise for forensic psychiatric care or treatment. The more somatic or psychosomatic complaints, the more the prison doctor (often a part-time GP from outside the prison) indicates and arranges basic health care, possibly with referral towards other somatic specialists. The responsibility for the quality of care remains at the general director of the prison, who is also responsible for the quality of the consultation.

Because of the complexity of the psychiatric and psychological problems of the patients it will often not be sufficient or according to the state of the art in psychiatric care, to confine prison care to medication alone. The latter can be done by promoting mental health care and mental health education for inmates, and if there is an indication that particular psychiatric care cannot be given, diversion may be required.[4] Therefore, within the prison system we know three degrees of mental health care leading to different institutions for diversion: basic

mental health care, forensic mental health care, and entrusted forensic psychiatric care (by the TBS Entrustment Act).

Basic mental health care is comparable with the usual mental health care in society. That means care by nurses, GP's, dentists and other medical care. The control of the quality of this care should rely on the laws and regulations on mental health care provided by the Ministry of Health and established in the prison rules. This kind of health care is provided in every prison setting as a standard. We already referred to this and decided not to call it forensic care, though most of this care takes place within the prisons. *Forensic mental health care* concerns mental health care as a formal treatment planning within the prison system as context of the interventions. This is called forensic because the factor of reducing the risk for recidivism is also taken into account. Most of the patients have psychiatric problems that make them suffer and influence their behaviour in a criminal way. Because of the prevailing negative effects of the detention, psychological and psychiatric consultation are also to be provided on this level. This means regular psychiatric care, social work with aimed at the inmate and his family, and, rehabilitation. Multimodal ways of treatment like psychotherapy, group psychotherapy, including multi systems therapy should have an equal possibility when indicated. The multidisciplinary way of diagnosing and indicating treatment is necessary to reach a certain quality of care for these patients who frequently have double or triple diagnoses.

Within some prisons there are special psychiatric divisions for the mentally disordered. For diversion within the same facility the general director of the prison can make the decisions. For a transferal between prisons the selecting agency of the Dutch Agency of the Correctional Services (DJI) has to be involved. These divisions still exist, but not on a large scale because of a new development. Recently in 2008 a penitentiary system reorganization[8] took place to improve the situation for mentally disturbed or otherwise vulnerable prisoners. The existing differentiation within the penitentiary system, consisting of relatively small wards in different prisons, is transformed into five large scale regional units (the so-called Penitentiary Psychiatric Centers, PPC's), offering special regimes aimed at the needs of the individual mentally disordered prisoner. In their staff participate psychiatrists, psychologists, general practitioners, nurses and specially trained guards. When required, the Ministry can hire professionals from the general mental healthcare to work in these centers. In general these PPC's will meet the same legal criteria for quality of care as are applied to facilities of general mental health care.

Hence, the other divisions will disappear. We mention them because they have not all disappeared yet. The first division is one for special care *(Bijzondere zorgafdeling, BZA)*, the other divisons are – in order of intensity of treatment

possibilities – the individual special care division (*Individuele Begeleidingsafdeling, IBA)* and the observation division *(Forensische observatie- en begeleidingsafdeling, FOBA)*. The FOBA still exists and is considered the same kind of center as the PPC's. The PMO has to decide whether the condition of an inmate or patient is severe enough to go to another division. The BZA and the IBA are divisions within (some) prisons, while the FOBA is a special division in Amsterdam.

While in prison, sometimes inmates need such urgent treatment that hospitalisation cannot wait for the trial to be held and placement in a PPC does not seem the solution. They are not 'suited' for the regular prison system. The Dutch system offers some possibilities to divert these inmates from the prison to a psychiatric hospital for psychiatric, or addiction treatment, or both. The NIFP is an important factor in this process, because they have to indicate whether it is really necessary to establish such an outplacement. The two possibilities to divert are Article 15 Paragraph 5 and Article 43 Paragraph 3 of the Penitentiary Principles Act, and, Article 41 of the Penitentiary Measures Act (PM):

Under the first Article, a suspect or convicted person can be transferred from the penitentiary detention center to a psychiatric hospital. This transfer can take place when the person has a mental disorder or mental disease. The selection officer of the Ministry of Security and Justice makes the decision about the transfer. The psychiatric hospital is in this case a non-judicial institution. Conditions for the transfer are: 1) the threat of an immediate psychiatric decompensation, 2) an absolute incapacity for the detention condition as a result of psychiatric disorders, 3) a psychiatric condition for which clinical treatment is appropriate, 4) a personality disorder that makes treatment in another institute than the TBS-institute much more suitable. Under Article 14 of the Dutch Hospital Orders (Framework) Act, the Minister of Justice can decide that a person with TBS has to be placed into a psychiatric hospital.

Under the second Article the director of the penitentiary institution can have the detainee transmitted to an addiction clinic for his treatment and necessary help. The director can decide whether the transmission is indicated or not, and under which conditions. Requirements for the transmission are: 1) the final date of the detention is decided, 2) the penalty does not remain more than twelve months, 3) clinical treatment in an addiction clinic is indicated, 4) the transfer is compatible with the steady implementation of the deprivation of liberty.

Article 41 PM allows the Minister of Justice to place mentally disordered detainees from the prisons to a TBS maximum security hospital when they meet the criteria: because of the severity of the mental disorder and the medical necessity for psychiatric treatment not suited for further detention in a prison environment, but too dangerous for a diversion towards the MHS via Article 15.5.

Continuity in care is one of the main targets of the general health services. Continuity is an ethical obligation to the forensic psychiatric patient who should not be confronted with a different therapy every time he has been diverted to another institute. Passing his medical file towards a new therapist is not sufficient to guarantee the continuation, supervision of this process is needed. It is also a professional principle for the different institutions involved with forensic mental health care to provide it. In this case the patient should always have some kind of institute to rely on so he does not get lost with his problems somewhere in society. With these institutes not only mental health care services are meant, but also in the end the services of the municipality: housing, social affairs, work. This continuity starts in an early phase, namely directly from the start of the detention. The continuity in care for inmates is founded upon the relational security, starting with a secure environment in the prison. Secure because of predictability, transparent regulations, an empathic and consequent attitude of the staff, acting upon the interactions between the inmates among each other and between the inmates and the staff. Motivating factors are also implied, like an atmosphere of tolerance, explanation of rules and interventions, offering choices of interventions, feedback on about current interactions, and education about it. Continuity of care means in this respect that the patient knows that his treatment will continue as long as necessary and that he will not be left alone when he has left the prison services. In short, diversion is already prepared for within the prison system.

Continuity in care also includes diversion by rehabilitation, which means introducing the individual with his mental handicaps into society again in a way that on the individual level the handicaps are diminished and risks are controlled. On the social level this means creating an environment in which the deficits in the patient's behaviour have been taken care of. With regard to this social rehabilitation the Probation Services in the Netherlands take the lead, as they undertake the initial risk-assessment before the patient leaves the prison or TBS facility, and in cooperation with the facility they organize a proper treatment plan.

Coercion within care can only be connected with forensic psychiatric treatment (when there is a risk for the patient or others, and when prevention is necessary because of deterioration of the disorder). In the Netherlands, even in the forensic psychiatric institutions, treatment cannot not be forced upon the forensic psychiatric patient, not even if he has entered the facility with a court order. Implementation of compulsory care is only allowed if the patient is in a psychiatric ward and a legal decision has been made by the civil court on the basis of a medical declaration about the quality and quantity of the risk. Placement in a psychiatric facility as such does not automatically allow coercive treatment. A new court decision is necessary for this. A (new) danger has to rise

for which, under a new paragraph of the law, a new psychiatric examination and a new treatment order are necessary. In the prisons coercive treatment is legally not allowed. Diversion is mandatory towards the prison hospital and observation centre (FOBA) in Amsterdam or its satellites (FSU, *forensische schakel units,* the forensic diversion units in the Prison Services), in 2009 united as Penitentiary Psychiatric Centres. Also referral to a general psychiatric hospital is possible, but only after a decision by a civil court that coercive treatment is necessary because of an imminent risk for damage. Coercion should not last longer than necessary (proportionality principle) and should consist of the least restrictive measure to ensure safety to others (subsidiarity principle). Regular examination and monitoring is necessary as this is a large responsibility: the side effects can lead to such an resisting and defiant behaviour that it becomes reason for applying the coercion; and that is not a sufficient treatment. According to both the civil law and a Criminal Court's sentence incarceration is possible.

Above we mainly discussed forensic care in prison and transfers to other institutions or hospitals. In the Netherlands, however, we also have possibilities for treatment after convictions as some sort of or instead of a punishment. These treatments are imposed by the judge in the verdict.

Securing Treatment in the Sentence itself

In the Netherlands it is possible to 'order treatment'. This means that the judge can decide that treatment is 'mandatory'. Since there are different options after a prison sentence to ensure treatment or transfer, the Dutch rarely use the "unfitness doctrine" (Article 16 Dutch Criminal Code) for diversion, though it is well known that the contrary is the case in other countries including Mental Health Courts.

In the Netherlands we make a distinction between sentences, like imprisonment, community sentences and fines, and so-called *measures* like mandatory treatment programmes in hospitals or outpatient clinics. This has to do with the Dutch responsibility-doctrine, which was also mentioned in Section 2. Once a convict is considered less or not accountable, there are possibilities for the judge to impose treatment. Measures are not so much retaliatory measures, but rather focused on social prevention.[9] A number of these measures see to the possibility to get treatment for mentally disordered offenders among them several possibilities of putting treatment central within the criminal law. The 'legal authorisation' is the only 'real' possibility to get a suspect or convicted person out of the criminal system into the civil system. The other possibilities all take place within the prison system – the patient being suspect or (already) convict -, implying

treatment by prison doctors or psychiatrists, or diversion to a hospital, or even as a sentence.

Entrusted forensic psychiatric care means treatment imposed by a judge: placement in a General Psychiatric Hospital (art. 37 Dutch Criminal Code), as mentioned above, is a possibility when a convict is considered not accountable for the crime(s) and therefore not responsible. Other measures are, the conditional ambulatory TBS (art. 38 Dutch Criminal Code) or the unconditional TBS in a maximum security hospital (art. 37a Dutch Criminal Code) and the measure ISD (placement in a prison treatment facility for recidivists: *Inrichting Stelselmatige Daders*, art. 38m Dutch Criminal Code). We will now explain these possibilities.

In addition to imprisonment, a convicted person who at the time of committing a severe crime was suffering a disorder can also be convicted to terbeschikkingstelling or *TBS*. After serving the prison sentence the convicted person is detained in a TBS-hospital for treatment. The aim of the measure is to guarantee the safety of society against this person both by preventing the person from committing more (new) crimes and at the same time by offering him a treatment. The TBS can be imposed with or without a warrant for secure clinical (intern) treatment. The TBS can be extended if necessary when the risk of recidivism still exists. After serious crimes committed by TBS-patients on leave the general public and also the politicians insisted on more security measures regarding the on leave-procedures of TBS-patients. Traditionally a step-by-step procedure in allowing patients to re-enter society formed an essential part of the treatment. The Ministry of Justice, responsible for the execution of the TBS-measure, decided to implement a stricter policy in giving permission for leaves of TBS-patients in order to prevent recidivism. Among other factors, this slowing down of the procedure for leave was one of the causes that the intramural treatment duration considerably increased. As a result the already existing capacity problems in the TBS-system have increased, notwithstanding the efforts of the Ministry to extend the capacity by building new clinics and to adapt prison units for the treatment of TBS-patients.

Another problem, the indefinite long stay in TBS, also became manifest. A growing number of patients were considered permanently dangerous. For them special wards were built, the so-called long stay units. Patients, admitted to these units, had to meet certain criteria like not having benefited from a treatment of at least six years and still being a continuous risk for re-offending. They were for the larger part facing a lifelong stay in these closed units without continued treatment. The length of the intramural treatment within the forensic psychiatric maximum security hospitals, has increased from 50 months in 1990, to 66 months in 2000, and to 114 months nowadays. Over the last 20 years the number of patients to be released from these clinics stayed far behind compared

to the number of new TBS-patients that are waiting within the prison system to be admitted.[10-11] There are several causes of these problems. Also, among those who were stabilized after treatment, more and more patients (to 50%) needed prolonged care within the general mental health care system because they are assessed not be able to live in their own household in the community. The Mental Health System appeared to be reluctant to admit these patients, even after the Ministry of Health had established medium secure units within the general mental health care system. Besides, there was a gap between the legal status of TBS-patients and their legal status as involuntary admitted patients in the general mental health care that made the transfer of a patient from one system to another problematic.[12]

To systematic re-offenders of relatively minor crimes, the measure Placement Systematic Perpetrators (*inrichting stelselmatige daders; ISD)* can be imposed. The systematic re-offender who meets the criteria (among other things, three irrevocable verdicts must have taken place in the last five years), is detained for two years. As part of this sentence, treatment and rehabilitation should take place. Most of the perpetrators in this group are drug addicts and people with (other) psychiatric problems.[13]

Sometimes the sentences are conditional and then the condition is used so that the convict will cooperate with the treatment. This is the case with the conditional ambulatory TBS, one form of TBS and less 'strict' than the unconditional TBS, but there are also other conditional sentences. Often the probation services and the NIFP are responsible for finding the treatment place. Within the recently (2008) started project 'Renovation of Forensic Care' [8] the National Agency has to deliver products of professional care by purchasing treatment programs (some of them clinical, including 'beds') in the mental health care system. This means that the Ministry has places at its disposal within the field that can be filled with forensic patients. Until now, about 70 providers have signed a contract with the Ministry of Justice, among them a lot of institutions for ambulatory care in the community for those forensic patients who need a continued support for living and working. These places are very important nowadays, because there is an immediate need for forensic out-patient clinics for those who are refused by regular out-patient mental health services after their sentence, but stay in need of social support. Beds can be used both for prisoners who need special treatment and for convicts who are obliged to have treatment because of their conditional sentence. After the conviction a convict can also be forced to follow some kind of clinical treatment, e.g. in a provision for addicts. Before this treatment is sentenced, the prosecutor needs to have one or more reports from the Dutch Forensic Psychiatric Institute NIFP – the number depending on the diagnosis, kind of treatment and the forensic setting that is necessary.[14]

Most of the time the convict has to wait in prison until the treatment can get started, although there is always forensic care in prison. Executing the sentence is the responsibility of the Public Prosecution Services, i.e., the Ministry of Justice. Sometimes there is also involvement of the Dutch Probation Services. The NIFP is responsible for finding the 'right bed', meaning that they have to find the right place, which fits the kind of treatment necessary, between the places that the Ministry has at its disposal. If the sentence contains only ambulatory treatment, the Dutch Probation Services are in charge of finding the right places. Most of these ambulatory places are not always reserved or paid for in advance by the Ministry, so they must be found ad hoc within the regular field of mental health care. The purchasing practice of the Ministry of Justice has been a big success until now, strangely though as the MHS until 2008 has strongly refused the in- and out-patient treatment of forensic psychiatric patients. Since January 1st 2008 mental health care completely purchased by the National Agency of the Correctional Services of the Dutch Ministry of Justice, and its financial budget for this forensic care comes directly from the State.

Conclusion

Although basic psychiatric treatment is possible within the prison facilities with a low threshold for admission, the patient can be diverted in the prison services to specialized psychiatric wards (e.g. FOBA) or to the newly opened penitentiary psychiatric centers (PPC's). Furthermore, in the case the accused's mental disorder plays to some extent a conditional role in his repeated offending, the court can use the possibilities of TBS for an intensive treatment trajectory to diminish the bad influence of the mental disorder on the re-offending.

The current forensic care in the Dutch prisons is partially a reaction on the 'revolving door patients' society encountered in the '80's of the last century. Because of their repeated offending in combination with a mental illness, the PMO's have started with case-finding in the jails and the possibilities for diversion toward treatment units have become more outlined and practised. At this point the Criminal Justice System meets the boundaries of the Dutch Mental Health System and its repeated refusal of accepting forensic psychiatric patients. By purchasing their services the Ministry of Justice has secured nowadays the monopoly on forensic psychiatric services in the community to provide continuity of care, founded on the proposed criminal 'Act on the Renovation of Forensic Care'.

As points of criticism we have to put forward that these legal and practical possibilities of the Dutch system of diversion are hampered by the large numbers of detainees with a mental disorder, as the different routes described are not immediately available to the needs of the Criminal Justice System and the

community is not always (and only to a certain limit) inclined to take up former mentally disordered detainees in sheltered living facilities. Another point is the shortage of forensic psychiatric and psychological expertise in these trajectories due to the unpopularity of the forensic services and its patients. From that point of view, with an easy diversion through both systems of Criminal Justice System and Mental Health System, one can question whether a detained patient has been diverted too fast and has become in that way stigmatized as a psychiatric patient instead of an autonomous person who is serving his sentence. Furthermore, the role of coercion has to be examined in the future as this infringement on the patient's rights can play both a positive and a negative way towards motivation for treatment; positive in the way that patients take their medications or to refrain from addictive drug taking, negative because of the devastating effects on treatment compliance when coercion becomes obligation. A special emphasis on this subject is necessary as within the realm of forensic care detainees are involved with various degrees of mental disorders and behavioural problems, which are as such in need of a sliding scale of interventions, and staff and patients are always working in the omnipotent presence of the penitentiary provisions and the CJS. Finally, it will be the government and the public who will have the last words in this psycho-medical discussion, and they aim their scope to one aspect of diversion: public safety.

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Residential Forensic Treatment Services for Mentally Disordered Offenders Submitted to the Internment Measure in Belgium[1]

Joris Casselman[2]

1 Introduction

In Belgium, as in many other countries, some offenders are judged irresponsible for the offence they committed, by a court, because of a mental disorder. Instead of being punished they are officially 'committed' to treatment. In Belgium they are submitted to an interment measure ('internering' in Dutch, 'internement' in French), in accordance with the Law concerning Internment, the so called Social Defence Law. Those mentally disordered offenders are called internees ('geïnterneerden' in Dutch, 'internés' in French).

There is an special priority reason why, in our contribution, we are limiting our attention to the residential forensic treatment services for internees. It is not because we consider that other treatment services than residential ones are unimportant or because we are not concerned about the growing number of mentally disordered offenders condemned to prison. To the contrary. But the reason is that in Belgium for many decades many internees are staying in prison, although they have been send to specialised treatment services by a court decision. The situation has been worse in the past but even today one third of all internees stays in prison, with almost no specialized treatment offer available. Our country has even been condemned several times by international organisations for not taking all internees out of prisons. After a very long period of stand still, the situation has improved in the course of the last decade, but there is still a long way to go. In what follows we successively describe the situation before and the situation after the year 2000.

2 Situation before the year 2000

In Belgium until 1930, mentally disordered offenders were admitted to closed psychiatric institutions and put together with all other severe mentally disordered considered to be dangerous. At the end of the 19th century some arguments were put forward to set up a special institution for all mentally disordered offenders.

1 We dedicate this contribution to prof. em. Tony Peters, an outstanding criminologist and friend, who died on the 20th of March 2012.

2 Prof. em. University of Leuven (Belgium).

However, a concrete proposal introduced by the Minister of Justice Jules Lejeune in 1890, was never adopted (1-2). Some decades later, after a long debate, a Social Defence Law was introduced in 1930 (3-4). Moreover, at that time, in some prisons, a 'psychiatric annexe' was available for psychiatric expert examinations of accused persons and for the 'treatment' of mentally disordered inmates (not only internees but also condemned offenders).

The 1930 law induced vivid discussions between psychiatrists and lawyers. In 1935 already, a special 'Commission Cornil-Braffort' was created trying to ameliorate the law of 1930 (5-7)[3]. However the proposals put forward by the 'Commission Cornil-Braffort' in 1939 were not honoured with any reform. Only after 34 years the 1930 law was modified in 1964. Its introduction provoked a renewed discussion between psychiatrists and legal professionals. After another 43 years a new law was introduced in 2007, but even in 2012 it is not yet clear when it will become operative. The new 2007 law will be discussed below.

We look more in detail now to the situation before the year 2000. Firstly, we give a brief outline of the legal procedure introduced by the Social Defence Law of 1964. Secondly, the problematic issue of the residential treatment of internees is elaborated. Thirdly, the propositions formulated in the final report of an ad hoc Internment Commission, issued in 1999, are summarised.

2.1 THE SOCIAL DEFENCE LAW OF 1964 (3-4) (8-9)

2.1.1 *Three conditions*

First of all, only proven offences with a qualification of a criminal or a correctional penalty are taken into consideration, in the Social Defence Law or Internment Law of 1964. However, in practice, some exceptions occur.

A second condition is the presence of a mental disorder that provokes loss of control. Three categories of mental disorders are mentioned in the law, namely: 'insanity', 'severe mental disorder' and 'severe mental retardation'. In addition, because of the mental disorder, the person should be unable to control his acts. Only full irresponsibility is foreseen, at least to the letter of the law. The mental state at the time of the offence and at the time of the appearance in court are both considered.

Thirdly, the presence of social dangerousness became an additional condition, resulting from jurisdiction.

3 Léon Cornil and Louis Braffort were both important Belgian criminal law specialists. Louis Braffort is the founding father of a training programme in criminology at the Catholic University of Leuven in 1929, being the first university based one in Belgium.

2.1.2 *Expert examination*

A psychiatric expert examination is not strictly obligatory, but very common. A residential observation in a psychiatric unit in prison under special conditions is legally possible, but it is almost never applied, due to the lack of specialized prison personnel and also due to the complexity of the matter.

2.1.3 *Decision*

The final decision is taken by a court, although very exceptionally the Minister of Justice can apply the measure of internment to a person presenting a severe mental disorder in condemned offenders during their detention period.

2.2 RESIDENTIAL TREATMENT

The further course of the execution of the measure of internment depends on decisions taken by a regional Commission of Social Defence. However, the crucial problem has been, since decades, the lack of (residential) forensic treatment services for internees. As a consequence in the period before 2000, in more than one third of the cases the internment measure was executed in a prison. The others were treated in general psychiatric hospitals or a broad range of ambulatory mental health and welfare services (9-10).

Most general psychiatric hospitals were (and are still) reluctant to admit internees because of the difficulties with involuntary treatment of offenders. However a limited number of general psychiatric hospitals were admitting internees, but only when they presented a low degree of security problems and when they could be integrated in voluntary treatment units (e.g. a unit for psychotic problems, a unit for sexual problems, a dependence unit).

The most important missing link was residential forensic psychiatric units for internees of the medium security and high security groups. It is all together incredible that some people are first committed to treatment instead of punishment by a court order and then kept in prison with almost no treatment services available.

2.3 INTERNMENT COMMISSION REPORT

In 1996 the Minister of Justice appointed an ad hoc Internment Commission, also called the Commission Delva. The final report was made public in April 1999 (11).

In the report many proposals were formulated regarding (a) the criteria of the measure of interment; (b) several types of expert examination before taking the decision and (c) the treatment of internees.

However, before concentrating mainly on the proposals concerning residential treatment, it is interesting to mention that the Internment Commission proposed to create a bilingual federal residential institute for the observation and evaluation of the most complex expert examination cases. This institute was conceived for the admission of suspects submitted to an interdisciplinary expert examination in order to give an answer to the question if the suspect can be considered responsible for his acts (like in the Netherlands, in the Peter Baan Centre in Utrecht). Another indication was the admission of prison inmates presenting complex disturbing behavioral problems in order to advice the prison administration after a period of interdisciplinary examination. The latter indication was the core business of a unit situated in a prison in Brussels and called POC (Penitentiary Observation Centre), that was discontinued in 1991. Another indication for the center was the admission in order to formulate expert advices concerning the orientation of internees to the most appropriate type of treatment. Finally, it was foreseen that the planned center should become the a platform for the development and co-ordination of forensic training and research initiatives. Unfortunately nothing of all this has ever since been realized.

Coming back now to the residential forensic treatment services, the Internment Commission was emphasizing that there was an urgent need for a network of specialized facilities providing treatment for internees on all security levels. This means facilities for the high security, medium security and low security groups of internees.

Firstly, although some members of the Commission defended the principle that not one internee should stay in prison, the Commission advised to keep a limited treatment capacity in a prison setting for some high security internees who cannot be treated in existing general psychiatric services or in new treatment services to be organised within the mental health system outside the prison setting.

Secondly, in order to limit to a minimum the number of internees in a treatment setting in a prison, the Commission advised to set up a number of closed and partly half-open forensic psychiatric units in general psychiatric hospitals for internees of the medium security group. For this new type of forensic psychiatric units the Commission was convinced that a co-operation was necessary between the (several regional and federal) Ministries of Health and Welfare at the one hand and the federal Ministry of Justice on the other hand. The main responsibility should stay in the hands of Health and Welfare Departments, and Justice should provide extra funds for the security aspect of the accommodation of the treatment units.

Thirdly, the Commission stressed the necessity of further development of the existing but far too limited possibilities of admitting low security internees in open treatment units within general psychiatric hospitals.

In general the final report of the Internment commission was received in a very positive way by the professionals active in the daily care of internees. A feeling such as 'it's now or never' emerged. However, in official government

circles a lot of resistance was build up because of the financial consequences of the realisation of the proposals of the Commission. It was a sensational television documentary that provoked a meeting with members of the Ministry of Health and Social Welfare and the Ministry of Justice on a federal level. From that moment on a very slow but positive development started off.

3 Situation since 2000

Two important parallel developments were helpful in partly moving out of the deplorable situation (12-14). Firstly, without waiting till a new law became reality, a number of forensic psychiatric units for medium security internees was set up, initially as pilot units. Gradually they received a more stable financial support and they were later on more and more considered as a part of regional networks of residential and ambulatory forensic treatment services. Secondly, although a couple of initiatives in order to arrive at a new law failed, in 2007 a new law was adopted, but even now (early 2012) it is not yet put in operation.

3.1 NEW FORENSIC TREATMENT SERVICES

In 2001 representatives of the federal Ministries of Justice and of Health decided to start a limited number of pilot projects in existing psychiatric hospitals, with, in the beginning, a rather complicated repartition of financial support. In Flanders (the northern Dutch speaking part of the country) a decentralisation was put forward, while in Brussels and Wallonia it was preferred to centralize all residential efforts for internees. Three psychiatric hospitals in Flanders were willing to admit internees with a 'medium security' qualification in a separated infrastructure with specific interdisciplinary teams. Since three regional Commissions of Social Defence (in Gent, Antwerpen and Leuven) are responsible for providing the best available treatment for internees in Flanders, the three forensic units were situated in the same regions (respectively in Zelzate, Rekem and Bierbeek). In Wallonia one central forensic hospital existed already and received extra support, as it was also the case for a general psychiatric hospital in Brussels.

In 2004 the Council of Ministers established a Working Group in order to speed up the further development of forensic care circuits. The summary report was submitted in 2005 (15). The Working Group was confronted with the lack of recent figures concerning the number of internees and their location. Therefore a day prevalence dated on the 15th of September 2004 was carried out (16). It appeared that on the 15th of September 2004 the total number of internees was 3306, 1710 in Flanders and 1596 in the rest of the country (Brussels and Wallonia). In Flanders 30% (505 on a total of 1710) was still staying in prison, and in the rest of the country 21% (343 on a total of 1596). It was not possible to

estimate how many of the latter group of internees were belonging to the high security group or to the medium security group. In Flanders 114 internees were admitted to the three medium security forensic units in the three psychiatric hospitals mentioned before and 24 in the rest of the country. In Flanders 1059 were admitted to regular psychiatric services and 772 in the rest of the country. The internees admitted to regular psychiatric services can be considered as belonging to the low security group.

The report concluded that one of the most urgent necessity was the availability of two new closed forensic psychiatric centers in Flanders in order to accommodate the internees still staying in prison. The need was also stressed for the further development of regional forensic circuits including several types of treatment services.

In 2006 the government decided to build two forensic psychiatric centers, one in Antwerp for 120 internees and in Gent for 270 internees. For the moment these planned centers are not yet in operation. Moreover, a better financial support was installed for the medium security forensic psychiatric treatment services. Finally, a number of complementary treatment services for internees were provided, such as residential long stay facilities, sheltered home facilities, forensic outreach teams and additional specific ambulatory capacity.

3.2 A NEW LAW IN 2007 (12) (17-18)

The adoption of the new law of 21 April 2007 was good news. Nevertheless, the final result is a far reaching compromise, a matter of mixed blessing. And for the moment it is even still waiting till it will become effective. We limit ourselves here to some general remarks first and thereafter we mention some special issues concerning the (residential) treatment of internees in the future.

Without any doubt some important proposals formulated in the final report of the Commission Delva of 1999 have been taken into account. More contemporary concepts are introduced. An expert examination will become obligatory. Throughout the whole procedure the legal status of both internees and their victims are better guaranteed. However, globally speaking the new law is too much oriented towards penalization. Too little attention goes to the specific situation of internees who are not punished but submitted to a security measure orienting them towards treatment. Not only the decision of the internment measure but also the decision concerning the follow up of internees will be taken by a court. In this respect, no psychiatrist will be part of the deliberation, in contrast with his current membership of the regional Commission of Social Defense. Unfortunately some important issues, such as the certification and payment of experts, are referred to implementing orders.

Let us look now shortly to the specific issue of treatment of internees. It is very positive that this time internment is clearly defined as a security measure with a double target, on the one hand assuring social defence and on the other

hand providing appropriate care in a perspective of social reintegration. Less positive is that the treatment aspect is clearly overruled by a predominant security perspective. No attention is given to the type and the quality of the provided treatment. The rigid and time consuming procedure will cause problems, especially when sufficient flexibility is needed in urgency situations. All this will not only hinder a smooth reintegration process, but in addition many conditions are anti-therapeutic.

4 Conclusion (12) (19)

For decades many internees in Belgium are staying in prison although they are oriented to forensic treatment services by a court order. During the last decade the situation improved but a long way is still to go.

Awaiting the effective application of the new law adopted in 2007 the Social Defence Law of 1964 is still in operation. Implementation orders are needed and they should include some practical adaptations.

It will also take some time before the two new residential centers for high and medium security groups of internees will be finalized. The regional forensic networks with a diversity of treatment services are still very incomplete. In spite of the recent efforts the demand for specific forensic psychiatric care will be greater than the available offer of services.

In order to support further planning it is urgently needed to dispose of a monitoring system collecting data concerning the number of internees at and the type of service they are staying. Although an appropriate monitoring system is lacking, there are enough indications that the number of internees is growing. A continuous evaluation of the use of the available services is important.

In order to reach a high quality treatment offer an intensification of specific training and research initiatives for a broad diversity of professionals is needed.

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Dilemmas and Problems in the Supervisory Relationship and the Supervisor's Function A Point of View

A. Stufkens

Introduction

The supervision of students in a psychoanalytic or psychotherapeutic training program is a field that contains many interacting domains with tensions, dilemmas and specific problems. The supervisor has to make decisions and maintain her[1] balance among potentially conflicting aspects of her role. She has to become conscious of her reactions to the supervisee, constantly decide about priorities, create a safe and optimal setting for learning, and offer expertise to the supervisee. Her function fits the metaphor of a tightrope walker in a circus. This spectacular balancing act is an artistic performance, not to be taken lightheartedly. It is a serious job, which requires a lot of exercise and self-discipline. Supervisors, however, never hear the amazement, anxiously restrained by the audience, nor receive a warm applause.

In order to be able to say something about problems in the supervisory relationship, we first have to define what we see as the fundamental stance of the supervisor. In a preliminary section, I will start with this. There are, however, other domains that, in fact, need clarification. For example, what is the supervisor's idea about psychoanalysis or psychotherapy? What does she consider competent work of the supervisee? How does she define the goals of supervision? What is her style of supervising? And, what is the style of learning of the supervisee? You can find a lot of diverging formulations in the literature about the goals and the supervisor's 'tasks' (13), ranging from broad descriptions to very specific ones. I do not intend to review the literature or to answer the many relevant questions. I will concentrate on the conflicting aspects and dilemmas in the supervisor-supervisee relationship and within the supervisor's role, rather than on the content of the supervisory work.

Formulated in the broadest terms, the supervisor has to help in learning to analyze or to work psychotherapeutically with patients in an autonomous, effective, spontaneous and authentic way, i.e. fitting in with the personal pathology, psychological make-up and creative capacities of the supervisee. Ideally, this is achieved through a process that takes many years in which theory

1 For reasons of clarity, I am using the female version when referring to the supervisor.

and technique become integrated in the supervisee's personality, thus creating a relatively stable 'working-ego' (20), and a certain simplicity and 'naturalness' (10) in the relationship with the patient. The supervisor has to be guided by the needs of the supervisee, who can develop confidence in his or her own capacities and maturate professionally and personally through the mutual reflection on the clinical material, the ins-and outs of the treatment, the treatment relationship and the patient's role in this relationship, the transferences and countertransferences,[2] and the supervisory relationship. Supervision is in essence a learning-alliance and "the crossroads of a matrix of object-relations[3] of at least three persons"(3).

Stance of the supervisor

According to my own experience, the supervisor is listening to the material on different levels and in different ways simultaneously. One of those, for example, is as a *diagnostician:* 'what is happening'? 'In which context can we understand this'? And, 'what does it say about the patient and the treatment relationship'? Other ones are as a *clinician:* 'what would I have done with it'? Or as a *teacher:* 'how has the supervisee reacted to it and what has he or she done with it'? Or, 'what kind of expertise can I offer at this juncture'? Maybe she functions in the first place as a *psychoanalyst*, trying to come into contact with her own (counter) transferences, and also with those of the patient and the supervisee in their mutual interaction. Fundamental to this kind of listening is curiosity in the unconscious processes that are at work in all three of the parties. The supervisor and the supervisee would not meet if there was not a patient, and the work is centered around the dynamic relationship between the supervisee and the patient. Therefore, the dyad of the supervisory relationship has a triadic foundation. The patient is the absent third.

However, there are more absent third persons, for the supervisee as well as for the supervisor. In a workgroup on supervision at a recent conference in New York, one of the participants aptly said: 'There is a crowd in the room'. Who are the other absent parties in this crowd? These are the personal analyst or therapist of the supervisee, other supervisors of the supervisee, his or her colleagues who are also the colleagues of the supervisor, the profession in general, and also the institute or organization to which the supervisor has to report. For people working with children there are even more absentees, such as parents or teachers. Sometimes, the field of supervision is called "uncharted territory"

2 'Transference' refers to "the displacement of patterns of feelings, thoughts, and behavior, originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship"(16). 'Countertransference' refers to the analyst's or therapist's conscious and unconscious thoughts, fantasies and emotional reactions to the patient.

3 In psychoanalytical terminology 'object' refers to a person in the outside world (external object), but also includes an inner representation of a person (internal object).

(2), but a wealth of literature can be found on almost every aspect, not only in the classical books but also in many articles in journals. Topics that have been explored are, for example, triads and its dilemmas, ethical questions, transferences and countertransferences of all of the three participants, identifications and their role in learning, phases and parallel processes, problems about power and abuse of power, evaluations, and the supervisor's dual role. Whilst scanning some of the older literature, it becomes evident that the same themes are always present, which is not surprising, but that the focus has changed. In recent literature, more attention has been given to the supervisor and her role-problems, transferences, idiosyncrasies and blind spots, and less emphasis is placed on the supervisee's learning problems, fears, defenses or weak spots. This is in accordance with the shift in the last decades towards a two-person psychology and the subjectivity of the clinician in the treatment.

As part of the fundamental stance of the supervisor, it seems important to me that she is aware of two central vantage points. The first one is that supervision is *not about what is right or wrong in the supervisee's way of working or in his or her interventions*. I have stated this concretely, but it is, of course, clear that 'not anything goes'(25). 'Right' or 'wrong' become irrelevant categories as soon as attention is given to something else. In the first place, within a safe and open collegial relationship, the focus is on the experiential reflection upon the dynamics in the relationship with the patient, in which the supervisor brings in her expertise. She does not claim to have the only correct point of view, but can offer a conjectural view that may differ from that of the supervisee. My first thought and implicit question is always: 'what motivated you' to say or do this or that, or to refrain from any form of action? This attitude invites the supervisee to reflect together upon the feelings of the patient and his or her verbal and non-verbal communication to the clinician, and to explore the reasons behind the reaction(s) of the supervisee to the patient. In my view, the behavior of each supervisee has to be taken as a 'clinical fact', ideally without an a priori supervisor's value judgment. This reflective interaction is focused primarily on what happens intra-psychically and inter-psychically in both parties, i.e. in the patient and the supervisee. Furthermore, it tries to investigate the conscious and unconscious motives of the supervisee. In this, one also examines the way in which the patient plays a role in these reactions, for example, one wonders if the patient 'seduced' the supervisee into a collusion, 'invited' her into an enactment,[4] or 'forced' the supervisee to take up an (emotional) position via projective identification.[5]

4 'Enactment' refers to subsymbolic mental functioning in the form of actions, expressing a tendency to repeating instead of verbalizing and remembering, or as ways of remembering and communicating.

5 'Projective identification' refers to a fantasized object relationship in which "parts of the self and internal objects are split off and projected onto an external object, which then becomes "identified" with the split-off part as well as possessed and controlled by it"(16). Usually in the definition of this phenomenon is included, that the external object inevitably also identifies with what is projected onto him or her.

Through this, it becomes possible to mentally construct a picture of what happens in the psychoanalytic or therapeutic process, in the patient, and in the relationship with the supervisee. One also gains insight into the specific characteristics of the dynamics of this couple. I am an advocate of the supervisor as "unobtrusive teacher" (8) who, nevertheless, will not shy away from challenging the supervisee regarding technical issues when necessary and needed. After all, in addition to promoting confidence and helping to reach autonomy in clinical work, learning has to take place. It is clear that this attitude is fundamentally at odds with a supervisory style in which the supervisor is using the supervisee to treat his or her patient, because in doing so, the supervisor is pretending to be the super-clinician. This easily leads to a right-or-wrong atmosphere in supervision and I consider such behavior as infantilizing and destructive. It undermines self-confidence of the supervisee and severely distorts the supervisory relationship. If the supervision is dominated by a permanent judging whether the supervisee is performing correctly or is making so-called 'mistakes', it is likely that falsity will creep in and that the supervisee will feel devastated. It is probably this attitude which has led many to suggest that the word 'super' in supervision evokes something authoritarian or degrading, or promotes idealization. In the past, some people have proposed to replace the word supervision by, for example, consultation (17,24,26,30). I do not believe that substituting words solves the dilemmas and complexities of supervision.

The second vantage point concerns the fact that *not only the supervisee, but also the supervisor, is involved in a learning process*. Following on from the stance mentioned before, it is self-evident that the supervisor realizes that a learning alliance is a two-way relationship in which both participants are active. This is a view voiced by others in the past, e.g. Windholz: "Experiential learning during supervision is a process which occurs both in the student and in the teacher. During this 'teaching-learning process' both participants also become observers of their own functioning...In the supervisor's work it guides him to an understanding of the student"(29). If supervision were only be a process of delivering some insights or knowledge 'from above', and did not contain this mutuality in the relationship, learning would be impossible for the supervisee (30). In this context, the parallel processes[6] can be of great value because they are experiential and usually have an element of surprise. Discussion of these will provide the supervisor with a better understanding of the supervisee who in turn will be enabled to experience greater empathy and/or a more profound comprehension of the patient. "Recognition of parallel process can be a powerful learning experience because it is experiential in nature. The therapist and supervisor literally experience and act out the therapeutic dynamics. The recognition of the process often carries a strong affective charge when it suddenly makes conscious

6 According to Ogden, parallel process is a misnomer ".. in that the relationship between the analytic process and the supervisory process is anything but parallel: the two processes live in muscular tension with one another and are all the time recontextualizing and altering one another"(17).

a troublesome unconscious process" (4). It is precisely the dynamic arising and developing in the supervisory relationship that offers opportunities and contributes to in vivo learning by both parties.

Triangles and relationships to absent third parties

In returning to triangles, I am limiting myself to three absent parties, namely the patient, the personal analyst or therapist of the supervisee, and the external institute or committee to which the supervisor has to report her evaluations. One can say that, for both the supervisor and the supervisee, very complex dynamics are at work in all of these relationships. I will try to formulate some of the elements which the supervisor has to take into consideration in order to maintain her balance.

The patient

A very relevant question is: 'for who is the supervisor'? There are people who are of the opinion that the supervisor has, in the first place, a function for the patient and for the conduct of the treatment, and only in the second place, for the supervisee. In my view, this is a confusing position, because it opens the way to adopt a stance in which the supervisor behaves like the previously mentioned omniscient super-therapist, who is using the supervisee only to get her ideas of how the treatment has to be done effectuated. My position is different: the supervisor is in a training situation with the supervisee and has to support the supervisee in his or her development and in the treatment process. This is the first and main responsibility of the supervisor. The supervisee is the practitioner, the doctor in charge of the patient, the therapist or analyst who, as such, is responsible for the treatment. Taking into consideration her function, the supervisor cannot be the clinician who treats the patient. However, this is a domain of potential tensions and dilemmas in the sense that the supervisor will have an opinion on how the treatment proceeds, and what the needs of the patient are. Sometimes, she has to explicitly clarify the patient to the supervisee. For example, by explaining what the patient as a child has experienced or might have felt, sometimes even by some form of role-playing. The aim of this is, that the supervisee will be more able to empathize with and understand the patient and the interaction with the patient, and as a consequence will be enabled to intervene in different or more adequate ways. At other times, it will be necessary to give priority to the experiences and emotional responses of the supervisee, for example to his or her frustrations or feelings of incompetence. It may only be possible at a later stage to connect those feelings with the pathology of the patient. In my opinion, the patient of the supervisee is most helped with a competent supervisor who restricts herself to and concentrates on her role as supervisor, and in this way contributes to the quality of the treatment. Possibly,

one could interpret this position as the indirect and derived supervisor's responsibility for the therapy.

In this field, another question is equally relevant: 'who is the patient'? He or she comes into the room in a version as it exists in the supervisee's mind, colored by interpretations, transferences and countertransferences. The supervisor reacts to all of this on conscious and unconscious levels and her personal reaction is added to the version of the supervisee, so that in the end, we can speak of a joint construction or a patient 'dreamed' (17) or fantasized by the supervisee and the supervisor. The patient as present in the supervisory relationship is their creation, and when it comes to the question about who knows the patient best, I suggest that the supervisee, given the real contact with the patient on conscious, preconscious and unconscious levels, has the best knowledge in this respect. There is a recent paper by Fink, who supervised a candidate (5). After some years, he came in contact professionally with the patient of that supervision. He discusses how it could be possible that he did not recognize this patient at all, even after considerable time in treatment. I think this underlines the idea of the patient as a joint construction of the supervisee and supervisor.

The personal analyst or psychotherapist

Another absent third in the room is the therapist or analyst of the supervisee. When the supervisee is in personal treatment, which is preferable when receiving supervision, this will be a potential source of conflicts, and when he or she is no longer in treatment, it is a complication to take into consideration as well. Tensions can develop, for example, due to feelings being stirred up, such as loyalty (in the supervisee), and envy, dislike, rivalry and competition (in both the supervisor and the supervisee's analyst). It is not unusual that in supervision all sorts of parallel transferences and splittings emerge. For example, negative transferences are directed towards the supervisor instead of towards the personal therapist, or the supervisor is idealized and the analyst denigrated, or vice versa. It may also happen that the supervisee is unable to adequately see and understand a particular patient because of the fact that the supervisee's problematic difficulties, e.g. pathological narcissism, are not adequately addressed in the personal analysis. It can be very strenuous for the supervisor to maneuver honestly and wisely under these circumstances, which is one of the reasons why I never ask the supervisee the name of his or her personal analyst.

An important element in this respect is connected with discussing transferences, countertransferences and enactments by the supervisee, which is by most authors considered to be an essential prerequisite for learning a 'good analytic technique'. In my experience, this depends on several factors. There are different modalities in the supervisory relationship and interaction and overlapping phases with their own characteristics and accompanying adequate supervisor-behavior (6,27,28,32). One can also discern phases in learning processes and different learning styles (18). The possibility of discussing transference and

countertransference-enactments is also dependent on the nature and quality of the supervisory relationship, the focus of the supervisor at a certain moment, whether the supervisee is in personal treatment or not, and the manner in which the supervisee brings it up in supervision or seems to hope that the supervisor can be of help. As a basic requirement, the supervisee has to feel safe enough with a trusted supervisor to show himself in his work. The first period of supervision has to be directed at enabling the supervisee to experience this safety. Dependent on their own development and advancement in training, supervisees usually need more guidance and support in this phase than later on.

As a second element, countertransferences and collusive enactments have to be related to the dynamic relationship between the supervisee and her patient, because this is around which the supervision is centered. From this perspective, the patient's pathology comes first. It includes the dynamic in the therapeutic relationship and the supervisee's reaction to what the patient consciously or unconsciously produces, performs, or provokes. This is the primary focus of attention; it is not the pathology and personal psychology of the supervisee. The part played by the supervisee inevitably becomes a topic in supervision, and preferably brought up by the supervisee, but the supervisor has to take care not to concur with the role of the analyst of the supervisee. She can encourage the supervisee to bring a matter for further exploration to the personal analysis in case the supervisee is in personal treatment. When this is not possible, she has to examine it more extensively with the supervisee, because it is an intrinsic part of the transference-countertransference constellation, but this is not to be done in an 'analyzing' way. The setting and the supervisory contract and relationship do not tolerate deep interpretations and intrusion in this respect. It will be better to stimulate the supervisee to do some more 'self-analysis'. Supervision becomes problematic when a supervisor starts behaving therapeutically with a supervisee, in this way forcing him or her into a patient-role which is incompatible with being a colleague-supervisee. When the supervisee's pathology is severely disruptive and evidently a blockade to proper treatment of the patient, and has also proved to be resistant to change via supervision, advice might be given to re-enter personal therapy or analysis. This recommendation needs careful consideration and consultation with others – in the first place other supervisors – in order to avoid that this advice is a consequence of the idiosyncrasy of only one supervisor.

The institution

Following on from the discussion about the previously mentioned absent third persons (i.e. the patient and the personal analyst or therapist), we conclude that the supervisor has to be aware that the patient is not the supervisor's patient and that she herself is not the supervisee's therapist or analyst. When we speak about the 'triadic system' of supervision, we mean the patient, the supervisee and the supervisor. There is, however, another third party which deserves our attention,

because it has its own complicating aspects. In psychoanalytic societies and institutes, there is an administrative body and committee overseeing the training which expects reports from the supervisor about the candidate's progress and clinical competence. Thus, the supervisor assesses and evaluates periodically the supervisee's work and reports her findings and opinions. She also has a decisive voice in the supervisee's graduation. In such a way, this absent party imposes a duality on the supervisor's role. The ensuing tensions can have different backgrounds and causes.

For example, there can be animosity between the supervisor and her colleagues within such an administrative body. The emotional atmosphere of an institute, society or group of colleagues directly influences the supervisor and supervisee (31). This reporting function can be felt by the supervisor as irreconcilable with the role of encouraging learning and helping to improve professional competence. Many supervisors feel uneasy with their double role or even consider the combination undesirable(13,17). Some say that "almost all supervisors find that evaluating a candidate is both difficult and unpleasant" (7). It is also unclear how and how much this evaluating part of the supervisor's task influences the supervisee's work (9,12). It is important to take into consideration also the anxieties and sensitivities of supervisees about the double function of their supervisor and about feeling judged and evaluated. These anxieties may leave the supervisee feel unsafe within the supervisory relationship, especially when the supervisor is not able to be aware of those. To reconcile seemingly opposite functions, I think that it is useful to make a distinction between interim evaluations (once a year or biannually) and the assessment at the end of training, which is usually performed in consultation with other supervisors.

An important goal of supervision can be that the supervisee learns to evaluate himself or herself by critically examining which are his or her good and weak spots, and in which aspect he or she needs to further develop and gain more knowledge. The supervisee's self-judgment can be improved through discussing this with him or her as part of the interim evaluations. I believe that it is desirable to pay attention in the training to this self-observing clinical performance appraisal, especially because it is a vital regulating function and an indispensable ingredient in later independent functioning. Furthermore, the supervisee also must have an opportunity to judge the supervisor[7] in these periodic evaluations, and has to be encouraged to do so as honestly and balanced as possible. In order to evade discussing real shortcomings on both sides and to avoid potentially narcissistic injuries, it is not uncommon that only compliments are given, which certainly will not fail to have its negative effects on the quality of the work of both supervisor and supervisee. It is self-evident that evaluations that are given without having shared them with the supervisee are altogether objectionable,

7 In the past supervisees even have developed an evaluation form in order to better assess supervisor qualities and shortcomings (15).

and in the past, these have contributed to a paranoid and persecutory climate in psychoanalytic education and group functioning.

There are some people who feel that the final evaluation of a supervisee, who presents himself for qualification or registration, can take place outside of the supervisor-supervisee relationship. They think that assessing the results of the training and the supervisee's clinical skills can be done by a third party. In this view, competence can be assessed – maybe partly – by others than the supervisee's supervisors. Up till now, I have not yet seen instruments that can unequivocally establish whether or not the final required levels of training are reached. However, in the pursuit of more transparency and clear standards of professional competence, this is a point that internationally receives growing attention. Apart from the question whether this process with external evaluators is desirable and possible, in a broader context, the question whether the design and organization of the present-day part-time training programs leads to the desired competence is also put forward (23).

With regards to the training status of the supervisee and his or her relationship to an institution, another point deserves special mention. Divergent opinions exist whether or not the patient should have knowledge of the fact that his or her therapist is a trainee and that the treatment is a supervised case. On the one hand, there is a view that informing the patient about this is undesirable, with the argument that it curtails the space for fantasy and undermines the effectiveness of the treatment. It is obvious that it cannot be denied if the patient enquires about it. On the other hand, it is recommended that this information should be given to the patient, because concealment would impede or harm the treatment. It might mean: "You don't inquire into my secrets and I won't inquire into yours" (14). Very frequently, supervisees are fearful that the patient will end the treatment 'prematurely' (i.e. seen from the interests of the supervisee). It is also quite common that patients react to their therapist's being in training with subtle blackmail, willingness to help, ridicule, or relief that there is a hidden 'expert' behind their therapist. No doubt, almost all patients have fantasies about the presence or absence of a supervisor or advisor, and experience specific transferences in this respect to the therapist as well as to the supervisor. It is a striking phenomenon that many patients, even when they are unaware of being presented in a seminar or consultation with colleagues, have dreams and fantasies about appearing in public. For example, on stage or TV, or in a version in which they find themselves on an operating table amidst doctors, like in the famous painting 'The anatomy lesson of Dr Nicolaes Tulp' by Rembrandt. Some of these phenomena I have seen in clinical seminars, and they probably indicate how sensitive patients can be about what goes on in the mind of their therapist.

The transference-countertransference matrix

In line with the increased interest in the part that is played by the analyst, is the interest in the supervisor's part in the supervisory process and relationship. This is a domain of the supervisor's self-scrutiny in which tensions, dilemmas and ambivalences threaten her balance. This shift of emphasis has, among other things, stimulated more empathy with the supervisee and his or her narcissistic vulnerabilities, but also a more detailed investigation into the supervisory relationship, in which conscious and unconscious anxieties, desires and transferences play a role for the supervisor as well (11,13,19,21,24).

Many years ago, in a series of questions about the supervisor, this one was raised: "can the supervisor recognize his own limitations?"(29) Indeed, problems and conflicts in supervision can after all also be caused by the supervisor's unconscious transferences to the supervisee. Entering this field means that attention shifts from the supervisee's blind spots (1) to those of the supervisor and her shortcomings. The unlucky term 'supertransference' intends to cover the supervisor's blind spots and also her specific reactions to a supervisee (24). In many articles, we find potentially discordant elements of the supervisory relationship, caused by the supervisor. These elements are, in fact, all related to and a consequence of the supervisor's narcissism and emotional state of mind. Let us try to gain a closer look and to discover what dimensions of love and hate, emanating from the supervisor, can emerge in the supervisory relationship.

There is the normal narcissistic wish to be valued as a trainer. This wish can become excessive and result in neglecting the supervisee's individual development and in imposing ideas and opinions. It is striking how often one encounters the warning against 'disciple hunting'(6,8,11). Apparently, a tendency to breed followers is frequently found and the destructive effects of so called 'charismatic' or solitary leaders in societies are well documented. A related domain of problems concerns harboring unrealistic expectations about the supervisee, out of narcissistic investment in supervising and the training function. It is obvious that frustration, irritation and criticism arise when the supervisee's progress or achievements do not meet these expectations. This can be compared with a parent who uses her child as a selfobject[8] and strives to be affirmed as the perfect parent by having an excellent child. Supervisors are usually aware of parent-child transferences, usually not of the ensuing enactments. This, in turn, can lead to coercion and misuse of power when supervisees are invited to identify to an extreme extent with the trainer and take her side at all cost. A further step can be the recruitment of disciples and the formation of factions within groups or societies. This is hatred institutionalized. An even

8 'Selfobject' is a central concept in self psychology and refers to a mode of functioning in relation to others (objects) in which they are needed for enhancement of the self and the experience of a vitalized sense of self.

more deleterious development would be that competent and gifted people withdraw or that a group splits up.

An adjacent domain of tensions and conflicts results from the supervisor's personal reactions to a supervisee who is a threat to her narcissism or a delight. It can be that a supervisee is better, more talented or more clever than the supervisor. Does this arouse feelings of envy in the supervisor? How will she cope with these and handle them in her contact with the supervisee? Is she able to realize that she is covertly trying to get the upper hand? A different situation exists with the more problematic 'pupil' who constantly needs her support and who is completely dependent on her insightful suggestions. Does she realize that rescue fantasies may be at work and that she might enjoy being desperately needed? An adjoining field consists of the supervisee's transferences to the supervisor. It can be that the supervisor is insensitive to the need of the supervisee for help, for example, with containing and mastering fears or feelings of incompetence. Candidates can experience shame, in that they, even with all their previous experience, are still in a situation in which they have to learn new knowledge and skills. Is the supervisor lovingly sensitive to this and is her behavior respectful and accepting, or will she turn a blind eye to a supervisee's problems in this respect?

A somewhat neglected area is the manifold versions of erotic feelings with their concomitant tensions and conflicts. "Scenes of instruction are potentially always scenes of seduction"(11). Just like male and female teachers in schools, supervisors can transgress borders and become more focused on the private person than on the learning process and development of the supervisee. For example, a remark about a supervisee's appearance will easily be experienced as improper in the supervisory situation. Furthermore, a supervisor can feel seduced by the admiration and love of a supervisee. In these circumstances, they can enter a sexual relationship, rationalized by the pretext 'we are both adults'. These sexual relationships occur and they are not only a violation of the code of ethics or a corruption of the supervisory relationship. There is evidence that the supervisor, by her attitude that rules do not apply to her, in this way also has a perverting effect on the relationships of her supervisee with future patients. Values that are significant for the psychoanalytic or therapeutic relationship in this respect also concern the supervisory relationship (22). I assume that, in the matrix of transferences and countertransferences in supervision, there is still more that can be made explicit. In order to be able to investigate in what way and to what degree the ingredients of transgressive behavior and boundary violations are connected not only with the individual of the supervisor and supervisee, but also with the pathology of the supervisee's patient, we need to have much more clinical supervisory material available to us.

Summary

This chapter describes difficulties in the supervisory encounter and tensions in the supervisor's role. As far as the fundamental stance of the supervisor is concerned, two elements are stressed. Firstly, supervision is not about what is right or wrong in the supervisee's way of working or interventions. These categories become irrelevant as soon as mutual reflective attention is given to the therapeutic relationship and the intra-and inter-psychic processes in both patient and clinician. Secondly, supervision is a learning-alliance and learning process for both parties. This attitude prevents an infantilizing or idealization-promoting atmosphere and can foster the supervisee's feelings of safety and confidence.

In the dyad of the supervisory relationship absent third parties play a pivotal role. Of course, central and most important is the patient. However, equally relevant are the personal therapist of the supervisee, his or her colleagues, the other supervisors, and the administrative body to which the supervisor has to report. Connected with these absent parties are tensions, dilemmas and problems for the supervisee as well as for the supervisor. It is argued that the supervisor has to be aware of the fact that, bearing in mind her educational task and first responsibility in a training situation, she cannot be the clinician for the patient nor the therapist of the supervisee. The evaluating and reporting function of the supervisor has its own problematic aspects and her dual role requires honesty and tactful handling of a supervisee's preoccupations.

A last paragraph is devoted to special difficulties and potential problems in the supervisor-supervisee relationship. Not only in the supervisee but also in the supervisor conscious and unconscious desires, anxieties, transferences and narcissistic vulnerabilities are inevitably at work and they are potential sources of disruption of a good supervisory relationship. In order to maintain her balance the supervisor has to be aware of these factors and to monitor carefully her own contribution to the supervisory process. Examples are given of the corruptive effects of abuse of power in its different forms.

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Sense of Injustice

Philosophical and Theological Remarks

Hans Schilderman

Injustice as forensic problem

How do we appreciate injustice? Injustice is an experience of something wrong, an unjustly act, unfairness, a want of equity. Often it is a result of a clash of interest between opposing parties. We respond to injustice in varied ways: by polite indignation, by political protest, by furious outcry or by lawsuit. Injustice is a trigger for basic and often negative emotions and the accompanying cognitions – fierce and disturbed as these can be – may prove to be subjective and flawed. As a consequence endured injustice is bound to be portrayed as a personal perspective or even prejudice; a matter of opinion or of taste to be most properly judged upon in court by applying principles of justice that underlie the rule of law. But is injustice well described as experience of social conflict; as an unstable emotion or erratic notion at best, and therefore most properly, competently or even exclusively assessed by a court of law? As can often be noticed, a default response to sensed injustice is to indict those that are felt responsible before a court of law. Are we increasingly sensible to injustice, or are we increasingly unfamiliar or even helpless in sensing what it actually means? What is the taste of injustice? This issue I want to elaborate and present it as a problem '*in forensis*': before the forum of those involved in forensic sciences.

Often, so it seems, we understand injustice as the inverse correlate of justice. In daily life, we assess injustice in terms of its opposite, and not without reason. Justice is an obvious term that is available in established normative descriptions that act in cultural settings (morality, religion), socialization strategies (education, professions), procedures of legitimation (law, rules of conduct), and institutions (families, schools, courts). Especially moral and religious philosophies of life are intrinsically linked with ancient ideas of a fair and proportionate distribution of joys and burdens among persons in order to establish and nurture communities. In the establishment of modern government, justice is the main principle that underlies the rule of law, and it is often backed by such diverse moral and religious standards like the rule of God, natural law, reason, dignity, human rights, or quality of life. These generic principles usually represent the idea of justice as a perfect or ideal notion. Justice is portrayed as an ultimate end or final cause. These principles represent standards of excellence and they are

usually oriented by questions of legitimation or aims of general theory building. They, however, may not represent the most proper object for studying experienced injustice. Injustice is usually felt – suffered so to say – throughout painful events, conflicts and misunderstandings, even if it is coped with in a serious attempt to come to terms with envisaged strong ideas of justice. Unfortunately, injustice is often far more close to life and thus the experience of justice results not from regulative ideas but by trial and error in daily life. A related characteristic issue is that the grand principles of justice that I just mentioned tend to imply a disinterested observer position or at least a concept of impartiality from which a fair judgment is gained and right decisions can be made. However, it is a basic question if such an independent position actually exists or is even in reach by effort. Coming to fair, right and just decisions remains a process that transects conflicting positions, that each reflect pertinent arguments and often suffers from lacking insights into the histories and contexts from which the experiences of injustice or claims to justice arise. At some distance of the regulative idea of justice, we are left with a discretionary assessment at best, in which justice is provisional and on an interim basis. It thus leaves every room for the possibility of injustice. What makes these universal approaches even more complex is that often an institutional or state perspective of justice prevails under the assumption that once the global framework for the concept of justice is set, normative issues within the state or inside the social institutions themselves require less attention. As a consequence, questions of justice regarding compliance with the state or living well within its institutions seem to be leftovers in the reasoning process.[1]

With this first sketch I do not intend to draw a pessimistic or even cynical picture of our social and legal norms for justice nor of our juridical institutions. On the contrary, probably not many will oppose the insight that what makes a fair society is the quality of the effort to arrive at just assessments. My point here is merely to note that an approach of injustice as lack of justice may likely fail to address injustice in its own terms. Indeed, if we look into in-depth studies in philosophy of law or consult research in the forensic sciences, injustice is seldom considered a phenomenon in its own terms. Therefore, in this contribution I will try to address the experience of injustice in its own right and as a personal concern. With that in mind, I will limit myself in this contribution by focussing on crime as an illustrative example of moral harm following from injustice. I do not aim to take the discussion of injustice into a technical account of criminal law, but merely allow an opportunity to reflect on these notions as they appear in everyday life. If people are affected by crime – and victims, perpetrators and their environments are by definition – how do we deal with injustice?

Forensic psychologist David Canter starts his introduction in forensic psychology as follows: '*Murder, robbery, arson, fraud, domestic violence, child abuse, extortion,*

rape, and other crimes are the stuff of fact and fiction. They always have been. Even the Bible has murder and fraud in its opening chapters'.[2] Crime is an expression and infliction of injustice. It indeed has always been around and it will be in the future, probably to some extent even regardless of what we do to prevent or to fight it. According to a more formal definition, crime can be understood as a publicly considered wrongful act against common law that – following particular proceedings – is punishable by a state authority. In criminal law one assesses crime in terms of culpability of persons, viz. the accused or the perpetrators, with regard to an external element that designates the wrongful act itself ('*actus reus*') and the internal characteristics that refer to the intentionality from which the act emerged ('*mens rea*'). Both are necessary to establish guilt. Of course, many other and more specific considerations can be brought to the fore when it comes to determine the criminal characteristics of the perpetrators' acts. Thus for instance, the American Model Penal Code[3] offers some standards for a reasoned judgment in the interpretation of criminal law. These include additional elements of the act, like conduct, circumstance and consequence, and mental characteristics like purpose ('*voluntas necandi*'), knowledge ('*animus nocendi*'), recklessness ('wilful blindness') and negligence ('inattentiveness').

This juridical or more specifically judicial perspective on crime is relevant in jurisprudence as applied in court settings, and by legal definition it suits the aim of establishing guilt and bringing criminals to justice. However, for the aim of this contribution I will offer a few philosophical and theological remarks that invite to focus on the experience of injustice that propels this pursuit of justice. Firstly I will go into the arbitrariness of injustice, that is, the severe and painful experience of falling prey to (criminal) circumstances beyond ones' control for which often no reasoned account suffices. Secondly, I will discuss the agency of injustice, which refers to its implied force and impact in the personal interaction between offender and victim. Thirdly, I will demonstrate that the notion of life-world shows that crime as experience of injustice is of a social and symbolic nature which may question the kind of reasoning that we often find in juridical procedures. In all of these three observations, I hope to clarify what the significance of the issue of injustice is from a theological perspective by pointing at the enduring elective affinity ('*Wahlverwandtschaft*') that religions have with the issue at hand. Finally, I will address the issue of justice as response to injustice, in which I will make the case for a proportionate support of perpetrators and victims.

Arbitrariness of injustice

One can raise the question if crime should primarily be regarded as an offense of the legal system and the rule of law or that is it best characterized as a random

event that puts victims in situations beyond their control in which they simply suffer from something in which they have no part. With this question, we enter the domain of '*victimology*' which studies crime at various phases of victims' involvement, say the events surrounding the criminal act, the process within the justice system and the coping process following the inflicted harm.[4, 5] Today, the victim role as such is increasingly being studied and given more proper attention. One of the more established theories in these victimology studies has the belief-in-a-just-world hypothesis as its focus.[6, 7] This theory basically says that as a default position, we experience our world as a just one in which everyone gets what he deserves. From relevant psychological research we learn that we are inclined to avoid arbitrariness of injustice by attributing crime to dispositional factors instead of situational ones. As bystanders we look for motives and other characteristics of both perpetrators and victims. In making sense of a criminal act, this strengthens the belief that we can explain crime in terms of person-related and thus impressionable factors that enable us at least principally to remain in control even in contingent situations. This mental mechanism is known as the fundamental attribution error, which safeguards us from the idea that our world is unpredictable. However, it may also very well contribute to the idea that victims in the end are – at least to considerable extent – responsible to their fate of being subjected to crime. The illustrative example of this assumption is the prostitute who is molested not by pure chance but because she gave opportunity and willingly and even for profit has put herself at danger. Also in less characteristic incidences of popular social reasoning, the mechanism remains the same. Any defendants' lawyer will selectively scrutinize the victims' credentials for factors attributing to his particular role in the criminal offense. The court symbolizes and institutionalizes this belief in the just world, and in hindsight it corrects for the experienced transgressions of the rule of law. This immanent belief, that in retrospect explains that even in overt confrontation with crime we remain to live in a just world, has its counterpart in the ultimate belief – often formulated in religious terms – that there is a universal force that in the end will take care of injustice and will put things right.[8]

This psychological way of dealing with our issue is of great importance and it helps us to understand the types of bias and self-interest that we have when we are confronted with crimes and search for satisfaction. One should however discuss this justifying tendency not merely according to psychological theories but also in terms of its philosophical aspects. Injustice is not merely a transgression of positive law but also a breach in the capability of moral judgment in that is undermines basic assumptions of reciprocity and equality.[9] The notion of arbitrariness is implied in crime in a fundamental way. Aristotle already pointed out that injustice is a friend of inequality.[10] From Aristotle's point of view, one needs to distinguish general justice where injustice is simply an overt breach of law, and particular justice in which injustice is a vice that

impels us to take more than we are entitled to on the basis of principles of equality and reciprocity.[11] A criminal offence is thus not only a threat to the legal system that is built on equality in jurisprudence; it also represents a breach of the cognitive assumption that we deserve what we experience; a belief that our world is just and that experienced events are properly distributed according to some principle of impartiality. The fact that the latter belief often stands contrary to the facts of life cannot simply be taken as a falsification. It at least must be understood and analysed as some sort of moral suffering that is a cognitive and affective reality in itself and significant in the assessment of crime. Philosopher of law Judith Shklar has written extensively about this interrelatedness of juridical and philosophical dimensions of injustice, stating for instance that in dealing with issues of justice and injustice we should face our own dark side that is represented in daily vices such as cruelty, hypocrisy, snobbery, treachery, and misanthropy.[12] This gloomy side of anyone's character is likely to be underestimated in the formal procedures according to which perpetrators are assessed on their legal shortcoming and moral flaws while victims are envisaged as carriers of legal rights and moral merits. This line of reasoning extrapolates perpetrators and victims by means of causal discrimination. However and maybe contrary to expectations, the argument does not by definition favour crime victims. This type of reasoning is primarily oriented at identifying the perpetrator and his cause for crime (the active side of injustice), whereas the consequences of crime in terms of dealing with the victims' harm and his loss of confidence in justice as such are often left unaccounted for and thus reinforce the injustice that was previously experienced (the passive side of injustice).[13]

There are significant theological observations to be made as well. As I already noticed, religions can be seen as cultural institutions that confirm and support our basic belief in a just world. But this is by no means the only observation to be made regarding religions' role towards injustice. Religions can be understood to put any arbitrariness of injustice on the social agenda. The cosmological and ethical characteristics of any religion suggest that as humans we are destined to live in a just world. Religions offer narratives and practices to experience and express this just world and it addresses confrontations with injustice with an appeal to God and on behalf of the moral communities that they represent. Religions indict injustice; they complain about it and they mourn its consequences. This can easily be demonstrated by a host of religious pericopes. If we take the first Testament of the Bible as an example, it exhibits instances of complaint from the side of the suffering: '*How long will you judge unjustly and show partiality to the wicked?*';[14] but also from the side of God: '*Why do You make me look at injustice? Why do You tolerate wrong? Destruction and violence are before me; there is strife, and conflict abounds*'.[15] God is portrayed as one who instructs regarding injustice '*Do not pervert justice or show partiality. Do not accept a bribe, for a bribe blinds the eyes of the wise and twists the words of the righteous*',[16] and as

one who takes sides: '*For the oppression of the poor, for the sighing of the needy, Now I will arise, says the LORD; I will set him in the safety for which he yearns*'.[17] Of course, these Biblical fragments are taken out of their historical and text context and they deal with different conceptions of injustice. They do however illustrate the point that religions do not express experiences of injustice merely at a psychological level but they understand them also as normative statements and as moral harms. What is more, they put these experiences in the perspective of overarching and cosmological notions of a natural, historical or social order. That being said, religions also have to deal with the inevitable inconsistencies that unjust events all too frequently pose to an envisaged and pursued world of justice. Religions do so in several ways. Thus, they may reinforce basic ethical codes and offer practical rules of conduct, or if these are broken, ritual procedures of punishment and redress. Religions also point at eschatological scenario's, claiming that justice will be regained in a promised afterlife, be it heavenly or in presented views of reincarnation where injustice is remedied or justice is in some way recovered. Finally, religions can be considered cultures to live with the inevitable contingencies of this world. Contingencies are unexplainable events that are beyond our control and happen by chance. Injustice often has characteristics that cannot be controlled or adjusted and religions are able to address these contingencies; dealing with contingency is the functional specialty of religion so to say.[18, 19] Thus, religions do not take injustice as an arbitrary notion but they are actively involved in countering that idea in terms of normative instructions and claims, by taking seriously the harm that results from injustice, and in dealing with the inevitable contingencies that accompany it.

Agency of injustice

A second remark that I would like to present, regards the assumption that our juridical system is oriented at bringing a perpetrator to justice, whereas we probably want to bring a victim to justice, viz. doing justice to him with regard to the experienced criminal event. From a formal juridical point of view, this idea comes to be easily identified with satisfaction from punishment, be it in a strong sense in terms of retaliation, or in a milder form as restitution, compensation or a redress of the situation. Justified as these approaches may be, they also run risks to misunderstand the issue at stake in terms of utility ('getting even'). Therefore we should discuss this in far more nuanced terms in order to address its full import for both offender and victim. The term 'agency' candidates as an observer notion of injustice, which may help us to avoid taking positions on beforehand in favouring one of the two roles.

Agency is the ability to choose for particular actions to interact in the world. It includes a more specific notion of moral agency, according to which we act on

the basis of moral choice and are accountable, that is, socially responsible and legally liable for what we do or refrain from. This more strict form of agency is usually applied to the accused or perpetrator requesting a rational account from the part of the offender. What is the offenders' moral stance or at least type of assessment of his actions and its consequences, even if the ethical significance of his reasoning seems below par? Some juridical understatement lures in answering this question since often any given answer cannot justify the accused' criminal acts. Therefore, answers can be expected to merely nourish the discontent about the injustice that was experienced in the crime. However, to look at values '*sub specie mali*' can be as intelligible as looking at them '*sub specie boni*'.[20] Whereas the mainstream of theorists argues that the orientation towards the just is intrinsically rational, they tend in similar vein to assume that an orientation towards the unjust is intrinsically irrational. This however can and should be disputed as some philosophers do, be it on teleological (Aristotelian or Thomistic) grounds[21] or on the basis of deontological (neo-Kantian) argumentation.[22, 23] Shklar whom I already mentioned is one of the philosophers who is keen to remind us of the traditions of Plato, Augustine and Montaigne and other more sceptical philosophers that point at the significance that vices have for the interactions in our private and public life. A myopic account of justice that characterizes vices as irrational leaves an important source to understand agency unaccounted for and thus easily abolishes moral deficiencies from the habitat in which they nevertheless thrive. As a result, moral failings do not get the proper attention in our understanding of both the criminal behaviour by the perpetrator and of the victims' coping with this offence.

The notion of agency (´self-constituting activity´) is crucial to any moral act. In any establishment of the cause of an action, the agent constitutes himself by willing to act according to what is understood to be good, even if that notion is formulated in socially remote terms. Thus, a motive is not – at least not only – a cause leading to an (criminal) effect, but (also) a moral principle that constitutes the identity of a person in its assenting pursuit ('willing') of this principle. This moral motivation explains an act from felt duty and can be considered just whenever performed from proper motive and unjust if done from improper motive. A criminal offense needs to be judicially assessed from this appropriateness of motive, but it needs to do so while taking account of the implied practical reasoning of the accused. This normative approach accounts for the implied autonomy of the accused to take decisions to act and constitute himself in that act.[24] This (deontological) reflection not only pertains to the accused perpetrator but also to the implied victim. The victim is not merely the factotum of a crime having been actually committed ('*corpus delicti*') but an agent who is implied in the crime itself. Perceptions of guilt, victim roles or crime perceptions may vary as much in the victim as they do in the accused. Mechanism of selective memory, stereotyping, scapegoating, transference and countertransference may lure in

victims as they do in perpetrators. This is not merely an issue of therapeutic relevance but also a morally relevant notion in that it requires the ability to distinguish (dealing with) injustice from (coping with) misfortune. A perpetrator is not simply a relentless agent, nor is a victim merely an unresisting human sacrifice. In the criminal act, they share a situation that is marked by bounds and by opportunities. There is principle autonomy at stake in both roles that assumes a reciprocal obligation and liability – on the scene and in hindsight – to account for the interactions between offender and victim.[25]

In religions, this normative notion of agency is crucially involved. It pertains simultaneously to an outer perspective of God and an inner spiritual and moral correlate in an assumed essence of man. These religious positions precede any social role or interpersonal relationship, even those that are involved in crime. Sociologist Niklas Luhmann depicts this relationship of God and the human soul as follows. In monotheistic religions God – like the soul – is an observer that holds a position from which He supervises all that we do or refrain from. The soul understands the death of the body but, contrary to God, he cannot grasp its own origin and destiny and therefore depends on God who oversees any boundaries of life and death.[26] This original view fuses private and universal notions of moral agency in religious terms. Of course these terms have a subsequent cultural form and spiritual significance, embedded in far more specific ethical prescriptions, canonical texts and ritual procedures. The basic point however is that religions install a basic position from which agency is constituted from an observer perspective that implies a spiritual relationship that ultimately does not depend on the interactions according to which we participate in social life. This view leaves also room to redefine those interactions that we experience as unjust.

It is here where the role of religion and morality also needs to be questioned. Can any religious definition of moral agency support universal claims while its values, norms, codes, laws and habits are based on historic and socio-cultural coincidence? Philosopher Paul Ricoeur made interesting observations regarding this relationship of religion and morality.[27, 28] According to Ricoeur, religions can first of all be best understood as pre-moral: religion precedes moral ethos and enables persons to act freely before any ethical or juridical judgment is made: an individual acts religiously before God and does not depend on any moral prescriptions on beforehand ('*Vor Gut und Böse*'). Secondly, the history of religious origins shows that religions can be considered as proto-typical radical-moral. Unlike a popular understanding of religions that characterize them as traditional keepers of civil decency, the origins of religions usually display a fierce criticism of the prevailing conventions, habits and traditions that characterize the moral ethos of a particular time and culture and in doing so religions put morality to the stand. They question moral discourse and ethical reasoning;

they trace morality back to its origin and thus can be considered as innovators of morality. Finally, religions can be taken as meta-moral phenomena. Religions transcend morality, where they demonstrate that not all issues can be dealt with ethically by pointing at the tragic aspects of human existence, its fragility and radical contingency. As William James mentioned, religion is an: '*added dimension of emotion, (an) enthusiastic temper of espousal, in regions where morality strictly so called can at best but bow its head and acquiesce*'.[29] Religions can speak out and reach out where morality has to remain silent. In doing so, religions safeguard the notion that in moral choice and in legal assessment there is no objective guarantee. These characteristics of religion enable both offenders and victims of crime to take a self-reflective stance that does not identify them merely in the moral or juridical terms that pertain to the crime in which they have been involved. On the contrary, it potentially offers them alternative viewpoints, vocabularies and repertoires to express themselves and interact in new ways. Of course these accounts of the potential positive functions of religion in defining agency do not present any excuse for all those circumstances where religions actually present dysfunctions and in fact contribute to injustice or inhibit the course of justice. With that in mind, empirical research may and must put these assumptions regarding the relationship of morality and religion to the test.

Significance of injustice

A third remark that I want to present is that the experience of injustice and any attempt to arrive at justice has socio-cultural characteristics that can easily be overlooked in an administration of law that is oriented at case-based reasoning. Let me clarify that. Crime causes moral harm. Crime affects our perception of value. Often it shatters our value system. This is particularly so whenever crime seriously affects our notion of common-sense and brutally invades the life-world. One characteristic of our values is indeed that they are latent. Values are usually asleep but are felt immediately, unambiguously and intensely when they are shaken up by unexpected actions that we experience as transgressions of the boundaries that define our sociocultural habitat. Dutch theologian and psychologist Han Fortmann once observed: '*If a fish would be able to come to discoveries, his last one surely would be the existence of water. Only when at the cart of the fish dealer he would know what it means to be an aquatic animal*'.[30] Our values are what water is to a fish: a socio-cultural habitat that hosts an implicit consensus of what is really significant in our life-world. Crime affects – and sometimes destroys – values. An interesting aim for research would be to find out which values are affected by which type of crime in order to establish insight into a taxonomy of the values that are put at risk in crime. My point here will however be another

one, namely to elaborate the concept of the affected life-world in experiences of injustice.

In philosophical terms, and while elaborating some phenomenological ideas of Edmund Husserl, social scientist Alfred Schütz has defined the life-world as a social effort to experience our immediate environment as meaningful and safe. In making sense of who and why we are, man designs his world in terms of motive chains from which he can explain his and others actions as building up the social reality of our world. These motives are linked together by chains of reasoning in the form of a temporal structure that informs us why we behave (in retrospect: '*das Weil-Motiv*') and with what objective (in prospect: '*das Um-zu-Motiv*'). The order that we derive from that has certain characteristics, among which feature its smooth significance ('*paramount reality*'), its character of immediacy ('*world in reach*'), its tangibility ('*pragmatic relevance*'), its sensory availability ('*wide awake*'), and its favoured and shared obviousness ('*universe of meaning*').[31, 32] Thus with Schütz one can maintain that values have an ordering function and actually create the social tissue of our world in terms of a meaningful structure that is based on a temporal ordering of events from which we understand our actions and are able to adequately communicate its motivations.

Crime is a wake-up call for values; of course especially so from victims' perspective but also from the point of view of his immediate and even remote audience. When confronted with an overt offence, we are not inclined to perceive values as favoured and cherished evaluations of the social life but especially as harmed dispositions. We experience this infliction in negative emotions such as frustration, anger, revenge, resentment and fear. However, this reaction – grave as it may be in itself and painful as its immediate consequences are – is not the sole characteristic of moral harm. Moral harm also relates to the damage done to what is considered proper behaviour and to the social and cognitive mechanisms that enable us to judge this behaviour in terms of right and wrong. Thus moral harm not only relates to a transgression of particular norms or values, but also to potential damage in our capability of moral discernment and to the social bedding that supports the shared standards for that judgment. This type of moral harm that encompasses these three characteristics: transgressions of social norms, infringement of moral discrimination and damage to collective trust in shared ethical standards, I propose to label as '*axial suffering*', where 'áξíā' is Greek for value or worth and axiology relates to the study of value discernment.

This notion of axial suffering can be applied to the distinctions that Schütz made with regard to the life-world. Crime is a breach of the life-world. A confrontation with crime affects the experience of the paramount reality of our immediate surroundings as a safe haven and a template for ordering our everyday interactions. Crime inhibits the grip on our immediate surroundings and damages our

capability to attribute meaning and experience significance. Of course the type and severity of criminal offence determines its impact and the pain of inflicted suffering. The point to make clear however, is that the confrontation with injustice is not adequately described by simply focussing on the criminal act, its intentions, and victim interactions, or by merely pinpointing the norms or laws that were transgressed. An exclusive emphasis on event, disposition and explanation easily looks away from the impact that criminal injustice has on the shared universe of meaning. Crime not only affects the legal order but also the order of meaning according to which we sustain our world as a moral habitat in which it is good to live. By employing a notion of axial suffering I aim to emphasize the consequences of injustice in terms of damage to the life-world in which we act from shared values and in an effort to assess what it means to live well.

My emphasis on notions of meaning and significance is one with theological interest. Religions can be considered to offer moral codes and ethical principles that define our life-world. This is probably a truism: religions still have a huge socializing influence in familiarizing subsequent generations with established norms that safeguard social environments. From a religious perspective, crime is obviously an affront to what any moral code in religion stands for. In many cases religions indeed cherish basic lists of ethical principles that stand out as main consensual guarantees that we live by certain ancient rules that define the moral identity of a community. Religions can be moral gatekeepers, not only in a conservative sense but as I have indicated also in an innovative meaning of the word. What is more, they also can guide people in practically applying moral norms and ethical principles in day-to-day issues and life-goals, be they personal or collective. Churches can be considered normative organizations of religions that pursue goals they consider morally worthwhile. They offer moral care for individuals and communities alike and in doing so reflect a socio-culturally ingrained – if at times disputed – authority. Religions thus have conceptions of justice that are relevant when we assess injustice and judge crime, and they also have certain means to address it.[33] This being said one has to point out that statements of the relationship of religion and crime are barely backed by empirical research.[34] The scarce evidence for instance shows some deterrent effect of religion on crime, but a lot of confounding influence still needs to be accounted for.[35] Thus, empirical research is still urgently needed to find out what role religions and churches have to address injustice, be it in the sense of preventing crime, addressing it as a moral issue, and in taking care of its consequences.

However, also apart from the issue of lacking empirical evidence one can question the religious role towards injustice on theoretical grounds. Religions are not well described as communities of interest that merely represent and

protect the core values of the life-world; they also symbolize the life-world and transform it in a metaphorical way that is decisive to understand any religious act of faith. According to a favourite definition in anthropology, religion is '*A system of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations seem uniquely realistic*'.[36] This definition by Clifford Geertz understands religion as attempt to realize subjectively felt moods and motivations – towards justice for our purpose – as decisively realistic phenomena in the outer world. It enhances the significance of morality by transforming it – in the act of faith so to say – as a realized state of affairs which is actually experienced in specific emotions of gratitude, courage or hope. Thus a religious attitude can be thought of in terms of a selective awareness that focusses on those meanings in the life-world that affirm that its envisaged ideal form is present or dawning. Now with regard to the perception of injustice and axial suffering as experienced in crime, this proposition may point at two diverging hypotheses. One holds that those who act in religious faith are likely to overcome harm of injustice because of a selective attention to look for alternative signs of justice in the criminal event or its aftermath. The other one holds that because of this selective attention to justice, they suffer harder from any harm of injustice, which may lead them to more severe reactions towards experienced crime. Again empirical research is needed to put hypotheses like these to the test.

Dealing with injustice

Up until now, I have presented some remarks regarding injustice, exemplified in crime, and I discussed the potential relevance of religion for this issue. Finally, in this paragraph I will address the issue of justice as a response to injustice, in which I will make the case for a proportionate support of perpetrators and victims.

It seems far more difficult to define justice as compared to injustice; probably since often the latter proves to be more close to life and represents a more likely object of our experience. Justice on the other hand is as I have mentioned a regulative idea with a long history of thought that is extensively elaborated in law. In getting a clear notion of justice it does matter if we attribute justice to persons and to God, to actions and to decisions, or to institutions and the legal system. If we take the legal system into account, we need to distinguish social justice, civil justice and criminal justice. Taking criminal justice at focus, the relationship with injustice seems obvious since crime pertains to a personal offence of publicly shared norms that elicits popular disapproval. An easy thought is that a moral discontent is also addressed by criminal law. However this suggests a

fitting overlap between morality and law. The shortcut syllogism then runs: *'if it is wrong, it must be illegal; if it is legal, it must be morally required or at least morally acceptable'*.[37] However, law may be less then morality and it may be more as well; they simply do not harmonize by definition. This has consequences for any view of criminal justice where a fault by the offender needs to be established. To determine guilt and responsibility, acceptable proof must be offered to demonstrate that the accused acted freely, knowingly and deliberately and thus that he was aware of both moral and legal aspects of his actions at the time and occasion of the crime ('*mens rea*'). Often however – as many cases indicate – the strict requirements of this principle cannot be ascertained and clear tensions with legal standards of public policy remain.[38] As a consequence, public discussions in criminal justice easily focus on the issue of punishment: an offense by a perpetrator – whose guilt and responsibility have been established by a court of law – requires repair in the form of a more or less equal damage to the offender as was exercised on his victim. Now, some are in favour of this view while others find it a relic that no longer fits into modern societies. Regrettably, these discussions easily amount in deadlocks where various types of reasoning collide and arguments of emotional satisfaction and those of rational polity represent dichotomous positions. In order to deal with that, I will try to derive some insights from my previous observations regarding injustice. Let me start by reformulating the issue in terms that I have employed before: how to invalidate the moral harm that results from criminal acts? Put in this wording, the burden of proof shifts from arguments that charge and burden the offender to an effort of redressing the situation that does justice to both perpetrator and victim.

One may hold that this approach of retribution starts from a notion of inequality, stating that moral and legal positions of offender and victim are simply different. All humans are vulnerable and inflicted harm of any kind needs to be counteracted with on a proportional basis. Harm is done and needs to be retaliated. The emotion that is present in this approach is revenge. Let me illustrate that with an historic event. Dutch Protestant Prince William of Orange battled the Spanish successfully in the 16th century, but on July 10th in 1584 he was assassinated by French Catholic Balthasar Gérard. Gérard was caught and subsequently punished for his crime: '*The magistrates decreed that the right hand of Gérard should be burned off with a red-hot iron, that his flesh should be torn from his bones with pincers in six different places, that he should be quartered and disembowelled alive, his heart torn from his bosom and flung in his face, and that, finally, his head should be taken off*'.[39] After days of preceding torture the decree was finally executed. It was a cruel punishment that even in the 16th century was considered very severe. The story illustrates an apparent need to re-establish a social and emotional equilibrium when crime shocks a community. The horror of this example does not exclude an argued explanation of the event. There are psychological and

traditional arguments according to which retribution actually does meet a rational account of proportionality.

Dutch psychologist Nico Frijda has described retribution as a way to restore the balance of suffering. He argues that vengeance is as rational or functional as any other emotion. Frijda points out that revenge protects against the sense of threat and that it reinstalls the equilibrium of pleasure and pain. Likewise it re-establishes the social order of power, the balance of which was upset by the inequality that a crime caused. Furthermore, revenge recaptures self-esteem while it also contributes to relief of pain.[40] This account is plausible, although one should add that hedonic motives and gratifying affects are one not the only mental processes to be taken into consideration. Empirical research also points at negative consequences of revenge, like a continuous rumination about the offender and a prevalence of disturbing affects that accompany the act of punishing.[41] There is more empirical counter evidence, but a point that remains is that from a psychological perspective, the argument against retaliation is not all that irrational. Quite on the contrary, retribution – in as far as it explains a mental mechanism – can be considered a lucid corrective device in re-establishing checks and balances.

There are traditional social motives for retribution as well. The '*lex talionis*' in the Bible highlights the ancient notion of reciprocity in retaliation: '*Anyone who maims another shall suffer the same injury in return: fracture for fracture, eye for eye, tooth for tooth; the injury inflicted is the injury to be suffered. One who kills an animal shall make restitution for it; but one who kills a human being shall be put to death*'.[42] The principles should however be applied within the setting of the rule of law: '*If a malicious witness comes forward to accuse someone of wrongdoing, then both parties to the dispute shall appear before the Lord, before the priests and the judges who are in office in those days, and the judges shall make a thorough inquiry. If the witness is a false witness, having testified falsely against another, then you shall do to the false witness just as the false witness had meant to do to the other. So you shall purge the evil from your midst. The rest shall hear and be afraid, and a crime such as this shall never again be committed among you. Show no pity: life for life, eye for eye, tooth for tooth, hand for hand, foot for foot*'.[43] This social principle of retaliation, far from being a merely irrational or aggressive emotion, is a rational and limiting principle that provides for proportionality in dealing with an offense. Since ancient times it was expected to be surrounded by judicial procedures that safeguard that no more harm was administered to an offender as was suffered by the victim. This rational and legally informed principle of proportionality needs to be distinguished from various forms of street justice in which principles of immediacy or premeditated delay are guiding principles.[44]

Previously, I introduced the notion of agency as a concept to clarify that in crime, offender and victim have a moral characteristic in common to pursue a good in their actions even when their interactions are under strain as in crime. In dealing with retribution this notion of agency requires a normative standard for which human dignity candidates. Dignity as a principle holds that there is an innate worth of any person and that any person is entitled to respect and to enjoy fundamental rights. Dignity as a concept is historically and metaphorically linked to the image of God. The '*imago Dei*' metaphor expresses divine similarity of God and man in the act of creation. Saint Augustine argued in '*The City of God*' that dignity originates from the immortality of man and entails a gift of freedom to choose and to bear responsibility for his acts. This theological tenet has strong philosophical counterparts. Kant has argued that dignity is rooted in reason and personal autonomy. From a Kantian perspective, dignity is the basic characteristic of humanity in as far as it is capable of morality, thereby formulating dignity in terms of the capacity to be autonomous. Dignity as an expression refers to an authentic choice to act according to a universal law that includes any other being in similar circumstances: we should treat one another as an end, never merely as a means. This universality claim offers a foundation for dignity as a regulatory principle in the legitimation of human rights that has found its expression in national and international constitutions and declarations.[45]

There are different ways in which dignity is relevant to the issue of proportionality in retribution. As guiding principle, human dignity is a universal principle that should be respected at all times, which surely does not correspond to the example of the torture and execution of Balthasar Gérard. However, it is one thing to maintain that dignity is inviolable but is quite another to establish the import of a crime with regard to a victims' or offenders' sense of dignity. To shed some light in this issue the concept of dignity needs to be elaborated. In a context of healthcare and quality of life discussions, philosopher Lennart Nordenfelt has distinguished various concepts of dignity. These can be applied to criminal settings of injustice. The first one is the basic principle of dignity that I have just indicated which Nordenfelt calls '*Menschenwürde*'. Here dignity is an inherent dimension of value pertaining to all persons regardless of their attributes and that clothes them with an innate entitlement to respect. This inherent dignity cannot be taken away and acts as basis for other human rights. The other three types of dignity are variables so to say that vary among people and circumstance. A dignity of merit depends on status attributes. This status can be formal if it is ascribed on the basis of social class or established positions, or it can be informal when it is acquired because of one's achievements. With this dignity of merit, persons can distinguish themselves among others and thus they are entitled to – and thus to a certain extent in control of – an awarded status. Next, a dignity of moral stature can be established that depends on persons' virtues, their character and their moral deeds that do not install rights but do command respect. Here, a

person installs himself as a moral agent to himself, which shows in sensed self-respect. And finally, Nordenfelt distinguishes a dignity of identity where worth is connected to one's physical autonomy, personal history, community and other extra-psychological qualities that nevertheless identify a particular person. It is dignity that we attach to ourselves and that identifies who we are, not so much what we are.[46]

The point that I want to make here is that different notions of dignity are involved in dealing with retribution at various phases of the events surrounding a criminal act. At the moment of the criminal event a dignity of identity is as at stake, since here the offender invades the private realm of a particular victim robbing him of properties that define his identity. This is likely to affect the moral dignity of the victim but not necessarily so, since a victim may retain a sense of self-respect in the experienced offense. In return, this does question the moral dignity of the offender, which we assume to be absent, but is it? Likewise one can ask what concept of dignity governs the rule of law as soon as the offender is brought to justice. Answers to these questions are not self-evident. Thus for instance, the lawyer's role in enhancing human dignity regarding the offender and victim positions can be criticized.[47] Finally, in rehabilitation of the offender, dignity of merit is at stake: will the offender be capable to gain status again in his community, and will his achievements enable him to gain a new position from which he derives a sense of worth? Thus, there is every reason to be precise in defining dignity in order to arrive at a proportionate view of agency that benefits balanced interpretations of offender- and victim-interactions.

Finally, there remains the issue of dealing with the impact of injustice on the life-world. How to go about with axial suffering? Can the damage done be repaired? Here principles of retribution do not suffice. Even if one acknowledges a rationality of revenge, one can question if its mental catharsis is beneficial to the victim and soothes his suffering in terms of affected values. One can probably maintain – as is often heard in voices opposing retaliating punishment – that retribution does not turn criminals into better persons. However, the claim that punishment does not help to prevent crime or support rehabilitation of the offender remains a utilitarian argument as long as the alternative for dealing with sensed injustice is not clarified. During the last decades, restorative justice is proposed as an alternative for retributive justice, and it indeed offers a way to deal with the sensed arbitrariness of injustice in victim and perpetrator interactions. Restorative justice aims to resolve conflict and repair harm in various forms of dialogue between victim, offender and community. Several characteristics stand out, such as victim support and healing, offender responsibility, retrospective dialogue, repair, prevention and reintegration.[48] Recent research bears increasing evidence for the positive function that restorative justice brings to bear in addressing the arbitrariness of injustice and in contributing to a proportionate redress of the situation. Especially guided

conferences in which offenders and victims meet, have effects in a reduction of reconviction and crime costs, while victims display reduced post-traumatic stress, desire for violent revenge, anxiety and fear.[49, 50] However, there are also others who point at the gap between the ideals of restorative justice and its actual practices. Far from being voluntary confrontations, restoration practices are often propelled by court orders or subtle pressures by stakeholders that make offenders participate at conferences and offer excuse on utilitarian grounds.[51] Thus questions remain if especially the healing strategies in restorative justice are sufficiently fit to address the moral problems and the axial suffering that is at stake. Restorative justice remains an innovative and promising concept that is still in development. Originated by religious initiative, it stands chances to mediate conservative and liberal positions towards dealing with injustice and arrive at a proportionate support of both victims and perpetrators.

In looking back, many questions remain that require attention. The ones that I have aimed to emphasize regard the actual experiences of the arbitrariness of injustice, the need to distinguish legal and moral aspects of injustice and the cultural role that religion may have in dealing with the contingencies of injustice. What I have subsequently emphasized is the need to look at injustice from an observer perspective of moral agency that addresses moral deficiencies of all parties involved, and where religion may offer symbols, narratives and rituals to facilitate this observer perspective of agency. I also have pointed at the need to develop the concept of axial suffering which entails the harm felt by injustice and that undermines the moral and symbolic network structure of our life-world. Finally, I have raised the issue of proportionality in injustice and pleaded for an elaboration of the concept of dignity in revisiting the notions of retribution and restoration. These are enormous questions. Far from simple answers, issues like these require on-going interdisciplinary studies and a shared research effort at a program level.

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Should the 'Insanity Defense' be Replaced by an 'Incapacity Defense'?

Gerben Meynen

1 Introduction

Currently, in the Netherlands, psychiatric evaluations of defendants are the subject of a vivid debate[1] (2). In fact, standards for legal insanity and psychiatric evaluations within the context of the insanity defense have often been the subject of discussion, within as well as outside of the Netherlands (3-6). From a philosophical perspective, some authors have proposed the idea of conceiving of legal insanity in terms of *incapacity* (7, 8). According to these philosophers, exculpation should be based on the presence or absence of certain capacities (such as the capacity to control one's behavior), rather than the presence or absence of a mental disorder. Of course, a lack of capacity is often brought about by a mental disorder but, at least in principle, it could be brought about by other conditions as well. What counts, from the perspective of moral philosophy, is the relevant incapacity, not the fact that a disorder brought it about. This chapter explores the possibility of an 'incapacity defense', asking the question: would replacing the 'Insanity defense' by an 'Incapacity defense' constitute progression in forensic psychiatry?[2]

The structure of this chapter is as follows.[3] In section 2, four influential standards for legal insanity in Anglo-American jurisdictions will be briefly discussed. We will examine their basic structure and we will look at the role mental disorder and (in)capacities play in these legal standards. Section 3 will then contain an analysis of the capacity-approach as suggested by Matthews (2004) and Vincent (2008), explaining why these authors conclude that insanity should be replaced by incapacity. In section 4, we shift our attention to the concept of patient's decision-making competence, a concept similar to that of criminal responsibility.[4] Interestingly, a patient's decision-making competence is usually approached in terms of certain *capacities* on the part of the patient. We will discuss this capacity-based approach and identify some of its strengths and

1 These evaluations are sometimes referred to as evaluations of the defendant's criminal responsibility. There is some controversy, however, about whether or not forensic psychiatrists should express their explicit view on whether or not the defendant is actually responsible for the criminal act. Some suggest that psychiatrists should not make statements about a defendant's (non) responsibility, because this is up to judge/jury to decide (an ultimate legal issue).

2 Although Matthews (2004) and Vincent (2008) do not mention the term 'incapacity defense', in this chapter this term will be used to refer to the approach they are suggesting.

3 This chapter is, in part, based on earlier publications(9-11).

4 For the similarities between criminal responsibility and patient competence, see section 4 and (9-11).

weaknesses, and determine their implications for a capacity-based approach to criminal responsibility. Section 5 will draw preliminary conclusions with respect to the possibility and desirability of an 'incapacity defense'.

2 Four Insanity Standards

In this section we will briefly consider four legal standards guiding insanity defenses in Anglo-American jurisdictions: the M'Naghten Rule, the Irresistible Impulse Test, the Model Penal Code, and the Durham Rule (or 'Product test'). As will become clear, the Durham Rule is in a relevant way similar to the Dutch approach to legal insanity. This section shows, firstly, that the concept of disease/disorder/defect[5] is central in all these legal standards. It also shows that the notions of 'incapacity' or 'inability' are already included in some of these standards.

2.1 M'NAGHTEN RULE

The most influential standard for legal insanity is the M'Naghten rule (1854) (3, 5). The M'Naghten rule was the result of a criminal law case. Daniel M'Naghten suffered from the delusional belief that the Tories (the political party) were persecuting him and, therefore, he intended to kill the Prime Minister, Sir Robert Peel. However, in a case of mistaken identity, M'Naghten killed the secretary to the Prime minister, Edward Drummond, instead. M'Naghten was acquitted on grounds of insanity. The M'Naghten Rule, which was eventually developed, has been phrased as,

> "[A]t the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong."[6]

Several elements in this legal standard can be distinguished:

1. The presence of a mental disorder/disease.
2. The mental disorder resulting in a defect of reason, such that
3. A certain type of knowledge[7] is lacking (about the nature and/or wrongfulness of the act).

5 The component of 'mental disorder' can be phrased in different ways (according to the approach taken in this chapter): 'disease of the mind', 'mental illness', 'mental disease', etcetera. These notions refer to some form of mental pathology.

6 M'Naghten's Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (H.L. 1843). See also Elliott (1996).

7 See also Becker (2003, p. 42) about the types of knowledge as two branches in the rule: "The M'Naghten rule has two branches. Either is a complete defense. The questions are whether the defendant at the time of the offense as a result of mental disease or defect was unable to know: 1. The nature and quality of the act committed; or 2. Whether the act was right or wrong. Both branches focus on the ability of the defendant to "know" certain things."(5)

It is noteworthy that the rule does not mention *all* the effects that mental disorders may have on a person's behavior. Although mental disorders may influence people's behavior in many ways, it is only the effect on the above-mentioned types of knowledge that exculpates a defendant. Still, M'Naghten leaves room for interpretation, discussion, and disagreement (3). For instance, does the 'wrongfulness of the act' refer to moral or legal knowledge?(12)

Although M'Naghten explicitly mentions pathology ('disease of the mind') as a requirement, it does not (explicitly) mention an 'inability' or 'incapacity'. In other words, M'Naghten does *not* state that due to a mental disorder a defendant lacked the capacity to know the nature or wrongfulness of the act. The rule simply requires that, due to mental pathology, a defendant *did* not know nature or wrongfulness of the act.

2.2 THE IRRESISTIBLE IMPULSE TEST

While the M'Naghten Rule focuses on knowledge, the 'Irresistible Impulse test" (*Parsons v State* 1887)(3) focuses on impulses that could not be resisted at the time of the crime. Explaining the nature of this legal standard, Gerber cites the Supreme Court of New Mexico as follows: "[Assuming defendant's knowledge of the nature and quality of his act and his knowledge that the act is wrong,] if, by reason of disease of the mind, defendant has been deprived of or has lost the power of his will which would enable him to prevent himself from doing the act, he can not be found guilty."[8] Becker deconstructs the Irresistible Impulse test as follows:

1. The defendant must have a significant mental illness.
2. The defendant's impulse must arise directly from the mental illness.
3. There must be no evidence of planning or premeditation by the defendant before the criminal act was committed.[9]

This legal rule recognizes that mental disorders may also have decisive effects on human behavior without primarily affecting a person's 'knowledge'. Although this rule might be considered a progression with respect to conceptualizing the morally relevant impact of a mental disorder on a person's actions, there is a serious problem attached to this standard as well. As Elliott (1996, p. 14) puts it, "the primary problem with the irresistible impulse test should be obvious. That is, it is impossible to distinguish between behavior that the agent *did* not control

8 The first part of this quotation refers to the M'Naghten Rule, then adding the 'irresistible impulse test'-formulation. New Mexico Supreme Court, State v. White, 58 N.M. 324, 270 P.2d 727, 731 (1954).

9 This is a quotation from Becker (2003). Notably, Elliott 1996 offers a somewhat different interpretation.

and behavior that the agent *could* not control. Merely because a person has not prevented himself from acting does not mean that he was unable to prevent himself from acting. As the American Psychiatric Association's 1983 position paper on the insanity defense pointed out: "The line between an irresistible impulse and in impulse not resisted is probably no sharper than that between twilight and dusk.""[10]

In other words, in theory as well as in legal practice it may be hard to distinguish clearly between an impulse simply not resisted and an irresistible impulse. The prominent legal theorist Stephen Morse (2011, p. 929) expresses this conceptual and practical concern as follows: "I readily concede that lack of control may be an independent type of incapacity that should mitigate or excuse responsibility, but until a good conceptual and operational account of lack of control is provided, I prefer to limit the insanity defense to cognitive tests" (12).

The notion of an incapacity or inability, meanwhile, is reflected in this standard, as it states "...has been deprived of or has *lost the power of his will which would enable* him to prevent himself from doing..." (emphasis added). Such a person has, in fact, lost a capacity or ability.

2.3 MODEL PENAL CODE (AMERICAN LAW INSTITUTE)

According to The Modal Penal Code (The American Law Institute, 1962/1985), "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law."[11]

In this standard, one knowledge-element is taken from M'Naghten (the wrongfulness of the action), and another element is added: to conform one's conduct to the requirements of the law. According to Becker, "The ALI [American Law Institute] test was viewed as a broader more expansive test of insanity as compared to the outdated M'Naghten test (...). The ALI test also broadened the insanity test to include a volitional or "irresistible impulse" component. The test focused on the "defendant's understanding of his conduct" and also on the "defendant's ability to control his actions" (5). Although the Model Penal Code does justice to the variety of ways in which mental disorders may affect human behavior, its popularity diminished after John Hinckley, who tried to assassinate President Ronald Reagan in 1981, was acquitted on grounds of insanity. As a result, many states in the USA returned to M'Naghten (5).

10 Original reference of the American Psychiatric Association's position (13) (p.685). See also Glannon (2011) on the problems of the notion of impulse control in mental disorder (14).

11 Model Penal Code. Official draft and explanatory notes: complete text as adopted May 24, 1962. Philadelphia: American Law Institute, 1985.

The Model Penal Code explicitly mentions the term *capacity*. However, it is clear that merely 'lack[ing] the substantial capacity" is not sufficient for exculpation: there is an additional requirement that this lack of capacity has to be brought about by a mental *disease or defect*. Still, the Model Penal Code is the first standard for legal insanity we consider which explicitly mentions the lack of (substantial) capacity. This enables us to ask the question: do we need the 'mental disease' here in order to be able to exculpate a defendant? In other words, if a person "lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law", isn't that enough to excuse this defendant for his action or do we need more information? More precisely, do we need to know that this incapacity was brought about by a mental disease? If not, the capacity-based approach that will be discussed in section 3 could be an improvement.

2.4 PRODUCT TEST; THE DUTCH APPROACH

According to the 'product test' (*Durham v US*, 1954), a defendant can be exculpated if the crime was the product of a mental disease or defect: "[A]ccused is not criminally responsible if his unlawful act was the product of mental disease or mental defect".[12] Such an insanity test differs considerably from the other three standards (the M'Naghten rule, Irresistible impulse test, and the Model Penal Code). These three tests define the legally relevant effect of the disorder: M'Naghten describes the area of legal interest in terms of certain knowledge; the Irresistible Impulse test focuses on the (in)ability to resist an impulse; the Model Penal Code defines its area of interest as appreciation of the criminality of the act and/or inability to conform one's conduct to the requirements of the law. The Durham rule, however, sets *no limitations* on the domains of human functioning that should be affected. The only requirement is that the influence of the mental disorder is such that the criminal act can be considered the *product* of the disorder or defect.

As Gerber writes (1975, p. 125), "The Durham standard views mental functioning as essentially unitary but multifaced. No single mental faculty determines the existence or nonexistence of sanity, just as no single faculty is responsible for the control of human behavior. Impaired control may result from a wide variety of causes in the psyche, not all of which are cognitional" (4). Conceptually, this position is interesting. One of the ideas behind Durham was "encouraging the fullest possible range of psychiatric testimony on the question of responsibility" (4). (p. 124) Nevertheless, the rule became unpopular(3) because it allegedly gave too much authority to the psychiatrist, resulting in "the domination of the courtroom by psychiatrists"(4). (p. 127) Gerber (1975,

12 *Durham v. United States*, 214 F. 2d 862 - United States Court of Appeals, District of Columbia Circuit 1954.

p. 125) states: "Clearly, it represents the psychiatrization of the criminal law, an attempt to transform into legal terms the notion that there are two modes of existence – one sane, and the other insane." Many people considered such a 'psychiatrization of criminal law' not to be a step forward. They were uncomfortable with an insanity standard that focuses on a mental disorder without defining the kind of influence of a mental disorder that is *legally* relevant.

In the Netherlands, there is no explicit legal standard guiding psychiatric assessment of defendants, like the M'Naghten rule, though the evaluation by the psychiatrist is still guided by a number of questions that have to be answered. These questions are (in brief):

1. Is the defendant currently suffering from a mental disorder?
2. Was the defendant suffering from a mental disorder at the time of the crime?
3. If so, did the disorder influence the defendant's behavior?

4a. If so, in what way?
4b. If so, to what extent?
4c. What conclusions can be drawn from this with respect to the advice offered concerning the defendant's criminal responsibility?(15)

Considering these questions, it looks like, in the Netherlands, we are using a variant of the 'Product-test' in the sense that the legally relevant kind of influence of the disorder on the defendant has *not* been defined.[13] The nature of the influence and the extent to which it, at the time of the offence, affected the defendant's actions, as far as is considered relevant *by the psychiatrist*, will be described in the report. In this sense, in the Netherlands, a great deal of 'authority' is given to the psychiatrist.[14]

In sum, Durham requires a *mental disorder* and its *effec*t on a criminal act ('product'), but does not mention the term 'capacity'. It does, however, leave open the possibility that the expert may describe the influence of a mental disorder in terms of incapacities.

2.5 CONCLUSION

According to these Anglo-American legal standards, the defendant has to be suffering from a mental disorder or mental defect. In addition, the disorder should lead to a legally relevant mental state (for example, a lack of knowledge)

13 Still, the term 'influence' is different from the term 'product', although in this context they are related. The term 'product' has been considered problematic as well, Becker (2003, p. 43): "The question of causation or 'product' is fraught with difficulties. The concept of singleness of personality and unity of mental processes that psychology and psychiatry regards as fundamental, makes it almost impossible to divorce the question of whether the defendant would have engaged in the prohibited conduct if he had not been ill from the question of whether he was, at the time of the conduct, in fact ill."

14 Of course, the final decision is up to the judge.

or – in the 'product test' – the act itself. The basic structure, then, is that the standard contains two elements:

1. The presence of a *mental disorder or defect*:
   a. M'Naghten: "*from the disease of the mind*".
   b. Irresistible impulse test: "*by reason of disease of the mind*".
   c. Model Penal Code (ALI): "*as a result of mental disease or defect*".
   d. Durham / product test: "*of mental disease or mental defect*".
2. Its *influence* in terms of:
   a. M'Naghten: "*as not to know the nature and quality of the act... that he did not know what he was doing was wrong*".
   b. Irresistible impulse test: "*lost the power of his will which would enable him to prevent*".
   c. Model Penal Code (ALI): "*lacks substantial capacity either to appreciate the criminality... or to conform*".
   d. Durham / product test: *any influence that makes the act the 'product' of the disorder*.

Although the four standards vary considerably with respect to the definition of the legally relevant influence (second element), they all share the first element: the requirement of the presence of mental pathology. Given the fact that the name of the defense is 'insanity defense' – having to do with being sane or insane – we should not be surprised that a mental disorder is required. Still, we might ask ourselves whether the way in which the second part of the insanity defense is described in some standards – like 'he lacks substantial *capacity* either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law' (Model Penal Code) – renders the first part concerning the mental disorder, in fact, *redundant*.

Notably, two of the standards conceive of the influence of a mental disorder in terms of 'ability' and 'capacity' and it is not only in the legal standards that we find these terms. Stephen Morse (2011, p. 923) conceives of the notion of insanity in terms of capacity as well: "Roughly speaking, the insanity defense is based on the premise that the legally insane defendant substantially lacks rational capacity or the capacity to control his or her criminal behavior"(12). Now is it possible and desirable to conceive of criminal responsibility *solely* in terms of (in) capacities?

3 A capacity-based approach to criminal responsibility

In contrast with current legal practice, Matthews as well as Vincent, both moral philosophers, have argued for a capacity-based approach to criminal responsibility(7, 8). Their approach implies that we should leave out any reference to

mental disorders in our standard for what we could then call 'criminal irresponsibility'.

Matthews[15] asks us to imagine Ben, a (very) young child, who is playing on a freeway overpass and "gleefully throws rocks over the wall and into the path of oncoming traffic. A fist-sized rock smashes through the windscreen of a car seriously injuring the occupant"(7). Although Ben is, in a way, responsible for the tragedy that has unfolded, we will not blame him for injuring the occupant. Now why is that? Is it because Ben is only very young, or is there more to be said about the reason for exculpation? Matthews responds that (young) children are not held responsible for their wrongdoings, not because they are young or because they suffer from a mental disorder, but because they lack certain *capacities* required for being a morally responsible agent (7). In fact, the reason that we do not hold young children responsible is not because of their age, but because of incapacity associated with their age. On this account, the child lacks certain capacities and *therefore* the child is not considered responsible. What counts for moral responsibility is a person's morally relevant (in)ability, which can be lacking because of *different* conditions and circumstances. Such ability, for instance, may be lacking because a person is only four years of age, or, if the person is an adult, because this person is suffering from a mental disorder.

Vincent argues along the same lines, saying that a mental disorder is "neither necessary nor sufficient for reduced responsibility". Like Matthews, she refers to young children, stating: "[T]hat disorder is not necessary for reduced responsibility (...), is plain when we consider young children–a group whose responsibility is reduced despite the absence of neurological disorder. We do not typically think that young children (e.g. 5 year olds) are fully responsible for the things that they do." So, the fact that children, who do not suffer from a disorder, can still be excused shows that mental disorder is *not necessary* for reduced responsibility. Furthermore, Vincent argues, 'mental disorder' is *not sufficient* for reduced responsibility either. Referring to Morse, she states that people with hypomania may still be fully responsible for their actions, although they are suffering from a mental disorder. In fact, as we discussed in section 2.5, the insanity standards make it plain that a mental disorder *per se* is never sufficient for exculpation, since they all require, in addition, the *influence* of the disorder on the person or the relevant act (although they define this influence in different ways).[16]

According to Vincent, "capacity and not disorder is what determines responsibility." So far, this appears to be a reasonable line of thought: if, ultimately, we

15 According to Matthews, his account (see also section 6) is an account of 'failed agency'. Its characteristics are: leaving out any reference to a mental disorder, or other underlying factors, and phrasing the elements of failed agency in terms of 'lacked the capacity to...' or 'unable to...'. His account is based on the notion of *moral* responsibility. Moral responsibility is usually considered highly relevant to criminal responsibility, see, for example, Morse (2011, p. 926): "Legal insanity is a legal and moral issue (...) The moral basis for the insanity defense is that in some cases mental disorder affects the defendant's capacity to act rationally or to control his behavior"(12).

16 See, however, note 13 on the Durham Rule.

are interested in the effect of a mental disorder – not just in its presence – why wouldn't we focus entirely on the affected capacities relevant to moral agency?

Let us, however, consider some problems that could arise if we formulate criminal irresponsibility in terms of certain incapacities, rather than in terms of insanity (mental disease or defect). Some of these problems are practical in nature, and some are more conceptual.[17] In the following section, we will consider two conceptual issues, both derived from discussions in medical ethics about the assessment of a patient's competence to decide about treatment options.

4 Standard for competent decision-making: a capacity-based approach

This section will look at the standard for an assessment which is in a relevant way similar to the assessment of a defendant's criminal responsibility: the assessment of patient decision-making capacity.[18] In principle, doctors have the moral and legal obligation to obtain informed consent from their patients. Valid informed consent can only be obtained from a patient who is competent to make the decision at hand. In the event of doubt about a patient's competence, his or her decision-making capacity will be evaluated. There are several significant similarities between assessments of competent decision-making on the one hand and assessments of criminal responsibility on the other (9, 16, 17). Some of these similarities are: both assessments take place at the intersection of medicine and law; regarding both assessments psychiatrists are considered experts; both assessments are normative (different from, for example, measuring blood pressure); both assessments evaluate a *specific* act or choice by a person; both assessments have been related to the topic of free will or free choice.[19] We will consider the conceptual approach to competent decision-making because it shows us how a normative assessment at the intersection of medicine and law can be effectively formulated in terms of *capacities*. Moreover, conceptual discussions about patient competence reveal that a capacity-based approach faces some challenges as well.

17 For instance, Morse (2011, p. 895-6) writes that the requirement of a mental disorder allegedly provides an 'objective marker' to the insanity defense: "One could jettison the mental disorder criterion in mental health laws, the presence of a mental abnormality, and simply address the other legally relevant behavior entirely functionally, but the presence of a mental disorder allegedly provides an objective marker that the person genuinely lacks the required rational capacity. The mental disorder criterion for mental health laws achieves this goal only imperfectly at best..."(12) Note that Morse uses the term 'functionally' whereas a capacity-approach would use the term 'capacity'. In this paper, I will not address the question of to what extent the notion of 'mental disorder' constitutes an 'objective marker' that should not be left out.

18 Other terms are: 'decision-making competence', or just 'competence' or 'competency'.

19 See (9, 10, 16) for a more elaborate comparison between assessments of competence and of criminal responsibility.

4.1 A CAPACITY-BASED APPROACH TO COMPETENCE

There is an ongoing debate on how to conceive of (assessments of) patient competence (18, 19). Interestingly, the approach to assessments of decision-making competence most widely accepted, does *not* include the requirement of the presence of a mental disorder (20). This approach has been proposed and elaborated by Appelbaum and Grisso (21, 22), and I shall refer to it as the 'Appelbaum-approach' or, more generally, the 'abilities-approach' to competence (18). Appelbaum identifies four abilities on the part of the patient that should be present in order for that patient to be considered competent to make a decision about treatment options. The ability...

1. to express a choice,
2. to understand the relevant information,
3. to appreciate the situation and its consequences, and,
4. to reason about treatment options (20, 23, 24).

At least at first sight, these four components appear to cover all aspects of competent decision-making, especially because they leave so much open. For instance, they merely state *that* one should be able to appreciate the situation and its consequences, without spelling out *how* this should be done. This conceptual framework has been found helpful in clinical as well as in research settings in many countries and jurisdictions for many reasons, one of them being that an assessment tool – the MacCAT – covering these four areas has been developed (22).

Note that each of the four criteria is phrased as an *ability*, and that *no* reference is made to a 'disease of the mind' or a 'mental defect'. This clearly shows that a normative concept, which is considered as being related to criminal responsibility, can be conceived of in terms of capacities, without any reference to mental pathology. In fact, not relying on medical diagnosis is often considered to be an advantage of this approach to competence, because otherwise the assessments of competence would be 'medicalized'[20] in the sense that a medical evaluation (diagnosis) would be required to answer the question of whether or not a person is competent (18).

Given the similarities between 'competence' and 'criminal responsibility', the characteristics of the Appelbaum-approach to (assessments of) competence suggests that, in principle, criminal responsibility could also be conceived of in terms of (in)capacities, without any reference to mental pathology. In the following two subsections, we will consider two lines of criticism regarding Appelbaum's approach to competence. These lines of criticism could be relevant to a capacity-approach to criminal responsibility as well.

20 To some extent, medicalization takes place as soon as a medical doctor (psychiatrist) is asked to perform an assessment.

4.2 WHICH ABILITIES SHOULD BE INCLUDED?

We might ask ourselves: could there be more to competent patient decision-making than expressing a choice, understanding the relevant information, appreciating one's situation and its consequences and having the capacity to reason about the options? The first line of criticism is that the four capacities in Appelbaum's model do not cover *all* the instances in which a person may be incompetent. Louis Charland used the character of Mr. Spock – "a being more or less without the capacity for emotion" (Charland 1998, p.69) – to show that a specific capacity was lacking in Appelbaum's (understanding of the) model: the capacity to experience *emotions* (25). He argues that Appelbaum's criteria focus on cognitive abilities, overlooking the relevance of emotions to competent decision-making. Appelbaum, however, was not convinced, on several grounds (26). But let us assume that Charland is right. What could this mean in practice? A patient who suffers from a mental disorder that predominantly affects cognitive abilities (such as dementia), will be considered incompetent because that patient does not reach the standard for competence according to Appelbaum's criteria. Yet, another patient, suffering from a disorder which leaves cognitive functioning intact, but whose disorder undermines the capacity to decide *with emotion* is considered *competent*, while, in fact, this patient is incompetent. In other words, Charland's criticism implies that the competence-undermining effects of some disorders/conditions are reflected in the Appelbaum-criteria, while competence-undermining effects of other disorders/conditions – those affecting a patient's emotions – are not. Charland's objection shows that even widely accepted and broadly formulated criteria could still be falling short in some respects.

What are the implications for a capacity-approach to criminal responsibility? Basically, the discussion shows that it might be difficult to identify clearly *all* the (in)capacities that lead to criminal (ir)responsibility. But that is hardly surprising, because it is always difficult to provide definitions or standards which are both theoretically and practically satisfactory to everyone. This was the case with M'Naghten as well: people considered this standard too stringent. In addition, the Model Penal Code was considered too lenient (see section 2). In this respect, the discussions in the sphere of medical ethics about the Appelbaum-criteria for competence do not show us a new problem, they only show that even an elaborate, robust and widely (internationally) accepted account in terms of capacities may still be overlooking relevant components. Still, as it appears, there *is* a way to circumvent this problem: to apply the strategy of the Product-test in a way that does not spell out the nature of the legally relevant effect. It merely states that the act should be the *product* of the *disorder*. Thus, by relying completely on the notion of *pathology*, the standard avoids the need to define the nature of the influence, either in terms of capacities or otherwise. This, however, is not an option for a capacity-based approach: it can no longer rely on the notion of pathology; it *has to* spell out the relevant capacity/ies. In this sense,

Charland's critique shows a way in which a capacity-approach may be more vulnerable than an insanity approach: it has to spell out the relevant capacities – which will always be open to criticism and debate.

Yet, rather than focusing on Charland's criticism we may emphasize that Appelbaum and Grisso have succeeded in formulating four abilities which are considered helpful in clinical practice and research in many countries and jurisdictions. And rather than focusing on (modest) conceptual problems, we may emphasize the extent to which Appelbaum's capacities-approach has brought clarity, agreement and uniformity in conceptualizing patient competence (see also (9)). This *could* mean that a capacity-approach to criminal responsibility has the potential to result in a transparent, robust and widely endorsed standard.

4.3 DO ABILITIES COVER ALL THAT IS RELEVANT TO COMPETENCE?

Let us consider another line of criticism. Tan et al. performed a study, using qualitative research methods, of decision-making competence in anorexia patients (27). They observed that these patients, although competent according to the four Appelbaum criteria,[21] were in fact not competent if something was taken into account that was not covered by these criteria: their values. In some of the anorexia patients, the value of being thin had become the most important value in their value system, overriding all the others, even that of being healthy.[22] Tan et al. argued that these values – like being thin being more important than being healthy – were *pathological*.

This term 'pathological' can be unpacked in various ways, but one way is to understand it as 'not authentic' or 'inauthentic'. As Tan et al. put it: "One implication of their being pathological is that these values do not represent the true or authentic views of the person" (27). Hence, according to Tan et al., although these anorexia patients are able to reason about treatment options, to appreciate the situation, to understand the relevant information and to communicate their choice (the four Appelbaum-criteria), their decision is nevertheless based on inauthentic values, and therefore, these patients should *not* be considered competent. Tan et al. write:

> "Unlike psychotic disorders which tend to be associated with apparently bizarre, meaningless or disconnected beliefs, there can be consistency, coherence and organisation within the value and belief systems which underpin the behaviour of patients who suffer from anorexia nervosa. The patient who has anorexia nervosa therefore may be able to give a coherent, consistent answer to the 'Why?' question, but still be making decisions based on 'pathological values' that arise from the disorder."

21 See, however, a study by Turrell et al., in which anorexia patients were found to show cognitive characteristics/problems related to the Appelbaum criteria for competence (28).
22 See also Meynen and Widdershoven (2012) on the study by Tan et al. (18).

Apparently, in anorexia nervosa a person's capacities remain intact, *but at the same time* something important has changed: the person's values become inauthentic, resulting in incompetence. The capacities remain as they are, but the material they work with (the person's value system), has changed. Rather than affecting capacities, anorexia affects authenticity. Tan et al. claim that such inauthenticity undermines, at least in some cases, a patient's competence (27).

Now what are the implications of *this* line of criticism[23] for an 'incapacity defense'? Note that capacities do not cover authenticity: inauthenticity is not readily expressible in terms of incapacity. Therefore, the basic threat to such a defense is that, as it appears, there are phenomena relevant for competence which *cannot* be expressed in terms of incapacities. This is a more basic worry than Charland's concern. If needed, his concern could be remedied by adding the 'capacity for emotions'. Yet, authenticity cannot just be added as another capacity, because authenticity is not a 'capacity', at least not in the usual sense of the term.

Could it be that the concept of 'inauthenticity' is also relevant to criminal responsibility? If this is the case, then there might be a serious problem for an 'incapacity defense', because, then, the notion of capacity cannot capture an essential aspect of criminal responsibility. Suppose a person whose values have been turned into inauthentic values because of a mental disorder, commits a crime – should we excuse that person? Note that the person is still a rational being, but he makes decisions that can no longer be considered authentically his, because his values – which play a role in moral decisions – have been pathologically changed. It appears to be that if, due to a mental disorder, such a person is no longer himself, this could be a reason to exculpate that person (29). More precisely, if inauthentic values have decisively influenced that person's choice to commit a crime, we may consider this action no longer *genuinely* his, and therefore (partially) excuse this person.[24]

Consider a patient who receives deep brain stimulation (DBS) because of chronic pain. Now, as long as the electrode is switched on, there is considerably less pain, but there is a peculiar side-effect from the successful treatment: her values have significantly changed, while her mental capacities remain intact. Based on these changed values (very different from the values she has when the DBS is off), this patient commits a crime.[25] Should she be exculpated? If we feel

23 The basic point is not whether Tan et al. are completely right about competence and anorexia, but that an intriguing issue has been raised: perhaps, not all the effects of mental disorders/conditions relevant to competence can be expressed in terms of (in)capacities.

24 See also the philosopher Haji (2010, p. 265) for the relevance of authenticity for moral responsibility: "The account of moral responsibility that I favour has at its core the analysis that one is morally responsible for performing an action if and only if one performs it in the (non-culpable) belief that one is doing something morally obligatory, right, or wrong, one has appropriate responsibility-grounding control in performing it, and it causally issues form authentic actional springs. So, responsibility has at least a control component, an epistemic component, and an authenticity component"(30).

25 See also (31), and see Klaming and Haselager (2010) on 'Personal identity, responsibility for action and mental competence' in their paper 'Did my brain implant make me do it? Questions raised by DBS regarding psychological continuity, responsibility for action and mental competence'(32).

she should be exculpated, this indicates that her changed values *are* relevant to criminal responsibility. Consequently, a capacity approach might not be able to cover all phenomena relevant to criminal responsibility.

In sum, unpacking the moral intuition that mental disorders excuse in terms of *capacities* runs the risk that relevant phenomena are overlooked. Mental disorders may undermine a person's competence in a way that is not expressible in terms of lacking capacities. Moreover, perhaps we *need* the word 'pathological' (referring to disease/disorder/defect) in order to express why, at least in certain cases, people are incompetent due to a mental disorder, just as Tan et al. use the word '*pathological*' with respect to inauthentic values due to anorexia nervosa. In other words, the effects of anorexia on patient competence make Tan et al. introduce the word 'pathological' into discussions on competent decision-making. This suggests that the notion of 'pathology' *adds* something to the capacities formulated by Appelbaum.

Before we return to legal insanity in the following section, let us consider another way in which competent decision-making has been conceptualized. In this variant of the Appelbaum approach, the four capacities are described, but they only lead to incompetence in those cases where the lack of capacity was brought about by a mental disorder or another defect or abnormality. According to the Mental Capacity Act (United Kingdom, 2005), incompetence is a condition that does not only entail a lack of certain relevant capacities, but, in addition, there is a 'threshold' criterion: "Assessing capacity is a two stage process. For a person to lack capacity, he or she must have an impairment of or disturbance in the functioning of the brain or mind, and this defect must result in the inability to understand, retain, use, or weigh information relevant to a decision or to communicate a choice" (33). The disorder can be considered a 'threshold' in this UK approach to competence, because if there is no disorder, the absence of certain capacities does not lead to incompetence. So, just like in the four insanity defenses (see section 2), there has to be a pathological condition.

5 Towards an 'Incapacity defense'?

Let us consider the options for a standard for criminal responsibility based on the analysis in sections 2-4. As it appears, there are, at least, four possible approaches to the criteria for criminal irresponsibility. These are (some explanation is added):

1. The *effect* of a *mental disorder* is the crucial issue: the crime was (at least to some extent) the 'product' of the disorder. This is the 'product test' or Durham Rule, and, in a way, it appears to be the Dutch approach as well. The legally relevant influence does not have to be defined either in terms of capacities or in any other way.

2. The legally *relevant effect* of the *mental disorder* is defined. M'Naghten is an example: the *lack of knowledge* as a result of the disease. Consequently, not all the effects of the disorder can lead to a successful insanity defense. For instance, impulse control problems (not affecting a defendant's knowledge) cannot lead to a successful insanity defense.
3. The capacity-approach, as suggested by Matthews and Vincent. This implies that a person is exculpated because of a lack of capacities, no matter how the lack was brought about (for example, it may be due to youth or mental disorder). Basically, incapacity replaces insanity. Matthews (2004, p. 416) offers the following account: "A person is not criminally responsible for an offence if at the time he or she carried out the conduct constituting the offence he or she failed the test of responsible agency. This test is failed if any one of the following three conditions is satisfied: (a) the person lacked the capacity to understand the nature of what he or she was doing; or (b) the person lacked the capacity to understand that what he or she was doing was wrong (that is, the person's conduct was insufficiently reasons–responsive, constitutively speaking, to conventional, moral or legal codes of behavior; or (c) the person was unable to control his or her conduct"(7). In fact, Matthews's proposal echoes M'Naghten and the Irresistible Impulse test as well as the Model Penal Code (ALI), while formulating the three components as *capacities*.[26]
4. A combination of a capacity-based approach and the requirement of a mental disorder. In this case, we define the relevant capacities (just like Appelbaum did), but only exculpate a person if the incapacities were brought about by a disorder. So, the disorder can be considered a threshold here, because without a disorder, the lack of certain capacities does not exculpate a defendant. This appears to be the way in which the Mental Capacity Act (UK) conceives of competence.

So, there are, at least, four options, which can, of course, be elaborated in different ways.

This chapter has explored the possibility of replacing the insanity defense with an incapacity defense (option 3). This possibility, in fact, entails two things: conceiving of the legally relevant phenomena as incapacities *and* leaving out any reference to a mental disorder. The first turned out not to be completely new: some of the legal standards already contain this notion of '(in)capacity' or '(in) ability. The second – leaving out any reference to a mental disorder or defect – is new; at least, it is not reflected in any of the legal standards we discussed. Is it possible and desirable to leave out 'mental disorder' in a capacity-based approach to criminal responsibility?

In order to be able to come to a decision on this, we should know more about the normative work that is done by the term 'mental disorder' in the insanity rules. As it appears, mental disorders are special entities. Although our behavior may be influenced by many mental phenomena, such as love, hate, hope, anxiety, etcetera, mental disorder is singled out as a unique phenomenon: *its* influence is able to exculpate a defendant, while so many other phenomena lack this power.

26 Matthews takes, in fact, the Australian Commonwealth Criminal Code (1995) as a starting point.

This characteristic is clearly expressed in the Product test, and in the Dutch approach to legal insanity as well. In addition, Tan et al. started using the term '*pathological* (values)' when describing the challenges for anorexia patients with respect to competent decision-making. In fact, the question, 'What do we lose if we replace the insanity defense by an incapacity defense?', invites us to think about the nature of mental disorder itself. If we know more about the nature of a mental disorder, we may be in a better position to determine its role in the exculpation of a defendant, and, more precisely, to determine whether or not the notion of psychopathology can be deleted in a future legal standard.[27] Yet, at the moment we lack a clear/uncontroversial account of what a mental disorder actually is(35-37).

In the absence of such an account, let us formulate three Pros and three Cons – some more theoretical and some more practical in nature – with respect to a capacity-based approach to criminal responsibility. We shall start with the Cons:

Con 1: It might be hard to define in some detail all the incapacities relevant to criminal responsibility (see Charland's criticism concerning Appelbaum's four-component framework).

Con 2: Perhaps some features or effects of mental disorders are not (easily) expressible in terms of incapacities (but should be phrased in terms of authenticity, see our discussion of Tan et al.).

Con 3: All the Rules in the insanity defense contain the component of mental pathology. This suggests that the notion of pathology is at the core of this type of exculpation.

Pro 1: The abilities-approach has been used regarding patient competence (which is a similar concept), and it has led to a conceptual framework that has been widely used in clinical practice and research settings in different countries and jurisdictions.

Pro 2: Conceptually, the argument made by Matthews and Vincent is attractive: people may be excused for different reasons. What counts, eventually, is the *absence or presence* of morally relevant capacities, not how their absence or presence came about. In addition, at least for the sake of transparency, it would be good to define the relevant capacities clearly, just as has been done in regard to patient competence.

Pro 3: Two of the four legal standards we discussed – the Model Penal Code and the Irresistible Impulse test – already contain the component of 'ability' or

27 Interestingly, Perring (2004, p. 489) writes in a paper called 'Conceptual issues in assessing responsibility for actions symptomatic of mental illness': "I will propose and test the thesis, (...) that all behavioral symptoms of mental disorders must be involuntary" (34). On p. 496 he states: "To summarize, I have found three ways in which we can count a form of behavior as involuntary: (a) It is the result of an irresistible craving or overpowering fear. (b) It is the result of an aberrant and temporary desire external to a person's true personality. (c) It is the result of a delusion. I am proposing involuntariness of all symptoms as a necessary condition of mental disorder, not a sufficient one." Within the context of his paper, involuntariness is directly relevant to responsibility.

'capacity'. This suggests the helpfulness of the concept of 'capacity' in this type of exculpation.

Would replacing the 'Insanity defense' with an 'Incapacity defense' constitute progression in forensic psychiatry? Given the Pros and Cons at this point it is not completely clear that an abilities-approach is favorable, let alone what form it should take. However, at least in my view, the Pros outweigh the Cons in the sense that they make further research on this topic definitely desirable.

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PART II: ABOUT BOUNDARIES IN PRACTICE

Forensic Psychotherapy in the Netherlands and the Essence of Psychiatric TBS-Detention *(terbeschikkingstelling)*

Hjalmar van Marle

Introduction

Nowadays our society is far less willing to tolerate any infringement on community security compared to 30 years ago. In this process of augmenting repressive policy forensic psychiatry – among others – lost its progressive aura of treating mentally disordered delinquents to start a new, less danger provoking life in the society. The work of the intellectual spearhead of forensic psychiatry, its professors at the different universities in the Netherlands, was less and lesser valued by their Boards and, when they retired, no successors were appointed. The Pompe Institute in Utrecht is until now the only exception though the scientific domain of the chair has been broadened to psychiatry and psychology. With the disappearance of these experienced psychiatrists, like F. Beyaert, H. Goudsmit, S. van der Kwast, W. Nieboer, G. Schnitzler, B. de Smit and M. Zeegers forensic psychiatry started losing its roots in clinical practice where the patient-therapist relationship was implicitly and explicitly core-business. While this generation was psychoanalytically educated the therapeutic relationship, ward atmosphere, criminal law and criminal policy were easily mutually connected and by reports to the government even translated in governmental and political policy.

When the Boards of Governance of the Dutch universities lost their confidence in the progressive powers of forensic psychiatry to further treatment and to enhance the security in the community, no more money was saved for these chairs, which next to their publications had also a huge influence on their students by their classes. By their lectures these professors educated their medical, psychological and juridical students the essence of therapeutic/non-therapeutic relationships and the influence of the total institutions in which forensic psychiatric patients were detained. On the threshold of the loss of so many knowledge and experience the Stichting Koningsheide ('Koningsheide Foundation') from the Dutch city of Arnhem was alarmed and choosed to establish professorate chairs for one day a week to save the lessons to students and to continue actual forensic psychiatric publications. J.W. (Koos) Reicher was the first Professor of Forensic Psychiatry, supported by the Koningsheide

Foundation, but was not able to accept the position due to his premature and sudden death on November 7, 1987. About a year later (in 1989) the colleague, who was selected to take his place, Antoine Mooij from Utrecht, entitled his inaugural lecture in Groningen, "On the interface of psychiatry and law."

In short order the Koningsheide Foundation established a sufficient 'critical mass' of professors such that continued debate ensured no question of forming a monoculture. In 1988 Antoine Mooij became Professor of Forensic Psychiatry in Groningen and in 1990 Hjalmar van Marle was appointed to the same position in Nijmegen (inaugural lecture: "The Predilection for Compulsion," 1993), succeeded in 2004 by Andries Korebrits. The next appointment supported by the Koningsheide Foundation was Karel Oei at the University of Tilburg in 1993 (inaugural lecture: "Fact and Fiction," 1995) succeeded by Gerben Meynen in 2012. In 1995 Dick Raes was appointed at the Free University in Amsterdam (inaugural lecture: "Wasted effort," 1996) and succeeded Antoine Mooij in 2008 in Groningen. This chair has been continued in 2010 by the appointment of Ko Hummelen on the Amsterdam chair Jan Hendriks, clinical psychologist, was appointed in 2010. All these professors are trained both as psychiatrists and psychotherapists.

This chapter shall consider the necessity of this approach to have the combination of science, professionalism and patient care, including the difficulties in achieving it, to show that forensic psychiatry is very vulnerable as it is made of trust between persons: patients, doctors, directors, civil servants and politicians. Its successes and failures have this common basis and as with any development uncertainty and sudden actions can devaluate the treatment and even provoke severe risks for the community. So it must be continually demonstrated that the entire bulwark of psychiatric detention rests upon nothing more than the relationship between two people. To keep this in mind.

Psychoanalytic psychotherapy

Psychoanalysis is no longer employed in clinical forensic psychiatric treatment, although the 'psychoanalytic minimum'(1) is repeatedly discovered and can once again been seen in recent psychotherapeutic trends. This 'minimum' is what remains when all the speculative constructions and personal interpretations are omitted and the greatest general consensus on the psychoanalytic therapeutic process remains. These include resistance and the importance of the unconscious in therapy, transference and counter-transference in the relationship between patient and therapist, the repetition compulsion, acting out within and outside the therapy situation, the timing of interventions (that is, the management of the therapeutic process), and the support which emanates from the therapeutic setting. I believe these are factors valid for every psychotherapy – to be sure often as

non-specific, non-theory bound factors – including for forms of cognitive behavioral therapy. Were these factors examined for their frequency and role within other therapeutic relations (besides psychoanalytic psychotherapy), it would make for an interesting investigation. This research is very difficult to put into practice, however, as evidenced by the attempts by psychoanalysts to do so for many years. My hypothesis is that every form of therapy can fail (by virtue of a premature termination, not coming to therapy, and acting out) if attention is not paid to these factors which deserve to be recognized as preconditions to successful therapy. I am thus pleased that a national investigation within the psychiatric detention system has now begun into the effects of J. Young's Schema Focus Therapy. I shall return to this shortly.

In the meantime, it appears on empirical grounds that psychodynamic psychotherapy is effective, just as effective as cognitive behavioral therapy. The average length of treatment was twice as long, however (2). Forensic psychiatric psychotherapy strives for the same goal as the other therapies within that field, namely the prevention of recidivism. It is, however, very difficult to show that specific treatments, principally those within a clinic, themselves lead to a reduction in recidivism during the years after being discharged from the clinic (3). It appears that many confounding factors play significant roles here. That psychotherapy is indeed effective with an important group treated by forensic psychiatry, personality disorders, is well established. In the EFP (Expertise Center for Forensic Psychiatry) series "Current Knowledge" Van Dooren, Duivenvoorden and Trijsburg published a meta-analysis of both Dutch and international inquires into the effects of psychotherapy on personality disturbances (4). They concluded that there was a medium effect size as concerns general complaints, aggressivity and impulse control, and that there was a high effect size for social and interpersonal functioning, the prevention of psychopathology, and depression

This meta-analysis also identified non-specific factors which led to success including principally those which are more part of the treatment relationship and a greater need for attention. Treatment relationships and their context play a large role especially with forensic psychiatric patients with personality disorders. After all, a personality disorder indicates a badly developed personality in which thinking, feeling, desire and doing are not in tune; the consequence of this is grandiose thinking, uncontrolled emotions, and impulsive and aggressive behavior. Continuity, predictability and reliability are the core values in the therapeutic relationship which permit the patient to value the therapy and the therapist. Forensic psychiatric patients are generally not familiar with this basis for attachment and/or have experienced traumatic circumstances that left them so disappointed that they no longer trust easily.

Clinical psychotherapy in psychiatric TBS-detention

The strength of the treatment is, however, very vulnerable and easily disrupted or destroyed by outside forces. I believe too little account is taken of this as regards political interventions, for example, imposing heavy sanctions on those who do not return to their clinic on time. The diagnosis of those placed in psychiatric detention cannot be compared to those in general psychiatry. This can be seen from the following(5): 80% of this population have personality disorders and 25% are psychotic. Of those sentenced to psychiatric detention 10% have a sexual perversion and 45% have drug-related disorders. Comorbidity within this group is 60% – that is to say that 60% of psychiatric detainees have two or more psychiatric disorders. This means that a large group has difficulties adapting to their environment, have problems with their identity and reality testing, and are dependent upon drugs for their well-being. How can one expect cooperation from such people in a therapeutic program? The crux of the matter is that they cannot cooperate, but need others to help them with the necessary support work (e.g., auxiliary ego).

Terms such as "holding environment"(6) and "containment"(7) play a large role from the beginning of forensic psychiatric forms of treatment. The holding environment and the containing-function of the psychotherapist imply the control and guidance of the patient's thought processes and emotions by supporting the badly regulated personality. This can take place via structure and scheduling, rest in small doses and diversion, and the opportunity to engage in behavioral exercises. The therapist secures their supportive qualities by emphasizing everyday reality and not avoiding them, and maintaining a clear presence when the patient's thoughts become confused and their emotions too strong. They thereby acquire an intuitive appreciation for these things because they often practice it well which leads to an increase in the power of the treatment and therewith its intensity for the patient. This appreciation translates into attachment within the therapeutic relationship. After all, the literature indicates that the number of patients who end therapy prematurely is greater when less emphasis is placed on support and too much on interpretations and confrontations within psychodynamic psychotherapy (8-10).

Therapy non-specific symptoms play an essential role in managing a certain treatment pressure. Bateman and Fonagy emphasize the essential theory-independent factors in effective psychotherapies for personality disorders, such as the large size of structure, that is, the "holding": setting limits and making appointments (11). This demands from the therapist the clear formulation of core problems and sticking to them, indications to the patient of general psychotherapeutic preconditions such as motivation to change, trust in therapy, the establishment of cooperation with the therapist, tolerating the therapists activities, and

taking in insight during treatment via a consistently therapeutic approach (12-13). The treatment programs in psychiatric detention are also tuned to each patient personally. There are support care programs for people with psychotic disorders, development care programs for people with personality disorders, specific treatment environments for the retarded, the incorrigible, and a rehabilitation division. Within the clinic there are specific treatment programs (modules) superimposed upon the socio-therapeutic climate. Socio-therapy has long been the cement between the various treatment activities within the clinical environment. Socio-therapy provides sufficient integration and generalization of what the patient learns from the specific treatment regimen. The main modules deal with preventing relapse and verbalizing the events that led up to the crime as well as the crime itself ("delictscenario"), the addiction modules for alcohol and drug addition, psycho-education such as the acquisition of empathy and apprentice work projects. There is also a choice of group or individual therapy, including a combination of both.

Research into the efficacy of psychotherapies within psychiatric detention settings is not copious although the length of commitment in psychiatric detention is sufficiently long for long-term therapy with post-verification. Psychiatric detention has had a large influence on the therapeutic climate within the clinic, however. After all, we are dealing with a high security setting in which the influence of external agencies (such as the courts and Ministry of Justice) also continue to play an important role in parole policy and the environment in which the therapy takes place. The period before a hearing to determine whether psychiatric detention should be extended is in my experience the least fruitful from a therapeutic perspective: the patient knows that those who are treating him must provide recommendations and is therefore very careful with what s/he says and is often colored by a certain paranoia. This external influence concerns primarily the safety of society and is compared to the promotion of the therapeutic process. The dependence of those providing treatment from these external institutions also works against the therapeutic relationship which, after all, is based upon mutual trust and cooperation between patient and therapist. The dependence upon external decisions (such as parole and the ending of psychiatric detention) often devalues practitioners in the eyes of their patients since indeed they can rely on many in the ward for support and motivation, but ultimately are dependent upon intervention "from the outside". The greater the interventions from the outside, the less patients trust their own therapists, and thus their commitment suffers on account of untrustworthiness in the therapeutic contact. In social and political thinking on control and manipulability it is difficult for non-practitioners to accept that the entire psychiatric detention facility is in fact dependent upon the treatment relationships which those sentenced to psychiatric detention seeks to maintain with his established treatment team.

Despite our knowledge of the therapeutic process, the length of treatment of those in psychiatric detention has increased considerably. The average length of stay for the cohort which began in 1995 was 9.7 years, while for the cohort which began in 1990 this figure is 7.3 years. Each year about one hundred of all those sentenced to psychiatric detention have their terms ended by the courts (2005-2009). This stark increase in the length of the average stay has led to defendants and their attorneys choosing this option less frequently. In recent years we have seen lawyers increasingly advising their clients against cooperating with the behavioral research necessary to inform judges about the personality of the suspect. A good indication for forensic treatment, including psychiatric detention, is thus missed, this often to the detriment of the suspect and as a consequence customized treatment which may well have been able to change their lives in a positive way miscarries. These far-reaching negative consequences are probably taken quite seriously given the continual discussion about this in the media. What people do not realize, however, is that the court may order psychiatric detention even without an independent psychiatric report ("Pro Justitia Rapportage") based on its own investigation into the case. Behavioral experts are expected to do their best when writing up such reports; if the report falls short then reporting the interference is sufficient. There are, however, cases in which the court is unable to assess the personality of the accused and cannot find any indications of deficient development or mental illness in the suspect's mental capabilities. In these cases it is up to the court to decide on psychiatric detention. Influencing the judge by having him consider earlier psychiatric files – whose relevance to the current case is, after all, not self-evident – constitutes an attack on Montesquieu's *trias politica* (separation of powers), for by bringing all kinds of earlier psychiatric descriptions to bear on the current case it makes it less defensible to forgo psychiatric detention. At the very least these should be supplemented by the assessment of an independent forensic psychiatrist.

The increase in the length of treatment does not immediately imply that its efficacy is thereby improved. How long a court-mandated psychiatric treatment should last to be effective is not known. When an independent six-year investigation was established it was assumed that treatment needed a maximum of six years to be successful. A more repressive policy with respect to granting parole (with longer stays as a consequence partly due to the anxious reticence of the treatment staff) does not immediately result in a decrease of recidivism in the long run because many possible cases of recidivism are discharged into society only later. For this reason this supposition cannot yet be empirically proven. In fact, not only is there little known about the effects of different treatments in the forensic psychiatric centers, but little is also known about the effect of non-specific factors such as waiting times, negative news coverage, the lack of perspective for the patient, and the lack of self-confidence among personnel.

Treatment efficacy research

Research into the efficacy of psychotherapy within complex psychiatric detention treatment is thus also very difficult. We must nevertheless make continual attempts to keep this question seriously in mind and investigate that which can be researched. In psychotherapy[1] the focus lies on every effort to avoid later recidivism: this view sees those sentenced to psychiatric detention more as men rather than brutes. In fact, psychiatric detention is a black box in which it is not known how the various spheres of influence (treatment, security, external controls and reviews, legal position, resocialization) relate. For years a recidivism rate of 10 to 20% after five years has been presumed and psychiatric detention has been seen as a single, collective intervention. More specific figures were recently published in the Factsheet 2010-14 published by the WODC[2] and the Ministry of Justice. This document shows that two years after termination of the psychiatric detention measure general recidivism from 1999 to 2003 was 22.9%, while recidivism for crimes deserving of psychiatric detention was 19.5% in the same period. For the period 1984-1988 these figures are 41.5% and 36%. This is a splendid success which probably also says something about psychiatric detention ("TBS") in that period, namely the great fervor surrounding psychiatric detention and the departmental memorandum entitled, "Safe and Sound" (2001). After 2003 the climate changed by virtue of increased public and political pressure on the Minister of Justice with regard to a number of psychiatric detention recidivism crimes in a relatively short period.

The problems involved with conducting effective research into psychotherapy among psychiatric detention patients is also caused by confounding factors as well as by methodological problems in setting up such an investigation. These confounding factors ('confounders', 'third variables') play a role in the treatment efficacy without their being directly noticed or measurable. The most frequent of these are the following.

- The absence of a context conducive to crime in the clinic, including others of the same age, criminal relationships, alcohol and drugs, unemployment, victims, etc.
- Closed psychiatric detention treatment has a large influence on patients in the clinic which creates a pressure cooker effect. The effects of the various parts of the treatment are lost in the face of this massive adaptation to the clinic environment. This influence is indeed so great that it is difficult to diagnose reliable personal changes which are also valid outside the clinic.

1 To be clear: I mean here all forms of treatment – including creative therapies, work and education – that seek to change behavior among those sentenced to psychiatric detention.
2 The *Wetenschappelijk Onderzoek- en Documentatiecentrum* (Scientific Research and Documentation Center) of the *Ministerie van Veiligheid en Justitie* (Ministry of Safety and Justice).

- Interventions by non-judicial powers (parole hearings) and the Ministry of Justice (parole policy) place a heavy burden on treatment relations at the clinic. Actions taken from a distance quickly make the treatment relationship feel impotent and insignificant.
- There are also the non-specific treatment factors which are difficult or impossible to measure, namely the degree of support in the psychotherapy itself or in the environment which helps patients cope with confrontations better, the psychotherapist's experience, and whether the patient is perceived by ward staff to be nice and/or worth the effort (as compared to the others).

And then we have methodological problems. According to the 'black box of psychiatric detention,' whose patients can only be measured as they come and go because we are unfamiliar with the intervening influences, research is very difficult as research methods into effect can only be implemented within psychiatric detention with great difficulty. When setting up studies of treatment effects of psychotherapy the following methodological problems come to the fore.

- The (now much in vogue) 'risk, need and responsivity' model(14) does not provide a theory for an underlying structure for the generation of further hypotheses about individual criminal behavior or diagnostic methods. The lack of a theory also make further development of this instrument impossible.
- The risk assessment instrument from which the empirical model derives its efficacy has not yet achieved a robust predictability probability of more than 0.7 in the last twenty years. That is to say, only two of three decision based on this risk assessment instrument are valid. Once again, and this time successfully(15), an appeal was made based on clinical judgment, but this time based upon the results of the risk assessment instruments including the structured professional judgment.
- Forensic psychiatry is not in a position to conduct sufficient external validity for a Randomized Control Trail (16). In order to do this one must select patients strictly and test them for a relatively short period. Furthermore, the criteria for treatment are clearly set forth, as is the intervention itself. A control group is virtually or entirely impossible to find.
- Lacking a clear theory of the origin of individual delinquency, there is insufficient clarity between a favorable therapeutic outcome and the recidivism rate of ex-patients (3). An improvement in the patient's condition and a positive treatment result are evidently not the only conditions to prevent the repetition of a crime.

Best practice at this moment are the quasi-experimental or naturalistic, correlational studies. Recently Fluttert demonstrated in his dissertation that a quasi-experimental, one-way case-crossover design, in which each patient is their own control, offers a good chance for insight into therapeutic efficacy (17).

Despite these difficulties, psychotherapy as a forensic treatment method is not viewed as obsolete. The Forensic Psychiatric Centers continue to offer this service. Recent information from various clinics has taught us that more than half of psychiatric detention patients have had psychotherapy at some time. The following studies on this subject, largely in the form of dissertations, have appeared and all are situated in one of the psychiatric detention clinics:

- psychoanalytic psychotherapy(13); Van Marle, 1995; (dr. S. van Mesdagkliniek);
- recidivism prevention and criminal activity analysis (Van Beek, 1999; Van der Hoevenkliniek);
- cognitive behavioral therapy (Timmerman & Emmelkamp, 2005; FPC Veldzicht);
- dialectic behavioral therapy (Van Den Bosch, 2005; Oldenkotte);
- hospital treatment (M. Philipse, 2005; Pompekliniek)
- aggression management therapy (Hornsveld, 2007; FPC De Kijvelanden); and
- out-patient forensic psychotherapy (Bouman, 2009; Pompestichting)

At the moment a large-scale investigation begun in 2006 into schema-focused therapy(18) is being supported by the Expertise Center for Forensic Psychiatry (www.efp.nl). This is another investigation currently underway of 72 patients with an anti-social personality disorder, specifically those with such a disorder not otherwise described by at least five symptoms from cluster B. The data thus far appears favorable, particularly when dealing with patients with a PCL-R score of more than 25. The provisional figures indicate that of this group more patients get paroled than from the group receiving the usual treatment, they are able to get paroled earlier, and that fewer repeat crimes are committed while on parole. For the time being there are hopeful results. This research will in any case be subject to critical inquiry regarding non-specific factors such as those named above.

Conclusion

Psychiatric TBS-detention as a criminal measure – whether as a controversial issue or a unwanted topic for politicians and civil servants – has long been a subject of public debate; over the years it has also been bombarded by creative suggestions some of which advocated more repression and some demanded more attention for its content. Once again the conclusion was that treatment within a penal framework remains an intrinsic contradiction even though the synthesis of both proves positive when the goal is 'treatment to prevent recidivism'(19-20). What is most striking, yet many people miss, is that this fantastic construction of official, public, personal and institutional interests is entirely based upon the one-on-one relationship between therapist and patient, in

both the therapy room and on the ward, a relationship which must be reinforced each and every day: trust must be proven. And when that relationship is put under pressure by forces which have nothing to do with that therapeutic process, it will quickly be reduced to the exchange of those technical skills which produce the greatest profit at the moment itself: 'Strategies of Psychotherapy'(21). All of this says nothing about the development of alternative behavior in the future.

Research into psychotherapy and treatment effect studies is necessary to show that psychiatric detention is not an idealistic hobby from the past, but based upon scientific insights. If this idea is to be accepted then it must be clear that every intervention from outside that relationship that seeks to increase control and repression leads to exactly the opposite result, namely the damaging of the treatment efforts by silencing the therapeutic dialogue between practitioner and the person in psychiatric detention. The victim is never forgotten here; not only is good treatment offered in order to prevent recidivism, but the therapist, being convinced that the victim and the patient are a real part of the crime, do represent in his therapeutic offer both of them.

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Mirror Mirror: Parallel Processes in Forensic Institutions*

Gwen Adshead

Abstract

In secure settings, a range of parallel psychological processes are operating out of consciousness, which affect the completion of the primary task of secure organizations; namely to care for and contain the wish to hurt others. I draw on individual, group analytic and attachment theory to explore the unconscious challenges to the work in any organization; and how this might apply in forensic settings. I suggest that it is possible to think of toxic family group dynamics being re-enacted when insecure attachment mental organizations are activated; and these dynamics are then reflected in a process of malignant mirroring across the different layers of the organisation. Awareness of these multiple reflections across the different spaces in forensic secure services may help institutions to hold themselves together when anxious and maintain integrity of therapeutic purpose.

Introduction

Long stay residential care was the mainstay of psychiatric treatment across Europe and the United States until it was replaced by community programmes in the late 20th century. Almost the only services now that offer long stay (two+ years) residential care are forensic psychiatric services that admit people whose disorders and behaviours have frightened others. Patients admitted to these services often spend five or more years in hospital; and those whose behaviour appears particularly risky, whose offences are inexplicable or whose disorders are resistant to treatment, may stay much longer (1).

It is sadly no secret that abuses and lapses of professional care take place in such settings; and they are often stigmatised and stigmatising institutions to live and work in. In this paper, I will explore how complex (and at times toxic) group dynamics may help to explain why it is sometimes hard for staff to think in

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forensic settings. I will draw on psychoanalytic, group analytic and attachment theory; and argue that the 'fire' under which staff have to think is a complex emotional heat that is generated by an interaction of group dynamics and toxic attachments in both patient and professional groups. I will close by offering some 'golden rules' for staff groups.

Mirroring in groups

We are social animals whose primate heritage requires us to live in groups. To do this successfully, we need a 'social mind': one that has the capacity to appreciate that others have thoughts, intentions and experience (2). This mentalising capacity has a number of sub-capacities and faculties, including the capacity to 'read' other people's emotions and respond to them. In non-human primates this process is not conscious, symbolised or reflected on; but in human primates, the expanded neo-cortex makes self-experience and language possible, which in turn makes group living more successful (3).

Early group analytic theorists (4, 5) noted that group members would seem to 'mirror' the emotions and communications of other group members; or unconsciously act out the behaviour and communication of key figures discussed in group members' narratives. Such a process could be positive and support the formation of rich interpersonal relating; but it could also be toxic or 'malignant' (6), and interfere with group process and development.

We now know that this 'mirroring' process in groups is the social manifestation of that 'social mind' described in primates; and it is a form of empathic non-verbal communication mediated through specific 'mirror' neurons in the brain. Mirror neurons are activated (at least in monkeys) by imitative interaction. In humans, mirroring may be understood as the persistence of a form of non-verbal and unconscious communication; which can be elaborated and extended by more conscious aspects of the self-reflective system, including the faculties of empathy and sympathy (which are mediated by a separate neural network in the frontal neo-cortex).

Such a rich array of emotional communication is vital for the making and maintaining of social relationships in groups, which underpins group survival. However, primate life is not always easy or pleasant; and hostility, rage, disgust and shame are primary emotions that are a natural part of the social life of primates (7, 8). Negative emotions will inevitably be communicated within and between groups; especially those emotions that involve the gaze and response of others, such as shame and disgust. Groups typically reject members who shame

and disgust them, or demean them in terms of rank: this process is highly stressful and reduces life expectancy and well being (9).

Any group of people living together for any length of time will therefore be emotionally affected by one another through processes of 'emotional contagion': one of which is the mirroring process, which is non-conscious, non-verbal and inevitable. Such mirroring processes are a challenge to traditional models of professionalism in health care, which usually state either

a. that good professionals don't have feelings about patients, or
b. that if they do, they should only be positive feelings, characterised as a kind of detached sympathy.

However, this traditional professional ideal does not represent best practice, but rather a Victorian ideal of masculinity (10). Health care professionals cannot help but have feelings about their patients, both conscious and unconscious; and I now turn to attachment theory as an explanatory paradigm for understanding those feelings.

Representations of attachments in mind: individual and group

Attachment theory integrates psychoanalysis with the ethological study of social animals; and starts from the position that man is essentially a social animal who needs relationships for survival, and whose early relationships with carers have unique characteristics that influence the development of later relationships (11, 12). Attachment behaviour is any form of behaviour which results in a person attaining or maintaining proximity to an "attachment figure"; an identified individual who is experienced as stronger or less vulnerable at that moment (13). Such behaviour is most obvious when people are frightened, fatigued or sick, and is assuaged by comforting and caregiving (14). It can be seen throughout the life cycle, especially in emergencies, and its biological function appears to be the protection of the developing and vulnerable organism. The formation of attachment bonds results in neurochemical and neurocytological changes in the brain; especially in the prefrontal cortex which regulates conscious and unconscious feeling (15, 16).

To say of a person that he is attached to, or has an attachment to another, is to say that he is strongly disposed to seek proximity to and contact with that individual, and to do so especially when distressed, anxious, injured or vulnerable. Bowlby suggested that the nature and quality of the attachment is represented in the mind as an unconscious 'internal working model' of both how to seek care; and how to give it. The attachment system in mind is therefore a mental representation (with both conscious and unconscious elements) of a dynamic system that

involves a care-giver and a care-elicitor (14). Attachment representations work as kind of internal homeostatic mechanism for modulating anxiety, fear and distress.

When the attachment system is stimulated (ie when the individual is in need, pain or danger), it produces neural signals that in turn stimulate physiological effects that influence thought and feeling in the neo-cortex. In a feedback loop, these thoughts and feelings produce more physiological manifestations of anxiety and arousal, which agitate the attachment system further. A '*secure*' system makes it possible to process anxiety and arousal effectively, which includes being able to reach out to carers and be comfortable with vulnerability. An '*insecure*' system can neither process anxiety or arousal well enough at times of distress; and those with insecure attachment representations will struggle to form useful relationships with care providers (17).

These attachment representations include representations of *groups* of which one is a member. It is known that babies as young as seven months are aware of a distinction between family members and those who are outside the family. This suggests that they have already formed a conceptual representation of the differences that signify 'my group of people' and 'not-my-group of-people'. Josselson (18) has suggested that normal psychological development includes a group representation which expands as new people are added to the 'group-in-mind'. This representation of 'groupishness' (19) is arguably part of the attachment system; and will affect how an individual relates to groups in the future, both work and therapeutic (20, 21). Group attachment systems may be secure or insecure in the same way as individual attachment systems; and may account for why some people find it easier to make therapeutic use of groups, while others seem to make toxic attachments to groups.

Attachment representations in clinical settings

Theoretically, we might expect to find high levels of insecure attachment in psychiatric services users; which may make it difficult for those service-users to relate effectively to professional carers. Research into attachment representations in clinical and non-clinical populations (22) provides supportive evidence for these hypotheses. As predicted, the majority of people in *non clinical groups* (58%) describe 'secure' attachment relationships: they seek care effectively when distressed; are 'comfortable' with the experience of being distressed, (insofar as they do not experience high levels of fear), and anticipate positive outcomes with carers.

However, in *clinical* groups, less than 20% of people are rated as securely attached; implying that most psychiatric care seekers have insecure attachment representations in their minds. There is also evidence that insecure people show a range of abnormal behaviours when they are distressed. They tend to either freeze, panic or deny feelings of distress, or they oscillate around seeking care and then withdrawing from it (23, 24). Specifically, insecure subjects struggle to regulate the proximity inherent in caring attachment relationships because their internal working models are not able to do the necessary psychological work of regulating affects of anxiety, distress and anger. There is a particular sub-group of insecure individuals who describe highly disorganised attachment representations and behaviours (usually after maltreatment in childhood); and unresolved distress from trauma and loss experiences. Disorganised attachment in children is characterised by confused and inconsistent attachment behaviour (24); and is associated with the development of clinical symptoms in adolescence such as dissociative phenomena and psychotic thinking. Disorganised attachment representations are much more frequently found in clinical groups (20%) than non-clinical (6%); and theoretically at least are likely to have disorganised relationships with carers when distressed.

Lastly, there is evidence that insecure attachment representations in the mind have a negative impact on *care-giving* behaviour in adulthood (25). Bowlby postulated that some insecurely attached children would grow up to be 'compulsive caregivers' in adulthood (26); which may be relevant to those who choose professional caring as a career. Insecure attachment in adults is associated with atypical care-giving behaviours with infants and older children (27); and parents who abuse or neglect their children are far more likely to be categorised as insecure than secure in attachment terms (28).

The implications of this research for forensic residential services are significant. If psychiatric services users generally have high levels of insecure attachment, then we may anticipate that the majority of forensic patients will have insecure attachment patterns, which means that they may find it hard to make and maintain therapeutic relationships with professional carers (29, 30). We know that 80% of forensic populations have experienced significant maltreatment in childhood, so they are likely to have developed disorganised attachment systems, and have unresolved trauma and loss experiences (31); which means that this forensic group may relate to professional carers in particularly bizarre and dysfunctional ways, including aggression, fear or toxic enmeshment.

This research also implies that there may a sub-group of *staff* with insecure attachment histories, who may be at risk of showing atypical or dysfunctional care behaviours; or may be more likely to get caught up in toxic attachment relationships with equally insecure patients. Some staff may have become care-givers *because* of

their own insecure childhoods; and although this could be turned to good use in some circumstances, it is possible that this group may be vulnerable to lapses of professional care, such as professional boundary violations.

Lastly, we may anticipate that those with highly insecure and disorganised attachment systems may struggle to attach to therapeutic groups, or relate trustfully to them. The paradox here is that recovery of a more pro-social identity entails attachment to groups of some sort; not least because social isolation is significant risk factor for violence.

The effects of unconscious anxiety in professional carers

In 1959, Menzies Lyth (32) published a ground-breaking study of why professional carers (in this case, nurses on general medical wards) were leaving the profession midway through training or taking excessive sick leave. She concluded that the nursing staff were *unconsciously distressed* by many aspects of the nursing process; such as performing intimate and distasteful tasks which can arouse feelings of disgust, fear, hatred or even excitement. Nurses might be also unconsciously envious of the care their patients received or aggrieved when patients did not improve or appear grateful for their care.

Menzies Lyth suggested that collectively the nursing staff developed *social defences* to enable them to cope with the intolerable feelings aroused by working in difficult and stressful environments (p 51-63). These defences were unconscious and helped to keep the anxiety unconscious also. They chiefly took the form of behaviours that helped the nurses avoid being in personal contact with patients; such as referring to the patients by their diagnoses or symptoms, or allocating so many patients to one nurse that they could not possibly be seen in a shift. Defences could also take the form of ritualistic tasks, such as checking and re-checking every action or decision. Lastly, there was an emphasis at senior levels on the development of emotional detachment as a sign of 'good' professional behaviour. A feature of a 'good nurse' was that they were willing to move from ward to ward with no notice, leaving distressed patients behind without a thought; and no suggestion that either patients or staff might have feelings about this.

Nurses were found to minimise their anxiety by the use of immature defences such as denial, splitting and projection (p. 74-79). These immature defences are commonly used by everyone at times of stress, but in the work situation, staff projected unwanted feelings that they could not bear to feel into other members of the nursing team. For example, teams became split into those nurses who

were "responsible" and those who were seen as "irresponsible". The 'responsible' nurses complained that the 'irresponsible' ones needed to be constantly supervised and disciplined, which led to more and more ritualistic checking behaviour, and prevented the 'irresponsible' staff from actually learning to do their jobs in a responsible way. Projection was not confined to fellow staff; anger and frustration of the work was also projected into patients, who were seen as endlessly demanding and troublesome.

Menzies Lyth concluded that these social defences operated to help the individual *and the institution* avoid the conscious experience of anxiety, guilt and uncertainty. But she also pointed out that such immature defences failed to do the job intended; not only did they not relieve anxiety but further anxiety was in fact generated by the defence itself, and conscious reactions to it. Staff still felt anxious and distressed, but the social defences meant that they were not allowed to know their feelings or express them. No attempt was made to enable the individual nurses to confront and face their anxieties and distress. They were therefore unable to develop a capacity to bear these anxieties more effectively. Without a capacity to manage their distress, it was inevitable that staff would drop out of training or go sick; leading to the staffing problems that were the 'presenting problem'.

Menzies Lyth's work has been applied widely, including in general mental health and forensic settings (33, 34). It is important work, for two reasons: first, because it shows how individual defences can become mirrored and intensified in a group situations in institutions; ultimately becoming mirrored and enacted in institutional policy and procedures. Second, it demonstrates how the care of the sick is stressful and distressing; and how impossible it is for staff *not* to have negative feelings about their patients from time to time. From an attachment theory perspective also, I would argue that residential care in hospital maximally activates care-eliciting and caregiving systems in both staff and patients; it is also possible that some of the staff in Menzies Lyth's study were particularly vulnerable to using psychotic defences because of their own attachment histories.

The psychological demands of residential forensic care

An important feature of forensic secure care is that it entails long term residential care i.e. where patients are not just receiving treatment, they are also living their lives. This type of care, which used to be the main form of psychiatric treatment, is now almost exclusively found in secure settings. Long stay residential care makes specific demands on staff; as described by Miller and

Gwynne (35) in their study of residential institutions for the physically handicapped and chronically sick: a group who used to be called 'the incurables'.

Using Menzies Lyth's approach, Miller & Gwynne found that long stay (even life time) residential institutions tended to operate either a 'warehousing' or 'horticultural' model of care. In the 'warehousing' model, patients were classified by diagnosis, and treated as utterly dependent objects, rather than people with lives to lead. The horticultural model emphasised growth of capabilities and independence; but sometimes overlooked patients' real need to be cared for. What Miller and Gywnne noted was the residents' experience of rejection, isolation from their communities and 'social death' because of the damage caused by their physical disability. They also note the lack of a social discourse for thinking or talking about those situations where adults are dependent on other adults for long periods.

These studies of psychodynamics in health care institutions have disturbing implications for forensic residential care. If toxic anxiety and institutional acting out is generated in *general medical* care (where there is an average stay of six *weeks*); how much more anxiety and distress may be generated in care of patients that goes on for *years*? Menzies Lyth describes general medical nurses struggling with feelings of disgust when dealing with patient's bodies; but in forensic settings, staff may have to struggle with feeling disgust and fear in response to what their patients have done with their bodies and to other bodies, and the disgusting or horrifying things that may be going on in patients' minds. Note that fear and disgust may be conscious reactions; but staff may also struggle to be conscious of less socially acceptable feelings, such as hatred, revenge or vicarious excitement.

Forensic secure care has much in common with homes for the 'incurables; not least because there is a strong public (and perhaps professional) perception that offender patients are beyond help. Forensic patients are rejected, isolated and experience 'social death': they have arguably acquired a distorted identity that they will not be allowed to shake off, no mater how much they try (36). Forensic patients are 'disabled' not only by their psychopathology; but also by the perception of their dangerousness, which frightens others, and justifies the removal of autonomy and independence.

Miller and Gwynne describe how the inner lives of the residents are expressed in the caring relationship; and the effect this can have on staff behaviour (p. 137). If this is true, then we may expect some disturbed and disturbing behaviour in forensic settings, not just by individual staff members but also in terms of institutional policy and practice; as has sadly been demonstrated by the repeated public inquiries into forensic residential care (37: Table 1). In the first Ashworth

Inquiry, there was evidence that staff had been physically abusive to patients. In the second Ashworth Inquiry, it became clear that staff had either colluded with patients in rule breaking behaviour, or turned a blind eye to it, or not noticed it.

These might seem like different kinds of problem, but in reality they are not. They are sad examples of how staff can get caught up in the emotions that forensic patients unconsciously evoke in them. Staff may have conscious reactions to the patients (which may be difficult enough to manage), such as hostility, rage, contempt and fear. They will almost certainly have *unconscious* reactions to the patients, when the relationship triggers off reminders of past relationships: either the patient's past or the staff member's past.

In Ashworth One, we can guess that the staff must have perceived the patients as especially provocative and threatening, to have reached the point where they used violence against patients (as opposed to organised restraint or some other socially sanctioned response). It may be that there was something about the presentation of the patients that triggered unconsciously in staff fears about their own capacity to become disorganised and anxiety about their capacity to contain the patients. Many forensic patients (especially with personality disorder) are anxious about containment of feelings, and they look to others to ensure they will not be overwhelmed. This anxiety is then mirrored by the staff, who may act violently in response to their own sense of panic that they are not in control. If in reality staff numbers are down, or the ward is particularly stressed, then the chance of staff feeling helpless and panicky is increased, which in turn may increase the risk of staff acting in a hostile way to patients. None of the above is an excuse for unprofessional behaviour, but it does provide a framework for understanding what happened and how it might be prevented.

Similarly, with Ashworth 2, it is possible that the staff felt equally overwhelmed and made helpless by the patients' cruelty and hopelessness. It is possible that they failed to notice what was going on and/or failed to take action because they felt there was no point in noticing or acting. In this way, they may have unconsciously identified with the victims of their patients, and also the victim part of each patient's history. Victims of violence characteristically 'freeze' and become passive in the face of danger; they can also experience overwhelming hopelessness and helplessness, which further increases passivity.

Staff may also have made an identification with the cruel and delinquent part of each patients' mind. Both cruelty and successful rule-breaking can lead to a (usually brief) sense of triumph that may have contributed to a cheerful atmosphere on the ward, which both staff and patients enjoyed. It is very human not to want to disturb what appears to be working well; especially when this means taking on people who have been violent and cruel in the past. Rule-breaking

patients who wanted to deceive staff may have gone out of their way to be pleasant and engaging, in a way which is hard to resist in secure settings, which are often otherwise so turbulent. The sad truth is also that staff members may be more trusting than the patients; which can lead to collusion.

Colluding with rule-breaking may also have been more likely in staff who themselves had a history of rule-breaking in their own childhoods; or who had also had experiences of being abused. Given the prevalence of childhood abuse and neglect in the general population, it would be surprising if some survivors did not becomes health care professionals; indeed, there is some reason to think that one way to cope with having had an insecure childhood is to become a professional carer in adulthood (26).

It seems difficult for large social structures, like organised work groups, to learn from disasters; and we can only surmise that institutions that are traumatised by their own failures suffer from complex trauma reactions that include dissociation and blanks where memories should be (38). People may be speechless after a disaster for many years; articulating what went wrong could be painful and shameful. It is understandably easier then for forensic institutions to identify a scapegoat, expel them from the group and then carry on as before; a parallel and mirror of how the forensic patients were admitted to the forensic institution in the first place.

Intensification of mirroring in multiple groups

To understand boundary violations in forensic health care, we must understand the intensification of mirror phenomena that occurs when there are multiple groups operating in a closed system (Figure 1). The patient group on a ward acts like a toxic family group, where there are multiple toxic attachments to professional carers and to peers. Wards can resemble the mind of a patient, which may be superficially calm and composed, but underneath there is real incoherence, madness and danger. Each patient brings not only his or her capacity for cruelty and causing fear in others; they also bring their histories of fear, helplessness and hopelessness. Staff must provide a type of intimacy in which awful things can be spoken of: either terrible feelings in the here-and-now, or the reliving of horrific events from the past. They must be emotionally available for patients; but at the same time be aware that some patients struggle with continuing wishes to harm, deceive or corrupt others. Perhaps what is most important is that the nurse understands that their own emotional response to their work may be a function of what the patient is evoking in his or herself.

Staff on a forensic ward themselves form a group of people who have to relate to each other and rely on each other in settings that are both stressful and dull. This combination of boredom that alternates unpredictably with high anxiety has been reported as being particularly stressful in occupational terms. Staff in secure settings must not only attend to the patients' needs; they must also attend to the organization's need for policies and procedures to be met to an ever more demanding standard. Some of these are essential for security and risk management (and therefore generate an urgency and anxiety) while some seem irrelevant, futile and facile; often because they relate to quality of care indicators that were devised for other non-psychiatric or non-forensic settings. The same tasks may be repeatedly requested by different managerial groups at different times; reflecting the huge managerial anxiety present in forensic institutions (39: p. 46).

All these tasks reduce the time staff have to spend with patients; just as Menzies Lyth described. However, although this may be consciously (and unconsciously) welcomed by staff who want to get away from patients, reduced time with patients increases both the risk that some aspect of danger will be missed, and anxiety about that risk, which then stimulates more and more behaviours designed to reduce risk and reduce contact with the patient who is the source of the risk (see Table 2: Case History)

All work groups struggle with task completion, and if the task is complex, then completion may be difficult. Groups go off task in a variety of ways: fight, flight, pairing, or adopting a rigid dominance hierarchy in which those at the bottom are ridiculed and belittled, and those at the top ignore information that might prevent disasters (39, 40). Such hierarchies also encourage internal competition between individuals and sub-groups of workers, which causes friction, resentment and inevitably failure to complete the task at hand.

Taking care: relational security and psychological mindedness in forensic institutions

So how might forensic services respond creatively to the challenge of working with highly disturbed people; and help both staff and systems to function better? First some acceptance of the difficulty and complexity of the task is essential. Improved awareness, acceptance and understanding will not abolish the problems; but may offer more functional ways of coping with anxiety and distress.

Bowlby (41) hoped that his attachment paradigm would make it easier to understand toxic therapeutic relationships as places where patients inevitably re-enact insecure attachment behaviours with carers. But if the therapeutic

relationship could offer a new 'secure base' to enable patients to manage their attachments better, then this would offer the possibility of more 'secure' ways of managing care seeking and giving with others in the future. This concept of a 'secure' therapeutic base has particular resonance when applied to forensic settings (41). Forensic patients need to become more *psychologically* secure; and the physical security system imposes space and time to think and develop psychological security. Inevitably, patients will enact their attachment anxieties in the here-and–now of residential life: not only in therapy, but generally with professional carers and patients on the ward. Each ward functions as a group of people living and working together in ways that affect one another: the staff and patients on a single ward together make up a large group (about 50 people) who function like a mini-institution, or a large extended family. These large groups need help if they are not to become gangs, or battlefields. Help includes reflective spaces for staff and patients; spaces which look directly at relational processes within and between different sub-groups of people (42).

Staff need to be psychologically secure enough to manage the conscious anxiety their job entails. They also need to be given room to become more aware of their unconscious anxieties. If this does not happen, then the anxiety is likely to be acted out in atypical and odd behaviours at work; a mirror of the ways that insecure patients act out their anxiety in bizarre and risky behaviours. Typically staff enact their anxiety in forensic settings by breaking the rules: most commonly in minor ways by being inconsistent with patients and each other, but (rarely) in more major ways by physical boundary breaches and/or turning a blind eye to such behaviour (37, 43).

The awareness, acceptance and understanding process needs to be taken up by all workers in forensic settings, not just nurses on the wards. The ward staff are first 'in the line of fire'; but like the infantry in battle, they are connected to and managed by senior practitioners and managers of the services who are responsible for what happens on the wards as much as the front-line staff. There is good evidence that non-ward staff (such as doctors or senior service health care managers) are just as vulnerable to acting out and boundary breaches as anyone else (44). Psychiatrists are particularly at risk of being formally investigated for *failures in team work* (45), which suggests either that psychiatry attracts insecure individuals who relate poorly in groups or that mental health teams are groups that struggle with terrible anxiety, and those who lead them may easily be scapegoated (46).

We also need to take better care of ourselves; and understand that this is a major aspect of keeping the boundary between our professional and personal identities. The literature on boundary breaking professionals indicates that they are often facing an attachment crisis in their personal lives; such as the birth of a child, bereavement or family distress. If their personal attachment systems are

activated, but no care is available at home, then these professionals may come to work hoping that the workplace will soothe them or take care of their distress; especially if they are coming to a hospital! If this does not occur, then they may respond with angry outbursts and behavioural displays of distress; or they may seek support from patients, or be gratified by patients' attachment to them in ways that are risky, and enhance the risk of sexual boundary violations. In forensic settings, this is especially risky because some patients are predatory, and become excited by others' vulnerability; and may be only too keen to engage in breaches of security.

So supervision and line management need to be flexible and skilled enough to make it possible to talk about personal matters; and need to engage with the reality that personal attachments may affect professional performance. This means that supervisors and managers need to become skilled in the types of conversation that need to take place; and it is no longer acceptable for 'supervision' of a health care professional to only focus on management targets or professional goals. The expectation works both ways; supervisees will be expected to reflect on their own psychological health and well being; and be prepared to explore the boundary between personal and the professional identities; and the tension or relationship between these two identities. The supervisory skills then lies in exploring just enough of the personal to understand the professional issue; and keeping the boundaries between supervision, management, friendship and therapy.

Conclusion: Golden rules for relational security in forensic systems (NB these apply to staff and patients alike)

- No-one is allowed to rubbish anyone else. Constructive criticism or comment is fine, not disparagement or denigration
- If you hurt someone's feelings, apologise. This doesn't mean accepting error or fault; only regret that someone important to the system felt hurt.
- People can, and must be allowed to be appropriately angry and distressed about events or changes that affect them without being attacked for it
- Pro-social banking in good times i.e praising good work, and thanking people for doing extra or contributing to someone else's work
- Promote curiosity: the culture of enquiry. The ability of group members to ask questions is usually the sign of a healthy group process.
- Triumph and disaster are imposters: they may not tell the truth about a person or an institution.

Table 1 Evidence that the primary task goes wrong in forensic settings

Abusive care: Rampton, The first Ashworth Inquiry (47)
Collusive care: The second Ashworth Inquiry (48); press accounts of sexual boundary violations by staff at Broadmoor hospital
Neglectful care: patient deaths in Broadmoor hospital: one homicide (49 NHS London, 2009) and multiple suicides.

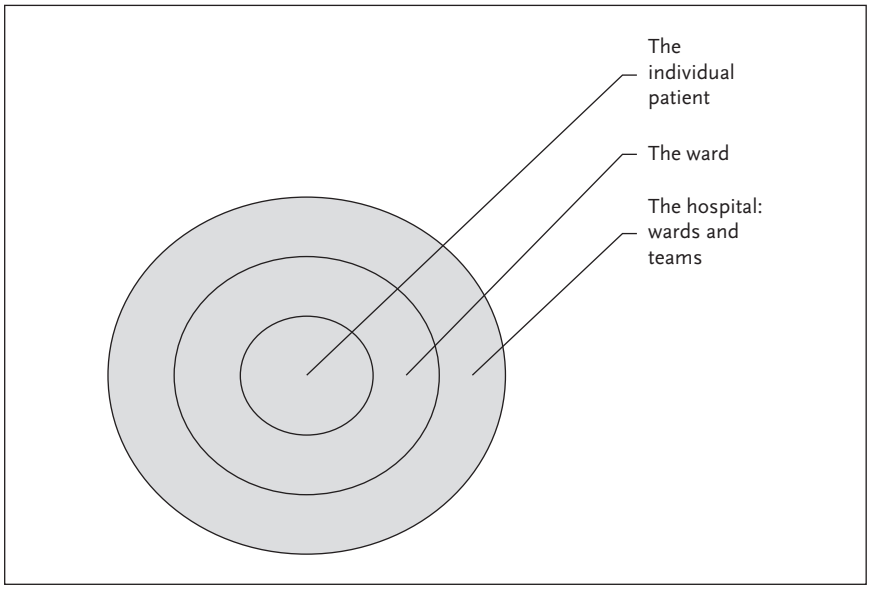

Figure 1: An ecological model of a secure hospital: made up of concentric groups of people carrying out different tasks for the group in the centre who are the group of patients.

Table 2 Case History

Bill kills a family member and is admitted to a medium secure unit. After admission, he is antagonistic to staff, disparaging of therapy and physically aggressive. Eventually he is transferred to a high secure hospital because of his violence to staff. Other family members give him the message that he will soon be released and live a normal life with them. Bill is generally disparaging of all types of therapy; except for individual therapy with a young woman with whom he flirts. He barely engages with ward and offence based group therapies.

In the High Secure hospital, staff give him parole that would normally be given to patients who have completed therapy and are not antagonistic to staff. Against the advice of his therapists, Bill is transferred from the High Secure hospital to another medium secure facility. Bill is initially compliant then becomes more aggressive and intimidating to staff. Eventually he is returned to the high secure hospital, in an event which is *an exact repetition* of the violence that led to his earlier admission. As Bill is escorted away by the police, he can be heard shouting, 'You can't do this to me, I'm not a patient'.

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The Forensic Psychiatric Expert Witness within the Criminal Justice System in Germany

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Introduction

Forensic psychiatrists deal with some of the most difficult patients in psychiatry. They are concerned with the assessment of complex cases, including risk assessment, and with the treatment of mentally disordered offenders, typically in secure settings such as secure hospitals or prisons. Furthermore, forensic psychiatrists act as expert witness in court, commenting e.g. on issues of criminal responsibility and competency to stand trial.

Forensic psychiatry is a subspecialty of clinical psychiatry which requires special legal and criminological knowledge and experience in the treatment of mentally disordered offenders. Forensic psychiatrists should have solid psychiatric training as well as practical experience in dealing with mentally disordered offenders. The double knowledge in psychiatry and law defines the subspeciality of forensic psychiatry and provides the ethical foundations for its practitioners [1].

The core concern underlying all the ethics-related precepts is the relationship between the psychiatrist and the evaluee [2]. In psychiatric ethics, the dual-role dilemma refers to the tension between psychiatrists' obligations of beneficence towards their patients, and conflicting obligations to the community, third parties, other health-care workers, or the pursuit of knowledge in the field. These conflicting obligations present a conflict of interest in that the expectations of the psychiatrist, other than those related to patients' best interests, are so compelling.

Forensic psychiatry operates within a certain legal and societal context which undergoes constant evolution. Laws are rules that guide human behaviour and as such are man-made. This means that concepts such as responsibility or competence are normative rather than clinical issues [3] which differ from country to country, sometimes significantly [4]. Therefore, while the ethical issues facing forensic psychiatrists might be similar across cultures, they do also depend on the specific legal system and service provision within each country [5].

Forensic Psychiatrist as Expert Witness

Forensic psychiatrists as well as forensic psychologists appear in court as expert witnesses, giving their opinion on specific issues as requested by lawyers or a judge. As such they have to act within the law but also have to accept the authority of the legal profession. Psychiatrists in court only provide an opinion while decisions are made by the judge or jury, a situation that differs from that encountered by the highly skilled forensic psychiatrist in his or her other work context and one that can cause discomfort or even resentfulness. Difficulties met by the psychiatric expert witness include harassment by the different parties involved in the trial [6], public criticism, difficulties in keeping one's dates, low reward, poor relationships with the legal profession partly due to unfounded attacks, loss of dignity and status as a consequence of the confrontation with sharp-shooting lawyers amongst others. Some psychiatrists avoid expert witness duties altogether because of the number of frustrations they are confronted with in court. They are glad that there are "masochistic" colleagues who are prepared to be available to act as expert witness [7].

Taking on duties as an expert witness is not only associated with external frustrations but has caused grave soul searching when accepting duties which originally are not core tasks of the psychiatrist [8]. The terms "criminal responsibility" or "guilt" in legal thinking do not exist as an empirical entity in psychiatry. Even if a medical expert does not comment directly on criminal responsibility – and he should not do as a matter of fact – his expert opinion aims at enabling this finding. Helping to select the criminal irresponsible has a serious side effect [9]: the forensic psychiatrist legitimates the punishment of individuals labelled as responsible. The psychiatrist takes on the, at first sight, humanitarian act of treating those who are not punished due to their mental disorder. This action however becomes problematic as the psychiatrist does not only undertake treatment but also custodial functions. The forensic psychiatrist is "changing side" [10], he moves from protector of the ill individual to being protector of the society [11].

In cases of psychiatric reports on refugees facing deportation, which bear considerable diagnostic and prognostic difficulties, the psychiatrist has a major impact on an individual's life which can have grave consequences including deterioration of existing mental disorders [5]. The most severe role conflict for psychiatrists exists in countries with capital punishment where forensic experts are used to assess the "competency to be executed", which could be achieved by treating the mental illness. Keane [12] argues in this context that physicians may be causing harm to co-victims resp. murder victims' relatives when they delay, halt or advocate against an execution.

An alternative to the difficult and sometimes reluctant engagement in legal work could be the total refusal, the retreat from the forensic field. But to go on a "total strike" is certainly not the ideal way to achieve important changes in legal practice [8]. Given the reality of expert witness work some authors have questioned whether it is justified to speak of humanitarian engagement of psychiatrists in this field [13]. Besides the mentioned possibilities to cooperate half willingly or to refuse expert witness duties there is also the option of willing adaptation and over-adaptation. This is what Robert Musil described in his novel »Der Mann ohne Eigenschaften« (»The man without qualities«) some decades ago (1952): the tendency of doctors to conform and to adapt to the expectations of the legal profession.

The forensic psychiatrist is indeed confronted with a double dilemma: Either he is legitimating punishment by labelling only a fraction of the accused as disordered and in need of treatment; in this case he might be called a servant of justice. Alternatively, if he is offering treatment for a large number of offenders he might be accused of brain washing and treatment tyranny. Psychiatry has been criticised for therapeutic nihilism and revenge; on the other hand, when progressive institutions were developed for the treatment of disordered offenders, therapists were criticised for applying too lengthy treatments based on unclear criteria with doubtful success. In public consciousness outsiders of the society are treated either too softly –as nowadays in many European countries – or too harshly. Forensic psychiatry, acting on behalf of society with the doubly stigmatized, is subjected to double reproach [7]. There is probably no subspeciality of psychiatry which has been more criticised than forensic psychiatry.

Despite discomfort, contradictions and resistance psychiatrists should not retreat from the forensic field. Psychiatrists can continue to work on humanizing the management of law breakers facilitating suitable treatment for those in need. This also means that cooperation with the legal system should not be refused as this allows to contribute experiences which may be helpful for the further development of the law. It is, however, always important to be watchful regarding attempts to instrumentalise psychiatry. In this context, the forensic psychiatrist has to adhere to role clarity: As a physician, he is primarily obligated to the treatment and well-being of the (incarcerated) patients and is not exclusively an agent of social control. Moreover, the general conditions in a therapeutic setting (e.g. dealing with medical confidentiality) have to be clear and transparent to the patients. This clearness and transparency should also found the situation of Independent Medical Examinations (IMEs) as described by the Scientific Section Forensic Psychiatry of the World Psychiatric Association [14].

Practical Aspects of Forensic-Psychiatric Assessments

When asked to provide an opinion on an offender, the Forensic Psychiatrist should obtain the consent of the examinee to provide the report to the requesting body. This means he has to ensure the examinee has the capacity to consent and understands the purpose of the report and that any relevant information will be included. He should also state whether the assessment is compulsory or not and provide information about possible consequences of both cooperation and non-cooperation. The information on probably negative consequences of non-cooperation can be (mis)understood by the examinee as enforcing his/her pseudo-voluntary consent. The Forensic Psychiatrist should explain the purpose of the consultation clearly and note that it is not a therapeutic consultation and that no help, suggestions, treatment, and possibly not even feedback, will be offered, with the exception of intervention if the examinee is at immediate and serious risk. The relationship is one of evaluation, and the fact that the evaluator is in no position to reassure the person on matters of confidentiality or privacy could mean that negative findings will endanger the interests and cause harm to the person being evaluated, regardless of this person's health and the evaluator being a physician [14]. Because of this, forensic psychiatrists may even be implicated in the criminalization of mentally ill persons [1].

If the examinee discloses confidential information which could jeopardise his social position (e.g. Case Report No 36 in [15]), one option for the examinor is to inform the judge privately about the material assembled so not to fail the expert duty in concealing pertinent information. How this material will be used, however, is for the judge to determine.

The compilation of third party information through interviewing family or friends, as is common practise in general psychiatry, can easily be construed as inadmissible investigation activity in forensic psychiatry, particularly if it happens without consultation with the examinee and the court and without explaining the right to refuse the evaluation.[1]

Prison physicians have a responsibility to request from the appropriate authorities (e.g. courts) a forensic-psychiatric assessment in cases where they suspect a disorder such as a psychotic disorder, a severe personality disorder or markedly reduced intelligence that may affect the prisoner's criminal responsibility, competence to stand trial or fitness to be detained. In this context, forensic psychiatrists should not, as a matter of principle, and in order to avoid a conflict of roles, assess their own patients [16]. They contribute to humanizing legal

1 In the Netherlands, this right of interviewing family or friends of the defendant is allowed in cases of investigation, ordered by the court or prosecutor.

procedures by providing expert information and their special view on the development of delinquent behavior in order so that justice can be done to the accused, while at the same time providing objective information. Forensic psychiatrists should present their specialist knowledge in such a manner that it is readily understandable to the legal client, and thus provide a basis for independent decision-making.

In dealing with deviant behavior, criminology and psychiatry have developed two parallel approaches that partly give different definitions of terms in their own specialist language, for example of the term psychopathy. The resulting communication problems, especially translating psychiatric findings and conclusions into the legal coordinate system, are an internationally familiar phenomenon [5]. The forensic psychiatrist should avoid overstepping competences and venturing into normative evaluation which is reserved for the courts. An uncontrolled (over)identification with the offender based on unrecognised counter- transference can lead to adoption of an exaggerated helper role. On the other hand, assuming the role of a prosecutor or judge can turn the evaluation situation into a cross-examination and lead to incorrect evaluation findings. What is required from the forensic psychiatrist is the psychopathological analysis of the mental condition of a perpetrator and his personality performed on the basis of empirical knowledge and competent specialist examination. The expectations an offender has of the forensic-psychiatric expert may involve not only the hope of a favorable outcome of the trial but also the need for exploration of the self and the delinquent acts in question. Thus, the expert gets assigned therapeutic functions, if only as a communication partner, which makes the completely neutral attitude of his role appear fictitious.

Assessment of Criminal Responsibility

The main task of the forensic psychiatrist in Germany is the assessment of the psychiatric prerequisites of criminal responsibility. Criminal responsibility is regulated in the Sections 20 and 21 of the German Penal Code.

§ 20 Non guilty due to mental disorders
Those who are unable to understand rhe wrongfulness of an act are acting without a feeling of guilt due to a mental illness, a deep disturbance of consciousness, feeblemindedness or another severe mental abnormality.

§ 21 Diminished guilt
Sentence can be lowered according to § 49 Abs. 1, if the capacity to understand the wrongfulness of an act or the capacity of insight is diminished due to one of the reasons listed in § 20.

The construction of the legal regulations concerning criminal responsibility requires a two step procedure: The first step includes verifying whether the offender suffered from a mental disorder at the time of the offense, which can be listed as one of the four characteristics listed in section 20: (mental illness, a deep disturbance of consciousness, feeblemindedness or another severe mental abnormality). In the second step it has to be verified whether the diagnosed disorder influenced the offender's competency to understand the wrongfulness of an act or to act according to insight.

The first step of checking the prerequisites of guilt regarding criminal responsibility refers to the existence of mental disorders diagnosed by empirical-clinical methods. Clarifying the influence of the diagnosed mental disorders on the competency to understand the wrongfulness of an act or to act according to this insight as normative characteristics is a question of a normative decision by the court. A process of attribution comes into being for which the expert witness is competent to provide findings and assessments based on his examination.

The following recommendations of an interdisciplinary work group serve as a guide to operationalise the forensic-psychiatric task. Firstly, these recommendations list the formal minimum requirements for expert reports on the question of criminal responsibility [22].

1. Specifying who ordered the report and which questions have to be dealt with
2. Specifying place, time and extent of the examination
3. Documentation about informing the examinee
4. A Statement in case of special methods of examination or documentation (e.g. video taping, tape recording, observation by other staff members, presence of interpreters
5. Exact statements about, and clear distinction between sources of information (files, statement of the examinee, observation and mental state examination, additional examinations (e.g. MRI, psychological tests)
6. Clear declaration of interpreting and commenting passages and distinct declaration of information and findings.
7. Clear distinction between secure medical (psychiatric, psychopathological, psychological) knowledge and subjective opinions or assumptions of the expert witness
8. Declaration of difficulties and uncertainties and the resulting consequences; if necessary, informing the ordering instance in time about further need of clarifications
9. Declaration of the tasks and areas of responsibilities of the participating experts and co-workers
10. In case of references, indication of these according to the standardized citation-principle.
11. Clear and distinct structure

12. Indication of the temporary character of the written report

The following minimum requirements in content are listed:

13. Thoroughness of the exploration especially regarding diagnosis and delinquency (e.g. detailed sexual anamnesis in case of paraphilia and sexual offenses, detailed exploration of the commission of offense.)
14. Mentioning of the methods of examination
15. Mentioning which findings were obtained, and by which methods. In case of use of unusual methods or instruments documentation of their contribution to findings and of their limitations
16. Diagnosis referring to a classification system (ICD-10 or DSM-IV-TR). In case of using another explanation, report why and which other system was used
17. Mentioning deliberations of differential diagnoses
18. Description of general impairments caused usually by the diagnosed mental disorder as far as this could be relevant for answering the questions
19. Checking if and to which extent special impairments were given at the time of the offense
20. Correct matching of the given psychiatric diagnosis to the legal terms
21. Transparency in the description of the assessment of the seriousness of the disorder
22. Offense related impairment with differentiation between the competency to understand the wrongfulness of an act and the competency to act according to this insight
23. Mentioning of alternative opinions

There is much debate in Germany about the assessment of personality disorders. Arguments in favor of the assumption of a so called severe other mental abnormality in case of a diagnosed personality disorder can be:

- Considerable abnormalities of affective responsiveness and affect regulation,
- Restriction in the way of life regarding the development of stereotype behaviors
- General or repeated impairment of the ability to shape interpersonal relationships and of the psychosocial functions due to affective abnormalities, conduct problems and inflexible and unadapted thinking style,
- General disturbance of the self esteem,
- Considerable impairment of defense- and reality- testing mechanisms.

Arguments against the classification of a personality disorder as another mental abnormality in the case of a diagnosed personality disorder are

- Abnormalities of affective responsiveness without considerable impairment in shaping interpersonal relationships and in the psychosocial functions
- Extensively preserved behavioral scopes
- Problem of self esteem without impairment in the shaping of relationship dynamics or regarding psychosocial functions,

- Intact reality control, mature defense mechanisms,
- Biographical development in correspondence with age.

A considerable impairment of the competency to understand the wrongfulness of an act as a consequence of symptoms of a personality disorder is usually out of question. Items speaking in favour of an impairment of the competency to act according to this insight can be:

- Intensivation of conflictuality as well as emotional destabilization in the time before the offense,
- Sudden, impulse-like course of the offense,
- Relevant pertaining factors (e. g. alcohol- intoxication),
- Close connection between ("complex") personality problems and the offense.

Items speaking against an impairment of the competency to act according to a given insight can be valid in case of personality disorders but not necessarily in case of other disorders (e.g. delusional syndroms)or specificities of behavior, from which conclusions can be drawn regarding mental functioning:

- Preparations of the offense,
- Development of the offense as resulting from dissocial behavioral tendencies,
- Commission of the offense according to a given plan,
- Ability to wait, long lasting offense,
- Complex course of the offense according to steps,
- Preventive measures in order to avoid detection,
- Ability to act in another manner in comparable circumstances.

In general a severe other mental abnormality leads at the most to a considerable impairment of the competency to act according to a given insight.

Risk Assessment

A further interdisciplinary work group [23] elaborated a catalogue of minimum requirements regarding form and content of reports dealing with the question of legal prognosis which was recently specified [24]. There is a high overlapping of the formal minimum requirements with those mentioned above in the context of dealing with the question of criminal responsibility. The following minimum requirements regarding content of the report are:

1. Comprehensive study of the files (including files from former offenses, prisoner files, files from forensic-psychiatric hospitals),
2. adequate conditions of examination,
3. appropriate length of the examination considering the degree of difficulty, possibly several taking days,

4. pluridimensional examination (development and current picture of the personality, history of illness and disorder, analysis of development into the offense and course of the offense),
5. thorough gathering of all necessary information (including discussion of discrepancies regarding facts with the examinee, checking of the consistency of the collected information, addressing of contradictions between exploration and information from the files),
6. observation of the behavior during the examination, mental state examination, detailed description of the personality,
7. Verifying the existence of empirically based criminological and psychiatric risk variables, possibly using adequate standardized risk assessment tools. Indication directed use of psychological testing for diagnostic considering validity problems, which could stem from the forensic situation. Thus, possibly an indication- directed use of other adequate additional examinations. Due to these minimum standards in sampling information a possibly exact diagnosis (referring to ICD-10 or DSM-IV-TR) should be established, in case of a given a forensic-psychiatric describable case.

The following minimum standards in writing the report are mentioned:

1. Concrete formulation of the questions from the point of view of the expert, e.g. relapse after release, misuse of mitigated prison conditions,
2. Analysis of the individual delinquency, of its background and causes (behavioral patterns, attitudes, personal values, motivations),
3. multidimensional biographically founded analysis considering individual risk factors (offense specific, illness or disorder specific, personality specific),
4. comparing to empirical knowledge about the relapse risk of comparable offender- groups (description of similarities and discrepancies),
5. Description of personality development of the examinee since the (last) offense considering risk variables, protective factors, treatment course and appropriateness (suitability) of the applied treatment methods,
6. Discussion of former expert reports,
7. Prognostic assessment of the future behavior and the relapse risk, for instance, misuse of mitigated prison conditions, especially considering the social reception room, the steering possibilities within the aftercare and the expected destabilizing and stabilizing factors (e.g. work, partnership),
8. Description of the circumstances, for which the assessment should be valid, and a description of measures by which the assessment could be reassured or ameliorated (risk management).

In this matter, a relevant task of the risk assessment report consists in verifying and discussing the general conditions, which allow a timely recognition of tendencies to reoffend, a prevention of first steps in this direction, and further going crisis intervention. The expert has to verify whether such possibilities do

exist, and whether the examinee fits into such a setting. The "social-reception room", supported living and work opportunities, measures structuring the day and the psychagogic means, controlled pharmacotherapy, specialized forensic outpatient centers, psychiatric und psychotherapeutic aftercare, legal guardianship and competencies of the family surroundings – all have to be assessed in a realistic manner and be related to a given time frame. Additionally it has to be considered which situation is to be expected after terminating time limited measures.

Forensic psychiatrists as well as forensic psychologists are crucially involved in the assessment of risk, particularly the risk of future (violent) re-offending, but also the risk of institutional violence. These assessments might determine whether an individual is going to be released or the level of security he will be treated in. In some countries (e.g. Germany) the law allows preventive detention, e.g. detention for the protection of others after serving a time-limited prison sentence. According to the law two independent forensic experts have to provide a legal prognosis. In cases of prisoners serving a life sentence or in cases of preventive detention release is only possible if there is no risk that the dangerousness of the offender persists. Therefore, risk assessments have major ethical implications for forensic practitioners [5].

The science of assessing risk has boomed in recent years with an increasing number of structured instruments being available to fulfil this task. It is generally accepted that structured risk assessment instruments increase the accuracy of prediction compared to unaided clinical judgement alone. Two main approaches of risk assessment tools have been described [17]: Actuarial methods and structured clinical judgement. In actuarial assessments, prediction is based on coding of mainly historical items that have been shown to be associated with future violence in a predetermined way. Findings are often presented as probability estimate of the future event of interest, e.g. violent re-offending. The appeal of such instruments (e.g. Violence Risk Appraisal Guide VRAG [18]) is the ease of their administration and the perceived (but deceptive) clarity of the outcome. Limitations of actuarial assessments are that they do not allow taking into account more sophisticated and detailed information specific to the individual, including dynamic variables and protective factors. Structured clinical judgement instruments (e.g. the HCR-20 [19]) serve as an aide memoir, providing a structure for the assessment while also relying on clinical expertise. They are based on a review of the literature with regards to factors relevant to future risk but are, unlike actuarial tools, not sample-specific.

For example probability risk estimates using actuarial assessment tools have been developed in a specific population and might not be valid in other groups. Therefore, an instrument validated in male offenders released from a high

secure prison in Canada may not be valid in women treated in the community in a European setting, and it should therefore be used with caution in such a population, if at all. Furthermore, all risk assessment instruments produce indications about groups of individuals but are limited in what they state about the individual. They generally do not differentiate the severity of violent re-occurrence or the timeframe in which to expect such an event [5].

No matter how sophisticated risk assessment instruments are, future behaviour cannot be predicted with any certainty, giving rise to particular challenges in balancing the civil liberties of the patient and the protection of the public from potential future harm by that patient. Buchanan and Leese [20], reviewing studies in which risk assessments were validated by follow up of actual future violence, concluded that six people would have to be detained for one year to prevent one person from acting violent during this time period. However, the question how much risk is acceptable to the society is not a psychiatric one. Society must decide how many it will restrain unnecessarily to protect us from the one person who might hurt us. This is purely a moral and political issue that must be left to the conscience of the community [21]. In an increasingly risk aversive society in Germany public pressure demands to reduce false negative predictions with the expectation to eliminate risk. However, reducing false negative risk prediction will lead to an increase in false positives which means that even more patients might be subjected to severe restrictions of their liberties, many of whom might have never gone on to commit a (further) violent offence.

While forensic psychiatrists will probably always be expected to make predictions about future risk, they should not lose sight of their primary duty as clinicians which are towards their patients. In the context of risk assessment, this does not mean that they should withhold information regarding risk from relevant agencies but rather that they should focus on the clinical task of treatment. This means managing rather than merely predicting risk. They also should educate policy makers and the population as a whole on what can realistically be expected in terms of risk reduction and the means necessary to achieve this task.

Development of Legislation in Germany

Mentally disordered prisoners in Germany are subject to special legal regulations [25], which can be traced back to the "*Dangerous Habitual Offenders and their Detention and Rehabilitation Act*". Although this law was passed by the Nazis in 1933, the year they came to power, it was actually the result of previous decades of debate and deliberation on the development of special preventive measures to ensure public safety against perceived dangers perpetrated by the mentally ill.

Apart from some minor modifications (most recently in 2007) these measures have continued to remain in place in the western part of Germany, whereas in the eastern part the forensic-psychiatric clientele changed after the 1990 German reunification, which necessitated the adaptation and further development of specific therapeutic concepts [25].

As we have already said there are no special diversion programs in Germany but in fact diversion happens via legal regulations that are based on the construct of legal responsibility. Those found incompetent to stand trial or declared not criminally responsible, but who are not considered to be dangerous criminals are, at most, hospitalized voluntarily in general clinical psychiatric institutions. Those found incompetent to stand trial or declared not criminally responsible or sentenced with their 'diminished' responsibility at least being taken into consideration and who may be expected to commit further serious crimes, are placed involuntarily in special psychiatric (forensic) hospitals (§63 of the German penal code). These hospitals held 6569 inmates on March 31, 2010 (Table 1).

There are no special mental health courts in Germany. It is the task of regular criminal courts to implement those legal regulations within the Penal Code which apply to mentally disordered offenders. For this purpose expert witnesses are appointed by the court or even at an earlier stage of the investigation by the prosecutor. Because of some disagreements between different schools of thinking amongst such experts, the above mentioned guidelines on minimal standards and expectations for such expert witnesses were published by a working group initiated by a German High Court [23].

If somebody is to be admitted to a forensic psychiatric hospital, expert witnesses from the fields of psychiatry and psychology are asked about the following questions by the courts: the perpetrator's criminal responsibility, the relationship between criminal offense and mental disorder (the so-called symptomatological complex), the duration of the mental disorder and, in the sense of prognosis, the degree of probability and the nature of future offenses.

Offenders with a psychotropic drug dependence syndrome and sufficiently concrete therapeutic prospects are confined to special detoxification centers in forensic psychiatric hospitals (§64 of the German penal code). The number of persons confined there was 3021 as of March 31, 2010 (Table 1). Expert witnesses from the fields of psychiatry and psychology are asked about the following questions by the courts: the diagnosis of an addiction or dependency syndrome, the relationship between criminal offense and the tendency to consume psychotropic substances (so called symptomatological complex), and in the sense of prognosis, the degree of probability and the nature of future offenses as well as

the prospects of healing the addict or of at least of securing enough time to prevent relapse into a condition of acute addiction.

Treatment and care for patients in forensic-psychiatric institutions are governed in Germany by legislation which differs among the various federal states (Länder). While the commitment to a psychiatric hospital is for an indefinite period of time – there are judicial procedures at least every year to check the necessity of further commitment; the commitment to an institution for the treatment of addicts is restricted to a maximum duration of two years.

All other mentally disordered offenders, such as schizophrenics, for example, who are not considered incompetent to stand trial or have not been declared not criminally responsible despite their condition, can be imprisoned unless the court imposes milder sanctions like a fine. Important selection intervention authorities are mainly the police, courts, and experts. Diversion refers to the removal of offenders from the criminal justice system at any stage of the procedure and court proceedings. The police may put a mentally disordered offender - who might be quite easily taken for a perpetrator – into a psychiatric facility instead of entering him into the criminal justice system by presenting him to an investigative judge, for example. If the police fail to attach special importance to mental illness or continue criminal prosecution, the district attorney as the prosecuting authority in Germany can drop the charges if the offender is obviously not fit to stand trial or considered to be not criminally responsible for his offenses, and the nature of the offense does not suggest a danger to the general public. Unless the proceedings are dropped, court decisions in a criminal case can become effective even without personal attendance of the accused in minor serious cases, since psychiatric experts are usually only consulted for trials involving a serious crime. Since the formerly not uncommon assumption that people suffering from schizophrenia are automatically to be considered "not criminally responsible" has become rarer these experts can in turn arrive at assessments that could lead to imprisonment if the court so decides. In individual cases it may depend on coincidental constellations whether a mentally ill person is committed to a forensic psychiatric institution or to a penal one.

Development of the prison and forensic psychiatric clientele

In Germany, there is a lack of methodologically sound studies on the prevalence of mental disorders in prison which examine a large, representative sample of a prison population with standardized diagnostic instruments and provide a diagnosis oriented on international classification systems. Due to this research deficit, current data which would enable appropriate treatment planning with

regard to the needs of mentally disturbed prisoners are not available. Thus an empirical basis does not exist for determining whether prisoners in Germany – as elsewhere – have an increase in mental disorders attributable to inadequate deinstitutionalisation programs [26]. This development which has been described for various countries, especially the United States [27], but also England [28] and Austria [29], cannot be applied to Germany as far as the period between 1970 and 1990 is concerned (Table 1): Only a slight overall increase in the number of prisoners was reported despite a marked reduction of beds in general psychiatry. Between 1970 and 1980, there was a clear reduction in the number of persons admitted to psychiatric hospitals in accordance with §63 of the German penal code, and by 1990 the number reached a level of about 2500. Only detoxification centers working in accordance with §64 of the German penal code registered a dramatic increase in the number of occupied beds. Penrose [30] pointed out in this connection that the sum of inmates remains constant across institutions, but in fact this is not the case for the development in Germany. The majority of patients with severe mental illnesses, some of whom had spent several decades in psychiatric hospitals, were able to be returned to the community with no detriment to their mental health [31]. Only after German reunification and up until 2006 was there a steady rise in the number of occupied beds in forensic-psychiatric hospitals and prisons with a simultaneous decrease in the number of beds in general psychiatry. This holds true even when taking the unification-related increase in population into account (Table 1). In recent years the number of occupied beds in forensic-psychiatric hospitals has continued to rise while the number of prisoners in the penal system as well as the number of available beds is about the same [32].

Concluding remarks

Mentally disordered prisoners in Germany are subject to special legal regulations, which can be traced back to the 1933 "Dangerous Habitual Offenders and their Detention and Rehabilitation Act". There are no special diversion programs in Germany but diversion does in fact happen via legal regulations that are based on the construct of legal responsibility. Diversion refers to the removal of offenders from the criminal justice system at any stage of the procedure and court proceedings. In recent years the number of occupied beds in forensic-psychiatric hospitals has continued to rise. Some recommendations of an interdisciplinary work group serve as a guide to operationalise the forensic-psychiatric task. These recommendations list formal minimum requirements for expert reports on the question of criminal responsibility and risk assessment as well as minimum standards regarding content and in writing the report.

Table 1. Forensic patients (Old West-German states including West Berlin), Prisoners and Patients in general psychiatric hospitals (Old West-German states including West Berlin 1970-1990, as of 1995 unified Germany)

Forensic psychiatry according to §§ 63,64 German Penal Code			**In Comparison**	
Year	**Psychiatric** Hospital (§63)	**Detoxification** Centre (§64)	**Prison**	**General Psychiatry** (available beds)
1970	4222	179	35209	117596
1975	3494	183	34271	115922
1980	2593	632	42027	108904
1985	2472	990	48212	94624
1990	2489	1160	39178	70570
1995	2902	1373	46516	63807
2000	4098	1774	60798	54802
2005	5640	2473	63533	53021 (2004)
2006	5917	2619	64512	52923
2007	6061	2603	64700	53169
2008	6287	2656	62348	53061
2009	6440	2811	61878	No information
2010	6569	3021	60693	No information

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Care or Justice?
A Moral Dilemma in Forensic Psychiatry

Susan te Winkel,Chris de Werd

1 Introduction

In 2010, State Secretary Fred Teeven stated that he wanted the measure taken that all forensic psychiatric patients that withdraw from their parole, are forbidden to go on leave for a year. Teeven stated that he wanted the measure to be preventive: 'I hope that people think: I don't want to run that risk" (1). He further added that, even though the number of withdrawals decreased the past years, every escape is a threat for society. The lawyer Wim Anker stated that Teeven is 'shooting on mosquito's with a canon', in 2010 there were 50 000 leaves, 31 times a patient withdrew from his leave.

This new measure does not stand on itself: a few years before the new measure the political party VVD argued that all leaves of forensic psychiatric patients in a forensic psychiatric centre (FPC) had to be suspended if one patient on leave violated the rules. These measures show that for society the emphasis is more and more on safety, in fact, the prevention of recidivism, and less on care for patients in an FPC. The care for individual patients is not taken in account in the rising of the measurements. It looks like measures related to justice can and do increase independently from care.

The goal of treatment in an FPC is to decrease the chances on recidivism to an acceptable level. This happens through a variety of treatments, which can be seen as a form of caring for the patients. In Forensic Psychiatric Clinic Dr. S. van Mesdag in Groningen, the Netherlands, the emphasis of the approach to patients is on care. This means that, besides the focus on the patient as a perpetrator of crime and the risk that the behavior of a patient involves, psychiatric practitioners are in fact caring for the patients and have to reflect the principles of a humane treatment of patients who are subject to involuntary professional care.

In this article, we discuss the relationship between justice and care. Both are aspects of the treatment given in forensic psychiatric hospitals and should go hand in hand. However, in some cases these two aspects also can be contradictory. Often a caregiver has to choose between what is good for the patient and what is good for society.

Take as an example, taken from actual practice, a patient who wants to write a science fiction novel. To do this, he says he needs a computer. However, computer use is very restricted for patients due to safety rules: with new

technologies, it is very hard to control the patient's activities on a pc. What is a good thing to do in this case? Where should your loyalty lie? This case shows that there is a moral dilemma between care and justice that needs to be solved in a good way. There are also other examples of the dilemma between care and justice: finding the right moment when a patient wants to go on leave unescorted, letting the patients work with knives in the kitchen etc. Even though many of such dilemma's are solved in protocols, new dilemmas arise and sometimes old protocols have to be revised: the tension between justice and care remains. These dilemmas need to be solved in a good and structured way, for professionals bear responsibility for their actions.

The goal of this article is explaining the origin of the dilemma. In this way, philosophy is useful by making conceptual relevant distinctions, for instance, what the difference is between several concepts of justice, the possibility of reconciliation with care and the central role of the professional in this process. The article tries to contribute to a way of solving it by the professional in the FPC. In figure 1, we firstly present a summary delineating the concepts used by the three parties involved: society, the professionals giving treatment and the patients. These parties place their emphasis on different principles, different means and different goals.

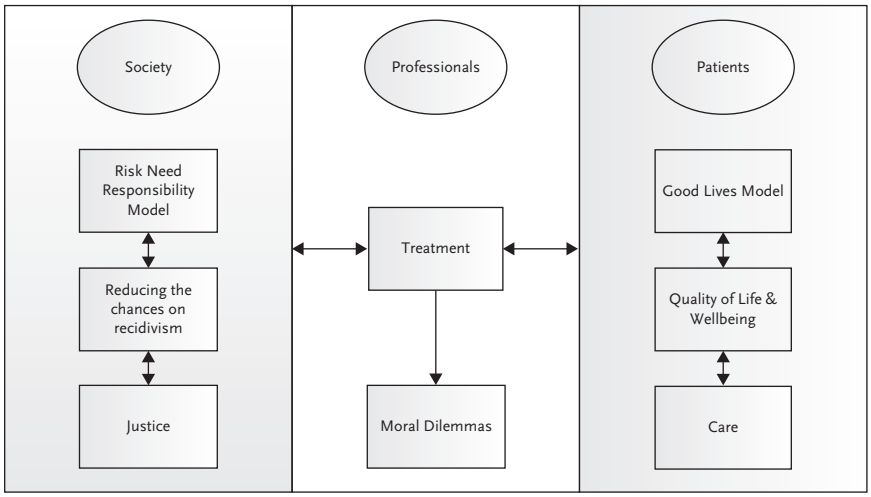

Fig.1

In section two, we will denote the RNR model and the philosophical basis of it as a means for forensic psychiatric treatment as seen by society. According to their view, reducing chances of recidivism in the first place is seen as a morally justified action. In the third section we look at the other side: the way the so-called Good Lives Model is implemented as a means of pursuing wellbeing (or quality of life).

According to this view, care is the pursuit of wellbeing. In the fourth, we discuss treatment, which has to reconcile the reduction of recidivism and wellbeing, or care and justice. In order to discuss the dilemma of care and justice in practice, we interviewed three professionals of a forensic psychiatric centre. We also interviewed patients to discuss what constitutes quality of life in an FPC. In the fifth section, we conclude by discussing how this dilemma could be resolved.

2 Decreasing Chances on Recidivism and Justice

In this chapter, we want to explore the role of justice in TBS. To do this, we will first explore the rationale for TBS and what is exactly is. Afterwards we will look at a model of treatment that focuses on the justice part of treatment. Last, the role of justice as a concept in TBS is discussed.

2.1 TBS

TBS is a penal law measure in the Netherlands; it is best described as detention under a hospital order. A person is detained under a hospital order when he or she has committed a crime on which the penalty is at least 4 years and the offender has a mental illness, which has contributed to committing the crime (2). The measure of TBS is executed in a forensic psychiatric centre (FPC), of which there are 12 in the Netherlands (3). The goal of an FPC is to protect society from the persons detained under hospital order, which we will from now on call patients.

The protection of society takes place in two ways. First, by literally separating patients from society through the freedom-limiting measure of placement in a closed and secured institution. The second way of protecting society is by stabilizing the patient's mental disorder and offering a rehabilitation program to make sure they are safe enough to return to society, i.e. the chances of recidivism are reduced to an acceptable level. The TBS-measure with compulsory psychiatric treatment is applied to a patient for indefinite time, and is reconsidered every two years. The average time spent in TBS is 9,5 year (4). The FPC Dr. S. van Mesdag is one of the 12 FPC's in the Netherlands. In this hospital, there are about 250 patients, all men.

2.2 THE RNR MODEL OF TREATMENT

The treatment in FPC's is designed according to a model. There are different treatment models, of which the RNR model is a widely used model (as a part of the What Works Principles): it forms the basis of most treatment and rehabilitation programmes (5). The abbreviation stands for Risk Needs Responsitivity, which are three aspects of the treatment (6).

- Risks: the treatment of patients with a higher risk on recidivism needs to be more intensive than the treatment of patients with a low risk on recidivism. The chances on recidivism need to be assessed by a risk taxation instrument, such as the HKT-30 or HCR-20 (7).
- Needs: the treatment needs to focus on the criminogenic needs of the patients: these needs, for example antisocial behaviour or abuse, need to be lowered.
- Responsitivity: the treatment has to be suited to the individual patient: the patient needs to be open to the treatment.

The RNR model works, according to different social scientifical studies (8). The model focuses on risk management and prevention of recidivism. These focuses closely relate to the goal of TBS: the lowering of the chances on recidivism. We can therefore say that the model justifies itself in following the goal of TBS.

2.3 RNR AND JUSTICE

In summary, the Risk Need Responsitivity Model focuses on the prevention of risk, on the criminogenic needs of the offender and on the responsitivity of the offender to the treatment (9). The model is aimed at reducing the risk factors that lead to crimes. The goal concentrates not on the promotion of wellbeing of an individual, but focuses on prevention of other crimes. As we will see later on, justice requires autonomous freedom and equality and this is the reason that a crime, committed by a mentally ill person, justifies involuntary hospitalization. The crime violates the autonomy and freedom of the other and treats him as something that is subordinate to the perpetrators needs. Therefore, this risk must be reduced by means of reduction of the dangerous behaviour, and this is precisely what the RNR model tries to do.

However, there is a reason to question this thought. The fact that society needs to be protected against particular behavior, does not offer any guidance for the treatment of a disorder in itself. The call for protection of society on the other hand is, at least partly, a right reaction to dangerous behaviour. It is a justified demand for protection. Therefore, the treatment in an FPC based on the RNR model mainly is aimed at justifying the actions to society and, in a more narrow sense, the judicial system. Towards the patient, this kind of treatment can only be justified insofar as their judgment is autonomous, free and rational.

3 Quality of Life, Wellbeing and Care

In recent years, the RNR model of treatment received a lot of criticism from a new model: the Good Lives Model (GLM). This strength based rehabilitation model focuses on the good lives for patients instead of focussing on risk and

prevention. The model states that by improving one's quality of life (by focusing on the so-called 'primary goods'), one is also decreasing the risks on recidivism. This statement is supported by recent research (10). The developers of the Good Lives Model state that the focus on prevention of the RNR model is necessary, but not sufficient for the treatment of offenders. Tony Ward et al. state that focusing on positive aspects, a good implementation of the primary goods is needed for a successful treatment program (11).

The GLM is a justified model because it supports the goal of TBS: the decreasing of the chances on recidivism. It focuses on quality of life, which is very positive, instead on risk and recidivism, which is negative. The GLM lays its emphasis on another aspect of treatment in comparison to the RNR model. Treatment, according to the GLM, is promoting the patients quality of life, which is caring for the patient. Justice and care are thus both aspects of treatment.

The GLM gives perfectly good reason to focus on the patient's quality of life, but the concept "quality of life" goes beyond the GLM. The model solely focuses on those aspects of Quality of Life (QoL) that it states are important. QoL is a broader concept: sometimes the QoL of a patient is not improved in an FPC; after all, the amount of freedom is limited. A patient´s QoL will be bettered when not in an FPC, which is not allowed by the GLM. The reason the GLM gives for this are pragmatical (improving QoL decreases recidivism), whereas we want to provide ethical guidelines to do this (12). Let us, first, explore the concepts quality of life and care and see how these are incorporated in the treatment in an FPC.

3.1 QUALITY OF LIFE AND WELLBEING

The concept of Quality of Life is a broadly explored concept in different fields of research. It has been extensively researched the past 30 years in health care and mental health care (13). In health care, one has to think about the influence of illness on the quality of life of a person. Measuring quality of life usually is carried out by a questionnaire. To give an impression of the amount of research done on quality of life: there are 711 questionnaires to measure quality of life of which 131 are specific for psychiatry and psychology (14). Most of these questionnaires state that to measure QoL a combination of subjective and objective indicators is needed. An example of an objective indicator is the amount of friends a person has. A subjective indicator is about the satisfaction on a domain of life, for example satisfaction with the amount of friends. In the field of social research, there is a consensus that QoL has both objective and subjective sides. Lehman, a pioneer in the QoL-research, developed a widely used definition of QoL:

> Ultimately, QOL is a subjective matter, reflected in a sense of global well-being, and this experience depends on at least three types of variables: personal characteristics, such as age and sex; objective QOL in various domains of life, such as income level; and subjective QOL in these same life domains, such as satisfaction with income (15).

The debate about quality of life is about subjective and objective indicators, and how these concepts are related. In philosophy, QoL is related to more concepts such as happiness and wellbeing. It is also linked to life satisfaction. When promoting one's well-being, one is increasing one's quality of life. There is a one-on-one relation between QoL and wellbeing (16).

For this reason, we will shortly discuss a well-known and widely used notion of wellbeing in this place to indicate what QoL means. This is the Capabilities Approach of Sen and Nussbaum. After this, we will discuss what improving a patient's QoL means in an FPC.

3.2 THE CAPABILITIES APPROACH

The economist Amartya Sen and the philosopher Martha Nussbaum developed the Capabilities Approach (CA). They state that a theory of wellbeing may not be too subjective: wellbeing is not only about having pleasurable experiences but also *valuing* the experience.

Wellbeing is according to Sen determined by two things: functionings and capabilities. Functionings can be primary, like being well nourished or they can be more complex, like having self-respect. Which functionings are important differs between individuals. I myself for example, might think it is important for me to be well educated, while another person may say it is important to do many sports or to be a truck driver. Functionings thus have a very subjective side: it is up to the individual to decide what functionings are important to them, but some functionings are necessary (like being well nourished or having social contacts).

Capabilities are important because they make functionings possible: capabilities are the freedoms and possibilities a person has to reach the functionings. Examples of capabilities are 'access to education', 'access to food' and 'access to health care'. A person needs to be capable to choose his functionings and therefore needs different capabilities, even if his does not use them. A person's wellbeing is thus determined by (1) the amount and quality of his capabilities and (2) by the functionings a person has that are valued en experiences as pleasurable by that person.

Martha Nussbaum has made the Capabilities Approach more objective, by adding categories in which the different capabilities are expressed. The categories, often called 'life domains' are developed in a way that everybody has to take a stance towards them: the domains are universal. She states that everybody has the same fundamental experiences but the way they are expressed differs from culture to culture and between individuals. The list of life domains is derived from Aristotle's Virtue Ethics and consists of these different domains: life; bodily health; bodily integrity; senses, imaginations and thought; emotions; practical reason; affiliation; other species; play and control over one's environment (17). The list is, according to Nussbaum 'open-ended and subject to ongoing revision and rethinking' (18).

When measuring one's wellbeing, following the CA, one has to ask about the personal satisfaction with different life domains and the capabilities and functionings a person has. An approach like the CA can be the foundation of the quality of life research. Quality of life and wellbeing thus deal with issues of personal satisfaction and is someway related to happiness.

Wellbeing in an FPC is about a positive evaluation (satisfaction) about different domains that matter for an individual in an FPC. To find out what quality of life means in an FPC, we interviewed nine patients.

3.3 ASKING THE PATIENTS

In the interviews, nine patients were asked about their quality of life to decide what indicators are important for the patients' wellbeing. What matters for quality of life in an FPC? The interviews were based on the list of life domains of the World Health Organization (WHO). The WHO developed a list of life domains which is applicable in different cultures. We asked patients whether the items of the list were important for their quality of life and why.

A sample of the patients (7 in total) of FPC Dr. S. van Mesdag was asked to participate in the interviewing: the sample is based on the different types of patients recognized by the WODC (19). The patients were all patients of the trough flow (where the main part of treatment takes place); inflow patients (where diagnoses take place) and outflow patients (where rehabilitation has its place) were not interviewed. These different types of patients were asked about what things are important for their wellbeing in a semi-structured interview. The patients were asked to rank different themes to importance to their wellbeing. The list of themes is not exhaustive; the quality of life of patients consists of more factors than the themes. The themes were chosen because they have a different meaning in TBS in comparison to the 'normal' life; the themes were developed from the list of the WHO. The ranking of importance showed the following:

1. Freedom	7. Social contact inside the clinic
2. Daytime activities	8. Faith
3. Sickness & Health	9. Medication
4. Social contacts outside the clinic / Treatment	10. Past
6. Future & goals	11. Compulsion

What matters most for the wellbeing of patients are freedom and daytime activities. It is not very surprising that freedom is a big deal for the patients: after all, that is the very thing they are missing. However, even in an FPC, freedom comes in degrees and has different meanings. Some patients are allowed to walk alone in the clinic without guidance, which is a form of freedom. Freedom is also found in other ways: one patient stated that:

> The fact that I can look outside of the window, that I see people, the view on society, so you feel less locked up, that is important. The visual contact with the outside world is important for me, and also for other patients of my unit (20).

Another patient stated that freedom is important, but treatment is more important because it leads to freedom:

> Freedom is not that important when you haven't solved your own problems (..). Now freedom is more important to me, because now things are clear [in my head]. You make your own road to freedom, that chance is given to you and you grab it with both hands. So freedom is of minor importance, but gets more important when you move to the outflow (21).

The second most important thing for the patient's quality of life is their daytime activities. These are, for example, therapies where activities like repairing bikes, metalworking, woodworking, working in the canteen and working on the small farm of the clinic are carried out. Almost all patients argued that having a fun and useful daytime activity is important. The main reasons they said it was important, was for having structure in their lives and to be able to do something useful.

Sickness and health is the third most important thing for the quality of life of the patients. As far as the patients acknowledge they have a psychiatric disorder, they state that they are happier when their psychiatric disorder gets not as much grip on them as it used to do. In treatment, the patients learn to deal with their disorder:

> Now I know what my problem is, I can put things into perspective. I know why I acted the way I did and the people around me also can understand it. That gives some peace (22).

In this way, a part of treatment improves the patient's quality of life. This act of promoting a patients quality of life in treatment is grasped by 'care'.

The interviews give an indication of what quality of life means in an FPC and what it means to improve the patients' quality of life.

3.4 CARE AND WELLBEING

The daily therapies and treatment of patients is often viewed from a caring perspective, as we will see in the next chapter. Caring activities form a great part of the daily treatment of patients. In fact, the entirety of treatment programs is sometimes viewed as caring programs (23). Care seems to be an important concept in the treatment of patients. Therefore, we will first explore what care exactly is. After this, we will look at the way care is implemented in treatment, by linking care to quality of life and the good lives model.

According to Virgina Held, care refers to an activity (24). Caring is an act of caring *for someone* and not merely caring *about* someone. It is the practice of responding to the needs of others. Care is also a value: 'we value caring persons and caring attitudes' (25). Care is a value that relates to social relations. Care, in her view, can be good or bad. Good caring relations are 'trusting and mutually considerate' (26). Diemut Bubeck defines care more precise:

> Caring for is the meeting of the needs of one person by another person, where face-to-face interaction between carer and cared for is a crucial element of the overall activity and where the need is of such a nature that it cannot possibly be met by the person in need herself (27).

Bubeck emphasizes the unequal relation between the one caring and the one cared for. This inequality becomes clear in the practice of caring in an FPC and that is why this definition of care can be used here. The patients have problems (e.g. psychological, behavioural) they cannot solve themselves. To make good treatment possible a patient has to realize he has problems, or he becomes aware of his problems during the treatment. Care has always a dimension of dependence on others: that is why we sometimes need care.

Care, according to Bubeck, has a face-to-face dimension but is not limited to the private sphere: care sometimes should be publicly supported, as is the case in an FPC. Caring, for Bubeck, is thus merely an action, as opposed to Held's notion of care as practice *and* value. We think Helds and Bubeck definitions of care have to be combined: care is a practice and a value. When caring for a person, your loyalties have to be with that person, this is a value of care. However, care is also meeting the needs of others which *they cannot meet themselves*. A patient washing another patients dish is not caring, for the other patient can do it himself too. This element of caring is essential, but the value element is also crucial. The professionals in an FPC do not have to have an emotional bond with the patients, but in their caring activities they need to be sincere, honest and directed towards the patient.

Patients that need care are, following Bubeck, patients that have needs they cannot meet themselves. Just as persons differ, the needs of persons differ. There are basic needs, but also needs that are chosen because someone thinks they are important. The term 'needs' is similar to Sen's term 'functionings'. As stated before, functionings are all the beings and doings a person manages to be. Functionings are things that give a person pleasurable experiences and are valued by that person. Caring is the act of helping someone to fulfill a functioning that a person cannot do himself. Since functionings determine a person's quality of life, caring is an action that helps to improve one's quality of life. Following the Capabilities Approach, access to care is a capability, which contributes to a patient's quality of life. In this way, it is easy to see the Good Lives Model as a form of caring for the patient. The model, which itself is partly based on the capabilities approach, aims at improving the good life for the patient whose quality of life for a great part

depends on treatment and on the caregivers. After all, in an FPC patients do not have many possibilities to improve their quality of life without the help of professionals.

4 Treatment

From the previous two chapters we conclude that both justice and care are part of the treatment in FPC's. Treatment in the FPC according to Risk Need Responsitivity Model or the Good Lives Model is focusing on the reduction of recidivism or on promoting one's wellbeing. Choosing between them means acting with an emphasis on justice or with an emphasis on care. However, how to prioritize them when you are considering a moral judgment about an action? Recent studies state that the GLM and the RNR have to work together, but the question remains how (28). How do justice and care relate to each other?

4.1 JUSTICE OR CARE?

Reducing the chances of recidivism and the focus on wellbeing reflects a tension between justice and care when treating patients in an FPC. To shed more light on this apparent dilemma we discuss the concept of justice and examine whether arguments from care can contribute to an ethically informed judgment about treatment in a forensic clinic. Understanding how justice is conceptualized and what the relation to care is, is important to get a clear insight in the difficulties of furthering the quality of treatment in an FPC like the Mesdag.

Justice is an ethical concept that plays a prominent role in ethical theories, from Aristotle to Immanuel Kant and John Rawls until now. However, it is no straightforward concept. Philosophically, it depends on the criteria for justice one uses: different ethical theories use different criteria. Nowadays, many philosophers support a so-called contractarian view, which consider justice as something people agree to. Although different, there is an important similarity between those contractarian ethics of justice; a similarity concerning the conditions in which people should choose principles of justice. People who agree about justice are all autonomous, free and equal and they choose rationally. The problem is that relations in the real world often are not equal but seems just. For instance the relation between mother and child, although of equal moral worth, is far from equal in terms of power, possibilities and freedom. Moreover, so is the relation between psychiatrist and patient in an FPC.

For several decades, an ethics of care, Care Ethics, provides arguments to justify ethically situations of inequality, arguments that support the pursuing of wellbeing in an unequal relation. Ethical care refers to moral judgments about the actions relating to caring relationships. It is the philosophical background

that comes closest to thinking about care in the forensic psychiatric clinic van Mesdag (29).

Virginia Held has provided five main characteristics of Care Ethics, which are applicable to most versions of Care Ethics (30):

- The central focus is on people who are dependent on others. For example the child which needs its mother for protection. A person is not viewed as an autonomous, independent and rational individual: we all need others to flourish.
- In Care Ethics, emotions are valued rather than rejected. Emotions need to be reflected on. In that way they can contribute to moral inquiries.
- The ethics of Care focuses on partiality and specific situations instead of focussing on universalistic and specific rules. It questions the priority of such universal rules.
- Care Ethics provides a new view on the division of the public and the private sphere. The traditional view separates the public and the private sphere, stating that the former is about politics and the public life while the latter has its place in the homes of people. Dominant moral theories state that only the public life is important for morality, while Care Ethics state that morality is also needed in the private sphere.
- The Ethics of Care sees persons as relational rather than autonomous, self-sufficient individuals. We have to value ties with others; autonomy seen from a perspective of Care Ethics is the capacity to form a relationship.

However, maybe due to the short existence of Care Ethics as a legacy of the feminist movement, there is no general criterion of justice based on Care Ethics. Also from a philosophical view justice and care appear to reconcile difficultly. As Virginia Held formulated it: "it may well be that the ethics of care does not itself provide adequate theoretical resources for dealing with issues of justice. Within its appropriate sphere and for its relevant questions, the ethics of justice may be best for what we seek" (31). It appears that another way of combining justice with care is necessary.

4.2 JUSTICE AND CARE

Justice and care are two irreducible concepts, but they are not contradictory. In practice, there is a relationship between care on the one hand and justice on the other. It is for instance plausible that *in*justice is incompatible with care. A mother who favours a child at the cost of another is not only unjust, but shows not a caring relationship, even indifference, towards the child that draws the short straw. However, is justice incompatible with indifference? Justice has to take into account carefully the interests of the victim and of the perpetrator; it is unjust to be indifferent to the fate of one of them. The question is in what way the concepts relate. To find out, we elaborate a privacy example philosophically.

Suppose, as psychiatric practitioner in a FPC, you have an appointment with a patient and he does not show up. You go to his unit and knock on his door. If

there is no response, you can do two things: you just walk in *or* wait until you are invited to come in. What to do? Considering the circumstances, (the patient has previously been convicted, it is a compulsory stay, as a professional you are in charge, the patient has failed to keep his promise, and there is a risk of deviant behavior) the question is whether others could reasonably reject the principle(the professional in this situation is simply allowed to walk in) (32). The answer is, it depends. Which burdens would the acceptance of this principle ("yes, it is allowed") impose on some, weighed against the burdens that rejection of this principle ("no, it is not allowed to walk in without permission") impose on others? The burdens associated with acceptance of the principle for the patient that it is allowed for the professional to enter the room without permission could be, for instance: infringement of privacy and trust, reducing the self-esteem of the patient and denying his autonomy. The burdens associated with rejection of the principle for the professional (but others too) could be, loss of control while there is a necessity of good supervision, diminishing responsibility by the patient, higher risk of recidivism in the future. The result of the assessment is, if acceptance creates greater burdens than rejection, than the principle can reasonably be rejected. Therefore, an answer *could* be that the principle should be rejected: it is *not* allowed to enter the room without permission of the patient.

The illuminating aspect of this example of an ethical judgment in the light of justice is that this theoretical answer on the basis of equality is questionable, not in itself, but in connection with the practice of care. The reason is that in practice there is no real equality between the parties: the professional and the patient. Therefore, the principle presumably shall be *accepted*, not because someone more powerful than the patient 'makes up' reasons that benefit acceptance, but because the theory of justice is limited to autonomous, free and equal parties. If you want to know what justice is in a situation of equality and freedom of the parties involved, you cannot expect that the answer is valid in a situation of inequality. It neither fits in a situation of an unequal relation between the professional and the patient nor in the relation between the professional and other parties who also have an interest in the outcome (colleagues, manager, juridical system, society), relations who often are unequal as well.

It is therefore important to realize when there is care involved that arguments from justice are necessary though insufficient. Necessary because the action has to be justified. There *is* such a thing as privacy. It is insufficient because arguments from an ethic of justice apply only to a situation of equality. Arguments from an ethic of *in*equality are needed to justify situations of inequality ethically. An ethics of care provides arguments about care to justify ethically situations of inequality, because the hallmark of an ethics of care is that it supports the pursuing of wellbeing in an unequal relation, (although it is limited by focusing on making itself eventually unnecessary, if possible).

There are two arguments that point toward taking responsibility to care for the dependant by the professional (33). To care is meeting the needs of others

and care meets the moral claim emanating from the person who is dependent. It means for the privacy example that for the actual relationship between the professional and the patient there are care ethical arguments that confirm the principle that it is allowed to enter the room without previous consent. However, considerations of justice based on equality could have led to rejecting this principle. Apparently, judging the situation is crucial. Is it possible to act based on equality? Or is it necessary to meet the needs of the patient because there is dependence? To decide which arguments are primary is a separate ethical consideration.

Our conclusion is that there is no direct relation between arguments from justice and arguments from care. Therefore, it is important to distinguish between arguments based on an ethics of justice and arguments based on care ethics. Both justice and care seem to contribute to a final, moral judgment about actions without deducing one from the other, recognizing that moral evaluation is not complete if one is missing. It would be like judging someone fat *only* based on his weight, not considering his length. Following this conclusion, we interviewed three professionals from the Mesdag on the relationship between justice and care and the dilemmas they face, in order to verify whether this theoretical link between justice and care corresponds with practice.

4.3 ASKING THE PROFESSIONALS

We asked three forensic professionals, a social therapist, a social worker and a psychiatrist, to what extent they feel that there is no direct relationship between the arguments of justice and the arguments of care when carrying out their work in the FPC. We interviewed them to figure out which role justice plays as an argument for actions and which role arguments from care - and how these arguments relate to each other. The content of the interview consisted of questions on general motives and reasons that underlie judgments about actions in relation to patients and compare these motives or reasons. Of course, these three interviews are only an indication of the relationship between justice and care we have established in the FPC. Dr. S. van Mesdag.

4.3.1 *The social therapist*

Our interlocutor works as a social therapist supporting the treatment of TBS patients. He does this by means of a treatment plan that is drawn up by a treatment coordinator. He assesses, together with the patient, the points the patient is able to work on, points that are linked to the crime-related behavior of the patient. It is an individual treatment but he is mentoring a number of patients. He has contact with all patients of the ward on a daily basis, anyway once or twice a week an individual mentor meeting with a patient. Things like finance, specific questions to him and things he must arrange for the patient are

discussed. He is also a sounding board or outlet, depending on the problems of the patient.

Speaking of justice in the TBS clinic, most arguments of the social therapist are based on the underlying belief that there are mutual agreements that he agrees with. Asking what he sees as the goal of treatment he for example replied: "For myself, I use the treatment plan as a guideline for my work as a social therapist, because we have agreed with each other about that. According to this plan, I try to carry out the treatment as well as possible. Making steps together, wherever they go." Immediately after this kind of arguments, reasons concerning the public interest prevail. For example, asking for his opinion about the voluntarily character of the treatment (admission is forced, the treatment is not) he says, "Tbs is to protect society, but that is done by treating someone. However, the treatment is not compulsory. The result is that a person for many years... turns a black eye to its own patterns, or these patterns can be avoided. How acceptable is that...? ...

In most cases, his arguments are not care ethical arguments. However, when such an argument is used, he finds that care is more important than justice is, and that the care a patient needs is most important. Asked whether he sees it as his task to protect society, he answers: "Yes, it is somewhere in your mind, but the treatment of the patient comes to me first." In most cases, he is weighing carefully. In a number of times care arguments are decisive and not arguments from justice. Such is the case when asked his opinion about the importance of personality factors in relation to environmental factors in the behavior of the patient. "I think the degree of socialization of the patient is very decisive. Perhaps 70%.... When you see how someone growing up has problems, already during pregnancy... Would I not become ill myself?"

In summary, it can be said that with regard to a TBS measure the social therapist sees acting according to justice as a matter of implicit or explicit agreement. If it really comes to care, the health needs of the patient are important. Most of the times, considering his arguments from justice and from care, he carefully balances arguments.

4.3.2 *The social worker*

The social worker's task is to contact and maintain the patient's relationships. She screens contacts (including family) and visitors and, in cooperation with the patient, weighs the value of these contacts for his healing. In the interview, she demonstrates experience and involvement. From what she tells about her work, the relationship between justice and care turns out to be as follows.

Regarding her ethical view on justice, many times the general interest of society counts as a decisive argument. For example, the privacy and autonomy of patients at any time is subordinated to security and control. In a smaller number of cases, the fact that people have equal rights determines her judgment. Sometimes her personal sense of justice counts, for instance, when she

described the powerlessness of patients who played a role in a criminal offense: "Look, the patients I work with are also victims. They are victims of their own problem, whether they choose for it or not."

In most cases however, the justification of her arguments for care is the need of the patient for care and support. In some cases, care overrides justice. An example is the reaction to a violation of the conditions for leave by a patient: "When he has violated the conditions for leave you have to find out what the reason is. Then you just stop the leave to examine how it could happen that he was drunk and what the reason of his behaviour is." Stopping the leave is therefore not a penalty but a means to find out how he has gone so far and what to be done. A number of times she describes care specifically as a relational issue. Her conception of justice is often (but not always) equal to the legal conception of justice. The emphasis of her arguments is on care rather than justice.

In this case, it can be said that, whether or not implicit, conceptions of justice play an important role in the argumentation of the social worker. They extend also to a judgment about the role of the family and personal relationships of the patient. Regarding the justification of her actions, the emphasis is on arguments from care ethics. To her, caring means to care for the patient and the network of the patient, aimed at promoting the wellbeing of the patient, but within strict boundaries.

4.3.3 *The psychiatrist*

The interviewee is an experienced psychiatrist. He has a staff function, and is responsible for the quality of care of a particular type of patient. In addition, he is a psychiatric practitioner, not only in his own department but also in other departments and in a policlinic outside the FPC. The arguments from justice that he uses seem to be based on assumed implicit or explicit agreements between people and hence seem to fit with theory. However, sometimes justice is understood as a personal trait, for instance when he said, "for me, [justice] is coinciding with the possibilities I have, that's very important to me. Injustice makes me angry."

Care is seen as support. There is a strong focus on promoting the quality of life of the patient. In some cases, care is therefore even more important than justice is. For himself, there is an increasing emphasis on the relationship between people and a decreasing focus on "the doctor who solves the problem of the patient". About his dealings with patients over the years, which have changed in a way, he says, "I always try to invite patients to interfere with me in a social way. That is what I do. I always say good morning, good afternoon. I always ask someone where he wants to sit." In some cases, care is considered as a legal or organizational task. The subject of the indefinite duration of the TBS leads to a discussion about costs of the TBS and the measures that should be taken.

Regarding the relationship between arguments from care or from justice, the arguments differ from one situation to another. Sometimes the focus is on care. This is, for instance, the case when he explains the way in which the TBS patient is offered support by the encouragement to take personal responsibility: "actually we say to someone, I give that responsibility back to you. We do know when a number of factors were interplaying, you could not weigh them, but from now on we do want you to be responsible for that feeling." Another time arguments of justice play an important role. For example, when a person who is charged for a crime is refusing cooperation with treatment (which is allowed). He says about this: "I find it hard to tolerate that such a person can escape a confrontation. There should have been one. I do think that, implicitly or explicitly, this conversation should have taken place."

We conclude that arguments from justice or from care used by the psychiatrist seem to be related strongly to the topic being talked about. At second thought, opinions look influenced by legal and organizational arguments. Legal and organizational frameworks (the psychiatrist though is in charge of the care of a department) are clearly present. For instance this becomes clear when he declares that certain things (e.g., a possible right of inspection of patient records by the Minister of Justice) are going too far, that they are unacceptable and he would consider withdrawing.

The overall conclusion according to these three interviews is that arguments from care in a 'justice setting' are mentioned only in connection with very unimportant things, e.g. permission to have an extra DVD. Arguments of care do not appear to generate justice. Conversely, arguments from justice do not appear to generate caring relationships. Arguments from justice and arguments from care mainly seem to be used in their own domain, which is not surprising, but in practice seldom cross over. It really is care *or* justice.

Both philosophical considerations and ideas from practice show that there is no direct relation between arguments from justice and arguments from care. Philosophical, because justice is about equal relationships between autonomous and free persons and care is not. In practice, because arguments seem to be used only within their own domain, justice or care. However, within juridical boundaries they are not mutually exclusive. The dilemma though is how to reconcile the two.

5 Solving the dilemma

The dilemma between justice and care is that on the one hand, caring is an action between unequal parties and on the other hand, justice requires equal treatment of all parties. In solving this moral dilemma, the question arises how arguments from an Ethics of Justice could contribute to an ethical judgment about care.

In our view, the ethical theory of T. M. Scanlon can contribute to solve the dilemma, because it assumes that a principle may be weighed carefully to determine what burdens the consequences of the principle entail. For instance: what is the burden of the consequences of the principle that a patient of a forensic clinic, as a part of the treatment, sooner or later will go on unescorted leave? Moreover, what is the burden of the consequences of rejecting this principle?

Scanlon describes in his book *What we Owe to Each Other* a (contractarian) theory of justice (34). His theory involves that *justifiability to others* is basic for moral actions - and not (like John Rawls) the state of equality that people rationally agree to, and not (like Kant) what principles could be willed to hold universally. What we morally ought to do is not what is rational to choose or will, but what we ought to do according to *principles that others could not reasonably reject*. On the other hand, the other way around, judging whether an act is wrong, is a moral judgment that judges whether a principle that permits someone to do something, by anyone reasonably can be rejected. For example, the principle which makes it possible to go unescorted leave of a TBS-patient will have consequences when it is accepted. Persons are less protected from dangerous behavior. Rejecting the principle is a burden to the interests of the patient. Which burden is the greatest? When the burden for the person who needs protection is smaller, the principle cannot reasonably be rejected. The principle, that it must be possible for a TBS-patient to go on unescorted leave, is morally just.

However, in this way one can decide what is just, but not what is promoting his wellbeing or in other words, not what is good for him. Is it good for a specific patient to go on leave unescorted? Can he cope with his freedom? That kind of questions cannot be answered by a principle of justice alone. To decide, you need also an ethics of care, for instance to assess the relations which have their impact on his treatment. How can arguments from an ethics of care contribute to an ethical judgment about care? Care Ethics provides arguments to justify ethically situations of inequality, because the hallmark of ethical care is that it supports the pursuing of wellbeing in an unequal relation. As said before, from Care Ethics there are two arguments for accepting inequality as a feature of a caring relation: first, in relations of care it is fundamentally important to meet the needs and the pursuit to wellbeing of those for whom we take responsibility. In a caring relation, persons are dependent of the care and this dependence is a moral claim to ethical care. Therefore, responsibility to meet the needs of someone is an argument to justify care.

The second argument that justifies unequal relationships is linked to the question whether or not actual relationships, equal or unequal, may take precedence over abstract ethical rules, like rules of justice. Sometimes the care for certain relationships (for instance children, family, the sick and the weak) is more important than justice is. Held: "the compelling moral claim of the particular other may be valid even when it conflicts with the requirement usually made by moral theories that moral judgments be universalizable" (35). This

position however is not without controversy. Some think that there may be no conflict between universal rules and actual relationships. Nevertheless, certain actual relationships justify care and take precedence over justice.

As there is no ethical theory that grasps both justice and care at the same time, a solution to the moral dilemma needs to be solved morally in both ways. Both weighing the burdens of a principle for justice *and* taking responsibility for care are needed to justify a judgment about good treatment. A solution to a dilemma of justice and care needs to be justifiable according to an ethics of justice *and* an ethics of care. This means that professionals, when faced with the dilemma, need to search for arguments that recognize justice and care. They have to search for places where the two ethics overlap. This does not mean that they are searching for a mere modus vivendi, but that they must try to take into consideration both justice and care. What constitutes good treatment is the creative search to grasp both justice and care.

6 Conclusion

In this article, we looked to treatment in the FPC in a philosophical and practical way. We found that treatment in the end was justified by arguments from justice *or* from care. Professionals in an FPC have to work from a perspective of reducing risks on recidivism, but also from a perspective of pursuing quality of life of the patient. In practice, the treatment can lead to a dilemma and therefore the professional gives priority to one aspect. This tension in practice also reflects a tension on a philosophical level, a tension between care and justice.

We showed how care and justice are both aspects of a moral judgment about treatment in an FPC, which leads to the dilemma between care and justice. Considerations in solving this dilemma have led to the conclusion that neither an ethic of justice, nor an ethic of care in itself can grasp care *and* justice. Stating that the two aspects are both relevant but irreducible, we think that arguments from both ethics have to work together as aspects of a moral decision. When confronted with a dilemma concerning justice and care, professionals of an FPC have to think about an overlap of the judgments according to the two ethics. Both arguments from justice and arguments from care have to be taken into account in order to provide justified care and careful justice.

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Developmental Trajectories of Delinquent and Antisocial Behavior and Their Differential Associations with Intellectual and Neurocognitive Impairments - A Short Review

Annemarie van der Ham, Ellemieke Nederlof

Introduction

Over the last decades, the development of delinquency has been the subject of extensive research, steadily enhancing the understanding of its antecedents and correlates. One of the most well-documented and robust findings is the phenomenon referred to as the age-crime curve; the finding that the prevalence of antisocial and delinquent behavior is low during childhood and early adolescence, rises and peaks in middle to late adolescence and declines from the early twenties, greatly dissipating by adulthood for the majority of individuals (1,2). The peak in the age-crime curve has been demonstrated to represent a temporary increase in the number of individuals who engage in delinquent behavior rather than an increase in their offence rates (1). From both self-report studies and conviction data, it is estimated that between 60 and 90 percent of adolescents engage in some kind of delinquent behavior, ranging from status offences and drug use to serious violence and sex offences, thereby constituting over half of the population of criminal offenders (3-6). However, the great majority of them have desisted from crime by their late twenties. Only a small group of individuals continues to display delinquent behavior throughout adulthood (1,4,5). It is this small group, though, comprised by approximately 5 percent of the male population, that has been shown to offend most frequently, persistently, and violently, and is responsible for over 50 percent of all crime (7-9). But why do some individuals continue to engage in delinquency, while most desist, and how can these persistent offenders be distinguished from the relatively common adolescent offenders?

Adolescence-limited and life-course persistent trajectories of offending

During adolescence, future persistent offenders have appeared not to be distinguishable from adolescence-limited offenders on basis of ethnicity, socio-economic

status, peer group, and the type and frequency of their delinquent behavior (10,11). Moffitt (5) has posed that, for discrimination between the two, information on preadolescent behavior is essential, a notion that has received considerable support. In 1993, she proposed a dual taxonomy to describe and explain the development of delinquent behavior from childhood to adulthood and the observed trajectories. She differentiated between two groups: the *adolescence-limited* and the *life-course persistent* offenders, which she argued each have a unique etiology and course (5). Variation was identified along the following dimensions: prevalence, period of onset, stability over time, stability across situations, deviance, individual disposition, and quality of the developmental environment.

The adolescence-limited group is the group that largely accounts for the peak in the age-crime curve. As its name implies, this group consists of those individuals whose offending is confined to the adolescent period. Their antisocial and delinquent behavior originates in puberty; they have no childhood history of such behavior, and is temporary; they are unlikely to persist during adulthood. As described above, the percentage of adolescents engaging in any kind of delinquent behavior is substantial. It is hence considered as virtually normative behavior, emerging in otherwise healthy, normally developing individuals. Moffitt (5) has attributed its emergence to the 'maturity gap', the years in which adolescents experience discrepancy between biological maturity and maturity as defined by society. She poses that this gap motivates them to mimic the behavior of older and delinquent adolescents, as a means to facilitate individuation and autonomy from parents and other authority figures and gain esteem from and affiliation with peers. Their delinquent acts are therefore likely to be instrumental and limited to only those situations in which they are profitable. Therein considerably aided by their preadolescent healthy development in most life domains, the adolescence-limited offenders are able to refrain from delinquency when they become adults and pass the maturity gap (5).

The life-course persistent group of offenders chiefly corresponds to the small proportion of individuals who persist in offending throughout adulthood, described above. Their antisocial and delinquent behavior originates early in childhood and, although in changing and worsening manifestations, is present in every stage of life. They may bite and display temper tantrums in kindergarten, steal and fight in middle school, and sell drugs in high school, which then may escalate to violence or sexual offences in early adulthood. Moreover, this behavior is manifested not only in every stage of life, but also in every domain of life (5). In contrast to the adolescence-limited group of offenders, who are quite common and whose engagement in antisocial and criminal activities is regarded as almost normative, life-course persistent offenders are rare and considered pathological. A multitude of unfavorable correlates and outcomes have been associated with this group, including a high likelihood of mental disorders,

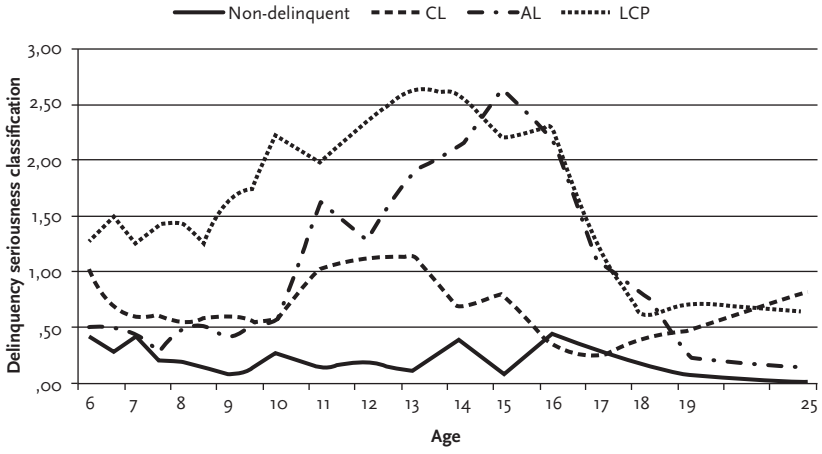
substance abuse, antisocial and psychopathic personality traits, low educational and occupational achievement, unemployment, and unstable relationships with partners and children (e.g. 5,8). Moffitt (5) has proposed that the origin of the life-course persistent trajectory of offending lies in the interaction between a child's dispositional liabilities, in particular innate or acquired neuropsychological and neurological deficits, and a disadvantaged developmental environment, which cause a chain of often adverse experiences that become imprinted in his or her personality and behavioral repertoire. These expand to every domain of functioning and, having become pervasive and persistent, prohibit the development of alternative ways of behavior.

A body of research has now corroborated the distinction between the adolescent-limited and life-course persistent trajectories of offending, yet has also demonstrated the presence of a third type of offenders (e.g. 8,12-15). A small group of individuals has become apparent that engaged in serious antisocial and delinquent behavior during childhood but displayed only low levels during adolescence, thus in disagreement with the life-course persistent pattern of offending and appearing to have largely desisted from crime. They were hence initially called the recovery group or the childhood-limited offenders. However, follow-up studies revealed that a large proportion of them was involved in criminal activities during adulthood, albeit in low levels, suggesting that they experience a suspension period in which they temporarily attenuate or desist offending (8). This group was relabeled the 'low-level chronic offenders'. Although still understudied, research findings suggest that they are characterized by internalizing psychopathology, social anxiety and neuroticism and show intellectual and neurocognitive impairments (8,12,15).

Figure 1 presents the trajectories of antisocial and delinquent behavior from age 6 to age 25 for the adolescence-limited, life-course persistent and childhood-limited or low-level-chronic offenders, along with that of the group of individuals who abstain from delinquency entirely, as recently replicated with data from the longitudinal Pittsburgh Youth Study (4,15,16). In correspondence with Moffitt's taxonomy, the adolescence-limited group starts off at low levels of delinquent behavior, comparable to that of the non-delinquent group, but shows a dramatic peak between ages 10 and 16 and then sharply declines to end at levels comparable to that of the non-delinquent group again. The life-course persistent group starts off with moderate to high levels of delinquent behavior which further increase between ages 9 and 16 and then show a steep decline but nevertheless remain moderately high throughout early adulthood. In agreement with more recent findings and the suggestion to relabel them 'low-level chronic offenders', the childhood-limited offenders show low to moderate delinquent

behavior in early childhood, increase to moderate levels between ages 10 and 15 and then decrease again yet appear to display a second increase in late adolescence.

Figure 1. Trajectories of antisocial and delinquent behavior from age 6 to 25 for the groups of low-level chronic or childhood-limited (CL), adolescence-limited (AL) and life-course persistent (LCP) offenders, along with the group of individuals who abstain from delinquency completely (the non-delinquent group). The delinquency seriousness classification, ranging from 0 to 4, is based on self-report data and represents the severity of the delinquent acts committed at each age, with 0 indicating that no delinquent act was committed, and 4 indicating serious delinquency (see 4,17 for further details).



Neuropsychological factors in the development of delinquent behavior

Numerous environmental and psychosocial factors have been demonstrated to increase the risk of developing antisocial or delinquent behavior, including childhood abuse and neglect, inadequate parental discipline, low parental involvement, family disruptions, having a teenage mother, negative peer influences, residence in high-crime neighborhoods, poverty and low socio-economic status (e.g. 4,17), and increasing evidence is now substantiating the longstanding claim that neurological and neuropsychological variations play an important role (e.g. 11,15,18,19). However, despite the corroboration of the adolescence-limited, life-course persistent and low-level chronic trajectories of offending, studies have generally compared groups of non-delinquent and delinquent individuals and have failed to incorporate the different pathways of delinquency when considering

the factors that impinge on its development. This paragraph will try to summarize the main research findings on the neuropsychological variations that appear to be of significance in the development of antisocial and delinquent behavior and its different trajectories. Findings on the psychosocial and environmental factors mentioned above have been described in more detail elsewhere (e.g. 4,17).

The association between antisocial and delinquent behavior and intellectual and neurocognitive abilities has been recognized and studied for decades (e.g. 11,15,18-22). Intellectual and executive functioning have therein been the predominant research focus, with studies generally demonstrating groups of antisocial and delinquent individuals to have deficits in these domains when compared to normal controls. As early as the 1970s, it was reported that offenders had significantly lower IQ scores then non-offenders (20,21), a finding that has been repeatedly replicated since and has been demonstrated to be independent of race, socioeconomic status, test motivation and differential detection (18,22). Particularly verbal abilities have appeared to be affected in delinquent individuals, which is also manifested by the finding that verbal IQ <performance IQ discrepancies are significantly more common among delinquent groups than among normal controls (18,23). The explanation for this association supposedly lies in the fact that individuals with low intellectual and particularly low verbal abilities generally have trouble anticipating the consequences of their behavior and generalizing information and behaviors, are less capable of problem solving and abstract and logical reasoning, have lower self-control and impaired moral development and understanding of social rules. Their range of strategies and responses to challenging situations is relatively limited, and, also partially attributable to expressive impairments, they are more likely to experience frustration and react with aggression or rule-breaking behavior. Independent of verbal and performance IQ, delinquent individuals have also been shown to score worse on tests of executive functioning when compared to normal controls. Executive functioning, although its definition is not entirely agreed upon, is often used as an umbrella term encompassing a set of cognitive processes necessary for goal-directed behavior. These include initiation, planning, monitoring and adaptation of actions, regulation of behavior and emotions, problem solving, decision making, verbal and abstract reasoning, inhibition, attention and attention control. It follows that impairments of these functions may manifest itself in decreased behavioral and emotional inhibition and the inability to foresee the consequences of one's actions and to generate problem-solving strategies and socially appropriate behavior in ambiguous contexts, and hence may attribute to the development of delinquent behavior. An extensive meta-analysis by Morgan and Lilienfeld (19) demonstrated favorable results on six measures of executive function for non-delinquent when compared to delinquent individuals, suggesting the latter have inferior verbal fluency,

cognitive flexibility and set shifting, abstract reasoning, concept formation, planning, inhibition and problem solving abilities. In addition to the impairments in intellectual, verbal and executive functioning, preliminary findings have recently pointed towards visuo-spatial impairments as well (15,24). These are proposed to interfere with the processing of social information and by this means contribute to the development of antisocial behavior, but yet have to be investigated more elaborately (15).

Concerning the different developmental trajectories of offending, Wolfgang (21) has demonstrated decades ago that offenders are not only characterized by intellectual impairments when compared to normal controls, but also that chronic offenders, supposedly analogous to the life-course persistent offenders, are more seriously impaired than non-chronic offenders. Later research has generally focused on the neuropsychological characteristics of the persistent delinquent individual exclusively, demonstrating clear deficits in this group yet leaving the adolescent-limited and low-level chronic offenders and, consequently, Moffitt's (5) proposed distinctions understudied. In one of the first longitudinal studies of the cognitive abilities differentially related to the developmental trajectories from Moffitt's (5) theory, Donnellan and his colleagues (25) found that adolescent-limited offenders had higher cognitive, predominantly verbal abilities than life-course persistent offenders. More recently, childhood-onset and adolescence-onset offenders were both demonstrated to have verbal IQ, total IQ and planning and successive processing abilities below the norm, while only the childhood-onset group was also impaired on attention functioning (26). This finding is partially in line with Raine et al. (15). Investigating longitudinal data from the Pittsburgh Youth Study, they found that at age 16, the future life-course persistent and low-level chronic offenders were impaired on intellectual abilities, memory and sustained attention when compared to the adolescence-limited offenders and a non-delinquent control group. A current follow-up of their study (16) generally corroborated their findings at age 26. The life-course persistent group of offenders scored worst on overall neuropsychological functioning, followed by the low-level chronic and adolescence-limited groups of offenders, respectively. Differences were most evident for the life-course persistent and low-level chronic groups of offending on the measures of verbal IQ, sustained attention, and impulsivity, which remained significant even after controlling for ethnicity, socio-economic status, head injury and substance use (16).

In sum, although the association between the trajectories of delinquent behavior and differential profiles of neuropsychological functioning from Moffitt's theory (5) has remained understudied, research findings have, on the whole, substantiated the proposition that life-course persistent offenders are characterized by profound neuropsychological impairments. More specifically, particularly verbal IQ, attention and self-control appear to be decreased in life-course persistent

offenders when compared to adolescence-limited offenders. Beyond the scope of Moffitt's theory, the low-level chronic group of offenders has also emerged to show significant neuropsychological impairments, that, although less severe, are in nature equivalent to those of the life-course persistent group.

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AUTISM SPECTRUM DISORDERS AND DISINHIBITED BEHAVIOURS: TOWARD A TRANSLATIONAL APPROACH

Willem M.A. Verhoeven, Jos I.M. Egger

I. A brief history of autism

Autism is a developmental disorder defined as a severe and persistent restriction in communicative skills, including lack of social and emotional reciprocity, as well as stereotyped and repetitive behaviours. Such an impairment of social interaction was already described in 1919 by the Swiss psychiatrist Eugen Bleuler within the framework of the negative symptom complex of schizophrenia. In the following decades, particularly in the German language areas of Switzerland, autism was viewed by Kretschmer in the early twenties as a schizoid temperament whereas later, he considered this disorder as a special form of schizophrenia. In line with this, in the mid-fifties, Leonhard assigned the specific disturbance in communication to the so called systematic schizophrenias.

Early infantile autism was originally described in 1943 by the Austrian pediatric psychiatrist Leo Kanner as Autistic Disturbance of Affective Contact. In a study of 11 children, he distinguished four behavioural characteristics, i.e., severe social withdrawal behaviour, obsessive desire for repetitiveness, persistent fascination with specific objects or thoughts, and severe language impairments. One year later, the Austrian pediatrician Hans Asperger reported comparable findings under the title 'Die "Autistischen Psychopathen" im Kindesalter'. Both Kanner and Asperger considered autism a contact disorder for children with severely impoverished relations with the environment (i.e., 'autistic aloneness') [1-3].

Under the influence of the then prevalent psychodynamic theories, untill the mid sixties, autism was largely attributed to family and environmental factors. In 1968, Rutter placed autism in a different perspective by demarcating the phenotypical presentation of both early infantile autism and schizophrenia from their biological underpinnings [4]. Lorna Wing can be credited for bringing the descriptions of Asperger from 1944 back to our attention in the 1980s and, on the basis of extensive childhood epidemiological research, for placing autism in a broader diagnostic context and developing diagnostic criteria [5.6]. Wing introduced the term 'autism spectrum disorder', which can be described on the basis of information from three domains: (a) social reciprocity, (b) verbal and non-verbal communication and imagination, and (c) a restricted, stereotyped pattern of interests and activities. The DSM-IV categories of Pervasive Developmental

Disorders that include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, are still based on this trias [7].

In her retrospective 'Reflections on opening Pandora's box', presented a few years back, Lorna Wing warns about stretching the boundaries of the autistic spectrum, which presently includes those who have normal to extremely high intelligence at the one end and those with a severe intellectual disability and limited social and communicative skills at the other end [8]. In such a manner, the diagnostic label of 'autistic spectrum disorder' can possibly be misused to attain care [9]. This is certainly not inconceivable in light of the quadrupled prevalence of pervasive developmental disorders across a period of 40 years (4.1 per 10.000 to 16.8 per 10.000), including somatic/neurological disorders that accompany autism [10, 11]. As to the latter, it has to be stressed that autism and Asperger's disorder are regularly associated with other syndromes [12, 13]. This is the reason why Gillberg, already in 1991, stated in his Emanuel Miller Memorial Lecture, that researchers and clinicians, rather than allow themselves to be guided by stereotypic (sub)classifications, should direct themselves by a more balanced view of autism as belonging to a group of empathy disorders through searching for autism-relevant endophenotypes [14].

In the following sections, a brief overview of the current neuropsychological and genetic explanatory models of autism will be given. Following this, three genetic syndromes frequently associated with autism and disinhibited behaviours will be discussed. Also, pharmacological treatment strategies with a putative antiaggressive effect are briefly elaborated upon. Finally, some conclusions will be drawn as to the manner in which modern insights from the various disciplines can be joined in a translational diagnosis and treatment of the autism-behavioural disinhibition complex.

II. Neuropsychological and genetic viewpoints

II.-1. NEUROPSYCHOLOGY

For the pattern of disorders encountered in cases of autism, roughly three neuropsychological explanatory models can be discerned. The first model is based upon the weak central coherence (WCC) hypothesis, which claims that patients with autism are inclined to attend to details as opposed to the whole during the processing of context-based information (i.e., strictly feature-based perception). As a consequence, the information is not understood as a meaningful whole and thus remains fragmented and confusing [15,16]. The second model draws upon the concept of 'Theory of Mind', which refers to the capacity to attribute thoughts, desires, and intentions to others. This capacity starts to develop around the age of three to four years and allows humans to take the

perspectives of others into consideration in their own thinking. Deficiencies in this domain can easily lead to social misinterpretations and socially inadequate behavior, which form the basis of the severe communication problems that people with autism show [17,18]. In this connection, the more general notion of social cognition may be called upon and a link made to, for example, diminished activity of the amygdala and deviant perceptions of one's own emotions [19].

In the last model, that of the dysexecutive functioning hypothesis, disturbed executive functions are assumed to play an important role. The executive functions (EF) are of major importance for the integration, steering, and control of processes required to execute purposeful behavior in new or complex situations. At a structural level, four frontal-subcortical circuits are involved in EF. The dorsolateral-prefrontal circuit has been related to executive cognitive dysfunctioning; the ventromedial circuit has been related to activation and motivation problems; and the medial- and lateral-orbitofrontal circuits have been related to disturbed affect regulation and disturbed social behavior, respectively [20, 21]. EF often involves the overruling of automatic responses in favour of more intentional behaviour. A capacity to flexibly switch between different behavioral repertoires (i.e., monitoring and shifting) is required for such overruling and typically found to be a problem in cases of autism [22]. Barnes-Holmes and colleagues view EF as rule-governed behaviour and thus behaviour that stands in contrast to contingency-shaped behaviour, which has been automatized. EF thus defined, is verbal behaviour that precedes other behaviour (i.e., verbal antecedent behavior) and therefore distracts the individual from his usual, automatic reaction pattern. Stated differently, the probability of an alternative behaviour is changed in the direction of a particular objective. In such a manner, thus, recent research on rule-governed behaviour connects EF with autism and an underlying Theory of Mind [23, 24].

11.-2. GENETICS

Autism can be viewed as a classic example of a disorder with a strong genetic basis. Nevertheless, a distinction must be made between the Autistic disorder as originally described by Kanner and the autism spectrum disorder, which can be viewed as a component of an array of clinical pictures and syndromes that are sometimes referred to as secondary or syndromal autism [25]. Given the complex interplay between genes and autism, a search for at least two types of genetic factors is of importance, namely: rare chromosomal abnormalities that can be directly related to core (i.e., classic) autism and *de novo* genetic variants that correlate with a vulnerability to develop disinhibited behaviours as part of an autistic disorder.

In several twin studies from the 1980s and 1990s using a strict definition of autism, it has been reported that there is a vary high contribution of hereditary components [26]. In order to advance the understanding of the genetic heterogeneity of autistic disorders, various techniques can be used such as (molecular) cytogenetic research, linkage studies, and association studies.

Linkage studies search for those parts of a chromosome that are found to be the same for all affected individuals in a family but different for the non-affected family members. A gene that contributes to the occurrence of a vulnerability for autism may lie in such a shared region. These studies have revealed a wide variety of loci, from which a considerable genetic heterogeneity can be concluded as well as the absence of single, specific locations for autism [27.28]. The same holds true for candidate genes that have been implicated in a large series of association studies. These studies investigate significant genetic differences between large groups of patients, on the one hand, and groups of healthy individuals, on the other hand [29,30]. Despite the equivocality of these research findings, it is clear that the pathophysiology of autism involves genes that code for proteins that are involved in the development and functioning of synaptic networks [31-33].

In the search for specific submicroscopic deletions, the fluorescence-in-situ-hybridization (FISH) technique has been used primarily to confirm a clinical diagnosis such as the 22q11 deletion syndrome. More commonly used these days is the whole-genome microarray technique. Here, details more than a hundred times smaller can be perceived when compared to microscopic cytogenetic examination [34, 35]. In this way, the complete genome can be examined in detail for the presence of microdeletions and duplications or so-called copy-number variations (CNVs). Of principal concern here are small quantitative, structural variations that are paired with a loss or gain of genetic information. For various neuropsychiatric disorders including autism, CNVs possibly involved in the vulnerability for the development of a disorder within the autism spectrum have been demonstrated using the array technique [36]. A more precise interpretation of the array results with the aid of bio-informatics, data from the pedigree and from clinical research among the affected individuals, is therefore essential [37].

In sum, linkage and association studies among patients with autistic disorders have revealed a large number of candidate genes and gene locations for which it can be assumed that they may be involved in the development of functional processes of the central nervous system. As stressed by Miyake and coworkers, autism spectrum disorders may be specifically induced by epigenetic dysregulations following environmental factors such as neuronal stimulation, malnutrition and maternal care [38].

III. The autism-behavioural disinhibition complex in three syndromes

III-1. FRAGILE X SYNDROME

The fragile X syndrome (FXS) is the most well-known genetic disorder related to autism and aggressive behaviours. FXS is caused by hypermethylation of an expanded trinucleotide repeat (CGG) in the 'fragile X mental retardation

1 (*FMR1*) gene' (Xq27.3). In normal individuals, the number of CGG repeats is 5 to 45 which is stably transmitted to the next generation. In case of a *FMR1* premutation, there is a small expansion of 55 to 200 repeats. In FXS, the number of repeats exceeds 200. As a result of this enlarged number of repeats, hypermethylation of the *FMR1* gene occurs which leads, in turn, to a shortage or complete loss of the FMR1 protein that is essential for dendrite and synapse formation, and experiential learning [39,40].

FXS is an X-linked disorder with an incidence of about 1 in 4.000 newborn males. Affected males show a variable degree of developmental delay, behaviour problems, and distinctive dysmorphisms such as a long face and large, prominent ears. Female carriers with a full mutation (<200 repeats) may present with or without impaired level of intelligence. Females with FXS and normal intelligence, however, have an increased risk of mood and anxiety disorders and of schizotypal personality disorder [41].]

For decades, it has been known that the severity of intellectual disability and the intensity of related behaviour problems is proportional to the number of repeats. The psychopathological phenotype of FXS includes, in addition to developmental delay, multiform anxiety symptoms, obsessive-compulsive characteristics, hyperactivity/impulsivity, and aggression. Epileptic phenomena are also frequent. Predominant, however, are autism-related symptoms such as social anxiety and withdrawal behaviour, stereotypies like flapping or biting of the hands, perseverations, extreme sensitivity to environmental stimuli, and, in general, decreased social reciprocity with an avoidance of eye contact [42].

Since the extremely heightened sensitivity to environmental stimuli is assumed to underlie the above mentioned symptoms, it is essential to reduce excesssive environmental sensory activation. Therefore, the treatment of patients with FXS is primarily symptomatic and aimed at the reduction of the most prominent behavioural problems, particularly impulsivity, hyperactivity, aggression and distractibility [43].

III-2. 22Q11 MICRODELETION SYNDROME

The 22q11 microdeletion syndrome (22q11DS) was first described in 1978 by Shprintzen as velo-cardio-facial syndrome and is caused by an interstitial deletion of chromosome 22 (22q11.2). The syndrome is associated with an array of somatic anomalies such as congenital heart and conotruncal defects, hypoparathyroidism, and facial dysmorphism. The prevalence of 22q11DS is 1:4,000 with an equal male-female distribution. The deletion involved in this syndrome can encompass multiple genes, with the T-box 1 (*TBX1*) gene as the most important. Its encoded protein is crucial for the development of specific brain areas, heart, face, and limbs [44].

During the past decades, it has repeatedly been reported that psychiatric disorders often occur in 22q11DS patients. These include psychoses in particular

[45-47], but also anxiety, mood, and obsessive-compulsive disorders [48]. In addition, in 15% to 30% of the patients with 22q11DS, autistic features and disinhibited behaviours are present [49-52]. Closer inspection of the neuropsychological phenotype, however, has demonstrated that both the psychotic and the autistic-like symptoms, including disturbances in the aggression regulation, evolve from a diminished comprehension of abstract and symbolic language, in addition to a limited capacity to correctly estimate the intentions, emotions, and behaviour of others [47, 48].

In sum, for 22q11DS, it is obvious that detailed analysis of the cognitive, emotional, and psychiatric profile is of critical importance for the choice of an individual treatment strategy.

III-3. METABOLIC DISORDERS

While genetically determined metabolic disorders are relatively rare, nevertheless, they often manifest with behavioural disorders and symptoms from the autism spectrum. From the metabolic disorders, the creatine deficiency syndromes represent a recently recognized group of diseases that are caused by inherited defects in the biosynthesis and transport of creatine. Two defects in the biosynthesis have been reported that include deficiencies of the enzymes L-arginine-glycine amidinotransferase (AGAT) and guanidinoacetate methyltransferase (GAMT). The third is a functional defect involving the creatine transporter mechanism. The latter is an X-linked syndrome caused by a defective creatine transporter and was first described by Salomons and coworkers [53]. It appeared to be the result of a hemizygous mutation in the creatine transporter gene called *SLC6A8* that was mapped to Xq28. Its prevalence is estimated to be at least 2% of X-linked mental retardation syndromes [54]. Since the *SLC6A8* gene is expressed in most tissues (e.g. skeletal muscles, kidneys, colon, brain and heart), several organ systems can be affected. The main organ involved in creatine deficiency syndromes is the central nervous system.

Patients show, apart from neurodevelopmental delay, epilepsy and speech disturbances, marked autistic, aggressive and self-injurous behaviours [55,56]. In patients with GAMT or AGAT deficiency, early oral creatine substitution treatment might effectively prevent neurological sequelae. In those with a defect in the creatine transporter gene *SLC6A8*, however, suppletion with L-arginine is not effective at all [57].

IV. Putative antiaggressive pharmacological strategies

Since the 1960s, all available antipsychotics have been used in the symptomatic treatment of aggression in patients with all kind of psychiatric disorders or aggressive behaviour as such. Most of the at present marketed antipsychotics

have an additional indication for the treatment of excitement and agitation. As far as positive results are reported, they deal with sedation, motor inhibition or reduction of aggression secondary to anxiety or psychosis. It should be stressed, however, that antipsychotics, especially the conventional neuroleptics, may provoke aggressive behaviour via the induction of akathisia, even after they are withdrawn [58, 59]. Whether the modern atypical antipsychotics or clozapine do reduce impulsiveness and aggressiveness independent of their antipsychotic action is still questionable. Recent data suggest that the atypical antipsychotic aripiprazole may have beneficial effects on aggression parameters like irritability in intellectually disabled patients with autism spectrum disorders [60,61]. Apart from the antipsychotic drugs, several other compounds can be used to alleviate behavioural disinhibition.

Since the early seventies, several studies have been performed with lithium for aggressive behaviour in a variety of patient populations [62-65]. The results of these studies, however, have to be interpreted with caution because of several methodological problems. The last two decades no relevant studies have been published.

For a long time, carbamazepine has been advocated for behavioural control, although only one placebo-controlled study is published that demonstrates, however, no effect on aggressive behaviour [66]. Some beneficial effects of valproic acid have been reported on aspects of behavioural disinhibition like irritability and impulsivity [67-69]. Although the anticonvulsants valproic acid, carbamazepine, oxcarbazepine and phenytoin are reported to have some anti-aggression effects, the results are still equivocal and the use of such compounds to treat aggression in clinical practice remains a matter for the prescribing physician [70, 71]. One study reports an anti-aggressive effect of topiramate in intellectually disabled patients and another is suggestive for attenuation of disinhibited motor behaviours in Tourette syndrome [72, 73].

The development of psychotropics targeted at discrete behaviours or functional disturbances is promising but biased by the incorrect premise that aggression is a unitary concept. Even if a biologically relevant taxonomy of aggressive behaviour in humans would be feasible, a simple connection with a biological parameter like a receptor or a neurotransmitter is highly unlikely [74]. In addition, it should be stressed that the activation of relevant biological systems depends on earlier experiences with the particular behaviour [75]. From pre-clinical research is has become clear that the neural circuits involved in many types of human and animal aggression, comprise multiple neurotransmitter systems and receptor subtypes [76, 77]. For that reason, it was recently postulated that the best strategy for treating aggressive behaviours may be developed via a translational paradigm targeting a specific subset of receptors [78].

V. Concluding remarks

The majority of patients with disinhibited behaviours in the context of the autism spectrum present with a mild to severe intellectual disability. In a substantial number of cases, moreover, the autistic disorder appears to be part of a genetic disorder. Apart from the changes of diagnostic concepts over the past decades, research on the genetic underpinnings of autism and related disorders confronts three major complexities. First, there is the large degree of genetic heterogeneity, which means that different genes can contribute in a varying way to the emergence of a disorder. A second difficulty is the polygenetic inheritance, that is, the simultaneous presence of multiple genetically-determined vulnerabilities that may be responsible for the development of a particular syndrome. A third problem lies in the well-known interaction between environmental and genetic factors during development from early conception on [9].

All mutations that are causative for the aforementioned disorders concern genes involved in the early development of the central nervous system. The search for vulnerability genes and epigenetic factors has made clear that disturbed synaptic functionality is involved in the pathophysiology of a certain, albeit small, percentage of cases with autism. This kind of knowledge might be relevant for the development of putative future pharmacological treatment strategies for a subgroup of patients with autism-behavioural disinhibition disorders.

For daily clinical practice, facial dysmorphisms in patients with autism in addition to intellectual disabilities, constitute the initial indication for modern genetic investigation. Epilepsy at young age and gradual deterioration of previously acquired skills warrant further search for a metabolic disorder. Future scientific studies may reveal to which extent sets of genes are involved in the pathophysiology of autism related disorders and their associated aggressive behaviours. In all cases it is clear that detailed information about developmental history, neuropsychiatric/neuropsychological profile as well as an elaborative inventory of family characteristics is mandatory for appropriate genetic search. This holds true for both the individual patient and for a group of well defined patients.

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THE MMPI-2 AND THE NEUROCOGNITIVE PARADIGM: ASSESSMENT OF PSYCHOPATHOLOGY AND PERSONALITY IN ALCOHOL ABUSIVE PATIENTS

Jos Egger, Serge Walvoort, Arie Wester

1 Introduction

Psychological assessment of forensic psychiatric patients should inform the clinician about a patient's adaptive qualities and should be able to originate appropriate treatment. In particular, this holds for forensic patients in whom chronic alcohol abuse is present [1]. For decades, it is reported that personality traits are important predictors both of treatment success and treatment drop-out in patients with Alcohol Use Disorders (AUD) [2, 3]. As a consequence, it is common practice to assess personality traits in AUD patients and to use this information in the process of treatment design and planning. For such an assessment of personality traits, often, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is used. The MMPI-2 is the most widely used self-report questionnaire for the assessment of emotional functioning [4].

With respect to patients with AUD, several studies with the original MMPI tried to define typologies or 'code types' of alcoholics [5-8]. These code types are still reported to be valid, despite the thorough revision that the MMPI has undergone for the construction of the MMPI-2 [9]. In their MMPI-2 typology study of AUD patients, Egger et al. [1] differentiated three types of alcohol dependence: (a) the antisocial, immature, risk-taking type, (b) the negativistic, alienated, schizoid type, and (c) the anxious, passive, introverted type. Although they found evidence for convergent validity with measures of temperament and character, they nevertheless concluded that cluster differences may have been influenced by cognitive deficits during abstinence (e.g., inhibitory dysfunctions). While MMPI-2 assessment is still standard procedure in many clinical settings, there is scarce evidence for the treatment utility of this diagnostic approach, that is, for the degree to which this form of diagnostic assessment enhances treatment outcome [10, 11]. One possible explanation for poor outcome is that underlying cognitive features can affect the endorsement of items from a self-report questionnaire in such a way that the level and pattern of scale-scores leads to clinical misinterpretation [12]. This is in accordance with the fact that there is a

growing body of evidence that the chronic use of alcohol influences brain functioning and adaptive behaviour in general [2, 13-19].

Indeed, several reports of cognitive dysfunctions are found in patients with AUD, including deficits in memory, executive attention, planning, the processing of environmental feedback, working memory, response inhibition [20-22], and a gradual decline of social and emotional functioning [22, 23]. All lead to the conclusion that detection of cognitive deficits is of major importance to the design of proper treatment strategies and to the maximisation of its outcome [22, 24].

1.1 ABSTINENCE AND RECOVERY

Although some cognitive functions will be permanently affected by chronic alcohol abuse, not all of them are irreversible. Manning and colleagues [25] describe AUD patients who after a longer period of abstinence show a gradual improvement of executive functioning. They conclude that, shortly after admission, a treatment program will easily outweigh the patient's cognitive capacities, whereas later on, when executive functioning, attention, memory and planning have gradually improved, patients may be more responsive to such a treatment program.

This is in line with studies who found a significant recovery of functions after detoxification [26, 27]. Bates et al. [23] point out that some functions return after several weeks, but others can take years to recover. A study on cognitive performance on long-term abstinent alcoholics (average period of abstinence = 6.7 years) reveals the recovery of most of the cognitive functions, except the spatial information processing ability [28]. Recovery of executive functioning is seen as the key towards a successful treatment [2]. Moreover, in AUD patients assessed with the MMPI and the Halstead-Reitan Neuropsychological Test Battery, a strong relationship was demonstrated between emotional distress (anxiety and depression) and executive functioning due to frontal lobe dysfunction common to cognitive and affective domains [12].

Apart from cognitive functioning, several studies also point at the partial recovery of emotional and somatic functioning. Dush and Keen [29], for instance, found that AUD patients, who were retested 30 days after inpatient treatment, showed a dramatic overall reduction in pathology and presume this to be due to the influence of toxicity and exaggerated symptomatology in the first month of abstinence. Other authors have suggested to view the consequences of AUD as a special form of traumatic brain injury (TBI) [30, 31]. Reitan and Wolfson [32], in their review on emotional disturbances and interaction with neuropsychological deficits, indeed found that head injured patients who recovered on neuropsychological functions, also demonstrated

MMPI-"recovery," i.e., decrease in profile level. In contrast, patients with serious cognitive deficits continued to demonstrate deviant profiles. This corroborates the findings of Johnson-Greene et al. [12] who noted that in some of these patients, the MMPI may be measuring the severity of brain dysfunction rather than their emotional distress, and suggests a replication with the MMPI-2.

The above studies underscore the scientific prudence that is needed in the interpretation of self-reports made by AUD patients. Nevertheless, it would be highly beneficial when a clinician, in the early phases of treatment, could have measures of both cognitive and emotional functioning at his disposal.

1.2 NEUROBEHAVIOURAL CORRECTION

In order to cope with the emotional and cognitive disturbances that may hamper adequate assessment, and to increase the validity of the MMPI-2 interpretation, several correction procedures were developed over the years and used in different patient groups on the MMPI [33, 44] and, later, on the MMPI-2 [34-37]. The Dutch adaptation of the MMPI-2 [38] provides a so-called neurological filter (Neurologically Relevant Items; NRI's) for patients with damage to the central nervous system. The authors describe the NRI's as items "related to symptoms associated with the direct sequelae of neurological pathology, such as lack of energy, muscle paralysis, slowness of information processing, trouble in concentrating or memory disorders" [37]. The NRI's contain items about symptoms related to attention, concentration, headaches, dizziness, visual difficulties, pain, mobility, nausea and loss of energy, the typical symptoms that AUD patients experience during withdrawal of alcohol. The physical symptoms tend to disappear within days, while the psychological distress symptoms take more time [39].

Van Balen and colleagues [37] identified their NRI's by asking a group of 40 experts (10 neuropsychologists, 10 neurologists, 10 psychiatrists and 10 physiatrists), who were familiar with brain damaged patients, for their opinion on MMPI-2 statements in three patients groups, i.e., patients with TBI, stroke, and whiplash. For the whole group, 48 NRI's were found of which 26 were specific for the whiplash group, 25 for the stroke group and 24 for the TBI group. The latter group was studied in more detail by comparing the item endorsements of the TBI patients with those in the normative sample. The TBI protocols were then scored using both the *rescored* correction procedure (NRI's scored in a pathological direction were rescored in the non-pathological direction) and the *prorated* correction procedure (a statistical correction adopted from Gass & Russell [40] to avoid overcorrection). It was concluded that in the acute phase of TBI, a prorated correction procedure is the preferred choice. The 24 NRI's

load on clinical scales 1, 2, 3, 7 and 8, content scales HEA and WRK. This is in line with findings where the clinical scales 1, 2, 3, 7 and 8 have been identified as containing the most neurological relevant items[40]. The 24 NRI correction has proven to be a reliable and valid tool in studies with brain-damaged patients [41].

In spite of its relevance for assessment practice, until now, no research has been conducted in which MMPI-2 typologies of AUD patients have been examined as to the validity of their interpretation when a neurobehavioural correction procedure would have been applied. This is a remarkable lack in clinical knowledge, particularly because both cognitive and emotional factors play an important role in the understanding of the patient's self-reported condition and of its course during abstinence. Unfortunately, while the NRI correction procedure was not available at the time, the original study of Egger et al. [1] does not address the difference in uncorrected and corrected profiles. However, re-analysis of its data would enable the study of the clinical significance of the MMPI-2 neurobehavioural (NRI) correction procedure in patients with AUD. The present study aims exactly at this.

2 Method

2.1 PARTICIPANTS AND PROCEDURE

We used the patient group of the study in 2007 including 222 alcohol dependent inpatients admitted to the St Paschalis addiction treatment centre of the Dutch Vincent van Gogh Institute for Psychiatry. All patients were classified as alcohol dependent according to DSM-IV criteria and 76.6% of them were men. Mean age of the total group was 42.2 years (SD = 9.6). The DSM IV classifications were obtained based on extensive neuropsychiatric assessment including a clinical interview comprising the elements of the CPRS [42] conducted by an experienced neuropsychiatrist committed to the clinic. Patients performing below average intellectual abilities were excluded from participation in this research. Patients participated only after obtaining informed consent. They completed the Dutch version of the MMPI-2 after 14 days of abstinence as a part of the regular diagnostic process [1]. In order to systematically compare corrected with uncorrected MMPI-2 profiles, uncorrected scores, *NRI-deleted* scores, and *NRI-prorated* scores were computed. In the NRI-deleted procedure, the 24 NRI's are discarded before scoring. In the NRI-prorated procedure, scoring was performed according to the description of Van Balen et al. [41]. Here, within each scale, the prorated raw score is estimated by

$$NNe + (PNe \times NNe / NN) \quad (1)$$

where NNe is the number of Non-NRI endorsements, PNe the patient's NRI endorsement, and NN the total number Non-NRI endorsements. Because Alfano et al. [43, 44] have succesfully employed the deletion procedure in patients with closed head injury and patients with neurologic dysfunction and since there are no prior studies about correction procedures in AUD patients, we decided to include both procedures in order to be able to compare them in the current study.

2.2 INSTRUMENTS

The MMPI-2 has been translated and standardized for Belgium and The Netherlands in 1993 [45]. Translation occurred according to international standards [46]. Internal consistency coefficients of the Clinical Scales are slightly lower in the Dutch normative sample than in the American normative sample. Cronbach's alpha ranges from .31 (Scale 5 for women) to .85 (Scale 7 for men) with an average of .64. Test-retest reliability coefficients of the Clinical Scales range from .43 to .86, with an average of .69. The Dutch norms highly correspond with those of the American MMPI-2 [47, 48]. Detailed information about the psychometric properties of the Dutch-language version of the MMPI-2 and the translation process is presented in the new edition of the MMPI-2 manual [38]. The validity of the Clinical Scales, Content Scales and PSY-5 Scales has been reported in relation to diverse Dutch clinical samples [49-55].

2.3 ANALYSIS

In line with the original study of Egger et al. [1], the NRI-corrected clinical scales are cluster analyzed in order to revisit the earlier described typology. Hierarchical cluster analysis of the Ward's method of the mean centered profiles was performed according to the procedure as described by Morey [56]. In addition, frequency of code types will be recorded per cluster to analyse the changes caused by the correction procedure.

3 Results

Both NRI deleted and NRI prorated corrected mean MMPI-2 profiles are lower than the original mean profiles. After *NRI deleted* correction, significant differences with the original clinical scales 2, 3, 7, and 8, indicate less dysphoric, somatic and apathetic symptoms (medium effect sizes). A similar pattern is found after *NRI prorated* correction, where differences are significant on 3 indicating lower levels of stress reactivity. Table 1 shows that the deleted correction procedure not only affects scales 1, 2, 3, 7, and 8, but also the other clinical scales. The results are summarized in Table 1.

Table 1. Mean scale scores of the original, deleted and prorated scales in 222 AUD patients

	Original		*Deleted*			*Prorated*		
MMPI-2 Scale	Mean	SD	Mean	SD	Cohen's *d*	Mean	SD	Cohen's *d*
L	46.53	9.61	46.53	9.61	–	46.53	9.61	[a]
F	73.69	21.54	70.82	20.82	.14	73.69	21.54	[a]
K	41.22	10.97	39.99	10.63	.11	41.22	10.97	[a]
1	60.58	14.90	59.22	12.42	.10	53.11	13.53	.53[b]
2	68.72	15.05	61.65	12.59	.51[b]	63.28	14.08	.37[b]
3	63.00	15.61	56.87	12.72	.43[b]	52.74	12.44	.73[c]
4	74.62	13.69	74.94	12.46	–.02	74.62	13.69	[a]
5	54.80	11.30	54.98	10.38	–.02	54.80	11.30	[a]
6	70.04	14.82	70.37	15.23	–.02	70.04	14.82	[a]
7	70.58	15.26	65.96	12.20	.33[b]	67.76	14.25	.19
8	70.29	15.85	64.25	12.61	.31[b]	65.83	14.17	.30[b]
9	62.37	13.95	60.15	12.96	.16	62.37	13.95	[a]
0	58.17	12.38	56.88	11.91	.11	58.17	12.38	[a]

Note. L = Lie, F= Infrequency, K= Correction, 1= Hypochondriasis, 2= Depression, 3= Hysteria, 4 = Psychopathic deviate, 5 = Masculinity/ femininity, 6 = Paranoia, 7 = Psychasthenia, 8 = Schizophrenia, 9 = Hypomania, 0= Social Introversion. [a] The prorated correction procedure only affects clinical scales 1,2,3,7, and 8. [b] Medium effect size. [c] Large effect size.

Cluster analysis of both *NRI prorated* and *NRI deleted* corrected profiles, reveals three clusters that show several significant differences, representing contrasting typologies of AUD patients compared to the original profiles (Table 2). While this is true for the clustering of both *NRI prorated* and *NRI deleted* data, the cluster profiles, however, share a prominent elevation of scale 4, indicating that impulsivity/disinhibition and lack of insight is at the core of all typologies.

Table 2. Code types of the original, NRI-deleted, and NRI-prorated MMPI-2 profiles of 222 AUD patients, according to Graham (2006)

	Cluster1			*Cluster 2*			*Cluster 3*		
Correction method	N	P	Code type	N	P	Code type	N	P	Code type
Original	122	55	4	46	21	6-8	54	24	7-2-8
Deleted	92	42	4	85	38	6-4	45	20	4-9
Prorated	81	36	4-2	75	34	[a]	66	30	4-9

Note. P = percentage.[a] A well defined code type of the prorated MMPI-2 profile in cluster 2 is not present. Clinical scales 4,6,7, and 8 are all elevated.

4 Discussion

This first study on the effect of neurobehavioural correction on MMPI-2 profile configuration of patients with AUD results in two important findings that, when not recognized, can easily lead to diagnostic drift and inadequate treatment planning. First, the decrease in scores of the corrected profiles as compared to the original ones, points at the overrepresentation of somatic complaints and demoralizational beliefs during the "acute phase," usually the first month of abstinence. This is in accordance with clinical observations in AUD patients during abstinence and earlier findings that these somatic complaints are merely a reflection of the patient's multi-problem crisis that nearly always precedes admission to an addiction clinic [19, 39, 57] producing elevations on MMPI-2 profiles [24, 29, 58].

Second, although several "typologies" can be discerned in these patients, both impulsiveness/disinhibition and problems in self-reflective capacities, tend to dominate the clinical picture, which suggests that in all AUD patients, a fundamental process can be identified that is associated with the documented effects on brain functioning of (excessive) alcohol exposure [2, 15, 18, 59].

There is a remarkable similarity between the here presented MMPI-2 profiles and those described by Dush and Keen [29]. Our current profiles show a prominent elevation of MMPI-2 clinical scale 4 representing impulsivity/disinhibition, lack of insight, immaturity, irresponsibility, low motivation to change, and less environmental adaptivity [9]. Impulsiveness is a common trait in AUD patients. It increases due to the toxic effect of alcohol on the prefrontal brain regions and causes, for instance, impaired decision making which, in turn, might affect treatment outcome [60, 61]. As such, it is a major risk factor, a vulnarability, for the development of alcohol addiction [62, 63].

Earlier clinical, neuropathological and neuroradiological studies found, along with the above mentioned effects of alcohol on the cortex, alcoholic cerebellar degeneration in more than 25 % of AUD patients [64-67]. The symptoms of alcoholic cerebellar degeneration resemble the symptom-complex known as the Cerebellar Cognitive Affective Syndrome (CCAS) [68] and may be indicative for the contribution of the cerebellum in the process of modulating higher-order cognitive and emotional functions [69, 70].

The impairments in social cognition in AUD patients, such as facial affect perception, emotional prosody, theory of mind, empathy, humor processing, self-awareness, interoception, and illness insight, are well documented [71-73]. That cognitive dysfunctions can influence self-report is also shown in a recent study with alcohol dependent patients by Lincoln et al. [74]. They found impairments in

the estimation and self-evaluation of past alcohol intake that could be attributed to verbal memory dysfunctions contingent upon chronic alcohol abuse. Moreover, a study with a homogeneous group of Korsakoff patients, found deficits in a story comprehension task specifically caused by executive dysfunction [75]. This implies that AUD patients, when filling out the 567 items of the MMPI-2, might as well be hampered by both the somatic complaints and reduced executive functioning during the acute phase of abstinence.

In early abstinence, uncorrected MMPI-2 scales tend to reflect symptoms of withdrawal and cognitive recovery, overestimating levels of psychopathology, and tend to underrate disinhibitory behaviours and impulsive traits. The acute effects of alcohol withdrawal and the partial recovery of cognitive functioning over time, appears to be associated with the decrease of MMPI-2 scales, which can therefore not be merely attributed to the effects of treatment only. The latter is suggested by Polimeni, Moore and Gruenert [76] but inclusion of cognitive parameters in the evaluation of treatment may limit their findings. Although one could argue that assessment should be postponed until most symptoms are in remission (e.g., Allen [24]), clinically, the early availability of information on psychological and socio-emotional functioning is of great importance to effective treatment design.

Our findings suggest that in the acute phase of abstinence the withdrawal effects can easily lead to wrong treatment planning, resulting in a more symptomatological approach. Such an approach (e.g. verbal group therapy for depression or anxiety and long psychotherapeutic sessions) is inadequate because it ignores the underlying cognitive deficits during the acute phase of abstinence and increases the risk of treatment drop out [2].

Despite the fact that the NRI-correction procedure is originally developed for the assessment of patients with TBI [37], it appears to be a useful tool to disentangle "demoralisation" and cognitive deficits in AUD patients during abstinence. Deleting NRI's from the item pool, however, compromises the integrity of the MMPI-2 [77, 78]. Hence, Arbisi & Ben-Porath [79] in their review on correction procedures, suggest that NRI's must be scored in a different direction in order to obtain an accurate measure of psychopathology (prorated scoring). They also recommend caution in the clinical application of the correction procedure, especially when using the MMPI-2 to assess the presence of affective disturbances following head injury.

The present study on the assessment of AUD patients during the acute phase of abstinence, underscores their warning and calls for the inclusion of more than one diagnostic measure when conducting treatment planning. The use of an MMPI-2 prorated correction procedure in AUD patients is warranted in the acute phase of early abstinence to avoid diagnostic misinterpretations, which may

affect treatment. Relevant variables for better treatment planning can specifically be found within the neurocognitive domain (e.g., cognitive and emotional functioning) with the adoption of neuropsychological measures in the assessment of AUD patients.

5 Conclusions

This study supports the use of a neurocorrective approach on the MMPI-2 to enhance validity and reliability in AUD patients during the acute phase of abstinence. In using a well-documented correction procedure, we found that impulsivity and psychopathic deviation can be identified as a common denominator in this group of AUD patients. "Corrected" MMPI-2 assessment can, therefore, be helpful in the accurate identification of the above aspects and does justice to the effects of alcohol related cognitive deficits on the diagnostic process. Given the adverse effects of alcohol on the entire brain resulting in a wide array of cognitive deficits, associated with AUD, it is expected that the application of such a correction procedure would provide patient descriptives (profiles, code types) in greater detail, thus enabling more adequate selection. In alcohol abuse treatment settings, validation studies are warranted to substantiate the relation between the NRI-correction procedure and relevant neuropsychological measures. Future studies must focus on investigating the validity of a correction procedure in AUD, the utility in treatment planning, and the role of underlying alcohol related cognitive deficits, such as problems in executive functioning, illness insight and personality traits in AUD patients during abstinence.

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Trauma, Psychosis and Regression

The Psychoanalytic Treatment of a Schizophrenic Patient[1]

Jonathan Sklar

Introduction

The issue of regression in psychoanalysis has always been a matter of much controversy. There has been much conflict around the idea that the analyst may be acting out his own difficulties towards the patient rather than being in the experience of part of the patient's unconscious object relatingness. Much of the heated misunderstandings arise from where the analyst is located in the clinical scene. The analyst, watching the patient unfold his material and then interpreting it, is in a different locus from the analyst being alongside and together with his analysand. The difference is even starker if the analyst expects and understands that the patient is "doing something" to the analyst, often in the negative sense, rather than inevitably being part of the exploratory analytic pair. A modern argument about the forces of regression wonders how the analyst can want to worsen the patient's already precarious balance by allowing such a direction to occur. As if such an analytic journey is too dangerous, or should the question be, dangerous for whom? Yet for some analysts, regression has been imagined as the equivalent to the gratification of a warm cuddle between a mother and a baby in order to make things better. Regression seen from such a position is regarded as superficial and certainly not going deep in an analysis. Furthermore it is linked to the anxiety that gratification is linked to dependency and that such a behaviour leads to the idealizing of the transference.

In this paper I will argue that for very ill patients regression becomes an essential analytic tool to enable that, which cannot and must not be put into words to have a place in the process of the analysis. Such patients invariably are intensely alone, beyond daring to trust another person up to this stage in their life. They also have a great fear of dependency perhaps because of earlier assaults on their capacity to trust as children. They have a life that can be thought of as being barely alive yet life is also held onto rather than suicide. Yet if regression becomes possible, the dependence that inevitably emerges is only a station on the path of really being an independent character. Although I will be writing particularly about psychotic process in the schizophrenic much will be germane for severe perversion, both

1 This is a modified paper from my book 'Landscapes of the Dark-History, Trauma, Psychoanalysis' published by Karnac, November 2011.

in the difficulties to be uncovered in the traumatic histories and the hard task of being in a therapeutic relationship.

Such very ill patients, if the Ferenczi-Balint view is acknowledged, require capacities in the analyst to be able to be in counter-transference states of mind that may feel terrible, containing as they do, aggressive and violent historical shards. These contain a mixture of what was done to the patient in early life, what was imagined to be done and what was the defensive reaction, conscious and unconscious to the other as destructive revenge. At times this may lead to the patient feeling worse as well as the analyst feeling despair as if this is a warning to go no further along such paths. For both it requires the letting go of the comfort of a known state of mind: for the patient, the sense of holding oneself through one's own defensive state, as the best, always available solution, despite its difficult consequences that have pushed him towards seeking analysis. For the analyst it requires leaving the comfort of ones known understandings and theory and becoming more lost in what seem very deep waters. Such is the analytic journey that, at times necessitates both in the couple holding their nerve, in order to see beyond the blackness.

Following Freud, regression was (and still is today) the essential concept for beginning to describe going back in time during an analysis. The patient, in a state of regression, finds themselves being within an experience that is in certain meaningful ways a re-experiencing of atmospheres and affects from his early object relationships. Pathological regression became a term used to conceptualise an understanding of the patient's recreation of scenes that may include early mental assault, which led to Ferenczi's concept of the defensive "atomization" (1) of mental structures. This idea of atomization came from Ferenczi's thinking about a mind being unable to bear containing and holding on to the integration of thoughts, feelings and history because of the intense painfulness of what would have to be known. Rather than just unconscious elements being split off, projected and abandoned, in more severe pathology the mental structure itself fractures under the psychic strain and falls to pieces. For Ferenczi this also had a protective function, in that the fragments still contained the many parts of the whole and the fragmentation enabled some capacity to retain the character of the individual, but analysis would be required to attempt to put the pieces back together in some new way. An analogy would be the restoration of a fractured stained glass window or a fresco in pieces on the ground, which could be restored bit by bit to view. Accompanying this process was the need to discover techniques to both understand and more importantly clinically, to emotionally connect with some patients who have spent their lives protecting themselves by existing without the other.

In the area of regression, Ferenczi's and Freud's views diverged. For Freud regression needed to be understood and primarily interpreted, but for Ferenczi

there was an additional emphasis on the being in and feeling of the experience. This was a shared experience that would involve both analyst and analysand. As Ferenczi wrote, "It definitely looks as if one could never reach any real convictions at all through logical insight alone; one needs to have lived through an affective experience, to have so to speak, felt it in one's body, in order to gain conviction." (2) He believed that action and acting were not necessarily defensive or about resistance, but that through the reliving of an experience repetition transformed remembering, leading to knowledge.

Ferenczi noted that the transference is a product of the combined unconscious inter-subjectivities of the patient and analyst. With his interest in clinical work, he treated a group of severely ill patients. For those patients with profound early mental fracture, he writes, "I have finally come to realize that it is an unavoidable task for the analyst: Although he may behave as he will, he may take kindness and relaxation as far as he possibly can, the time will come when he will have to repeat with his own hands the act of murder previously perpetrated against the patient." (3) This is an invitation for the analyst to realise that he may himself have to be in the traumatic centre of the patient's emotional life, with his own counter-transferential affects in identification with the attacker. This is about understanding and not doing. Such a position anticipates Winnicott's radical idea that the "subject destroys the object, and the object survives destruction, such that the subject can use the object." (4) It is a call to carefully examine the contents of counter-transference, in order to evaluate the possibility that it contains a re-enactment of early trauma. It also points to the vital importance that the analyst survives all assaults on the analytic position and maintains that stance without retaliation.

Following Ferenczi's pioneering work in describing the vicissitudes of what happens to subject and object in regression, Michael Balint further developed the clinical and theoretical field. He felt that just citing to the patient the connections between fixation and regression led only to a theoretical bleakness or even therapeutic stagnation. Balint valued Searles's and in particular Winnicott's studies of regression in the analytic setting. He was also heartened by Anna Freud's stress on the benign aspect of regression in her 1963 paper, "Regression as a Principle in Mental Development." (5) He was particularly interested in the analyst's share in promoting or even provoking regression and in his technical responses to it. He felt that such matters were ignored by a literature that seemed to concentrate on Oedipal psychology. Balint believed that the understanding and the technical implications of the phenomena of regression belonged to an interaction between a particular analyst and a particular patient, in other words the field of two-person psychology.

Ferenczi had discovered how many patients felt their parents to be remote and cold with them. He understood this in relation to the cold, detailed, analytic mirror position, which could easily become the re-enactment of the original trauma. This led him to re-examine technique in considering the idea of offering small areas of gratification in order not to re-enact such distance. Freud, for instance, had provided soup to the Ratman prior to a session, or as part of one thus being aware of analytic atmosphere. Ferenczi discussed gratification in particular in his seminal paper, "Confusion of Tongues" (1) in which he developed the theme of professional hypocrisy; the analyst may well be thoughtful and clever with interpretations but if this is applied at an emotional distance from the patient, as a doing to or a giving of something, then the analyst may be perceived, as perhaps the parent had been seen, at an emotional distance. As Ferenczi describes, "The analytical situation – i.e. the restrained coolness, the professional hypocrisy and – hidden behind it but never revealed - a dislike of the patient which, nevertheless, he felt in all his being – such a situation was not essentially different from that which in his childhood had led to the illness." (6) This is the meaning of Balint's concern for analysis to reach an interpenetrating mix-up with the analyst being in a moment of emotional authenticity.

However, what Ferenczi did not bring into the picture, or know enough about at that time, was the stickiness of sado-masochistic resources in the patient who might then abuse his offer of kindness. This was especially so with the difficult (borderline-psychotic) patients who were referred to him. Ferenczi was confronted by the movement of pulling away from and empathy towards the patient, with such states sometimes changing quickly within moments in a session. He realized that the analyst's mental state is as important in elucidating the status of the patients' mind as the associations of the patient. Balint acknowledged the counter-balance in every analysis of the forward and backward motion of counter-transference in our internal sensations of cold and warmth towards the patient, the meaning of this historically, and its impact on the here and now.

In examining the concept of trauma, it is interesting to see how both Freud and Ferenczi conceptualised the idea. Freud concentrated on what was happening in the individuals - their ontogeny and sexuality. Ferenczi's focus, in addition, was on the individual's relationship to the world around her or him and on the organism responding to the changing environment. This was the beginning of the description of objects and their relationships – the new field of object-relations. Whilst Klein's second analyst, Karl Abraham, has been regarded as an early influence on the development of her object relationship theories, her first analyst, Ferenczi is usually unacknowledged in her theoretical development. Ferenczi encouraged her early work with children. Klein cites Ferenczi, in her preface to "The Psychoanalysis of Children": "It is to him (Ferenczi) that I owe the foundations from which my work as an analyst developed." (7)

This field, as envisioned by Ferenczi, consisted of the unconscious affective relationships between the individual and the parents, including the parental couple's relationship as imagined and internalized. In addition there are the lateral relations with siblings, those present and those only imagined and their impact on the couple. Which child is imagined to be, or actually is, more or less favoured and why, can become very important areas of mental life that will be repeated, as repetition is found in the imaginary. Describing the environment of the clinical relationship, Balint connected his ideas with Anna Freud's "need satisfying object", Bion's "container-contained" and Winnicott's "good enough mother", "primary maternal preoccupation" and the "holding function" of mother.

Balint expected that the real problem is not about gratifying or frustrating the regressed patient, but about how the analyst's response to the regression would influence the patient-analyst relationship and, by it, the further course of treatment. Balint thought that it was inept to increase the power of the analyst by satisfying the patient's expectations. But, if satisfaction occurs not by increasing inequality, but by creating an object relationship in the pattern of "primary love" he thought it was worthy of being seriously considered.

Balint's work on regression culminated in his publishing "The Basic Fault" (8). For him, the ability to obtain something good, which the baby or child had experienced too little of, might become available in the analysis. It led him to hypothesise an analytic direction, which could then lead to new internal character changes – ego development which he called a "New Beginning" (9). In the state of new beginning, an increase in symptoms led to an increase in tension, which led to a moment of gratification of particular urges, which could lead to a tranquil, quiet moment of well being. He thought that all such new beginnings happened in the transference, leading to a change in the patient's capacity to love and hate with a lessening of anxiety. Whilst the idea that the ego could develop through analysis was Freudian, Balint's title, containing such hope for change, has an idealising quality. Balint called the new beginning an 'arglos state' describing it as "a constellation in which an individual feels that nothing harmful in the environment is directed towards him and at the same time nothing harmful in him is directed towards his environment" (10). Rather than this being a guileless, innocent and simple state, it can be regarded as a pre-paranoid state. For Balint there was a crucial move away from Freud's idea of regression as entirely inside the patient's mind, and instead the new beginning was about a two-person psychology. "As development of object relationships was not a fashionable topic of the day, hardly any notice was taken of my findings, although I reported about them repeatedly" (10). At times in the analysis the analyst just has to be there as a substrate, like – to take Balint's analogies – to being the air in our lungs or the water outside the fish, which is also flowing through its gills. It is a description of the analyst as substance. Balint is describing regression as benign. He separates it from

malignant regression with its constant demand for addiction – like gratification, which is only in service for the purpose of demanding more.

Balint was interested in what he perceived as confusion within the concept of regression

One example was a state of withdrawal in regression, which, he noted, had been examined in Winnicott's idea of "being alone in the presence of the analyst" (11). Balint observed that some patients could be almost entirely absorbed in the area of their own creation. Overall subject was so complex that different aspects could easily be picked out from the whole, as if they were the more worthy of attention, leading to a fragmentation of understanding of the term in itself. This is like the parable of a blind man describing an elephant only by the part he is touching at that moment. He described a "going back to something primitive to a point before the faulty development started and at the same time discovering a new better way of functioning" (12). Regression was for the sake of progression. Yet his concept of basic fault was too simplistic a term to describe a multiplicity of points of trauma in the early life of a person and their development in the world of internal object relationships due to an/the environmental setting when the baby was growing up. Like other theorists he divided the field into benign or malignant regression.

Balint was very wary about the analyst being perceived as omnipotent. It is easy to see that this modern technique of interpreting transference first must lead to a picture of the world consisting of a rather insignificant subject confronted with mighty knowledgeable and omnipresent objects who have the power of expressing everything correctly in words, an impressive example of whom is the analyst. Balint was keen to point out the oral dependence that would follow if this was taken too far, and described how during treatment conducted in such a way, nearly all transactions between patient and analyst happen through the medium of words which reinforces the oral aspect of the clinical situation. This led him to be interested in silence in the clinical setting.

"I have experimented with the technique that allows a patient to experience a two-person relationship which cannot, need not, perhaps even must not, be expressed in words, but at times merely by, what is customarily called, 'acting out' in the analytic situation. I hasten to add that all these non-verbal communications, the acting out, would of course be worked through after the patient has emerged from this level and reached the Oedipal level again – but not till then. At the Oedipal and even at some of the so-called pre-Oedipal levels a proper interpretation, which makes the repressed conflict conscious and thereby resolves the resistance or undoes a split, gets the patients' free associations going again; at the level of the basic fault this does not necessarily happen.

Interpretation is either experienced as interference, cruelty, unwarranted demand or unfair impingement, as a hostile act, or a sign of affection, or is felt so lifeless, in fact dead that it has no affect at all" (13).

Interpretation is available for when the patient emerges from the deeply regressed state, or begins to emerge, as a means of bringing understanding into being with the primitive affect of the regression. However, now the patient has experienced a different way of being with the other, of being psychologically held and contained by the psychic dimensions of the analytic room, time and space.

These concepts are about trying to make contact with patients who have had good reason to be extremely wary of such possibilities. What follows is a part of a case study describing the clinical details of what I have just been describing in theory.

Mrs. B. – Some Clinical Material Relating to a Schizophrenic Analysand

This material comes from the analysis of a middle-aged schizophrenic woman who was in six times weekly psychoanalysis for some years. The extra session on a Saturday became the means of underpinning enough of a holding state for the patient not to need to continually regress in a serious way in the long gap between Friday and Monday. Also it averted the need for the patient to enact leaving analysis, unconsciously perceived as abandonment, by becoming so ill as to require psychiatric admission. The description of the clinical work directs attention towards an attempt to be in touch with some of the profoundly difficult states of pathological regression of the patient, together with some thoughts on technique in relation to the position of the analyst.

Mrs. B. had been in the care of psychiatrists for many years. They had diagnosed her as schizophrenic during several periods of hospitalisation. The patient was usually in such a regressed state in the consulting room that she eschewed the couch opting to sit on the wooden floor in a far corner of the room from me. For much of the time she sat in silence with her head hung low. Despite seeming to be indifferent to being in the session, she acutely observed despite giving an appearance to the contrary. Perhaps surprisingly, outside the consulting room she held an important professional position. There, her ideas and concern for others' care was well known in the community and she seemed much respected. Yet this carapace was instantly shed on entering the analytic space.

To begin with I shall describe a common situation occurring in this analysis in order to examine the difficulty of dealing with a verbally silent patient clearly manifesting intense affect. The following description is not from one particular

session, but it is a description of a common atmosphere when being in the consulting room with her. I will write partly in the present tense as a way of being in the moment with her and as a format for bringing the material to life.

The patient moves from the doorway that she has entered to the nearest corner of the consulting room. She places herself like a naughty child who comes to be punished, often meaning that for her, the excesses of violence and sadism in the night dictates that she must be in that position. In addition, she may kneel in an attitude reminiscent of prayer, for forgiveness, for salvation or as a pastiche about how useless is, in the analysis anticipation of the next night's cruelty. Whichever it is, as a particular start to a session, it is with such a range of possibilities that the patient begins.

I sit quietly waiting and gradually I feel the patient gazing at me – to gauge my mood state, to see whether I am perhaps a little safer to be with, or whether to take my silence as an irritation. Meanwhile from her state I sometimes have a hunch about what damage happened to her the previous night. If the latter, I seem often to be correct in my thoughts about the physical harm that she has done since the previous session. At this time in our work together, in between sessions, she takes a sharp carving knife and deliberately slices her upper arms, sometimes her breasts and explores her vagina and anus with the knifepoint. After such attacks, the way she sits on the floor or in a corner is a silent indication of the soreness of her body.

Usually, if she tells of such events, she speaks in an affectless manner and the patient remains surprised that I am affected by the horror of that activity. To her, she has banished feeling and is nothing and worthless. Thus, it is an activity that is of no consequence to, or for, her. It is a piece of enacted sado-masochism that she believes has nothing to do with herself. In time she was able to recognize the internal battle. The force inside her tells her to cut, implying that she will obtain relief. She fights the cruel direction by thinking about analysis, her analyst, of the room we work in and by holding pieces of gravel she has taken from my driveway. The fight is won or lost. If she fails to draw blood, the battle for survival the next night is heightened, seemingly to demand a blood sacrifice.

The analyst is placed on a tightrope in relation to such material. If I am silent, the patient is left to think that I too, do not mind the cutting of flesh, and may even ignore it, as does the patient. Also, the silent analyst may be perceived as being silent like the mother who did not speak up against what her husband was doing to the child, and thus be hated by the patient for not helping. On the other hand, if I speak logically with an interpretation about cruelty in relation to the patient-analyst couple, it may be understood in an intellectual way but the patient will still be left with the great problem of why there is a need for repetition. The patient may begin to feel that she does not hate the analyst, differentiating him

for a moment from her father in the transference. Yet what really matters is whether she thinks she can observe the analyst as indifferent to what is going on. The patient is able in the silence to push and pull the material and her observation on what might be understood by her and me, in many directions.

It seems essential that such a patient is able to begin to see the pain she is actually able to emotionally inflict onto the other. Hence, the slow surreptitious looks and glances at the analyst to see his face and posture. The clinical work often seems to be in the following arenas of unconscious object relationships: Is the patient in a room with a primary loved father in the transference? Is the transference about a sadistic bully, attacker, and rapist, who the patient has to be very careful of inciting? Is the patient, in the transference, the child who in identification with the cruel father she is also tormenting? This would require the analyst to be in the position of voyeur. Furthermore, it is possible within the complexity of ideas to think all this from the opposite psychic position that the analyst is at the behest of a bullying mental assault: both require to be thought about and, in time, interpreted.

One essential clinical task then is reality testing so that the patient may be able, perhaps for the first time, to be in a room with a man who is not going to assault her. Thus, her old nostrum that "all men are the same" can begin to break. Depending on such variables in the atmosphere of the room, the rest of the session follows. If the patient detects a cut-offness in the analyst, the session stays turgid and empty. The patient feels absent and the analyst is left to wait. The patient may perceive the affect in the analyst, which may be true, as inevitably the analyst has feelings at the assault the patient persists in making on them both. She may then go over to a painting above the couch and examine the gap between that and the wall. In particular, she seemed to be looking for a safe place between the picture and the wall in order to project a fragile ego in anticipation, in her mind, of the next assault. It is as if the patient had found refuge on high. She is then at one with the Gods and can look down at the scene of what mere mortals do to and with each other and that is enough for her to feel a little bit safer.

If the patient detected – by my posture or my interpretation or the tone of my voice – something that suggested I was with her and had some understanding of her, the session becomes very different. Tears trickling down her face are at first ignored by her before sadness encroaches. She may be in a frame of reference in which she begins to know again that two persons need not only be about a violent sado-masochistic relationship. Now she has to experience a deeper pain and a pain that cannot be relegated to nothing with just a cut. This is the pain of experiencing reality that is not just some nighttime phantasm. At this point, she can be very sad, deeply distressed and depressed at the knowledge of her awful history as a victim. This state of mind is very hard for her to maintain for long,

but when in such a state, the analyst has a patient more in touch with reality. Being in touch with extremely painful affect had been warded of, until now, by splitting mechanisms, which eschewed any connections between then and now.

Ferenczi struggled with the problem of masochistic repetition: "If the analyst succeeds in creating a conscious link between the delight and unpleasure in a specific situation that really existed, the compulsive character of masochism then ceases to operate, to be replaced by rationally justified capacity to endure unpleasure for the sake of the advantages anticipated in the future"(14). Instead of constantly returning to the masochistic pleasure, which the onlooker finds so terrible, the analysand may learn to forgo such well-known and entrenched psychic defenses. The reality of such a painful psychic state with its horrid antecedent history can then come to be known and felt by the patient, rather than just projected into the other as being the cruel onlooker, allowing other possibilities to open out in the future rather than just masochistic repetition. The problem is that Mrs. B. does not feel she has any future, thus why does she need to change? She has children, but she has repressed the possibility that she has any effect on them, as she has repressed the idea of her having any effect on her parents or they on her.

So far the clinical atmosphere has served to particularly to illustrate the view of two-person psychology in relation to the regressed patient. How the analyst responds and is perceived by the patient is technically crucial to whether there is an increase in the difference between the two, especially with an increase in omnipotence, or, a lessening of tension as the past ceases to be re-enacted by the working couple. This leads to the possibility of a benign experience in the regression and a move towards the development of a depressive state.

I will now describe some more of Mrs. B's behaviour and states of mind. The patient often starved herself. She banged her head, cut and excoriated her body and attempted to cover up the damage under her voluminous clothes. She over washed and generally had such contempt for her body, preferring to have no skin, or that only her mind should exist. Her anxiety at both swallowing solid food and defecating could be understood as a rejection of such an orifice perceived as a perverse sexual place that she needed to wipe out. After much work was done in examining her difficulty in eating solid food, one example of counter-transference horror followed. Mrs. B arrived for her next session with much satisfaction showing on her face. With spite, I was informed that she had indeed attempted to swallow something solid. She had left the consulting room at the end of the previous session and on her way out, in the garden, had found some dog faeces to eat. The reader may readily appreciate the sado-masochistic attack and its humbling influence on the analyst. What followed was an exploration of whose shit she had imagined eating – she thought it was from

my dog, meaning my shit with all the unconscious confusion of good food and excrement, mouth and anus, herself and myself, creativity versus paranoid attack. All the while I was being constantly observed as to how I was experiencing this event and whether would be able to bear the psychic pains. Could I really hold on to the idea that psychoanalytic work was creative and mutative rather than just a load of shit that only deteriorated her at best or at worse just had no effect on her whatsoever. All such thoughts and feelings required patient elaboration in words and sentences, in order for her to discriminate, to realise that the other, in the room with her, was different from what she had been so very used to. One way that a child, continually and unremittingly assaulted both mentally and physically, can survive is to signal to herself and another, that nothing existentially matters at all. In the light of this, eating shit, as if it is of no consequence, is a powerful defensive tool.

Mrs. B. dreamed and/or hallucinated, often vividly and invariably about some extreme attack that someone was doing to someone else. She was not necessarily the victim or the victimiser, but she was often the onlooker and there seemed to be no escape from the repetitive horror. One way of reading this case therefore would be as a psychotic intensification of Freud's 'A Child is Being Beaten', with the affect in the object relationships drastically increased and concretized. Very often, the patient discovered in the morning that she had enacted some ghastly action following or during a dream or hallucination. An example of this was a dream in which someone was cutting someone and when the patient awoke in the morning, she found that her body has actually been cut quite viciously with a pin or a piece of glass. Often the attacking object had been unconsciously left around in order to be used in the subsequent attack. The assaults by the patient on the analyst, who listened to such horrific material, were accepted by the analyst amidst sufficient boundaries. This was to enable the patient to know the reality of needing to be alive and to survive and to bring herself to analysis. In time, Mrs. B. gradually realised that I could survive her assaults and that I was not a mechanism. She was then able to develop feelings about the assaults. The cutting of her body, which she had done since the age of six and for many years nightly as an adult, became a much rarer event. For such change to happen, the patient had to be able to begin to look at her blackness, her vicious repetitive dream world, her psychotic states and her denial of such a process in order to know her private trauma at the hands, we both suspected, of paedophilic parents.

Her intense aggression could be viewed now as identification with both parents. As the object of her attacks moved in the transference from her body to the analytic process, she was able to begin to see and feel the pain in me and also in her sense of concern for the other, and in time, gradually, herself. For someone who trained herself hardly to exist, this was an achievement.

As Winnicott has noted, for some patients the only way of reaching an understanding of what took place is not to remember but to be mad in the analytic setting. Such a patient unconsciously organizes delusional transference and the analyst accepts this and tries to understand it.

The following vignettes from two specific pieces of material are first, about sexuality and second about Mrs. B's dream life.

The patient began with some material from when she was five or six years of age, at which time she first remembered beginning to have a conscious phantasy that she wished she were a boy. She thought that if she could pull her labia enough it would develop into a penis. She had an omnipotent thought that if she wished hard enough then it would happen. She experimented by urinating whilst standing up. All this took place in the extreme fear of being found out by her parents. It seemed that such a phantasy was a form of defensive thinking in order to escape sexual abuse, which by now we both were convinced was at the core of her history. Soon in the clinical material the nature of the conflict between actual sexual abuse and destructive, defensive constructions becomes more clarified, but at this moment our shared 'madness' was generated by clinical progression of the treatment. I think the unconscious idea behind such phantasy may be that "if I am a boy, my father will not want to abuse me, therefore I shall make myself be one of those and life will be better". I think it is likely that such a construction was shattered some years on, when she spoke about her brother being invited or forced by the parents into the paedophile circle (of which she was already at the centre) to have sex with my patient, his sister. I think the shattering of her mind, at this particular point, led to that defensive structure moving into a psychotic arena. Now she had a powerful enduring thought, at certain times, that she did have an erection. Although she knew intellectually about her anatomy, she could not disconnect the psychotic thought that she was a potent man. She was thus able to seemingly defend herself from assault by being the character with penetrative activity rather than having to be on the receiving end of being penetrated. This was certainly enacted by putting some sharp point into her skin, her anus and her vagina, to prove the power of her psychotic construction and her contempt for her body in identification with her paedophilic parents.

From such reconstruction, one would need to think about psychotic manifestations being the outcome of a mental state developed from previous actual trauma. We do no justice to the disruption done to the mind, its atomisation and reforming together in a psychotic state by just naming it as an example of the irreducible "death drive". Such mental disruption clearly involves huge amounts of aggression, both towards the subject and the object. Nonetheless, if this is not analysed in great detail, in my view, then the concept of death drive can appear to be just a name to cover the gap in knowledge. In this context I am in agreement

with Jonathan Lear's view in his book "Happiness, Death and the Remainder of Life" that, "The theory of the death drive makes it look as though it is offering a real theory-linking aggression up to other phenomena and forces – but it is only a seductive gesture in the direction of theory" (15). Whilst the patient's perceptual state that I have been describing is clearly in the realms of aggression, just stating that as a descriptive interpretation, including "look what you are trying to do to me" belies the immense possibilities of a re- enactment of history and the move to Balint's crucial possibility of a New Beginning of object relationships. Otherwise there is only repetition.

Analysis becomes a means of enabling the (re) establishment of the internal structure that includes 'letting go' or mourning that, which has been damaged in the mind, allowing the capacity of mastery and its relinquishment to begin to emerge alongside playing. If this happens, the patient may emerge to know the possibilities of the other in the room, a move away from hopelessness towards hope contained in the clinical dyad. This requires courage, in case, alongside this positive direction, there is also a return to the sado-masochistic nightmare of real early torture of some children. I am arguing that some clinical conditions, psychosis, perversion and in particular schizophrenia have roots in previous early actual traumas, both physical and mental. The idea of the death drive is not a sufficient explanation for the complexity and brutality of these events and their aftermath. An intellectual knowledge of the possibility of the destructive instinct is a very poor substitute for finding it within the experiences of the analyst-analysand. Yet refinding the aggression behind the repetitious emptiness in much of the clinical, leads to a refinding as capacity to play inside oneself and with the other, which can develop into clinical improvement.

Dream Life and the Schizophrenic

In the next vignette, Mrs. B. was five minutes late for the session. She apologized, saying that the traffic was very intense. Then she hovered at the end of the couch for seven or eight minutes silently. Eventually, I interpreted that despite her apology for being late she seemed somewhat unmoved in her silence for several more minutes beyond that. She said she did not know what to say and that everything was a muddle. Then she told me that she had woken up from a dream. This in itself was unusual, as it was often very difficult to know whether she was having auditory and visual hallucinations when she was awake at night, or whether she was dreaming. This time it sounded as if she was describing a dream.

It consisted of her feeling very frightened because a large funnel was chasing her. She was able to explain to me that her anxiety was that the point of the funnel which was nearest to her was actually going to be put over the whole of her. She

thought this was rather silly. My private thought was that she was being chased by a combined genital, as an example of her genital confusion. It happened that the penis part was facing her but equally menacing was the opposite side, the vagina. However, this in itself seemed to be a progression from her feeling in other dream states that she had a penis attached to her body. This dream construction, at least, was separate from her whilst trying to attack her back.

It was also unclear why it was so frightening to be taken inside the funnel because if she went into the point she would come out the other side. I interpreted this and she agreed. She then winced and remembered that when she was a little girl, her father would put her in the bath, place a funnel between her legs in her vagina and attaching it to the taps he would scald her with boiling water. She said this was the only time that she knew about the use of a funnel other than using it to put oil in a car. I interpreted that she was remembering the cruelty that her parents did to her and, in particular, to her body and that she very often was like them in being very cruel to her own skin. She said, with a little voice, that she knew.

There was a pause. I said that I thought that her fear of the funnel might represent her coming through the front door, the funnel part, into the vestibule and then coming into my consulting room, which was a large room in a barn with a roof rising to an apex, which could also be an unconscious motif for the funnel. If this was so, then she actually was coming in through the point of the funnel, as my consulting room represented the widest part and she was frightened of that and our work. There is a clear implication of sexuality to such a description, yet I was reluctant to interpret it in that way as I felt that she was in a more primitive state of mind.

She said it was very frightening coming into the room, but also she thought that perhaps it could help. She then became rather frightened, still standing at the end of the couch and said that the words Paradise Lost had come to her mind, but it was silly. I said maybe she was in touch with the Lost Paradise when she imagined she was inside her mother and that ever since being born she had lost Paradise. She then said that other fragmentary thoughts were on her mind. One, in particular, was the word "domino". She couldn't understand why that word came to her mind. I interpreted that maybe it was next to the word "domination" which she was not allowed to say. At this point, she said "Shut up" in a menacing voice to me and to an internal imago that something must not be revealed. I said she knew the word domination very well because she had been subject to it as a child. In our work together she saw me as dominating her at times and I certainly felt her as dominating me, such as in the silence for several minutes at the beginning of the session where it seemed that she was in control. She began to cry and again said in a vicious tone "Shut up" and then, "will I be helped with all

this?" I said that behind her was a couch and on the couch was a blanket and, if she used those, there could be a sense of her being looked after for a few minutes, and then, the image of the funnel would be something that could look after her which she would also have to leave at the end of the session. Mrs. B. was then able to lie on the couch, cover herself with the blanket, adopt the foetal position and seem to be in a more peaceful and quiet repose until the end of the session. This had never happened before.

The muddle at the start of the session led to the remembering of a dream. The idiom of the attack, with all its concomitant anxieties and pleasure was experienced in the transference. The experience contained in the dream and taken up in the transference led to a movement from paranoia to a remembering of early trauma. Or from psychosis via regression, to a position of understanding in the analyst and the patient that enabled the patient to cry and be in a depressive state whilst being cared for.

If the analytic technique is preoccupied with neurotic defenses and neurotic mechanisms it may avoid connection with psychotic processes. If one is interpreting as if the psychotic process is neurotic, it is quite likely that interpretation will fail when the patient is functioning in the area of psychosis. It is such confusion in this area that can lead to treatment failure.

In the psychotic arena and I will include states of perversion as well, patients may not be able to hear and accept interpretation and digest and work it through. A relationship between two people in a room may not even exist. It is possible that one's sentences and interpretations are not heard as words but as things, (cf. Freud's differentiation between word presentation and thing presentation (16). The patients may not know that another person is even in the room with them. When the analyst does speak, the patient may perceive the sentence as a device to penetrate, so care is required in imagining which part of the body receives such things in a state of pathological regression. This is particularly relevant with those patients who really have been attacked and sexually assaulted earlier in their life.

Winnicott postulated a process in which something awful was actually seen by the child, which led to a de-hallucination in which it was covered over. Subsequently a series of hallucinations begins to fill up the hole produced by the scotomisation. He described such a process as being compulsive in that it had to be repeated again and again. As I described in the beginning of this chapter some patients need to be psychotic in the transference in order to arrive at memories of a very disturbed and distressing kind, which belong to an earlier time. In other words, the psychosis is the blackness concealing early severe trauma as well as the hallucinations which express it and which are the source for understanding and interpretation.

For Mrs. B, being in the consulting room was felt at times as being in the place where sexual assault took place. It was both of us surviving the immense pain of being again in the moment of the trauma that eventually enabled construction of the past. Together we discovered near unimaginable aggression that had been done to her as a child by her parents and other paedophilic adults, constantly repeated as well as seemingly disconnected from the patient's apparent history.

To be alive, to anticipate advantage of the future with hope must mean that she has to be in touch consciously with her past history. Instead the patient had been left in a place in which there is an immensely painful physical and mental repetition, but at the same time repudiation of such a state.

Ferenczi writes, "I know from other analyses that a part of our personality can 'die', but though many parts can survive the trauma, it wakes up with a gap in its memory, actually with a gap in the personality, since this is not just a memory of the actual death struggle that has selectively disappeared or perhaps has been destroyed but all the associations connected with it as well" (17). Patients often have a phantasy that if they are told what is going on, then all the difficult stuff will cease. If the patients have already given themselves up to death, they have no need of memory, which exists only when one knows one has a future. This is a very different understanding of death than the death drive. By this I mean that many patients with horrific early trauma have one solution to deal finally with the immense psychic pain- that is to kill themselves. Ferenczi is struggling to acknowledge unconscious ambivalence in such patients who do not commit suicide but rather suppress being alive in their life as a way of managing to continue. Partly being dead, as in a flattened affect, enables the true self, as Winnicott called it, to survive. Analytic treatment makes conscious the repressed memories and it's deep psychic pains, eventually enabling mourning of life until now (knowing about the 'dead bits' of oneself) with the possibility of then being freer to live an alive life.

The world of Mrs. B. was full of auditory, visual, tactile and kinesthetic hallucinations, which seemed to be fragments of previous real attacks, returning to haunt her in the emptiness she created by wiping out the offer of a real creative life. There had been such a massive breakdown of trust that the patient's need for absolute control of the real world left her in a psychotic dream world. This attempt at mastery achieved the opposite, as the destructive imagery became the dominant culture of her mind and one that she often trusted in more than her analysis.

Whilst remaining alive, such patients can be understood, in André Green's memorable idea of the "Dead Mother" (18) as tending the shrine of the mother. Such mental structures maintain unconscious connectedness with mother, who neither seemed to care, nor offer enough concern or love. For Mrs. B, mother

was the perverse attacker who penetrated her and also did not protect her from father's penetration. She identified with the negative aspects of mother and thus kept mother alive in a perverse shrine, where she worshiped the non-changingness of their lives. Breaking free meant a move towards an emotional life that included mourning, both the mother she had and hated, as well as the mother she wished to have and did not. A deep aspect of the death-destructive drive is to not let such a mother complex die. It is a profound dynamic that binds the analysand sado-masochistically with their objects in order for nothing to change. It contains the phantasy that by staying still, not moving physically and psychically, one will not be perceived by the aggressive penetrating object and so will continue to just survive. At the same time it allows the potential for identifying with the aggressor. At this point the question is about whether one harms another, as was done to oneself or protect the other by damaging oneself physically. Self harm enables a destructive play that re-enacts early attacks received whilst simultaneously protecting the other and disidentifying with the aggressor. Identifying and disidentifying simultaneously is the complexity of this aggressive clinical state.

Destructiveness and Countertransference

The psychoanalysis of a psychotic patient is a severe challenge to the integrity of the analyst's capacity to bear knowing the thoughts and more importantly the feelings that lie buried within the auditory, visual and tactile hallucinations. Sometimes the analytic task consists of having the patience to uncover the horrid traumas, such as exhuming dead bodies with a gradual exposition of how terror came about. No matter how ghastly it is for the onlooker, it needs to be managed. However, the atmosphere of the analytic position is that unconsciously the patient expects the severe assaults to be repeated by the analyst. Thus the paranoia is enacted through the patient's great fear of the analyst. Though the analyst does not physically touch the patient, the patient will feel the emanations of assault, having projected them on the analyst in order for them to be returned, yet again, against the patient, as paranoia becomes the central scene of the work canvas.

To complicate matters even more, the patient, having identified with the aggressor(s), verbally and sometimes physically, attacks the analyst. Of course, such material is a communication, enabling the analyst, being in the transference in the position of the young patient, to feel the pain, terror and dread of that which the patient felt was done to them. That said one needs to bear up against what may be such a severe attack as to attempt to kill the analyst. At times this is no mere psychological posturing, but is an extremely concrete attack, embodying the full force of hatred in the patient, to attempt to actually destroy the analyst and the analytic knowledge.

One day Mrs. B. had secretly brought a carving knife into the session and acting with stealth, but in a peculiarly obvious way that something was the matter, attempted to stab me to death – the voice demanded it. It is with interest that I can report that on the occasion that this happened, I had a sixth sense of some impending assault. In my counter-transference, I felt a mixture of intense tiredness at the task and in addition an alertness to the minute details of my patient's physicality in the room. Even before the knife was made manifest from inside a towel where it was wrapped inside a large handbag, I had interpreted following ten minutes of anxious painful silence, that there seemed to be a massive attack going on in the room and that it was causing her a great deal of anxiety. This led to the patient exposing the knife, saying that she wanted to plunge it into me as a way of appeasing the voices. I offered to look after the knife. Her relief was intense, when she carefully and slowly gave the knife handle towards the analyst/me to look after. She was hugely grateful of the care given to her at being able to share her cruel hatred towards the other, that also contained, fused together, her desire for revenge against her parents.

The capacity for differentiation between them and her analyst and the establishment of solid boundaries allowed her to know her wish to kill the analyst and also to know that he was also alive enough to the problem to be able to survive the assault. The nightly cutting of the body, as an attack on the self, was refound in the transference, by Mrs. B. attempting to put the knife into the analyst. Her body was his body, in the same dynamic way that his dog's shit was food for her mouth: an interpenetrating psychotic muddle, to paraphrase Balint, that in its understanding returns the vicious paranoia to a benign mutual understanding. Aggression against the self moves to the other. This enables the activity to be understood and interpreted, in time, both in the transference of the here and now and in reference to the past parental assaults. The difficult task of disentangling phantasy from reality needs to be attempted in the examination of the violence in the transference and counter-transference. However this can only really happen once the real threat of a real, sharp knife in the consulting room has been acknowledged and neutralized. Otherwise the psychotic state of the patient may understand the not dealing with the weapon as a psychotic invitation by the analyst, issued through masochistic desire to be knife-penetrated as a way of being at one with the other.

The analyst must be extremely thorough in examining his own desire for revenge against such assault. Of course the patient expects to be attacked back as she feels she has been for most of her life by her primary objects. The patient may be constantly in a state of expecting that the treatment will just be stopped. This may take the opposite form of the patient trying to stop therapy in order to pre-empt her phantasy of the analyst's punishment of her coming true. Sometimes the patient's expectation of the analyst's desire for revenge (in identification with the

patient) is an accurate reflection of the analyst not being able to stay further in the quagmire of the transference-countertransference. The patient's wish and expectation of being too much for anybody to cope with can then come true. The analyst may think that he has done enough in an impossible case, but this needs to be perhaps understood as a revenge motif and instead perhaps the analyst can continue to do analysis with the patient. At this point the analyst can make a clinical decision about whether the patient is unworkable with, as there is such a high risk of violence, primarily towards the analyst. Psychiatric care as an inpatient needs to be considered. However, if the home situation is amenable enough, analysis of the psychotic state (to include such violent fantasies with the analyst taking all necessary precautions in order to stay with the storm) can result in an analytic movement to a benign state in which interpretative work can be done about the preceding violent crisis.

The capacity of the analyst to bear such work is clearly connected with the analyst's own state of mind. Difficult or impossible patients may well be treatable by certain analysts, as long as they only have one such case currently in their practice. Working in analysis six sessions weekly then becomes an intense holding that converts the consulting room into the holding of the mental hospital that enables the patient to stay with the clinical material with the analyst. If the patient is returned to the mental hospital, their own unconscious aggressive phantasies will continue, but in the absence of the analyst who will be understood as not able to bear it. The authenticity of who is doing what for whom is crucial at such moments. It is easy to say that the patient requires more or a different form of care, but if there is silence about how the violence impacts the analyst, the patient will often reverse such a thought projectively into the mind of the analyst, as if it originated in him. Again, as in the history, this will be experienced as being cruel, pushing her away and into an environment that is far from placid and benign – as anyone who has spent nights in a psychiatric unit can testify.

In the examination of counter-transference phenomena, the horror of the knowledge can lead to the analyst accepting, as it were, the patient's own defense of being at a distance. The sense of becoming used to horror needs to be thought about so that despite being "battle-hardened", one is still able to feel. Consciously, Mrs. B. strove to stay in the crack in the ceiling, looking down at the scene! This was an affect-less position, in order to survive. Without doubt the analyst also occupies such a space at times, with his own unconscious defensive structure available. So perhaps the actual assault on the boundaries of the analyst by bringing a knife into the frame is an unconscious attempt to get closer and to enable initially the analyst and later the patient to be in touch with the terrible affect of murder, murderous guilt and then expiation. Such material is an ordinary part of the neurotic Oedipus complex. However, for the psychotic patient, it is experienced as a concrete thing. The real danger of an explosion of

violence makes such work with a psychotic patient extremely difficult. It does not stay in the realm of the imaginary, but of action, and often dangerous action.

In the fifteenth century, Paolo Ucello painted a mysterious picture of St George and the Dragon, which can now be found in the National Gallery, London. At a quick glance it seems as if St George, on a white charger, is rushing to the rescue of the damsel menaced by a large green dragon. This scene takes place with a background of a rocky cave to the left and a forest with a cloudy swell like an eye on the other side of the picture behind the horseman. Yet, the damsel is not distressed. In fact she is holding a lead attached to the dragon that is her pet. Such a picture provides a very vivid example of how the therapist needs to exercise great caution prior to rushing in to effect a rescue. The death of the maiden's pet animal is not something that is going to lead to a positive therapeutic experience or alliance. Killing the patient's protective dragon may not be accepted well initially. As a motif it reflects the simplistic idea that the analyst will rescue the patient from their tormenting illness, even if coming upon a woman and a dragon in the forest, it would be hard not to think about danger – for the maiden or oneself.

The noose around the dragon represents the seriousness of the symptoms that need to be respected, especially as, by reversal, it may be understood as the psychotic patient being tightly in the grip of the kept dragon monster. As a surface picture of the primal scene and the struggle between a damsel and a knight, one could think of the scene of the psychosexual work of a neurotic transference. Yet the dangerous presence of a fire-breathing dragon in the center of the primal scene is indicative of work with psychosis. This psychotic functioning takes place in darker recesses – the darkness of the masochistic maternal cave and the paranoid paternal monitoring eye. In both states of mind, the actual trauma inflicted on the baby, the child and the adolescent, is a decisive factor in the structuring of the sexual state of mind.

One needs to see despite being blinded and the patient's terrible task is to catch sight of that which was real and feel it rather than to constantly deny its existence whilst simultaneously repetitively manufacturing it in present times.

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The Insecurity of Security in Detention in a Hospital

A.Goosensen, T.I. Oei

I Introduction

Detention in a hospital [1] (TBS or tbs) is an order for treatment imposed by the court on people who have committed serious crimes and who suffer from a psychiatric illness or disorder. This disorder influences their behaviour. The court can impose tbs in combination with a prison sentence. The court can impose tbs only, when psychiatric examination has determined that they suffer from a mental disorder (Website Justice Department).

There are two variants: tbs with a nursing order and conditional tbs. The hospitalization with (enforced) nursing is the most drastic form of tbs. The tbs-patient is placed in a hospital (Forensic Psychiatry Centres/Centers; FPC's) and undergoes treatment. The court imposes the tbs-order for a period of two years. However, the duration can be extended every time with a period of one or two years. Basically, tbs lasts for four years maximum. In crimes of violence, which cause danger to others, the enforced treatment can be extended every time, until the patient's death. In conditional tbs the tbs-patient does not stay in a hospital but the court puts conditions on his behaviour. For instance the patient is compelled to undergo treatment or is not allowed to use alcohol or drugs. If he fails to comply with these conditions the court can change conditional tbs into tbs with a nursing order. The maximum duration of the term for which conditional tbs can be imposed is nine years. The maximum prison sentence jointly imposed with conditional tbs is five years.

As long as the danger to society does not go down to an acceptable risk, time and time again the court has the option of extending tbs with one or two years. Every six years an independent group of experts advises the court whether extension of tbs is still desirable. It is therefore possible for tbs to be for life. After a number of years these patients are mostly transferred to longstay facilities. Also in those cases the court will see the tbs-patient every two years to determine whether extension is necessary.

1 Website Justice Department.

The number of new tbs orders has been going down in recent years, after years of growth. The rapid increase in the duration of the treatment is mainly considered to be the reason for the decreased imposition of tbs. We will first explore increase, decrease, and duration of treatment and recognition of tbs. Then we will investigate the meaning of the developments for the potential tbs-patient, the court, the professional providing treatment, the advisory committee for the review of tbs-leave, in how far they may affect the developments and what the effects on security can be. We will then present two viewpoints to start working on reducing the duration of treatment. In the first place a practical one in which we deal with the handling by the hospitals of leave authorizations and in the second place a result-oriented structuring of the treatment. After a discussion we will arrive at a number of conclusions and recommendations.

II Definition of the problem

As a result of the increasing demands for security the entire tbs-sector seems to be separated, no longer a part of society. The effect of treatment during tbs on the risk of re-offending has been demonstrated, and on the basis of parliamentary enquiry (Committee Visser 2006) tbs has become accepted politically. The number of withdrawals was strongly reduced. The inspectorate for the application of sanctions concluded that practically all FPCs fully or largely meet the review criteria. The quality certificates have been made, the percentage of positive recommendations by the advisory committee for the review of leave from tbs for 2009 stood at 87.2% not including the percentage for lagging on the basis of 6.3% postponements.

Yet so far no reversal of the decrease was found. There is a persistent rise in the duration of treatment, making it impossible for the court to maintain -even to a small degree- the principle of proportionality. Possibly up to 2004 there was a not quite realistic increase in the number of impositions, in an absolute sense the present decrease considerably surpasses the increase.

On the basis of this fact we may suppose that there is a category of convicts in our prisons that will return to society, now and later, insufficiently prepared, untreated and with too high a risk of re-offending. Politics, the judiciary, the directorate forensic care, the advisory committee and the hospitals, the tbs-patient and other chain partners each in their own way contribute to the improvement of the sector. Everything considered the chance that because of present efforts the number of serious re-offences will increase rather than decrease is big: the optimization of the parts seems to lead to sub-optimization of the whole. Because of this and because of the ethical reason of proportionality mentioned before we think it is important that the duration of the treatment is

reduced, and we would like to find out whether there are ways leading to a reduction of the duration of treatment which are at the same time acceptable within the existing tbs-system.

One question to be asked primarily is how the number of impositions has developed and what this means for re-offending. Another question is how the duration of treatment has developed and what this means for the sector. Next there is the question whether and how the primary process inside the FCP can be accelerated, firstly within FPC Oldenkotte and secondly in the entire sector.

III Method

The examination was started with a literature search into the dynamics in the field of tbs regarding volume and effectiveness. For this search we also used the management information portal of the directorate forensic care. Subsequently on the basis of literature search and the analysis of figures on the level of the tbs-sector and on the level of FPC Oldenkotte we looked for the measure of delay in treatment and additional undesirable effects. In order to examine two ways, namely the handling of authorizations for leave and result-oriented dealing with risk factors within a certain course -which may possibly contribute to a solution of the problem of the expanding duration of treatment- we analysed the situation at FPC Oldenkotte. Also, on the basis of a comparison of the handling of leave authorizations in other hospitals and national policy respectively, we have examined whether the situation can be considered exemplary.

IV Dynamism within the sector regarding volume and effectiveness

Ever since the introduction of the 'psychopaths act' in 1928 (1) there have been several fluctuations in the imposed number of tbs. The State Asylum for Psychopaths and the protestant tbr hospital[2] Oldenkotte at Rekken which was started in 1929 in the tradition of the religious segregation of those days and the department for tbr-patients started within the Roman Catholic psychiatric hospital St Willebrord at Heiloo one year later were soon unable to deal with the influx of patients. Apart from the high numbers the seriousness of the issue and the danger of the open institutions constitute too big a problem. The State Asylum at Leiden is also unable to deal with the influx. Because of the strong growth of the measure the 'psychopaths emergency act' was introduced in 1933, in practice called the 'stop act'. Public prosecutors are ordered by law to be

2 tbr (detention at Her Majesty's pleasure) is the precursor of tbs (detention in a hospital) instituted in 1988.

sparing with demanding tbs. After World War II this emergency act was abolished. A sharp rise results, 250 tbr detentions are imposed per annum on average. The absolute post-war low is halfway through the eighties. Between 1995 and 2004 the volume of the sector rises from 650 to 1369 beds (2). In spite of this doubled volume the number of transients [3] remains high in this period. The average wait for a transient patient is more than one year. An increase in duration of treatment (see table 3) combined with a clear upward trend since 2000 of the number of new impositions (see table 1) of tbs is the root cause of this. Volume within the sector is increased to 2132 beds in 2009.

Table 1: number of unconditional impositions tbs per year

1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
171	155	192	216	241	239	214	188	185	128	114	99	94

A considerable part of the increase in volume was spent in the form of temporary contracts, so-called 'tenders'. But the number of impositions is halved between 2004 and 2009 as shown in the table and has been further decreasing since. The trend does not seem to have bottomed out yet. The still increasing duration of the treatment (see table 3) does not compensate the effect, the waiting list is drying up, and growing overcapacity looms. March 2010 the first tender contract is not continued, in 2011 the second only partly. Since 2008 conditional and unconditional terminations of outnumber impositions (see tables 1 and 2). This, with some delay for the jointly imposed prison sentences, leads in 2010 to a slight decrease in the number of tbs-patients that are being treated. The coming years, if there is an unchanged number of impositions[4], this decrease in the number of patients will continue. On top of cutting recently developed volume, staff have been made redundant or temporary contracts were not continued. After years of a growth scenario we now face serious shrinkage.

Table 2: number of terminations per year

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Termination totaly	88	80	83	120	98	111	101	97	96	109
First termination:										
Termination tbs	43	50	55	61	44	60	56	55	49	48
Conditional termination	35	34	51	42	50	34	16	57	69	119
Died	5	6	6	13	10	12	11	13	12	14

An increase like the one that occurs in the years up to 2004 is hard to explain on the basis of the two criteria that must be met for an imposition. On the basis

3 Person whose tbs term has started and who awaits admission to a forensic psychiatric centre in a penitentiary institution; tbs en getal 2008, begrippen omschrijving (tbs and number, description of terms).

4 Source MIP 2011(management information portal Directorate Forensic Care).

of these criteria there must be a very serious crime or a pathological disorder or a defective development of the mental faculties of the offender. In the period up to 2004 occupancy of penitentiary institutions increases by 50% whereas occupancy of forensic psychiatric centres is more than doubled (2), not including transients. There is a rising number of detainees of the category with a prison sentence of four years and over, we occasionally see a considerable fluctuation, but not by 50%. The number of prison sentences that were imposed increases by 30%. An important annual increase of the number of Dutchmen and naturalized people with a pathological disorder or defective development of their mental faculties is not an obvious reason for this increase. The number of offences with over-average possibility of tbs then goes down over the period 2004 till 2009 by about 30% (3). The even more rapid decrease in the number of impositions tbs will not have been brought about by improved national mental health.

Criticism also fluctuates and then mostly in the form of tidal waves of media attention in the tbs-sector, mostly in the wake of an incident. However, the parliamentary inquiry, chaired by MP Visser, instituted to provide a definitive answer to the question of the existential justification of tbs, in 2006 concludes that the system does not have to be revised, but must be adapted on a number of points. Among other things, an independent advisory committee for the review of leave was instituted and the maximum duration of conditional termination of tbs with enforced treatment was extended from three to nine years. To be able to make pronouncements about the effectiveness of tbs-treatments the re-offending figures of former tbs-detainees are compared to those of former convicts. The examination leads to the conclusion that the risk of re-offending after treatment in a forensic psychiatric centre is 50% of the general re-offending risk after a stay in a penitentiary institution (2).

Seven in ten grownups who have served their prison sentences will re-offend within six years, after tbs-treatment almost four in ten will re-offend. During the seminar 'duration of treatment and tbs' a re-offending reduction of 40% due to tbs-treatment was mentioned (4). These conclusions do not reduce the crumbling away of tbs.

V Duration of treatment and undesirable effects

The accused can refuse to undergo the projustitia examination by the Dutch Institute of Forensic Psychiatry and Psychology (NIFP), and will often do so on the advice of a lawyer. This phenomenon is rising strongly. It makes it more difficult for the court to impose tbs with clear motivation. In that case it is only possible when in spite of the refusal it has been established that there is a mental disorder. One important motivation for the accused to refuse to cooperate with

the examination is in the first place the ever increasing duration of the treatment (see table 3) and the fact that there is also the risk of being ultimately referred to a longstay institution. Another reason that is mentioned is the image problem, an image problem which, according to one lawyer (5), not only holds good in society but also among criminals. December 2010 the average duration of treatment of the tbs-population not including the longstay is 5.7 years, which is longer than the average duration at the termination of tbs ten years ago. The average term for longstay patients is 14.7 years. In December 2010 this concerns 188 patients, so about 10 per cent of the entire tbs-population.

Table 3: average duration of treatment in years at termination of tbs

1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
5,0	5,4	5,5	5,9	6,3	7,0	7,0	7,4	7,4	7,9	8,4

A global calculation shows that the total duration of a tbs-imposition comes down to the sum of the duration of the sentence which (gross) in 75% of the cases means less than three years, a transient time which until recently was about one year and a duration of treatment that is still going up. To be added to this are the phase of a potential trial leave, the phase of a possible conditional termination with the risk of restart tbs if the conditions are not met, and the risk of longstay. The expectation value will then rise to over ten years, an expectation value which seems to surpass itself again every year. A gross prison sentence of fifteen years has a lower expectation value with its conditional release after two thirds of the term are up. In order to make an examination possible the State Secretary wants to make it possible by law that psychiatric data from the past are used to determine the mental make-up of the accused. The development outlined here has caused the court's principle of proportionality to suffer. The lopsided relationship between duration of treatment and administration of justice also appears from the classification used by the Directorate Forensic Care of transient patients and residential patients, on top of the longstay category. The first six years a patient is classed as a transient patient, with a higher daily rate. The question whether or not extension is in order only becomes an actuality considering the duration of the treatment when a patient is categorised as a non-transient. Because the principle of proportionality could not be maintained, the development of the duration of the treatment has also become an ethical question.

In combination with the increased duration of treatment we find delayed leaves during the treatment. The percentage for unaccompanied leave within three years after hospitalisation in an FPC went down almost linearly between 1997 and 2005 from well over 50% to about 15% (6). For the year 2008 46% of the tbs-population does not have authorisations (4). Treatment and review are inextricably linked within the primary process of tbs. Leave is an important means for the patient to practise what he has learnt and also for the hospital to review the progress of the

treatment. A patient's leaves must be within the margins of the authorisation given by the minister to the hospital after advice by the advisory committee for the review of tbs-leave[5].

The trend we indicated here makes clear that leaves have been treated with increasing caution and that the fear of making mistakes has obviously grown. This is only one side of the matter. The request for an authorisation and its review has gone through an intensive process of professionalisation. The leave review framework is used. This framework is a format according to which the hospital must supply information about previous history, the offence, the offence scenario, diagnostics, treatment plan and the place of leave within this plan, risk analysis and risk management respectively. In 2005 the Inspectorate for the Application of Sanctions recommends greater clarity about the role of the review of leave authorisations. The question is whether it is a limited, traditional, marginal review or a review more for content for which essential expertise is necessary. The move towards professionalisation makes for clarity, no longer a marginal review of the procedure as before, but also a careful review of content and consistency. One important effect is that a marked shift within the framework of tbs from the judiciary to the minister.

The coupling of treatment and review is endangered by the delayed grant of authorisations. The number of modules, whether laid down in a care programme or not, does not automatically increase in proportion to the duration of treatment. On the basis of too high a pressure of treatment there is no indication for extending treatment. The treatment has become watered down.

The will to tackle the problem of growing duration of treatment is clearly there. On the basis of parliamentary enquiry and the resulting progress reports, politics have handled tbs more carefully than ever. There is a seminar by the advisory committee for the review of leave. The Directorate Forensic Care as buying agent of care adopts a flexible position wherever possible. Probably on account of the decreasing demand the forensic psychiatric departments admit patients rapidly and the managements of the FPCs have given joint advice. Leave management became markedly improved. Nationwide the number of withdrawals is going down strongly (see table 4).

Table 4: Number of withdrawals during leave

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
tbs	104	108	115	82	103	73	43	33	29	23	42	38
old	21	26	26	21	18	12	4	4	4	0	1	3

5 AVT: met ingang van 1 januari 2008 ingesteld op basis van het advies van het parlementair onderzoek (instituted per 1 January 2008 on the basis of advice of parliamentary inquiry).

But the practice for the professionals remains unruly. It does not lead to an acceleration of the treatment (see table 3). In FPC Oldenkotte the intention to accelerate the treatment was explicitly expressed in the memorandum 'perspective Oldenkotte 2008'. Intramural treatment should take less than two years. The length of treatment of patients with a termination of tbs is in FPC Oldenkotte in 2007 6.5 years (10 patients, 8 of whom from trial leave), in 2008 6.3 years (13 patients 4 of whom from trial leave), in 2009 7.9 years (17 patients 6 of whom from trial leave) and in 2010 6.7 years (17 patients 5 of whom from trial leave). It is striking that in 2010 a disproportionate number of patients were granted (conditional) termination of tbs, whereas there was as yet no question of transmural of trial leave. This holds good for 11 of the 17 terminations in 2010. There are five terminations from trial leave and one from transmural leave. On the basis of his own professional convictions it seems that the treatment specialist is unable to give foundations for the termination in spite of or owing to this dilemma. Nor does he manage to come to advice regarding termination with the aid of a thorough review of leaves. The court accepts such advice. Last three years 36% of the (conditional)terminations are contrary to the advice (see tabel 5). What also sometimes happened was that an authorisation for leave was denied and that subsequently, also on the basis of the advice given by the hospital, the patient's tbs was terminated. This is in conformity with the experience of the probation service (7) These actions do not have any lasting effect on the average duration of treatment. The average duration of treatment of the transmural patients, these are the patients outside the security of the hospital, is an acceptable yardstick. This duration has remained stable in FPC Oldenkotte in the past three years, about 6.6 years. There is a tbs sector, but the chain itself, the primary process does not seem to function in an interconnected way.

Tabel 5: Relation advice fpc and (conditional) termination 2009 – 2011

Advice	Total	Conditional termination	Termination
Prolongation	21	14	7
Conditional termination	22	19	3
Termination	15	1	14
Total	**58**	**34**	**24**

VI Acceleration by systematically handling the leave margins

For a number of years already there has been a ready opportunity to reduce the duration of treatment in a simple, ethically responsible way. In January 2005 residential leave was replaced by transmural leave. The aim is the simplification of leave policy and augmentation of the chance of earlier exit into mental health care. Till that time separate authorisation was needed for the patient to be admitted to a department outside the security and the authorisation for residential leave must be applied for in order to be able to exit into another institution or

independent residential situation under the direct responsibility of the hospital. This means that an authorisation for transmural leave in many cases was not directly used to have transmural leave, but as a basis to be able to stay in a department of the hospital outside the security. The transmural leave itself only starts when the patient exits to a house of his own or to another institution. Residential leave is for a duration of three months, and can be extended once by another three months. Trial leave must start after six months at the latest. One important aspect is that trial leave does not count as duration of treatment. Transmural leave does not have a maximum duration unlike residential leave.

At first sight transmural leave seems a nice arrangement in practice. There is no need for the professional to request authorisation for trial leave quickly or at all. This means a lot less administrative bother. Funding is guaranteed, problems concerning paying for the bed like they may occur during a time-out trial leave do not crop up. Also it will be easier during a period of expansion for the FPC to meet the agreements about volume expansion made on the basis of the temporary 'tender volume'. FPC Oldenkotte seems bigger because the beds of sub-contractors and independently living patients can be included in the volume. We are dealing with a virtual capacity.

If at the start an acceleration of transmural leave should be caused in relation to transience, this effect will be undone by the following long duration of transmural leave (see table 6). The average duration of transmural leave in Oldenkotte on 31 December 2010 for the fifteen patients is well over 21 months. It is thirty-six months for the eight patients who have been transmural for one year or longer. In contrast to the advantages mentioned before it is not only the effect on the duration of treatment that is especially disadvantageous. There is also a counter indication of the content of treatment because the hospital dependency is not cut back further. During transmural leave the hospital remains fully responsible for the treatment. This is in contrast to trial leave during which the probation service adopts the supervision and regularly once every two months will report to the hospital. Final responsibility, however, remains with the hospital during trial leave. Furthermore there is an ethical problem, because the patient may expect to be 'rewarded' for the extra effort with some progress towards trial leave, as long as there is no counter indication. Finally there is financial damage for the hospital, because the rates are determined among other things by the number of residential patients, which in this way remains unnecessarily high.

Table 6: Duration transmural leave FPC Oldenkotte per patient in years on 31 December 2010

0,03	0,12	0,27	0,45	0,51	0,66	0,75	1,45	1,62	1,83	2,12	2,68	3,17	4,29	6,83

The special thing is that information to the professionals providing treatment by means of advice to management, tabling the problem, outlining the consequences, laying down in a management contract and an annual planning did not lead to focused actions by the professionals to allow patients to go on trial leave. Ultimately it was laid down in leave management that when a patient goes on transmural leave the multi-disciplinary team will discuss after four weeks whether there are counter indications for requesting an authorisation trial leave. The patients are scheduled once every four weeks in the multi-disciplinary team of the department for the purpose of jointly considering whether extension of the transmural leave is justified and to safeguard the progress towards trial leave. The transmural leaves are then explicitly laid down in the information system for confirmation. The results of these efforts are visible at the end of 2011 (see tabel 7). This year this will therefore not yet lead to a reduction of the average duration of treatment in FPC Oldenkotte and to a smaller degree in the entire tbs-sector, but rather to a slight increase due to the arrears situation. Positive effects are not expected before 2012/2013. Bringing about a change that actually is welcomed by everyone proves in practice to be very difficult to realise, not only within the sector but also within a hospital.

Considering the relative division of authorisations per hospital,[6] in which FPC Oldenkotte is by no means exceptional (see table 7), there are also - despite the fact that the various hospital populations are not entirely comparable – clear opportunities for the sector to push back the undesirable effect to the duration of treatment caused by the transition residential leave to transmural leave. The fact that especially FPC Pompestichting, FPCs Veldzicht and Dr. Henri van der Hoeven Hospital have longstay-patients in their populations may have caused the picture to shift towards accompanied leave.

Table 7: Relation authorisations accompanied, unaccompanied and transmural leave

	accompanied	unaccompanied	transmural
Tbs total dec 2010	40,7%	24,5%	34,8%
FPC Oldenkotte dec 2010	33,7%	27,7%	38,6%
Tbs total dec 2011	42,0%	25,4%	32,6%
FPC Oldenkotte dec 2011	40,7%	30,9%	28,4%

The idea that the duration of treatment can be reduced by a systematic use of trial leave is supported by the fact that since 2004 in spite of the sector growth the number of trial leave granted has shown a marked decline [7] (see table 8). The figures for the first few months of 2010 do not indicate a change in the trend.

6 Source: Management information portal DForZo (Directorate Forensic Care).
7 Source: Management information portal DForZo (Directorate Forensic Care).

The trend differs strongly per hospital. The split in 2005 when residential leave is changed into transmural leave is remarkable.

Table 8: Number of authorisations trial leave granted in the tbs-sector per year

2001	2001	2003	2004	2005	2006	2007	2008	2009
41	60	60	85	37	48	25	39	35

VII Result oriented working on risk factors within a course

From the INK[8] perspective FPC Oldenkotte has an activity oriented tradition. The executive official determines the focus, what is important, what to work on and how. In the dynamic setting of tbs the focus is mainly determined by ad hoc situations. There is an incident, obstructions occur, the law demands something, etcetera. Corridor chat quickly picks up on things which go wrong and are being dealt with in terms of 'having to fluff up the pillows'. There is an 'ad-hoccracy'. It is hard to build quality and quality strongly depends on the people present. We have seen two examples of this after the entire treatment top left and one example when after a reorganisation the departmental management of socio-therapy was made redundant. The degree to which the wheel has to be re-invented turns out to be irresponsibly high.

In 2007 and 2008 there are two serious incidents, the first during a transmural leave, the second during an unaccompanied leave. Also because of the leadership crisis that developed at the same time, a prolonged admission stop is imposed on FPC Oldenkotte and Oldenkotte has the dubious honour of having a paragraph of its own in the ministerial tbs progress reports to Parliament. The internal analyses and the reports of the Inspectorate of Health Care and of the Inspectorate for the Application of Sanctions make clear among other things that the treatment plans are insufficiently up to date and target-oriented and that the leave granted falls outside the leave margins or that the action plan was insufficiently adhered to. The findings do not solely concern the incidents but are exemplary for the general trend.

The incident in 2008 caused leave management to be given a systematic process form. For each activity within the process leave management, which strongly overlaps the primary process treatment, it has been laid down which professionals are involved, which instruments there are, which information system or know how system is used, which procedures and working instructions there are, which achievement indicator may possibly be used and what are potential quality issues. The ultimate result is that since September 2008 till the end of 2011 there

8 Instituut Nederlandse Kwaliteit (Institute Dutch Quality).

have only been four withdrawals. Paradoxically by example it was a female patient who actually wanted to put herself once again under the supervision of FPC Oldenkotte. Analogous to a token suicide attempt this might be termed a kind of 'token withdrawal'. In January 2011, the patient, on transmural leave, during a short unaccompanied leave on the grounds of a forensic psychiatric department withdrew from supervision by leaving the grounds in order to drink alcohol. She then phoned that she wanted to be collected. Preceding the withdrawal, she made it emphatically clear both verbally and by her actions, among other things by auto mutilation and by her refusal to have her wounds seen to, that she wanted to return to FPC Oldenkotte. Restrictive general measures are therefore not only security frameworks from the point of view of tbs, but they are also very effective measures for the patient. Serious withdrawals did not occur. The target in the annual plan is a maximum number of two per year. After all the risk of a withdrawal cannot be excluded.

An important underlying result is that in fact every patient has a treatment plan that is updated every six months. This is reviewed every month by means of management information. The requests for authorisations are born multi-disciplinarily and the freedoms are agreed multi-disciplinarily on the basis of the authorisations and are monitored every week. Also the scheduled leaves are explicitly assessed every week by the head of treatment together with the treatment coordinator and the team leader sociotherapy and are daily monitored in advance in the accessible shift and the hospital wide multi-disciplinary morning sessions. Sociotherapy and others on the shop floor actively contribute to the quality of leave management. Thinking and doing are no longer separate. It is also important that technically a leave cannot be introduced in the information system[9] without the head of treatment having registered the treatment plan, the freedoms plan, and the freedoms of the patient. And without this registration the patient cannot pass reception which registers the actual times of the leave in the system. The head of treatment is now not only in charge of leave, but he also directs it. After a period in which there is occasional resistance against the process leave management, in which there are complaints about the extra work because of the registrations and there is at first a lack of knowledge of the interplay between authorisations, freedoms and leaves the heads of treatment do not want to give up their role in the process any more and multi-disciplinary support is strong. It now goes without saying that the heads of treatment are part of the process, also have and perform their task there. The personal qualities of every member of the primary process now have a better chance of being used.

9 MITS: monitor information system tbs.

In order to be able to use those qualities to their optimum when tackling the acceleration of treatment, the process as described in leave management is used as a model. After all once more involvement, know how, experience, assessment skill and various other skills of the professional must be applied effectively and efficiently. The opportunities must not only be there, they must be identified and grasped.

Working towards targets is a fine thing, getting results is better. In 2008 it was laid down in the memorandum 'perspective Oldenkotte' that a patient is entitled to a hospital treatment which, two years after the plan of treatment was drawn up, provides clarity about the next route. The continuation can then consist of resocialisation, further treatment, placement in psychiatry or re-selection. This target requires intensification of the treatment and leave route. Another event that year is the presentation by the first physician[10] to the executive in which he suggests making risk assessment the central issue of treatment. The efforts and the instruments of treatment must then be focused on the reduction of the risk factors on the basis of HKT-30 and along with that the reduction of the offending risk. The reasoning is that society demands security and protection that the security risks are measured with risk assessment instruments and that FPC Oldenkotte works with HKT-30. The idea is that historical indicators are static and unchangeable, the clinical indicators relate to present behaviour and are therefore potentially changeable and the future situational indicators refer to protective factors in the context and therefore can also be influenced. The predictive validity of the clinical and future factors of the HKT-30 is good, which may provide important handles regarding risk management after termination (8). There may be changes in the score on the historical scale concerning infractions of conditions for treatment and supervision (9). These scores can only increase, for instance when a patient has broken agreements or rules such as the use of drugs, disorderly behaviour in the hospital or withdrawal from supervision during leave. This part of HKT-30 has considerable predictive value concerning later re-offending (10). By means of risk assessment during the diagnostic phase the re-offending risk can be determined and the static and dynamic risk factors identified. Properly executed risk assessment can help in adequately assessing the re-offending risk of a patient and in this way prevent violent behaviour. Risk assessment instruments –using the know how of today- are not meant for making absolute pronouncements about the chance of re-offending in any individual case. They function as a check list, leaving room for weighing and interpretation for the professional who provides the treatment.[11]

10 TBS Behandeling in het FPC Oldenkotte, B. Simons (tbs-treatment in FPC Oldenkotte).
11 Website EFP (Expertise Centre Forensic Psychiatry).

As we mentioned before the inspectorate established that the treatment plans are insufficiently target oriented, which is a condition and also an opportunity for reaching an acceleration of treatment. Targets and means are getting mixed up, it is insufficiently clear which means are used for which targets and whether certain means are used at all. As such the treatment plan does not conform to the law. The practice till then is that each time after the multi-disciplinary discussion the targets are set again, also in the sense that there is no fixed list of targets which might be supportive. The need for a fixed list of clearly formulated targets has now been combined with the focusing on the risk assessment and the target to intensify and accelerate treatment. The idea was elaborated in a concept focused on treatment targets in a treatment plan which consists of a limited number of dynamic risk factors of HKT-30 which have been given the function of result areas. We speak of result areas because the risk factor used in the treatment plan indicates which risk area must be worked on, and the degree to which is determined by the difference between the actual value and the value which corresponds to the exit situation. The treatment plans were set up in this format, this year the profiles of indicators fitting the exit target will be determined and thus the results we strive for. The results of HKT-30 will be the norm for use in the extension advice and the request of leave authorisation, making this way of working nicely adaptive to the chain.

In the elaboration we did not set out to develop an instrument that can be blindly used, but one that supports the clinical evaluation of the multi-disciplinary team in combination with the care programme. Other principles are that it can clarify for the patient why it is important to work on a certain risk area and that it gives us the opportunity to review present know how. A graphic representation of the field of tension between the result score to be achieved and the actual score can be supportive, although care should be taken.

As we said before, process leave management is used as a model. There is of course the multi-disciplinary treatment cycle which takes six months. But the open agenda for the weekly multi-disciplinary discussion of each department (MDT) is set up in such a way that every patient comes under discussion once every four weeks.

Annually per patient a risk assessment is made on the basis of HKT-30. This may or may not lead to the reducing score desired. At the start of the treatment route the exit target is determined. With the aid of diagnosis, offence analysis and risk management plan a score which fits the exit target can be drawn up. Like we said above, this can not be an absolute score. Ultimately the professionals will weigh and interpret the results. In this way the development of the treatment can be followed by means of a table or perhaps a histogram (see appendix I, table 9/ diagram 1). It is not necessary to reach a score of zero per dynamic risk factor of

HKT-30. A treatment focused on exit into an RIBW will work towards a different result than a treatment focused on independent living.

The idea is further to allocate the treatment per risk factor to those disciplines or modules whose forte this is. The competences per discipline or module are therefore balanced against the risk factors. A first score by clinical psychologists, a gz-psychologist and the first medical professional shows that making the present vision and know how explicit does not automatically lead to an unequivocal matrix. It is therefore all the more important to make the used know-how more explicit and to improve it by reviews. This review is mainly done by peer assessment, by having the professionals periodically given scores by their peers. On top of that after some time it will be possible to use a database with the risk assessments, coupled with the modules and disciplines used.

Like we said before the intention is not to develop a rigid structure; the scientific basis is too narrow for that and human reality too complex. The professional's clinical judgment and assessment skills are not to be ignored, but must be supported. At this moment FPC Oldenkotte has the care programme psychotics, the care programme personality disorders, the care programme autistiform disorders and the care programme vice. The care programme 'supplies' a packet of treatment modules, risk assessment 'demands' a packet of modules. On the basis of this material and their clinical judgment and assessment skills the professionals can then choose a maximum of five risk factors and with the aid of the matrix in the treatment plan link these to one or more modules. The treatment coordinator chairs the multi-disciplinary discussions and designs the treatment plan, the head of treatment is responsible for the treatment policy and he reviews the plan against the policy.

This does not yet complete the two treatment cycles, that of the discussion of the treatment plan and the multi-disciplinary team. This completion is achieved by linking the reports for the discussion to the risk factors. The reports for the discussions and the legal notes are joined, reports are made by risk factor. In the discussions of treatment plans the legal notes of the entire period can be consulted. In the case of the weekly multi-disciplinary departmental team the patients are reviewed once every four weeks, the legal notes are scrutinised every eight weeks. Sociotherapy reports per risk factor in the legal notes. The professional or trainer now still reports as usual, but after determination of the definitive matrix he (or she) will report for those factors that have been linked to his (or her) module as core competences.

To further streamline communication the daily reports of the members of the treatment team will be electronically available to each member of the multi-disciplinary team by means of journals. Every four weeks the treatment

coordinator and the multi-disciplinary team will review the factual use of and the developments within the modules on the basis of these journals and on the basis of the legal notes. In this cycle, the care planner, a socio-therapist, who is involved with the patient as a kind of mentor and supporter, has a special role. He or she is not only the reporter of the legal notes, but also the person who directly and indirectly through colleagues, supports the patient in the daily business of finding his way in the treatment. This may mean that the care planner reflects with the patient about the targets set, but also helps to express personal ideas. The patient also gets the opportunity to supply his own reports and in the discussion of the treatment plan in principle he will be present. The team leader sees to it that as far as possible the care planner can be present in the discussions about the patient linked to him (or her). Additional effects of this report structure are that report pressure is lessened and that the legal notes are a neatly ordered source for subsequent risk assessment. To underline the importance of the flow through, the progress in the treatment, a core dossier has been started on the basis of the format used for the request of authorisation of leave.

Per module, department or discipline there are a number of core competences linked to certain risk factors. We have already stated that this concerns an allocation that must continue to be evaluated and examined. Other questions are then whether sufficient competences are available but also if there isn't a surplus of disciplines with common competences, questions that go with the transition from supply to demand oriented treatment. For the disciplines and the professionals it is important to realize the core competence, to do what you are good at well and to strive for improvement. From the multi-disciplinary discussion no extensive targets are made at departmental level, in principle in the treatment plan there is only the conclusion that from you as a professional, together with the patient, and possible in cooperation with other disciplines, a result is expected per allocated risk factor. The module 'impulse control training' helps patients to handle their impulses. As might be expected this module scores maximum points in the concept matrix where impulsiveness is concerned. But it also scores that way for animosity and coping skills. Creative therapy does not score maximum points for any risk factor. That is a tricky thing. It might be argued that impulse control training takes on more than it can handle, but also whether this training is not or could not be of greater value for the risk factor substance abuse. In creative therapy the question may be asked whether core competences have been overlooked. Also whether this therapy has perhaps more of an indirect preparatory task in the treatment course, enabling the patient to take part in for example impulse control training. It ultimately means an opportunity to use professional freedom and competences to their optimum.

Up to 2010 FPC Oldenkotte has a circuit division, a circuit for psychotics and a circuit for personality disorders. There is also a department focused on treating

patients with autistiform disorders. Another distinction is the division intramural and transmural. Suited to and in support of working on the basis of result oriented treatment routes FPC Oldenkotte has made a division of departmental environments on the basis of the components control, cure and care. A route focused on a forensic psychiatric department will comprise departments with a higher use of control and care with the accompanying competences than a route focused on living independently. The emphasis will then be on cure.

The intensification and augmentation of result-orientation is a condition for an acceleration of treatment, but no guarantee. The will, as expressed in 2008, has not yet led to a striking acceleration of treatment. The chance of accelerated flow through and outflow is therefore optimized by laying down the treatment route right from the start, not only the entry and exit terms of risk assessment, but also where the progress through the departments and the requests of respective authorizations for leave are concerned. The essence is that the route in a first instance is a clinical basic route of four treatment plan periods, and a follow up. This is supposed to lead to clarity as to the progress of the treatment after slightly more than two years such as formulated in the memorandum 'perspective Oldenkotte' (see page 324). A principle that logically follows is that the request authorization accompanied leave is made within ten months after admission, to enable the patient to start accompanied leave if possible within a year. Another principle is that after the start of transmural leave, after four weeks a request is made for authorization trial leave. The route is described on a digital card for which the added principle is that failure to request or deviating from the devised treatment course is a serious matter and must be explained to a central body. It is only this body that is authorized to adapt the treatment course.

In the memorandum 'Forensic care and perspective' in which the FPCs together supply a vision regarding content of the future of forensic psychiatry it is postulated that a transparent prognosis of the intramural stay of forensic psychiatric patients within a framework of standardized leave routes will contribute to a shortening of the duration of treatment. The safeguarding of security and adequately answering for decisions made remains a requirement. When this principle is laid beside result oriented working with the use of the roadmap, a sector wide move concerning the duration of treatment seems to be a possibility.

VIII Discussion

A first remark must be made about the vision of the chance of re-offending, namely re-offending while on leave. In the arena of the network around tbs a more or less linear relation is laid between the number of withdrawals and the number of re-offences. Several measures were based on incidents and were also

aimed at regaining the peace in politics and the media. The Oldenkotte football team no longer plays in the league, whereas the worst incident from a remembered history of many years is the fact that one patient with autistiform problems threw in stink bomb in the opponents' dressing room during half-time. The withdrawal we mentioned on page 328 is a striking example that a withdrawal may even imply placing oneself under supervision. The law demands treatment, security and legal position to be balanced and therefore also reviewing. FPC Oldenkotte did know a period of two years without any withdrawal, for daily scores of leaves, but in the achievement indicators takes two withdrawals into account. After a long decline in the number of withdrawals we find a relatively sharp increase from 23 to 42 in 2010 on a national level. The decline was related to a more stringent policy,[12] how do we explain the increase? Has the number of re-offences during leave now gone up? Further examination may reveal that the minimum number of re-offences, and we think that that is the heart of the matter, is perhaps reached with a doubling of the number of withdrawals if a withdrawal does not automatically imply that a patient has lost all perspective. Now a patient, there are of course exceptions (among whom the female patient we talked about and the others) will have lost his authorization after a withdrawal for at least a year. The delay in the treatment will be even longer. A withdrawal, within the framework of reviewing and assessing the risk of future re-offending, is a serious signal (11), within the security framework it is a risk, seen from the perspective of the legal position it is a violation by the patient of the cooperation, but within the framework of the treatment it is an opportunity. A multi-staged approach seems more appropriate. Treatment and review after all follow a carefully outlined roadmap, why not a reversed roadmap? The law offers a wide range of possibilities to professional and patient for restoring the cooperation in a responsible manner. After all the central theme in the law is cooperation from an unambiguous legal position on the basis of equality.

Proportionality is a second point. Two perspectives can be mentioned to maintain this principle. One practical reason is that the added value of intramural treatment of more than two years is zero,[13] rather counter-productive. A ceiling that is highly surpassed cannot be explained from this perspective, exclusively from the perspective of confinement and thus longstay. Another point is the matter of ethics. There are guidelines for retribution after an offence. It should also be possible for a tbs patient to relate to that. Now this is impossible, even though the course of the treatment shows no or hardly any deviations. By tackling the principle of proportionality again the underpinning of the follow up or a potential (conditional) exit becomes extra exciting, but the path of least resistance is avoided.

12 Source: Tbs in getal 2009 (tbs in numbers).
13 Memorandum perspecitive Oldenkotte.

To be better able to transfer guidance to the probation service recently a new form of guidance was instituted, forensic psychiatric supervision. Guidance takes place on the basis of ACT.[14] The outpatients' and day clinic of the foundation Oldenkotte, De Tender, took part in a pilot. The pilot led to the conviction that the surplus value of forensic psychiatric supervision was demonstrated, as a transition and an addition to guidance by the probation service during trial leave. Beside the argument of the reduction in the duration of treatment in our opinion this constitutes one more argument in the plea to reinstate trial leave.

We think it is also important that the arrangements are what they are, not only in a technical sense, but also for what the sector wants to achieve with them. The professionals get bogged down, whether they be the ones providing treatment or the judges. Then they look for and within the arrangements find their own solutions, which from the point of view of the sector are hazardous. There are quite a few questions to be asked. One such question is: When to advise conditional termination and when not to. Other questions are: When a conditional termination is counter indicated in advance for a certain category of tbs patients or what the effect is on the risk of re-offending if trial leave is skipped with conditional termination. When does it make sense, when is it proportional to terminate tbs unconditionally and not conditionally? Conditional termination is not an easy alternative to get around the present struggle via transmural leave and trial leave. Along with the chance of a careful buildup towards independence a relapse during transmural leave or trial leave has a quite different meaning for the patient than a relapse after conditional termination. Trial and error are part of human life and in their development our patients are only human. They need carefully structured diminishing guidance not only to be able to err responsibly but also to be able to try again.

There is not one important moment when all the players in the chain come together, there is no superior player in the network. The sense of urgency to develop a policy as a sector does not seems to be there yet, even though the memorandum 'forensic care in perspective' is an important positive signal. However, for the development of a sectorwide policy and fine tuning this is essential (12). It seems to make awkward developments in the routes of treatment, reviewing and extension possible. There is the assessment of the request for leave. The hospital requests the authorization, the advisory council reviews the request and advises the minister. The patient does not contribute. The extension session is another occasion when players meet. The judge extends or terminates, the public prosecutor demands, the hospital advises, the patient is there supported by his lawyer and sometimes the probation service's advice is sought. Historically we can speak of a shift in principle of the responsibility for the progress of the tbs

14 Assertive Community Treatment.

imposition from the judge to the minister, the marginal assessment of requests of authorizations for leave has decidedly become an assessment for content, and determines the progress of treatment. We should ask ourselves whether the present relations are not based on obsolete foundations. It seems a good idea to bring back the responsibility more to the court, for instance by having all players meet in court. For instance the judge not only pronounces on the extension but also on the authorization for the coming year. It is up to the patient to see to it that the hospital translates the authorization into freedoms in that period. Then the patient becomes better able to practise what he has learnt and present this to the judge reviewed and all. If it does not work this way, the parties concerned have some explaining to do in court the next year, and by the same token the patient's own responsibility is done justice.

Another point is the visibility of the problems in the sector. A division can be made on micro and macro level (13). The professional providing treatment feels hampered in his treatment, the manager faces loss of revenue because of the high number of residential patients, the advisory committee for the reviewing of tbs leave improves the format requests for leave even more, it is only after several extensions that the judge gets some insight in the development of the patient and the minister is saddled with a serious problem after every incident. Everyone makes up his own solutions. Ultimately this leads to sub-optimalization. For 2011 Directorate of Forensic Care is spearheading trial leave, Oldenkotte has been doing this already for a few years. The professionals providing treatment are shortcutting the path to extension as they see fit, the judges follow their example, to a degree that it seems as if there is a strong policy backing this up. Good insights in the possible effects of this on the figures for re-offending are still missing.

IX Conclusions and recommendations

The various policy moves aimed at making tbs more secure lead to a more of less successful optimizing of parts of the chain. The final result, however, is a sub optimizing of the whole. The number of tbs impositions is going down more strongly that could be expected. This increases the chances for unnecessary victims in the coming years. We are taking the chance of unnecessary re-offences seriously and on the basis of what was said before we come to the following critical consideration.

Fast growth and even faster decrease show that determining optimum volume of the tbs sector is a difficult problem. History has more examples like that. However, some simple arithmetic with the expected duration of treatment shows that the present situation exerts a strongly motivating force on the potential tbs-patient to refuse the examination. The number of refusals influences the number

of impositions. A possible intervention by the minister to make access to historical data easier so that the judge can nevertheless impose tbs, can contribute to the prevention of future re-offending. Whether the intervention will be carried out is still unclear, and there remains the question whether the intended effect will be achieved and what the (undesirable) side-effects may be. Even when it is successful it does not relieve the sector of the obligation to reduce the duration of treatment. The sector has argued the importance of reduction by asserting that a prolonged treatment may even be counter-productive. On top of that proportionality weighs heavy.

Sectorwide systematic handling of the various authorizations, particularly the authorization for trial leave, can in the short term lead to a reduction of the duration. We can say that reviewing and progress will then be coupled in a way that will appeal to the patient more.

But for an acceleration of treatment on the basis of a result oriented route more time and energy is required. The use of the risk factors of HKT-30 may be supportive. A widely carried intention in practice proves to have insufficient to no effect at all. Working on the basis of a specific time path puts other demands on the professionals and the patient. The structure which was started with the aim of providing support may be felt to be restrictive and present ideas about (own) competences are explicitly under discussion. Yet this structure would seem to be necessary considering the 'unobtrusive' way in which the lengthening of the duration of treatment stole into the process. To safeguard the speed of treatment there must be some jarring or friction somewhere when processes threaten to be delayed.

The intention in FPC Oldenkotte is that we are working by projects towards a measurable result on the basis of the risk assessment instrument HKT-30. The care programme supports the route and the competences of the various disciplines must be focused on certain risk factors. In this process the clinical assessment casts the deciding vote. The result is also central when requesting authorization for leave and advice for extension. The request for leave is central again in the patient file of FPC Oldenkotte, the so-called core dossier. The combination with the outlined route must lead to a considerable acceleration of treatment. Considering the fact that all hospitals are struggling with increased duration of treatment there is good reason for the entire sector to come to an obligation to achieve results within the treatment route. An obligation to put in effort is obviously insufficient, people work hard enough. We think that the route outlined before can support the professionals in a way that gets the best out of them in the dynamic world of tbs and offers the patient the chance to complete his tbs treatment in an 'old style' tempo.

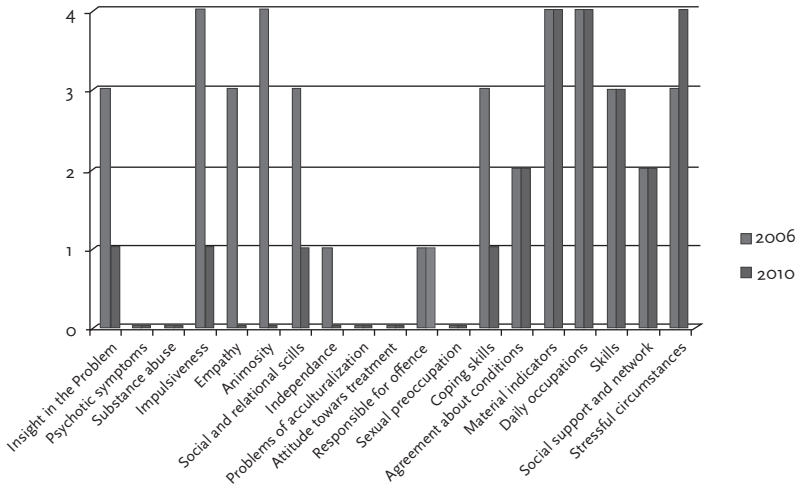
In view of all this we recommend to come to a sectorwide and recognizable way of working which complements each other's efforts and contributes to optimizing the whole. To do so it is not only important to chart the entire process within the chain in an unambiguous and convenient way but also that we all ponder how to respond to deviations which may occur in all shapes and sizes at any moment in the treatment processes. Transparency on the basis of security for all concerned is a necessary condition, not only for arriving at helpful cooperation, but ultimately for reducing the risk of re-offending.

Appendix I

Table 9: Development of the clinical and future risk factors in a patient from 2006 till 2010

	Insight in the problem	Psychotic symptoms	Substance abuse	Impulsiveness	Empathy	Animosity	Social and Relational skills	Independence	Problems of acculturalization	Attitude towards treatment	Responsible for offence	Sexual preoccupation	Coping skills	Agreement about conditions	Material indicators	Daily occupations	Skills	Social support and network	Stressful circumstances
2006	3	0	0	4	3	4	3	1	0	0	1	0	3	2	4	4	3	2	3
2007	3	0	0	3	3	4	3	0	0	1	1	0	4	3	4	4	4	2	4
2008	3	0	0	3	3	4	3	0	0	1	1	0	3,5	3	4	4	3,5	2	4
2009	2	0	0	1	1	1	1	0	0	1	1	0	2	3	4	4	4	2	4
2010	1	0	0	1	0	0	1	0	0	0	1	0	1	2	4	4	3	2	4

Diagram 1: The clinical and future risk factors from 2006 and 2010 (Categories identical to those of Table 9)



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Probation Service at a Crossroads?

Role and Position of the Probation and Rehabilitation Service in Forensic Psychiatric Supervision

Jaap A. van Vliet

1 Introduction

> *As a young adolescent the man started using soft drugs and as a result was expelled from school. Following a registration with RIAGG he was placed in a children's home for some years. From the age of twenty he was a frequent substance user. He got hold of these substances because his father was a dealer. There were contacts with psychiatrists and psychologists and he was on an anti-psychotic medication that is prescribed with schizophrenia. Over a period of eight years he was admitted eight times to a psychiatric hospital with diagnoses such as recurring paranoid schizophrenia, recurring poly-hard drugs use and ADHD. During his hospitalizations he took no medication, did not satisfactorily comply with agreements and frequently withdrew from treatment prematurely in spite of advice to the contrary. He was ultimately given Tbs* (1).

In the introduction of a theme issue on Mental Health Care and Justice of *Justitiële Verkenningen* [Judicial explorations] from 1991 concerning such a track record it was stated that many stories can be told about it. "Two of them have far-reaching consequences. From the point of view of the *judiciary* the track record is evaluated as to the degree of guilt casu quo attribution and the need to make society secure. From the point of view of *mental health care* a person with a mental disorder committed an offence as a result of his condition and needs help" (2) Dangerous or mad, that is the division that is sectorially made.

Tbs is a special measure courts can impose on people who suffer from a personality disorder and/or a serious mental health problem and have committed a serious crime. They are therefore not (completely) responsible for the crime and increase the (see also about tbs Van Marle p. 187; Goosensen & Oei, p. 317 of this book) risk of re-offending. The Dutch courts decide on agreed dates as to whether or not a Tbs measure needs to be extended. They do this every year or every two years. The measure can only be extended if there is an unacceptably high risk that the convicted person will re-offend or will commit another serious offence. Behavioural expertise is required in assessing this risk. The court receives advice from the treating clinic, a psychiatrist and, when probation is involved in the case, from the probation service.

The probation service has a legally firmly embedded mandate to guide the Tbs-patient during his return to society and to supervise this return. Also because

of incidents with Tbs-patients who returned to society, a new way of guidance and supervision was recently developed, in which the treating clinic, the GGz (general mental health care institutions) and the probation service cooperated and enhanced each other's expertise, more than had been customary in the past. The aim was to reduce the risk of re-offending as far as possible.

In paragraph 2 of this chapter[1] Forensic Psychiatric Supervision is dealt with. Paragraph 3 deals with the problems regarding the links between the judiciary circuit and the GGz. Paragraphs 4 and 5 outline the role of the probation service and paragraph 6 is concerned with the importance and the danger of risk assessment and risk control. Conclusions are drawn in paragraph 7.

2 Forensic psychiatric supervision

On the basis of the recommendations made in 2006 by the parliamentary 'Committee Visser' (3) concerning improvements of the Tbs-system the probation service in cooperation with the Justice Department and the Forensic Psychiatric Centres (FPCs) has been dealing with the task of improving the activities of the probation service within the Tbs-framework. Internal quality improvements were made, such as trainings, the structuring of casuistry discussions and the improvement of the cooperation between the various clinics, but the prime aim was cooperation in the outflow phase. This resulted in Forensic Psychiatric Supervision (FPT), a system of cooperation in which the expertise of the probation service and the expertise of the clinics is utilized as fully as possible for individual Tbs-patients in the final phase of their treatment. This is done in order to promote the safe outflow of Tbs-patients from clinics while at the same time further improving the security. Later a similar system of cooperation was started for conditional Tbs, spearheading the improvement of the links between the judiciary circuit and the general GGz in particular. One important issue in this system is the transfer of information from GGz professionals, frequently behavioural experts, to the judiciary circuit.

By now the necessary experience with FPT has been acquired, research has been done by WODC (4) [Scientific Research and Documentation Centre] and an inspection report was produced by the Inspectie voor de Sanctietoepassing (ISt) [Inspectorate for the Application of Sanctions] (5). The reports provide a hopeful picture of the developments, and further developments are in full swing. The expertise of the probation service is developing into an identifiable profession in the forensic field promoting possibilities of cooperation with other professions.

1 Based on a lecture, held at the congress of Forensic Psychiatric Supervision of 29 November 2011 in Ede, The Netherlands.

(6) An independent and clear positioning of the probation service enables the promotion of continuity in treatment, guidance and supervision of clients/ patients with a judicial label.

3 The borderland between the judiciary and general care

The development of the FPT has a long previous history. It would be good to bear this in mind when it seems as if solutions to problems in the borderland between the Judiciary and Care do not seem to be readily available. (7) Many of the problems of linking up are explicable, because procedures in the various sectors are subject to specific laws and regulations, to differences in operational cultures and professionalism and not least to the question which social task is to be performed per sector. Yet the question remains how it is possible that in this field differences and contrasts could or can persist for so long while so much social and personal damage seemed to result and vast amounts of studies and recommendations were published in this field that pointed in viable directions. And, apart from the necessary improvement of the Tbs-system, a great deal of attention must be paid to improving the provision of care and assistance to those in the borderlands between the Judiciary and general care and assistance institutions; as long as the General Mental Health Care (GGz) fails to hold on to this group of people it will be difficult to provide the necessary GGz-care to conditional Tbs-patients or Tbs-patients after their treatment in an FPC.

In 1991 the Nationale Raad voor de Volksgezondheid (NRV) [National Council for National Health] published an important recommendation about 'forensic psychiatry and its interfaces'(8). Among other things it dealt at length with research and the report of the aforementioned contrast between the *judiciary standpoint* and the *mental health care standpoint* which leads to policy dilemmas and in practice to awkward situations. The NRV recorded among other things that the target group of forensic psychiatry consists to a large extent of 'borderlanders', people who seem to be out of place in many care and GGz institutions. The recommendation said that "These 'borderlanders' narrowly miss qualifying as justice material (too ill to be imprisoned), narrowly miss qualifying as National Health risks (too healthy to be admitted to a psychiatric hospital); do not qualify for FPK [Forensic Psychiatric Clinic] (not psychotic), do not qualify for Tbs (no risk of offending); narrowly miss qualifying for RIAGG (too addicted); do not qualify for CAD [Counselling for Alcohol and Drugs] (too psychiatric)". The NRV furthermore recommended cooperation between and association of general institutions, the GGz and judiciary assistance, such as the Tbs-sector and the probation service (8). Further recommendations were made to come to a programmed approach and to develop regionally oriented forensic psychiatric circuits. The way in which these circuits may or may not have

developed in various places has been scrutinized but will remain out of discussion here (9, 10).

Many times already the judiciary, for example the Penitentiaire Kamer [Penitentiary Chamber in the Court of Appeal in Arnhem, The Netherlands] has given similar signals. In penal sessions they regularly encountered people who had received treatment before in the GGz, but had subsequently dropped off the radar, revolving door patients, care dodgers and others that proved to be beyond the powers of the GGz. For instance in 2003 the vice-president of the court in Arnhem expressed the opinion that serious crimes and impositions of Tbs-sentences could have been prevented if the perpetrators in question had been given better or in other words more consistent guidance in the past and would not have had to struggle with their problems alone so long (11). Van Kuijck and Vegter opined earlier that "it is generally known that among offenders there is a considerable number of people with a mental disorder. There may be a link with the (dis)functioning of the mental health care."(12)

It was and is bothersome that the judiciary does not keep registers that might underpin such pronouncements; frequently people are guided by impressions and not by systematically recorded practical experiences. And if there is a link between the (dis)functioning of the GGz and the increase in Tbs-sentences, what sort of link is it, can it be influenced, what other influences play a role? In my scrutiny of this aspect I arrived at the conclusion that there is evidence for the hypothesis that most people who are given Tbs have already been in contact with or been treated by a mental health care institution and have been 'lost' by these organisations. Previously there has not been research into the link between care and treatment and committing a serious Tbs-crime. There is a correlation between care history and crime behaviour, but no proof as to causality. My research makes it possible to look further into the relation between the nature of the contact between the Tbs-patient and mental health services before the crime is committed (13).

But also other studies by the Raad voor Maatschappelijke Ontwikkeling (RMO) [Council for Social Development] (14) and the Gezondheidsraad [Health Council] (15) support the conclusions drawn by Van Kuijck and Vegter.

The 2007 report published by the RMO 'Punishment and Care: a singular couple' produces an extensive analysis and it is argued that people with mental and psychiatric problems who are offence risks are trapped in 'systems' that do not correspond to their situation. Care institutions only come into action when there is a clear call for assistance, but we happen to be dealing with people who cannot (yet) call for help (14).

My own more extensive literature survey and file research in the Penitentiary Chamber regarding people who at a later date were given a Tbs-sentence (and

whose judiciary previous history was already known during their treatment) showed that their care and treatment in general care could suddenly be terminated by the professionals or the patient himself without any referral to an institution that *could* offer adequate assistance and without there being any sort of more or less enforced care or aftercare. When these patients ended up out of view of the care institution and committed a serious violent offence, they ran a heightened risk of landing in Tbs. One conclusion was that the fragmented way in which care and assistance are organized from this point of view contributes to an increase in expressions of dangerous disorder and ultimately in the increase of the number of Tbs measures. The patient's own responsibility was indeed very broadly attributed to the patient himself whereas the possibilities of danger to the environment were hardly taken into account (1).

4 Is the probation service at a crossroads?

At a symposium twenty years ago occasioned by the aforementioned NRV recommendation, entitled 'Forensic psychiatry: a long way from home', I argued among other things: "Social-psychiatric probation activities function at a crossroads of the judiciary, forensic psychiatry and various general provisions, both within and without mental health care. I think therefore that this may be a provision that can function centrally in a network of care coordination that is required for the intended group of clients." (16)

At the time there was little enthusiasm within probation service policy and management to start fulfilling such a role. In the reorganization of the probation service that took place a few years later there was even the introduction of "*from the viewpoint of a flexible deployment of all personnel, in the organization one single function group, namely that of probation officer*", thus doing away with substantive specialities, such as in the field of social-psychiatric work, penitentiary rehabilitation activities and the performance of community services. It was thought that probation officers should get a wide and profound insight in the (im)possibilities of the entire probation spectrum and that therefore they should acquire experience in several specialities. In order to achieve this, job rotation was incorporated in every employment contract as a uniform measure for all probation workers, providing a probation worker with a three year assignment after which job rotation would take place (17).

This did not lead to a central function of the probation organisations in the field of Tbs activities, it appeared a couple of years later. On the contrary, the role of the probation and rehabilitation service in Tbs had, despite the position the 'Tbs contact functionary' fulfilled, become very much more indistinct. Voices from the Tbs field spoke of being unacquainted with the position held by the probation service in forensic psychiatry after the reorganization of 1995,

invisibility of central management in the actual work practice, uncertainty about the organizational structure and a plunge in acquiring expertise and formation of networks (18). But the report of the Committee Visser in 2006 contained recommendations that started up changes within the probation service, among them the development of the FPT as described earlier.

Whatever the case may be, because of the very nature of the probation activities, the probation and rehabilitation service functions at a crossroads (19) [2] of the judiciary, forensic psychiatry and various general provisions, both within and outside of mental health care. The tools available to the probation service are limited, there are no physical means at hand to oblige clients to do something or to keep hold of them when risks are threatening. In order to achieve his goals the probation and rehabilitation worker must first and foremost utilize his own possibilities of creating a relationship with his client and his possibilities to procure assistance and cooperation from other professionals, GGz institutions and suchlike. After and alongside this there are methods, protocols and tools that enhance the professional execution and accountability of the activities.(20)

In the FPT the cooperation between FPC and probation service is not free of obligation, but, in contrast, laid down in arrangements, whereas at the same time the possibilities for individual approaches and the development of new cooperation concepts have not been immovably 'nailed down'. In this way the probation service can be the specialist in everything that happens outside the clinical phase, while the FPC deploys its expertise in the field of forensic psychiatry and treatment for a long time after the clinical phase. The probation and rehabilitation service cooperates in the clinical phase and contributes its expertise concerning the possibilities outside the clinic.

5 Further development of the role of the probation service

The exchange of information about the client who is under the supervision of the probation service in the framework of clinical or ambulatory FPT and who is receiving care or treatment in a GGz provision within this framework is of great importance in the cooperation between the probation and rehabilitation service, GGz and Tbs. This exchange of information often met with objections (and with various professionals in GGz still does). Meanwhile a "Proposal for a tripartite agreement in the supervision with conditional care Cooperation Probation Service – GGz – Justiciable" (20) developed by GGz-Holland and the three probation organizations may provide a solution to some of the problems in the borderland between judiciary and care outlined before. The proposal's intention

2 I am consciously using the word 'crossroads', just as in 1991, instead of the word 'chain' that is currently in fashion in the sector. 'Chain' suggests that there is a series of consecutive activities and processes, but the complexity of this work is that several activities and processes take place *after, alongside* and *interwoven with* each other. These 'chains' of processes and events have to be linked up.

is on the one hand that the (GGz) carer or professional will be able to function on the basis of his own professionalism and within the limits of his professional code and that at the same time the probation and rehabilitation service receives sufficient relevant information regarding care and treatment to be able to account for the process of supervision and for the assessment of the risk of re-offending to their principals.

The framework of supervision that makes care and/or treatment possible can only exist and if need be extended if the probation service supplies the principal with adequate argumentation for making up his mind about his.

In spite of the tripartite agreement this remains a complex business because professional care and treatment demands sufficient trust between professional and patient for the treatment to be meaningful, also when there is an enforced framework. This complexity is also connected with the differing perspectives of the judiciary and GGz that were mentioned earlier: are we dealing primarily with a dangerous or with a disturbed person? The debate then is mostly not whether there should be an exchange of information but more particularly what information should be shared and to what extent in the view of the professional the patient's privacy should be affected.

It is important to bear the foregoing in mind, because many professionals in the general GGz, but also some probation workers, are inclined to share only that information that *they think* is relevant in the framework of the patient's treatment and guidance plus the security of the environment. This may lead to disappointment or lack of understanding when the court decide against their recommendation for instance for the conditional termination of Tbs. The court is fairly frequently regarded as a necessary intermediate station that should really be facilitatory to the process envisaged by the professional and the supervisor. From that point of view it would be a good thing to consider that for the court in reaching its decision the recommendations of professional and supervisor will weigh heavily, but that the court will also take other considerations into account in coming to a verdict. Proportionality[3] can be one such consideration but also the (inadequate) foundation of the risk of re-offending can be a factor. For, when Tbs with compulsory psychiatric treatment is not maximized as for duration, Tbs can be extended in every stage with one or two years. But as soon as the risk of re-offending has been reduced to an acceptable level, Tbs should be terminated, even if in a psychiatric sense treatment has not yet been finalized (21). One additional factor is that the court is free to ignore the recommendation of experts to extend the Tbs measure and may for instance order the probation and rehabilitation service to formulate conditions for a conditional termination of the measure. Frequently the probation service fails to comply with this order.[4] For a long time it was not generally known in the probation service that in 2001

3 Proportionality means the duration of the Tbs measure in one particular case in relation to the duration of the measure or the length of the term of imprisonment in a corresponding offence.

4 Whether this [still] happens is not known, as far as I know there is no central registration.

in a session concerning an extension the court in Arnhem ruled that the probation service is not at liberty not to comply with the court's order to formulate conditions for a (conditional) termination of Tbs. In this case the probation service had been ordered to do such a study, but the probation service refused (22)[5]. The conclusion now is that the probation service as an executive organization is at liberty to formulate objections to a conditional termination of the hospitalization, but that the service is under the obligation to report about possible conditions and their execution. This ruling of the court has force of law (23).

6 Risk assessment and risk control

The probation service has worked hard, among other things regarding the preparation of trial leave and the conditional termination of Tbs, to develop a policy regarding risk assessment and control. The tools used for diagnosis and risk assessment are not exclusively aimed at fathoming a client's situation, but also at charting possible risks with a view to 'risk management' or 'risk control'. Among other things incidents concerning Tbs-patients and rehabilitation clients and the public and political reactions to these incidents have given a new impulse to the importance of risk management and control but this sometimes leads to far-reaching risk dodging decision making, also in the probation service.

In this time politicians, scientists and policy makers rather frequently start from the premise that working on the basis of risk control is a new development within the judicial domain. Erroneously; those with some more experience in probation and in forensic psychiatry know that as far as the standards of the time are concerned, re-integration was linked to the control of re-offending risks. To illustrate this I will now describe a case from my own practice.

> As an adolescent Wim emigrated from Amsterdam to Australia with his parents. He was unable to strike roots there and quickly became involved with police and courts. He is even sentenced to a prison term for climbing a prison wall: please note, not from inside out, but from outside in. If I had not read this in official documents I would not have believed it. He had travelled a couple of days, hitch hiking, to visit a mate in prison, but he had narrowly missed the weekly visiting hour, and waiting another week was no option for him. 'Impulsive' is one of the characteristics of behaviour attributed to him in the PBC. But also: a camp follower; he is easily swayed by others.
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> After a number of years Wim returns to the Netherlands with his parents and ends up in a relief centre in Amsterdam. He becomes friends with a man, like him without sufficient means to make ends meet. They commit thefts and mug people in the street to get their hands on some money. In a park, late one night, they mug an old woman. She does not intend to give up her cash. They start bashing the woman until she is

5 Verdict 28 May TBS 2001/041 LJN AB1827.

lying dead on the ground. They lift her purse and split the money between them. Later Wim will say that he did not hit the woman, that he just watched the goings on. He felt very sorry for what had happened, certainly when he understood that the woman was dead. And yes, he did take the money, for things could not be undone and they had to do some shopping anyway.

I first meet Wim in a Tbs clinic when he can have trial leave. He is angry that he is still in Tbs regime and that his friend only received a prison sentence and has been out on the street already for quite some time. He feels more heavily punished. I tell Wim that his friend perhaps was more aware of what he did and that he, Wim, should learn to make up his own mind and not allow himself to get carried away.

When Wim has his trial leave –he is living in lodgings, not far from our office- he turns out to have very few skills as yet. He sometimes avoids contacts with me, sometimes he comes in, all hot and bothered, and starts making demands, at other times he is depressed because he thinks he can never manage on his own. A short time after the start of his trial leave I send Wim back to the clinic to straighten things out together. Subsequently his trial leave is once more started and this process is repeated a few times. All in all the trial leave will be suspended and restarted 4 times in three years, because the situation has become too complex for me to be able to assume responsibility for his actions. But I carry on and I voice my confidence in him that we can restart his trial leave as soon as possible.

Wim lives in an apartment of his own at the moment Tbs is terminated. I have told him that adding another year would not be a bad thing for him, and also recommended this to the court, but the court was obviously of a different opinion; there is after all such a thing as 'proportionality' and anyway there have not been any punishable activities for years. Well, once Wim came to my office with a book he had nicked in the library, and wrapped up nicely, which he wanted to give me as thanks for services rendered. I expressed my gratitude for the gesture, but returned to the library with him where he returned the book with apologies. And there were several similar cases in the past few years when the general condition 'that the convict shall not be guilty of any punishable fact before the end of the probationary period' was not fully adhered to; in 2012 these might have provided several reasons to report him to the prosecution service and for the termination of the supervision. But more important than penalizing him for these punishable offences it appeared to me (I should really say 'us': the members of my team, the psychiatrist our team, the clinic and ultimately also the court), it appeared to us better to provide him with a pro-social role model, to show him that you can tackle a conflict, that you can make your own choices, that you can set your own limits without this leading to being rejected by the other party. And if the other party should reject you, you have at least maintained your self-respect.

When Tbs is terminated Wim calls me triumphantly to say that there is no need for him to see me any more. I confirm this but add that I would like to drop by shortly to say goodbye and to thank him for his cooperation in the past years. But even before I can go and visit him, Wim is in the waiting room of my office. He wants to tell of the difficult situation he has been in, what he found difficult in it and how he solved the problem. On one other occasion he comes to me with a carving knife and a claw

> hammer: 'better if you should keep them for me for a while, Jaap', he says, 'I have to be careful.'
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> Up to the moment I leave the probation service, years later, he may drop in daily, may sometimes stay away for long stretches of time, and when I think too much time has elapsed I will phone him to ask how things were. In all the years that have passed since then, I know that Wim has not committed any serious relapses, until this very day; I regularly see him walking around in the city.

In an article from 1989 I described the experiences of my probation team after we had supervised some 50 trial leaves in the period 1983 – 1989. "For control it is not a matter of 'keeping in check, keeping the client on a short leash' but of creating a framework within which a responsible experiment is possible for the client: for the interests neither of the Tbs-patient, nor of 'society' (in most cases: the victim) are served with a possible re-offence.

In order to be able to properly supervise a trial leave and to be accountable for it a concrete trial leave plan is required, containing sufficient elements to account for the course of the trial leave and on the basis of which, should the need arise, recommendations can be given about the desirability of whether or not to terminate the measure. Should the trial leave be cancelled then the Tbs-patient will usually on the advice of the probation service return to the clinic for some time. (...) Practical experience shows that the cancellation of trial leave mostly does not disturb the relationship between the probation worker and the Tbs-patient. In such a case the patient is confronted with a reality (limits are set and upheld) and eventually will have a greater feeling of being taken seriously than when an all-accepting obligation-free approach would have been chosen. This is also apparent from the fact that many Tbs-patients after termination of the measure keep up an assistance contact with the probation service, certainly if conflicts occurred during the period of trial leave" (24).

Structured risk assessment did not exist yet, but risks, of course, there were. In combination with a policy that is focused on a 'tough approach' risk assessment leads to emphasizing risks. Chances are that on account of this to an increased degree 'behavioural change', among which expressions of reactance and resistance of clients, is now only interpreted as risky, as a result of which ever more risks are seen and there is less eye for supervision targets in terms of perspectives and opportunities. A trend therefore towards a static view of man with less eye for opportunities for change. Not risk assessment as such, but risk assessment in combination with a policy focused on a 'tough approach' leads to this underlining of risks. This tendency is also mentioned by Gelsthorpe et al. in the framework of pre-sentence reports by the English probation service. They argue that risk assessment leads among other things to a fuller investigation as far as quality is concerned, but that there is a danger in stressing negative points and shortcomings (25). If this trend continues in the preparation of the conditional termination of Tbs, people may try so hard to exclude all possible

future risks, that a treatment paralysis occurs. The curious situation then namely occurs, that the Tbs-patient whose treatment has progressed so far that, in the view of both behavioural experts and the court, the danger of offending has substantially lessened, is denied the corresponding return to society. It is of great importance that the court continues to maintain a position of independence from the penal chain and the probation service in order to prevent the Tbs-patient to be 'chained' to the system for principles of policy that are in themselves correct.

7 Conclusion

The foregoing stresses the need for the probation service to underpin advice in the framework of Tbs and FPT adequately, with facts. In its recommendations to clinic or court the probation service must express an opinion both of risks and possibilities. It is important that the correct information from the GGz is provided to the probation service, without this information disturbing the process of assistance or treatment. The "Proposal for a tripartite agreement in supervision with conditional care Cooperation Probation – GGz – Justiciable" offers room for experiment to substantiate this condition.

Professionalism requires that recommendations are founded on arguments and expressed in a language that the recipient finds both understandable and persuasive. Information from a possible care or treatment setting should not be lacking. It renders to the probation service and the probation worker the authority that is part of the nature of the activities and a full and independent position in the execution of Tbs.

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Routine Outcome Monitoring in Forensic Psychiatry: FPC2landen and FPC de Kijvelanden

Frida van der Veeken, Stefan Bogaerts, Jacques Lucieer

Introduction

In 1988, Ellwood developed Routine Outcome Monitoring (ROM) as a response to the "chaotic" American health care system. Medical care was expensive, diverse disciplines did not share insights into the patients wellbeing and the increased number of patients and complexity of medical care jeopardized sound decision making. The effects of decisions made by patients, physicians and health care executives were unclear. Patients requested more information about their health progress and possibilities, management teams and insurance companies were interested in the costs of health care outcomes (1). In the Netherlands, similar concerns were questioned in mental health care institutions and the pressure to get more information on treatment outcomes was getting bigger (2). ROM can be used for different purposes; however, our definition is consistent with Elllwood's definition of ROM: "The primary goal of ROM is to obtain better insight in the treatment progress of the individual patient and to make rational choices concerning treatment by systematical measurements of patient disease, functioning and wellbeing" (1). In this chapter, we discuss the development of ROM in two Forensic Psychiatric Centers (FPC's), namely FPC2landen and FPC de Kijvelanden. Three measurement tools have been composed for different patient groups.

Since the start of ROM in Dutch mental health care, several expert groups have discussed ROM and three primary performance indicators related to treatment effectiveness have been specified, namely: 1. Change in symptom severity. (measurement of symptoms related to mental health problems); 2. Change in daily functioning and 3. Change in quality of life. (subjective experience of quality of life). These indicators can be seen as important outcome measures for psychiatric treatment. A reduction in symptom severity, the improvement in daily functioning and quality of life are important treatment goals (3).

It is of great importance to select a limited set of highly relevant instruments (4) that restrict the work load for patient and therapist (5). An extensive set of instruments is very time intensive and does not guarantee success (5). Even more, it can lead to a plethora of information what counteracts the feasibility of

ROM (6). ROM assessment should be conducted at relevant moments in treatment (7); at the start of treatment, during a multidisciplinary treatment evaluation and at the end of treatment. An assessment at the beginning of treatment can contribute to the treatment indication and plan and to the diagnostic process (8). Assessments during treatment and at the end offer important information about treatment progress (6; 9).

The Rom application in the Dutch forensic psychiatric setting expires slower than in other sectors within the mental health care. In FPC's, patients are forced and involuntary hospitalized (TBS-order). A TBS-order is imposed by court when an offender committed a crime as a consequence of a mental disorder with a high risk to re-offend with a minimum sentence of four years (10). The offender's responsibility for the crime is considered diminished to fully absent (11) and they will be admitted for a minimum of two years with or without prior imprisonment. Every one or two years, the court will review the necessity of admission and decides whether the admission should continue or discontinue. The two main goals of TBS are protecting society and decreasing risk of recidivism. Therefore, risk assessment is very important in clinical forensic psychiatry (12).

In the Netherlands, the risk of recidivism is assessed by weighing risk and protective factors. The Historic Clinical Future-30 items (HKT-30), or the Historic Clinic Risk-20 items (HCR-20) (supplemented by the 9 HKT-30 items) (13), are yearly scored ordered by Law. When psychopathy and sexually delinquent behaviour are present, then the Psychopathy Checklist-Revised (PCL-R) and the Sexual Violence Risk-20 (SVR-20) should also be scored. With these instruments, the main risk and protective factors are covered. Other instruments are under development; however the added value of these instruments for different patient groups is not yet demonstrated.

As an alternative to the HCR-20 and focused on the Dutch population, the HKT-30 was developed by the 13 Dutch FPC's and includes Historic (H), Clinical (K), and Future (T) factors (14). The HKT-30 is an instrument with more dynamic items than the HCR-20 (2) and shows a higher predictive validity (15; 16). Also the HKT-30's final judgment is more accurate than for the HCR-20 (AUC = .73 vs. .64) (17). Currently, sponsored by the Department of Correctional Institutions, the HKT-30 is being revised. The most important risk factors and inadequate protective factors for future risk of recidivism are f.e., a lack of problem insight, medication incompliance, substance abuse, impulsivity, hostility, inadequate coping skills and problematic social networks (14).

The underlying rehabilitation theories of Routine Outcome Monitoring

The Risk Need Responsivity model (RNR) and Good Lives Model (GLM) are rehabilitation theories, which emphasize the importance of risk and protective factors. A rehabilitation theory is a theory composed from values, principles, etiological assumptions, and clinical guidelines (18). The RNR model comprises three core principles (19). The risk principle assumes that the risk of recidivism can be reduced when the treatment intensity is matched to the risk of recidivism. The need principle focuses on the criminogenic needs or dynamic risk factors. The responsivity principle emphasizes the importance of personal strengths, pathology and personality factors that strengthen the treatment effect. The RNR model also emphasizes the general personality and cognitive social learning (GPCSL) perspective on criminal behaviour. Learning criminal behaviour can be reinforced by personal expectations of rewards and consequences, empowered by an internal and external motivation and the presence of a target (19). The Good Lives Model (GLM) is developed by Ward and Stewart (20) as an answer to the limitations within the RNR model (f.e., limited treatment responsivity, lack of motivation) (12). The GLM focuses on the enlargement of skills and sources in order to live a better life (20), with the aid of a good lives plan and primary human goods as happiness, knowledge and friendship, (20; 21) gained in a socially accepted manner (21). Secondary or instrumental goods are manners to gain and maintain the primary human goods. Risk factors are considered obstacles (internal or external) that counteract the primary human goods. Goal of the GLM is to complement the RNR model (20) and to show a different way of life, namely one without a criminal lifestyle (21).

Routine Outcome Monitoring in forensic psychiatry: patient heterogeneity, general instruments and specific patient populations

Besides the focus on the three performance indicators daily functioning, problem reduction and quality of life, an important fourth indicator within forensic psychiatry must be addressed, namely the reduction of future recidivism (22). In line with the RNR model and GLM, both risk- and protective factors can be emphasized. Within the Dutch forensic psychiatry, ROM is very young; valid and reliable studies on treatment effectiveness are quite scarce (23). However, reliable and valid insight into treatment in terms of progress, stagnation or decline, is complicated by the heterogeneity of the population and the selection of the instruments (general and specific). Hereinafter, we elaborate patient's heterogeneity, general ROM-instruments and the application on antisocial, psychotic and mildly intellectual disabled patients.

Patient heterogeneity

Although all patients are legally defined, the group is very heterogeneous (12). In FPC2landen and FPC de Kijvelanden, three different main groups can be identified: the social therapeutic group, mainly patients with a cluster-B personality disorder as primary diagnosis; the supportive group, mainly patients with a primary diagnosis of schizophrenia and mildly intellectual disabled patients. The social therapeutic group resides in a social therapeutic environment, where group functioning plays an important role. The modification of negative and anti-social personality traits are of interest here (10). Patients within the supportive group are more vulnerable patients with a psychotic disorder and require more guidance, training, counseling and structure. However they also often suffer co-morbid personality problems, mostly with anti-social features (10). Considering ROM, for the benefit of the treatment, it is important to observe the strengths and weaknesses of the patient and to control for an overload of expectations. In patients with schizophrenia, it is not only important to reduce psychotic symptoms but also to improve general functioning (3). Patients with a mild intellectual disorder (MID) often face limited adaptability and learning capacities. The American Association on Intellectual and Developmental Disabilities (AAID, 2010) identifies three components of adaptive behaviour: 1. Conceptual skills (language, reading, time and number concepts); 2. Social skills (interpersonal skills, responsibility, wariness) and 3. Practical skills (daily living activities, occupational skills, healthcare use).

Important to mention with regard to ROM, self report instruments are not suitable for all patients. Especially for the latest group, it can be difficult to question a patient about subjective experiences due to cognitive, communicative limitations (25). It is very likely that socially desirable answers are given or multiple choice questions will be misunderstood (25). For supportive patients with psychotic problems, self-report lists are limited available and not recommended for severely confused patients (6). Questioning of significant persons (close related) can be an alternative but research has shown that the inter rater reliability between patients and significant persons is low (25) and not all patients in forensic centers have a social network with whom a close and, or therapeutic relationship is maintained.

Considering to the differences in treatment needs and strengths and weaknesses of the three patient groups, standardized instruments must be used to focus on the most significant factors that represent an indication of treatment progress. For de Kijvelanden and 2Landen, beside the use of general accepted instruments proposed by the expert group ROM and adopted by the working group Quality Forensic Care, other instruments are needed to measure treatment progress of the three different patient groups

The HKT-30 as a general instrument

At least once a year, The HKT-30 (and SVR-20) is conducted in FPC 2landen and de Kijvelanden and included in the ROM assessment (once a year, the SVR-20

only for sex offenders). The predictive validity and the reliability of the HKT-30 are good (AUC = .72, ICC = .77), and an ICC> .75 (28) can be seen as very good (29). Because the changeability of the dynamic items is limited over a short term period, (30) it is also important to choose a ROM tool that plug's in on the indicator risk of recidivism and does show progress over a shorter period. However, ROM has no intention to be a risk assessment instrument that can predict recidivism in the short term. Moreover, in the context of ROM, half-yearly measurements are the maximum attainable. It remains the responsibility of the treatment team to observe, discuss and treat changes in dynamic factors.

The Health of the Nations Outcome Scales

The Health of the Nations Outcome Scales (HoNOS) maps the mental health and social functioning of psychiatric patients (31). The HoNOS consists of a psychotic and a neurotic dimension and is independent of language and pathology. Institutions that already use the HoNOS report that the HoNOS contribute to the treatment evaluation and the measurement of changes in important life domains (31). A Dutch study of 559 patients shows a reasonable to good reliability (alpha = .78, ICC = .92). It also appeared the HoNOS is sufficiently valid (31). The HoNOS provides individual and group understanding of the seriousness of the problem on different areas. An advantage of the HoNOS is that the scoring is relatively little time-consuming (± 15 minutes). An optimal scoring of the HoNOS is obtained by a consensus score between someone who knows the patient well and an independent investigator. The HoNOS consists of 12 items with a five-point scale divided into four subscales, behaviour, limitations, symptomatology and social problems. Three extra items are added, namely maniform disinhibition, treatment motivation and medication adherence. For the benefit of secured settings, the HoNOS secure is developed. This instrument contains seven additional items that indicate the need for security and risk management. This concerns both risks and the need for physical, relational and standard management at the current and shortcoming period (32). Research on the HoNOS secure shows reasonable validity (Cronbach's alpha = .73). The inter-rater reliability ranges from moderate to good (ICC = .39 - .88). The first five items have a good inter-rater reliability (ICC> .64) but the last two items show a moderate inter-rater reliability (ICC =. 39 - .53). The last two items require some explanation prior to the measurement (32).

Routine Outcome Monitoring for Social Therapeutic forensic patients

Risk of recidivism: the Forensic Treatment Evaluation (IFBE)

A social therapeutic environment treats patients with an anti-social lifestyle and clinical scores on, mostly, a Cluster B personality disorder, as impulsiveness, hostility, substance abuse and lack of empathy. Within a social therapeutic

environment, the Instrument for the Forensic Treatment Evaluation (IFBE) has been developed to measure treatment changes. This instrument is based on the dynamic factors of the HKT-30 which has shown to be dynamic and changeable, and has a predictive value for the risk of recidivism, and some items from the ASP NV (33). The IFBE consists of 29 items including three sub-lists, namely substance use, physical aggression and sexually transgressive behaviour. Factorial structure research shows three components namely, treatability, antisocial behaviour and general skills. The IFBE uses a seventeen-point scale to indicate progress on the items (33). The IFBE is independently scored by multiple therapists. This has the great advantage that the patient is assessed from a multidisciplinary view on patients' functioning and discrepancies can be discussed (33). Besides the IFBE practitioners report, the instrument also contains a patient self-report version (34). Patients score the same items which of course are translated in a patients-transcript. The patient can score his own behaviour what can offer very useful information for the therapeutic conversation and the future treatment plan. Figure 2 illustrates a fictive patient report derived from the IFBE.

Quality of life: The Manchester Short Assessment of Quality of Life (Mansa)
The Manchester Short Assessment of Quality of Life (Mansa) measures through a short interview (± 15 minutes) or a structured questionnaire. The Mansa is a shortened version of the Lancashire Quality of Life Profile (LQLP) which has shown to be sufficiently reliable in several countries. However, the interviews take very long, some questions are unclear defined and questions regarding sexuality are missing. The Mansa has been developed with consideration of these shortcomings (35). The Mansa includes three parts, namely static personal characteristics such as age and gender; personal characteristics such as education and subjective items concerning psychological health, social and intimate relationships, sexuality, housing and financial situation. Items are scored on a seven point scale (36). Research shows a high correlation of the MANSA with the LQLP. The internal consistency is reasonable (alpha = .74). However, the instrument is related to everyday life items and not specifically to symptoms and psychopathology what of course will influence the scores (35). In our ROM-tool, clinical psychopathology can be abstracted from USER (electronic patient information), the IFBE (self-report and practitioners version) and the HoNOS.

Routine Outcome Monitoring for Intellectual Disabled forensic patients

Risk of recidivism: the Dynamic Risk Outcome Scales (DROS)
Within a mild intellectual disabled group, the DROS is used to measure risk factors. The DROS measures fifteen dynamic risk factors based on the dynamic risk factors of the HKT-30. The factors are divided into 43 items and scored on a

five-point scale, except for factor fifteen (social networks), which uses a combination score (37). Research (37) has shown that the internal consistency of the different items is moderate to good (.69 - .90) with a very good overall internal consistency (.92). In a study with 82 patients, the DROS shows a medium effect after 12 months (Cohens' d = .60) and for 34 patients the DROS shows a large effect after 24 months (Cohen's d = .93) and therefore is more dynamic than the HKT-30 (Cohen's d =. 33 and .66). This change is considered valid on the basis of the correlations with the K-items on the HKT-30 after 12 and 24 months (r = .74, and r = .69). The DROS is conducted biennial preferably by someone who knows the patient well and has sufficient current observations to evaluate the current cognitions, behaviour and skills of the patient. Also, the assessor must possess sufficient clinical knowledge of the population and has to work accurately. Settings already using the DROS judge the instrument as an added value in the treatment and evaluation of intellectual disabled patients (37). Figure 3 illustrates a fictive patient report derived from the DROS.

Quality of Life: the Intellectual Disability Quality of Life (IDQOL)
IDQOL is based on the DUCATQOL (measurement of the overall quality of life (QOL) of hospitalized children). The IDQOL requires an affective evaluation of the patients' various aspects of daily life or work and is intended for patients with an IQ higher than ± 60. By the use of simple images that convey satisfied or dissatisfied emotions, the patient may give a subjective (affective) judgment about his own life on three domains, social environment, environment in general and life related aspects. The internal consistency of the scales (alpha's respectively .77, .73 and .80) and the total instrument (alpha = .87) is satisfactory to high (38; 39). An advantage of IDQOL-16 is that the questionnaire is relatively short (16 items) and that people with intellectual disabilities have contributed to the construction phase (38). For the intellectual disabled group, an IDQOL-16 is used, with the extra subscale, satisfaction with medication derived from the IDQOL-44. The list is administered by an independent (not involved in the treatment) researcher. During the interview, it is important to verify the patient's understanding of the questions and whether the patient can connect own experiences to the questions (38).

Social functioning and adaptive behaviour: the Social Self-Reliance Scale (SRZ-P)
Mild intellectual disabled patients experience more difficulties on conceptual, practical and social domains. The Social Self-Reliance scale (SRZ-P, sociale redzaamheidsschaal) is developed in order to measure skills of independency of mild intellectual disabled patients on four areas, Self-help (f.e., table manners), communication (f.e., read, understanding of others), socialization (f.e., use of public services) and occupation (f.e., work and leisure time). The instrument measures independence behaviour in the community (40). The SRZ-P is rated as 'good' by the Committee on test affairs, Netherlands (COTAN). Research shows

that patients who exhibit problem behaviour need more guidance and therefore score lower on self-reliance in the field of living (3). Research also shows that patients with a low labor performance, show more difficulty with adaptive behaviour (41). The internal consistency of the SRZ-P is good to excellent (.92 and .94) for the total scale, the subscales vary between .80 and .91. The inter-rater reliability for the total scale was good (r = .93) for the subscales, the correlation lies between .74 and .93 (40). The SRZ-P can contribute to both the evaluation of leave-request, as adaptive behaviour is tested and practiced during leaves and to the functioning on living skills within the clinic.

Routine Outcome Monitoring for supportive forensic patients

Risk of recidivism: the Forensic Treatment Evaluation (IFBE)
For patients with a psychotic vulnerability, we also choose for the IFBE and if possible, it is preferred that the IFBE-sr is scored under guidance. However it is important to examine the mental state of the patient. When a patient exhibits symptoms such as delusions or hallucinations then it is not designated to fill in the IFBE. As mentioned earlier, the IFBE is considered to be an adequate instrument to assess treatment progress for patients residing in a supportive treatment environment. Psychometric qualities of the IFBE will be published soon (42).

The Positive and Negative Syndrome Scale (PANSS)
In a supportive treatment environment, a significant number of patients regularly suffer from psychotic episodes according to the DSM-IV(43). It is important to reduce the psychotic symptoms and therefore important to effectively measure the change of these symptoms (3). Studies show that a psychotic disorder, like schizophrenia can show a changeable pattern (44). The PANSS is recommended in the consultation document "ROM for patients with severe psychiatric illness" (EPA) (45). The 30-items PANSS yield a good impression of the positive and negative psychotic symptoms for typological and dimensional assessment and gauges the relationship between positive and negative symptoms and general psychopathology (3). The Dutch national remission working group (46) developed the PANSS remission Tool. The selected PANSS items are compiled by an international group of researchers (44), eight major symptoms have been selected. These eight include three psychotic symptoms, three negative symptoms and two disorganization symptoms (46). This instrument focuses on the personal development of the patient and can be conducted in a small amount of time. For these reasons, we include this instrument in the ROM-tool for treatment evaluation.

Social functioning and adaptive behaviour: the Social Self-Reliance Scale (SRZ-P)
We already discussed the SRZ-P in relationship to mild intellectual disabled patients. Notwithstanding this instrument was originally developed for mild

intellectual disabled patients, it can also be used to measure treatment progress among mild intellectual disabled and normal intellectual psychotic patients. Patients with psychotic disorders also show problems in the area of independency skills (3).

Quality of life: The Manchester Short Assessment of Quality of Life (Mansa)
The Mansa can be used to measure quality of life among patients with severe psychiatric disorders such as schizophrenia and schizophrenia related sub classification like the paranoid, disorganized, catatonic, undifferentiated and residual type (43; 3). It is very important to consider whether the patient is mentally able to fill in the questionnaire.

IFBE report

The IFBE is scored inpatient by three clinicians. The ROM output will be compiled in a report with a summary of the scores which is based on the method developed by Schuringa (47). The report describes the general treatment outcomes at different times on three factors, namely Treatability, Problem behaviour and General skills. The graph further displays the treatment direction on the three factors. The separate items are displayed through bar charts and a narrative explanation of the scores. A higher score represents positive behaviour, a lower score negative behaviour. For example the highest score on the item "actual substance use" stands for "no use of substances in the previous period" and the highest score on the item "coping skills" stands for "adequate coping skills".

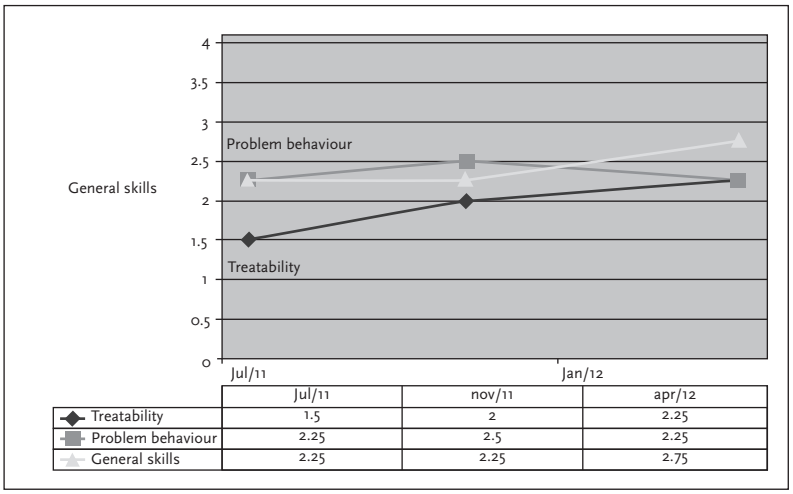
	= treatment goal
Bold	**= Risk factor**

Figure 1. goal and risk factor

The bar chart displays the last and previous assessments of patients. The narrative report shows the number of therapists who scored the survey in the column "number". The column "change" represents the change compared to the last assessment, "▲" exhibits a positive change (progress) and "▼" represents a negative change (decline). The column "agreement" concerns the agreement between the three therapists for every score (48). A moderate or low agreement represents a disagreement between therapists. The column "item" relates the item of the IFBE and the column "patient" the actual assessment of patients' behaviour. This report evaluates treatment goals for the upcoming period (six months) and allows us to define patient's risk and protective factors. When a risk factor occurs the item will be displayed bold. When an item is defined as a goal, the item will be displayed with a grey background:

Name Patient: Date MDB 0-1-1900

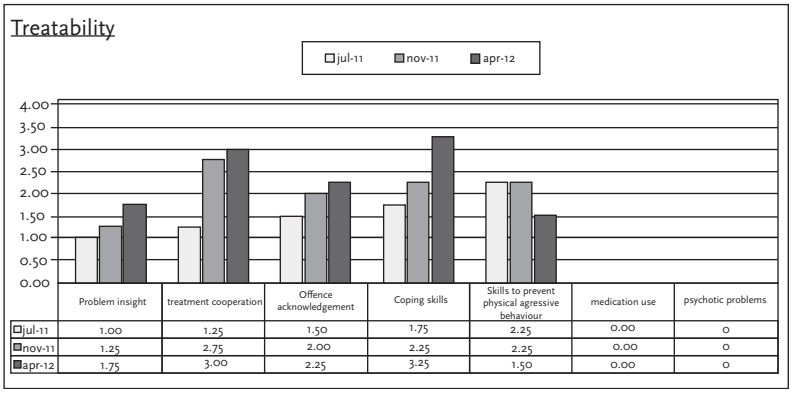
ABSTRACT



	Jul/11	nov/11	apr/12
Treatability	1.5	2	2.25
Problem behaviour	2.25	2.5	2.25
General skills	2.25	2.25	2.75

Treatability

Item	Patient	Agreement*	Change	Number
Problem insight	Does have problem awareness, but does not behave hereinafter.	high	▲	3
Treatment cooperation	Works actively, sometimes obstinate or indifferent	high		3
Offence recognition	Partly takes responsibility for the offense, however also partially blames others or circumstances.	high	-	3
Coping skills	Sufficient coping skills, stability is doubtful during persisting problems	high	▲	3
Skills to prevent physical agressive behaviour	Limited skills to prevent physical aggressive behaviour	**moderate**	▼	2
Medication compliance				0
Psychotic symptoms				0

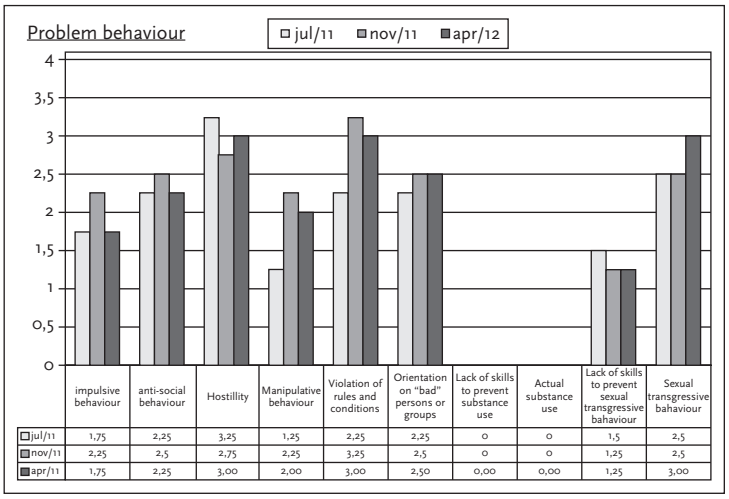


	Problem insight	treatment cooperation	Offence acknowledgement	Coping skills	Skills to prevent physical agressive behaviour	medication use	psychotic problems
jul-11	1.00	1.25	1.50	1.75	2.25	0.00	0
nov-11	1.25	2.75	2.00	2.25	2.25	0.00	0
apr-12	1.75	3.00	2.25	3.25	1.50	0.00	0

Figure 2. IFBE report (48)

	= Treatment goal
Bold	**= Risk factor**

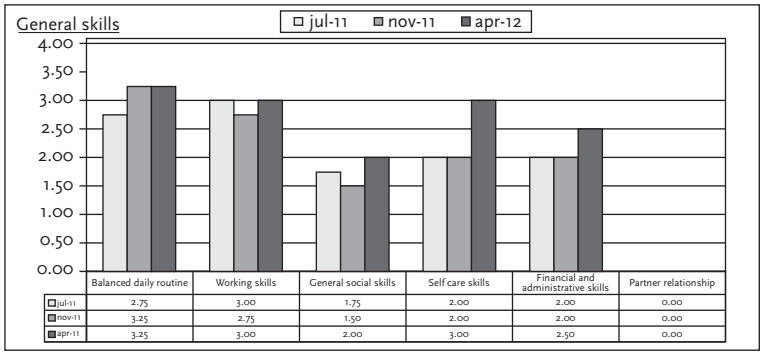
Problem behaviour				
Item	**Patient**	**Agreement**	**Change**	**Number**
Impulsive behaviour	Shows some impulsivity in behaviour, has ability to somewhat control behaviour.	high	▼	3
Anti – social behaviour	Does not consider other sometimes, and can cross boundaries and/or causes conflicts.	high	▼	3
Hostillity	Hostile, manifesting in occasional irritation, carsing, anger and/or making negative statements	high	-	3
Manipulative behaviour	Takes advantage of others in a manipulative way, sometimes.	high	-	3
Violations of rules and conditions	Adheres to all rules and agreements, but does moderately verbally protests against rules.	**Moderate**		3
Orientation on "bad" persons or groups	Has some persons in his network that do approve of violence or a criminal lifestyle, however they do not influence him.	High		3
Lack of skills to prevent substance use				0
Actual substance use				0
Lack of skills to prevent sexual transgressive behaviour	Has limited skills to prevent sexual transgressive behaviour.	High	-	3
Sexual transgressive behaviour	Does shows inappropriate behaviour, like staring or making inappropriate comments.	**Moderate**	▲	3



	impulsive behaviour	anti-social behaviour	Hostillity	Manipulative behaviour	Violation of rules and conditions	Orientation on "bad" persons or groups	Lack of skills to prevent substance use	Actual substance use	Lack of skills to prevent sexual transgressive bahaviour	Sexual transgressive bahaviour
jul/11	1,75	2,25	3,25	1,25	2,25	2,25	0	0	1,5	2,5
nov/11	2,25	2,5	2,75	2,25	3,25	2,5	0	0	1,25	2,5
apr/11	1,75	2,25	3,00	2,00	3,00	2,50	0,00	0,00	1,25	3,00

General skills				
Item	**Patient**	**Agreement**	**Change**	**Number**
Balanced daily routine	Often has a balanced daily routine	high	-	3
Working skills	Has some problems with working skills of daily routine.	high	-	2
General social skills	Sometimes gets in trouble due to a lack of social skills. **This was**: Gets in trouble due to a lack of social skills regularly.	high	▲	3
Self – care skills	Minor deficiencies in self-care skills, does not necessarily need support. **This was**: Shows deficiencies in self-care skills, patient needs and accepts support.	high	▲	3

Financial and administrative skills	**Shows deficiencies in financial skills, patient needs and accepts support.**	**high**	**-**	**2**
Partner relationship				**0**



	Balanced daily routine	Working skills	General social skills	Self care skills	Financial and administrative skills	Partner relationship
jul-11	2.75	3.00	1.75	2.00	2.00	0.00
nov-11	3.25	2.75	1.50	2.00	2.00	0.00
apr-11	3.25	3.00	2.00	3.00	2.50	0.00

Figure 2 illustrates a fictive report concerning a patient who committed a sexual offence. We observe some progress on the factor "*treatability*", f.e., the item "problem insight" increases (table 2). However problem insight still remains insufficient what can be seen as a risk factor. The factor "*problem behaviour*" indicates limited skills to prevent sexual transgressive behaviour. The patient can be impulsive, shows some verbal hostility and does not consider others. The factor "*general skills*" displays limited progress on the item "*general social skills*". As can be seen in the figure, future treatment will focus on several factors. Partner relationship is considered to be a risk factor due to historical factors but is not relevant at the current time because the patient is just at the beginning of his inpatient treatment. The patient completed the Manchester Assessment of Quality of Life and the IFBE self-report. The Health of the Nation Outcome Scales is rated by the head of "risk management and treatment". These scores are not displayed in this chapter.

Dynamic Risk Outcome Scales Report

In this paragraph, 15 risk factors and items are shown in figure 3 based on the schedule developed in Trajectum Hoeve Boschoord (49, 50). Table five displays codes based on codes also developed in Trajectum Hoeve Boschoord (51). Within FPC2landen, the DROS is scored in consensus between two therapists. In the section "Periodic goals" (see figure 3), scores are reported for the two last measurements (Score 1 and score 2). The column with the title "achieved" displays differences between the two measurements with; "+" (positive change/ progress); " –" (negative change/decrease) or; "=" (no change/stabilization) (see

table 5). A progression of 1.15 on a scale score is considered meaningful (51). When a factor is scored two times with a "+" (progress of two on a scale), we assume a meaningful progress on that factor.

The section "treatment necessity" displays which items are considered risk factors (R) and other treatment issues (A) (see table 5). The column "UP" displays the treatment perspective and the column "treatment" presents the necessity of treatment progress for the benefit of the treatment perspective. "!"shows preferred progress; no improvement relates to problem behaviour within the current treatment perspective and "!!" stands for an essentially required progress (see table 5); without improvement, serious problems could occur within the current treatment perspective (51).

Within the section periodic goals, specific goals for the upcoming period can be highlighted. During treatment evaluation, treatment changes between previous and current evaluations can be observed and treatment goals can be involved. In the column "goal" a "+" stands for progress and "(+)" for medium progress. The code "S" stands for stabilization of a higher (4 or 5) score and the code "-" means that no improvement is foreseen in the next period (see table 5) (51).

Table 5: Codes in DROS schedule (51)

Column "achieved"	
+	Positive progress
–	Negative progress
=	No change
Column "goal"	
+	Enough progress to attain a higher DROS score
(+)	Progress, however not necessarily enough in order to attain a higher DROS score
S	Stabilization of a higher DROS score
–	No improvement planned for the upcoming period
Column "Risk factor"	
R	Risk factor
A	Treatment issue, but not necessarily a risk factor
Column "treatment goal"	
!	Desirable progress
!!	Essentially required progress

Dynamic Risk Outcome Scales
K. Drieschner, B. Hesper (2011).
Patient X
Department x

Risk variable		Item	Treatment necessity: Risk factor	UP	Treat - ment	goal	Periodic goals: Score 1	Achived	Score 2
Problemknowledge/ problem insight	1.1	Responsibillity	R		!	(+)	3	+	4
	1.2	Awareness risk, riskfactors and					4	=	4
	1.3	dansersignals Acceptance own limitation/disabillities	R		!!	+	2	+	3
Attitude towards	2.1	Recognition current nessecary prof.				+	3	+	4
Current treatment or supervision	2.2	care Attitude towards current professional care	A	R I B W	!		3	+	4
Ideas and expectations of post treatment situation	3.1	Necessarycare	A		!	+	3	+	4
	3.2	Remaining elements	A		!	S	4	=	4
Treatment/supervision	4.1	Commitment to change				S	4	+	5
Cooperation	4.2	Medication compliance	R		!!	+	2	=	2
	4.3	Rule confomity	A		!!		3	+	4
	4.4	Transparancy/openness	A		!		2	+	3
Criminogenic attitudes	5.1	Attitude towards fysical violence	A		!	S	4	=	4
	5.2	Egocentrism	R		!		3	+	4
	5.3	Attitudes towards antisocial behaviour	R		!!	(+)	3	+	4
	5.4	Attitudes towards prosocial conventaion					4	-	3
Coping skills	6.1	Coping with conflictual interactions	A		!		3	-	2
	6.2	Coping with risk urges	R		!!	(+)	3	=	3
	6.3	Coping with remaining stressors	R		!!			+	3
Hostillity	7.1	Hostile perception and attitude	R		!		4	-	3
	7.2	Resentment and revenge					4	+	5
	7.3	Resentments					5	=	5
Sex-related cognistions	8.1	Sexual preoccupation	R		!!	+	2	+	3
And sexual trangressive	8.2	Sexual misinterpretation					5	=	5
Behaviour	8.3	Sexual transgressive behaviour	R		!!	+	1	+	3
Impulsivity	9.1	Toughtlessness					5	=	5
	9.2	Sensationalism	R		!	(+)	3	=	3
Maintaining stabilising and prosocial structures	10.1	Maintain prosocial contacts	A		!		3	=	3
	10.2	Maintain meaningfull daily activities	A		!		3	+	4
Self-reliance	11.1	Hysien	A		!	(+)	1	+	2
		Nutrision	A		!		3	=	3
		Ciracadian rythm	A		!	(+)	3	-	2
	11.2	Literacy	A		!	(+)	2	+	3
		Count				(+)	3	=	3
		Sense of time/telling time					3	+	4
Social skills and behaviour	12.1	Basic social skills and behaviour				(+)	3	=	3
	12.2	Subassertiveness	A		!		3	=	3
	12.3	Collaboration skills	A				2	+	4
Addiction,	13.1	Yearning for substances or gambling	R		!!	(+)	3	=	3
Substance usc	13.2	Idealise substances/gambling					5	=	5
and gambling	13.3	Accountability for substances/gambling	R		!	(+)	3	+	4
Psychotic symptoms	14.1	Delusions/delusional ideas	A		!		4	=	4
		Hallucinions					5	=	5
	14.2	Psychotic vulnerability	A				3	+	4
Social network	15.1							=	

Figure 3. DROS schedule

This description is based on a fictive patient with a mild intellectual disability who has committed a sexual offense. The patient resides permanently in a forensic psychiatric center (high risk security). The patient received previous treatments in psychiatry and detention. Important risk factors, presented in figure 3, are "problem knowledge and problem insight"; "medication compliance"; "copings skills"; "sex-related cognitions and sexual transgressive behaviour", "sensationalism"; "egocentrism"; "substance use"; "attitude towards antisocial behaviour" etc. (see figure 3).

For evaluation purposes, required treatment progression is expressed by several items such as; "acceptance of own limitations"; and "medication compliance"; "attitudes towards antisocial behaviour"; "sex-related cognitions and sexual transgressive behaviour" etc. The DROS displays progress on several scales, especially on the risk factor "sex-related cognitions and sexual transgressive behaviour" and "treatment/supervision cooperation". The item medication compliance remains problematic. Also coping skills and self-reliance are problematic. The item "hostile perception and attitude" shows an increase of negative behaviour in the past period.

In the following evaluation period, the focus could lie on handling stress, training of self-care skills and risk management with a focus on hostility. The patient completed the Intellectual Disability Quality of Life interview and therapists complemented the Social adaptability Scale-P (SRZ-P). The Health of the Nation Outcome Scales and Health of the Nation Outcome Scales Secure have been rated by the head of "risk management and treatment". These scores are not displayed in this chapter.

Conclusion

Three instrument tools have been discussed for ROM assessment for anti-social, psychotic and mild intellectual disabled patients in Forensic Psychiatric Centers. The prevention of recidivism and the protection of society is the main purpose of forensic psychiatric centers. This main goal can only be realized when multidisciplinary treatment-related between goals (psychiatric, psychological, social, nursing, education) are achieved. Treatment-related goals should be seen as moderators that contribute to reducing recidivism. The many expert groups that reside in the Netherlands have concluded that three basic instrument must be part of the forensic ROM-tool, namely the HKT-30, the IFBE and the DROS.

However, knowledge and advices from adjoining clinical domains with much more ROM experience cannot be ignored. Therefore, in the FPC's 2Landen and de Kijvelanden, we decided to involve specific patient-related instruments and

developed a ROM tool for psychotic, personality disordered and mild mentally disabled patients.

Finally, the purpose of ROM is primarily to identify treatment quality and to inform practitioners periodically about the stagnation, deterioration or improvement of a patient's progress on various life domains and risk/protective factors. ROM offers the practitioner tools to achieve insights in risk profiles and provides handles to adjust treatment if indicated. ROM is also intended to inform the patient. The involvement of the patient in ROM procedures provides information what can be used in therapeutic conversations.

ROM is also mentioned to use as a benchmark instrument. In recent months, there has been a lot of controversy about benchmarking. However, in our vision the therapeutic relationship is central and the triangle, patient-practitioner-institution, shapes that therapeutic relationship. Benchmark has nothing to do with primary treatment purposes but serves other goals.

ROM results also provide research opportunities. As mentioned earlier, only a limited amount of studies into the effectiveness of forensic psychiatric treatment has been conducted and most studies have shown that the number of observations is often very small. Some forensic psychiatric centers already use ROM outcomes for the purpose of clinical decisions. Recently, De Vries and Spreen (52) studied the use of the HKT-30 to underpin decision making in treatment, such as the start of a rehabilitation process. The combination of the factors substance use, impulsivity and lack of empathy appears to predict violations in the rehabilitation process what also was found in the study of Bogaerts, Spreen, Horváth, Polak and Cima (53).

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Psychopathy and Risk Assessment in Intellectually Disabled Forensic Patients Old Problems and New Insights

M.J.V. Peters, J. Hendrickx, I. Jeandarme, C. Pouls

In the past years, there has been an increased interest for people with intellectual disabilities (ID) in the forensic context, for several reasons: 1. Research on prevalence estimates of ID in the forensic context has increased, 2. Research on the development of appropriate risk assessment tools has advanced significantly in the past years, suggesting that there are several valid assessment tools for ID offenders 3. Innovations in treatment research have been evaluated, more specifically in the area of anger-violence and sex offender treatment.[1,2] This chapter will mainly focus on the first two lines of research.

Offenders with ID comprise a heterogeneous and complex population to investigate. This explains to some extent the large variability in prevalence rates that have been found. Furthermore, methodological differences in research on ID offenders and variability on how ID is defined further adds to this complexity.[3,4] The most recent studies are estimating the prevalence of offenders with intellectual disabilities in various criminal justice settings at between 2 and 10 %.[5] While a large number of studies claim that this population is to some extent overrepresented in the former context (e.g., 2-10 % versus 1 % in the general population)[6], the methodological differences between the published studies on prevalence rates and the heterogeneity of the studied samples as described above, make it difficult to make firm statements on this topic.

With the emerging trend of increased interest in prevalence rates of forensic ID patients, research on risk assessment has mounted in the past years. Current studies clearly describe both the framework for assessment and new instruments that have been shown to predict sexual and violence offending.[7,8] It must be stated that work on risk assessment for ID offenders took a slow start in comparison to similar work on other offenders.[9] Camilleri and Quinsey[8] reviewed the risk assessment literature and concluded that, despite new insights in risk factors and effective predictors, with moderate to good predictions of violence offending in forensic ID patients using actuarial methods like the Violence Risk Appraisal Guide (VRAG),[10] more research is necessary on using sexual and violence risk assessment tools within this population to keep up with the progress that is being made with other offender groups.

When reviewing the risk assessment literature, one of the most important clinical variables is personality disorders with cluster B personality disorders (like antisocial personality disorder, narcissistic personality disorder, and borderline personality disorder) being the best predictors.[11,12] Recently Morrissey and Hollin[13] reviewed the literature on antisocial and psychopathic personality disorder in forensic ID populations. They describe a clear progress in the understanding of personality disorders in ID populations and also review valid evidence in using the Psychopathy Checklist-Revised (PCL-R)[14] and Psychopathy Checklist: Screening Version (PCL:SV)[15] for the assessment of psychopathic traits. In general they concluded: "Considerable progress has been made in the last 5 years regarding the assessment and understanding of the specific personality disorders of APD and psychopathy in people with ID in forensic settings. Nevertheless most of this work has been conducted with those with mild to borderline disabilities, and it is important not to disregard the measurement and diagnostic problems, which remain, particularly for those populations with moderate disabilities. [...]. Where psychopathy is concerned, some caution continues to be indicated in interpretation of PCL-R scores obtained in people with ID, although there are initial indications that the PCL-SV may be a more valid measure than the PCL-R for ID populations. [...]. Finally, until further research is published, careful consideration should be given to applying labels which can result in negative outcomes for individuals with ID, including being detained in secure settings for lengthier periods and being excluded from services. If used, these diagnoses should have clear clinical utility, by helping clinicians to conceptualize and make sense of behaviour and interpersonal functioning, and to target treatment appropriately".[13(p144)]

In line with these new insights and requests for more research related to the role of APD and psychopathy in forensic ID patients and risk assessment tools, this chapter will present some new data on the use of the Dutch translation of the PCL:SV[16] in a sample of Belgian forensic ID patients. At the end of this chapter, avenues for future research will be highlighted. We will start this chapter with providing you a general overview on definition and diagnosis of mental disabilities and the current state of knowledge on the importance of psychopathy and risk assessment research in ID populations.

Defining intellectual disability

In forensic practice, the most widely used definition for ID comes from the Diagnostic and Statistical Manual of Mental Disorders[6] and the International Classification of Diseases and Related Health Problems (ICD-10).[18] The DSM-IV-TR[6(pp82-83)] defines intellectual disabilities as: "Significantly subaverage intellectual functioning (i.e., at least two standard deviations below the mean) with an IQ of

approximately 70 or below on an individually administered IQ test (criterion A) and concurrent deficits or impairments in present adaptive functioning in at least two of the following areas (criterion B): communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety, and with an onset before age 18 (criterion C)". Codes are further stratified into for mild (IQ level 50-55 to approximately 70), moderate (IQ level 35-40 to 50-55), severe (IQ level 20-25 to 35-40) and profound mental retardation (IQ level below 20 or 25). The ICD-10 criteria on mental impairment are in general quite similar. IQ scores are often obtained through the use of the Wechsler scales, with the Wechsler Adult Intelligence
Scale-III (WAIS-III)[19] as the most frequently used scale. Recently, the WAIS-IV[20] has been published.

Although IQ scores are of importance in underscoring the diagnosis, relying only on for example the WAIS-III scores doesn't underpin all of the cognitive functioning domains. Taking into account the whole picture of cognitive abilities, together with adaptive functioning is of uttermost importance in exploring further assessment possibilities and in delivering adequate treatment.

On a conceptual level, the definition of ID has evolved significantly over time. This conceptual diversity can also be seen as one of the major problems in this field, hampering the comparability of empirical research.[21] Most importantly, the large diversity in which ID is described and measured throughout the empirical literature is responsible for this conceptual confusion. The variability of assessment methods investigating intellectual disabilities greatly differs in reliability and validity, with most of the time a strong focus on intelligence quotients (IQ). It should be kept in mind that IQ is a necessary, but by no means a sufficient prerequisite to determine ID. Getting insight in the functional impairments (i.e., emotional, social, behavioural) is of equal importance. In forensic assessments, this is frequently overlooked or not properly assessed (e.g. via the Vineland Adaptive Behavior Scales[22]; Hayes Ability Screening Index[23]).

This latter comment has to do with a second problem stated by Uzieblo et al.[21] (p28) relating to the lack of theoretical underpinning in ID assessment: "On the other hand, assessment of IQ in criminal justice and mental health-related areas appears to be informed more by practical aspects and needs rather than grounded in a solid theoretical model [...]".[a]

a Providing the reader with an elaboration on these topics would bring us too far and is therefore beyond the scope of this chapter. We refer the reader to the manuscript by Uzieblo et al.[21]

Risky business or not?

When discussing ID in the forensic context, lay people often assume that there is a strong relationship between ID and criminal behaviour, with ID possibly lowering the boundary for a criminal act.[24] This was supposedly reflected by high prevalence rates of ID in offender populations. Trent[25] describes in his book on the history of ID in the USA several examples from the popular and scientific press at the turn of the nineteenth to the twentieth century linking ID and crime. As is frequently the case, the lay-mans held beliefs were not supported by scientific data. In contrast, scientific data have shown that a lower intelligence is no strong predictor of committing offences, with effect sizes in the small ranges (r = 0.20).[26]

Despite the discrepancies in definitions and assessment methods, at present it seems that ID offenders are to some extend overrepresented in forensic practice. Based on setting level, its seems that offenders with ID are substantially more present in mental health settings (12.8% in in-patients with forensic involvement and 20.8% in psychiatric in-patients with ID in general)[3] compared to prison settings (e.g., prevalence rates ranging from 0.5-1.5% in a systematic review[27] and 1.3% in a recent study within a prison setting[28]).

Prevalence rates are also influenced by the type of index offence, level of ID, and subsequent referral. For example, Hogue et al.[29] found that ID offenders who committed arson were not equally distributed across three levels of security settings in the forensic context, despite uniform assessment of ID across all groups. These researchers found that rates of arson as an index offence depended on the setting with low rates (2.9%) in the community sample and higher rates in the medium security sample (21.4%). Furthermore, the relationship between ID and specific types of index offences (i.e., sexual offences) has thus far not been substantiated[28], although consensus on this topic has not yet been reached.

In search for specific risk factors, the question has been asked as to whether forensic and non-forensic samples differ on specific historical background factors. In a prototypical study, Lindsay et al.[30] found that in the forensic ID sample age, distinct problems with relationships, anger, aggression, physical and sexual abuse, and recidivism rates were related to the index offence. A similar study was carried out by Raina and Lunsky.[31] They found that the forensic sample significantly differed form the non-forensic sample on the following variables: greater history of substance abuse, increased diagnosis of psychotic disorders and more ID in the mild and borderline category. No differences were found on personality disorders, emotional disorders and medication. In a subsequent study carried out by Lunsky, Gracey, Koegl, Bradley, Durbin, and Raina[3], they found that the forensic sample (comprising of 12.2% of the total inpatient

sample) tended to be younger and male, were more likely to have a history of substance misuse disorder and less likely to have a mood disorder. They also found trend-like differences in that forensic ID patients were more likely to be neglected in childhood compared to the non-forensic sample. These indices of childhood neglect were further replicated in a study carried out by O'Brien and colleagues[32] (n = 477 offenders with ID). In this study, O'Brien and colleagues[32] found high rates of childhood neglect, physical health problems, adult mental health problems and perinatal adversities in the forensic ID sample. Lindsay et al.[33] found high prevalence rates of physical and verbal violence in the offender ID group.

Related to prevalence and background characteristics of forensic ID patients, it can be concluded that due to methodological and conceptual problems, establishing the correct prevalence remains difficult in criminal justice settings. Furthermore, offenders with ID tend to be more frequently diagnosed with substance misuse and show higher levels of other mental disorders. They also tend to be younger and a relationship with childhood neglect and perinatal adversities is frequently found. Given the fact that most of these studies relied on cross-sectional data, no causal inferences can be made. This needs to be established in future longitudinal research.

Assessment of risk

Risk assessment has a long tradition within the forensic context, primarily to assess the 'dangerousness' of a forensic psychiatric patient. Later on, this risk assessment was also used to assist judicial decision-making such as releasing an offender back into the community.[10] In the following paragraphs, we will describe some recent papers on risk assessment in ID. Giving the reader a complete overview of the risk assessment literature in ID is beyond the scope of this chapter.

Research on different risk assessment instruments (i.e., actuarial and structured professional judgment) has advanced significantly over the last decade, with a strong focus on conventional offenders. Related to ID offenders, one could state that research took a slower start but is now steadily mounting. A risk factor is generally defined as a characteristic, experience, or event that, if present, is associated with an increase in the probability (risk) of a particular outcome over the base rate of the outcome in general (unexposed) population.[34] The risk of behaviour that is harmful to others then needs to be established.[35]

Risk assessment for future violent and sexual offences can be defined as one of the most important fields in forensic psychology. Related to the field of ID, there are now several studies that have compared the predictive validity of several risk

assessment tools. For example, Gray, Fitzgerald, Taylor, MacCulloch, & Snowden[36] evaluated the PCL:SV[15], the HCR-20[37] and the VRAG[10] in a group of 146 offenders with ID and 996 general offenders that were all discharged from four independent sector hospitals and were followed for a minimum of two years. In general they found that for the ID group, the three assessment instruments predicted future offences indicated with a medium to large effect size for both violent and general recidivism. These predictions were greater for the ID than the non-ID offenders, although the differences were modest. A paper by Lindsay et al.[38] describes an evaluation of the VRAG, HCR-20 and the Risk Matrix 2000[39] in a sample of 212 ID offenders from different secure settings. In this study, participants were followed for one year. In this study, the VRAG and HCR-20 gave the best predictions for violent offenses with a medium to large effect.

Quinsey, Book and Skilling[40] (2004) further investigated the predictive validity of the VRAG and found that the instrument was not only good at predicting future violence but also that there was a relationship with treatment progress.

In a recent research paper on risk factors for recidivism in offenders with intellectual disabilities, 145 ID offenders from four independent medium secure units in the UK were investigated and followed between 1990 and 2001 on different criminal history and deviant lifestyle variables.[7] The predictor variables were criminal history and deviant lifestyle variables. Future criminal convictions served as outcome measure. The number of previous offences, previous acquisitive offences, previous drugs offences and the number of previous bail offences were predictive for re-offending. Furthermore a history of alcohol or drug abuse also accounted for a small group difference. Overall, criminal history variables were significantly related to general recidivism. Furthermore, subsequent analyses found the Offender Group Re-conviction Scale (OGRS)[41] had an excellent predictive efficacy in ID offenders.

The use of risk assessment tools, designed primarily for general offenders, in an ID population however raises several questions. Not all of these instruments are validated on an ID population and they don't take into account specific issues relevant to ID. As a result of this criticism several specific ID tools have been developed such as the Assessment of Risk and Manageability with Intellectually Disabled IndividuaLs who Offend (ARMIDILO),[42,43] and for the Dutch speaking the Dynamic Risk Outcome Scales' (DROS), which was primarily developed to measure treatment progress.[44] In a comparison with other risk assessment tools the ARMIDILO was recently found to be the best predictor for sexual reconviction among offenders with special needs.[45]

Furthermore, Camilleri and Quinsey[8] point to another important aspect of risk assessment in ID offenders: the relatively high recidivism rates. They state that

although research has found good predictive validity of the available risk assessment tools in ID offenders, several ways could lead to better and new insights, like understanding the theoretical link between ID and offending that may help to identify new risk items, etc. Not only static and more statistical predictors should be involved, but also dynamic or changeable predictors. These are factors that relate to the context or environmental factors that are mostly present close in time to the occurrence of the behaviour of interest and will also affect the probability of the behaviour occurring.

In conclusion, current valid methods for the assessment of future (sexual) violent behaviour within known criminal offenders seem to be equally effective when applied to ID offenders. However, these instruments do not take into account ID specificities like the complexity of the 'intelligence' concept, potential differences in prevalence and recidivism rates between ID offenders and 'regular' offender samples, specific ID risk factors and the need for appropriate support and treatment strategies. The findings until present are somewhat inconsistent given the limited studies. Also specific risk assessment tools for forensic ID patients haven't been sufficiently tested so far. For a valid and intervention-orientated approach to ID risk assessment, there is a need for further diagnostic differentiation as well as uniform research methods.

Antisocial personality and psychopathy

Both antisocial personality disorder (APD) and psychopathy have particular relevance to forensic populations, but it was until recently that these constructs have been explored in forensic ID samples.[13] Given the convergence (antisocial behaviour) and divergence (affective and interpersonal functioning in psychopathy in contrast to APD), the clinical construct of psychopathy is closely related to, but can be differentiated from APD.

A large body of research has established that a diagnosis of APD and psychopathic personality has a strong link with recidivism in general offender populations, particular for violent crimes.[46] For this reason, either having a diagnosis of APD or psychopathy are items that are highly weighted in several violence risk assessment instruments including the VRAG and HCR-20.

The relevance of personality and the possibility of cluster B personality disorders is now more and more seen as a relevant area for forensic ID samples. The pertinence of the identification and measurement of APD is relevant for two reasons. First because of the relevance in structured risk assessment methodologies, since more and more assessment tools ask for the presence or absence of

APD or psychopathy. Second, treatment and management of the disorder are of vital importance.

There has been a long debate about the relationship between IQ and psychopathy. Cleckley[47], in his early conceptualisation, ruled out the possibility of a psychopath having significant ID. Since then, studies from the nineties of the last century did not find an association.[48,49] However, more recent insights using pathway analysis have found that intelligence and certain aspects of psychopathy are related.[50,51] More specifically an association was found with the interpersonal factor of psychopathy and a negative association with the affective and, to a lesser extent, the lifestyle factor. The fact that both correlations somehow rule each other out could be an explanation for finding no correlations between the overall psychopathy score and intelligence, as found in earlier studies. Future studies should further look at more diverse groups within ID samples, since most of these studies only used borderline to high average range intellectual disabilities.

Since the review by Torr[52] in which it was stated that this issue of personality disorder in forensic ID populations had not been addressed, substantial progress has been made. However, there still are ongoing theoretical difficulties in conceptualizing personality disorder in general and psychopathy in particular in this group. There are difficulties in defining what actually constitutes personality disorder in ID populations where developmental delay can affect personality maturation. Until now, not much is known about the normal development of personality in people with ID. Also there is debate whether the diagnostic criteria should be different to those without intellectual disability. Morrissey and Hollin[13] addressed this issue further in particular regarding the assessment of antisocial personality features. In concluding their review, these authors state that APD presents in much the same form and expected frequency in forensic populations with mild ID than in other forensic populations. Also the validity of the PCL-R, the most widely used measure of psychopathy in offender populations, was found to be similar to that observed in other male offender populations.[53] However there are problems in applicability of the PCL-R for ID and the predictive validity needs to be further explored. Although the PCL-R was predictive of treatment outcome[54] and post-release violent recidivism,[55] it did not predict institutional aggression.[56] The PCL:SV had good predictive validity in an ID sample in relation to reconviction.[36] The PCL:SV seems to have better face validity as it has more inclusive classifications of antisocial behaviour and does not include certain items of the PCL-R that are problematic. A number of methodological and practical issue have been identified when using the standard PCL-R within forensic ID patients. (e.g., items pertaining to relationships and sexuality). First, the deficits in communication and adaptive functioning that are clearly present in ID can have consequences for specific key features

of psychopathy. Second, the psychosocial environment in which people with ID grow up could limit the possibility to show behaviour manifestations that are prototypical for psychopaths, like employment or relationship histories. Third, items pertaining to criminal behaviour in normal populations are often interpreted as 'challenging' behaviour in ID people, and therefore not reported. A fourth problem relates to the rating of specific characteristics within the PCL-R that could overlap with functional aspects associated with ID itself like deficient affective experiences.[57] Finally, it can be difficult to carry out and retrieve valid and reliable information from interviews with ID people.[8] In response to these difficulties, Morrissey[58] developed practical guidelines for using the PCL-R and PCL:SV in ID offenders.

In conclusion, psychopathy seems to be a valid construct within (mild) ID. Related to identifying psychopathy in ID people, the PCL-R shows adequate psychometric properties but clearly has problems in the applicability and predictive validity of future violence needs to be further established. The shorter PCL:SV version could overcome certain of these problems, i.e., shows better face validity as it has more inclusive classifications of antisocial behaviour and does not have some items that are problematic in the PCL-R (e.g., related to relationships and sexuality). The predictive validity of the PCL:SV is at best modest to satisfactory and psychometric properties are until now not well investigated in forensic ID samples. Given these facts, the following research was carried out to establish psychometric properties of the PCL:SV in a forensic ID sample.

The use of the PCL:SV in forensic ID patients

What we know so far

The Psychopathy Checklist: Screening Version (PCL:SV)[15] was created with the goal of having a shorter measure that approximated the PCL-R. This resulted in the PCL:SV being a 12-item psychopathy screening measure. The PCL:SV is a rater-based method that functions optimally when used with a semi-structured interview and review of collateral information. The scoring methodology is similar to the PCL-R, in which each item is scored on a three-point scale ranging from "0 = trait cannot be detected", to "2 = trait present to a substantial degree", leading to a total score ranging from 0 to 24. According to the authors of the PCL:SV, the total score is a dimensional measure of the degree to which a given individual matches a "prototypical psychopath". Furthermore, the authors state that it is difficult to specify a single 'best' cutoff score for the PCL:SV. Instead, they argue that, in practice, scorings of 12 or lower on the PCL:SV can be considered non-psychopathic. Patients scoring between 13 and 17 clearly have psychopathic traits and should be further evaluated with the PCL-R.

Scores of 18 or higher offer a strong indication of psychopathy and warrant further evaluation with the PCL-R.[15]

Listing 1. Items of the PCL:SV[15]
1. Superficial
2. Grandiose
3. Deceitful
4. Lacks remorse
5. Lacks empathy
6. Doesn't accept responsibility
7. Impulsive
8. Poor behavioral control
9. Lacks goals
10. Irresponsible
11. Adolescent antisocial behavior
12. Adult antisocial behavior

The main goal of the present study was to investigate psychometric properties of the Dutch translation of the PCL:SV (research version)[16] in a forensic sample with ID, of which there are no known psychometric properties yet. There is, however, international literature reporting on the psychometric properties of the original PCL:SV[15]. In general, this literature shows good to excellent alpha coefficients (α ranging from .84 to .87) and inter-rater reliabilities (ICC = .84) for the original PCL:SV.[59,60,61] The PCL:SV was constructed to measure two correlated facets of psychopathy: interpersonal/affective (items 1 to 6) and social deviance (items 7 to 12). In the initial development study of the PCL:SV[15], this two-factor model was found to be the best fit in their total sample of 496 participants, comprising of forensic/non-psychiatric, forensic/psychiatric, civil/psychiatric and noncriminal/non-psychiatric samples. More recently, Hill, Neumann and Rogers[62] tested the factor structure of the PCL:SV in a sample of 149 male forensic psychiatric patients and found acceptable model fit for the two-, three-, and four-factor models in this sample. However, in this study the four-factor model achieved the most robust fit indices, and also outperformed the three-factor model in predicting institutional misbehavior at a six-month follow-up. The factor structure of the PCL:SV is far from settled and future research hopefully continues to study this and its relationship to external variables (e.g., violence).[51]

With regard to offenders with ID, only the study by Gray, Fitzgerald, Taylor, MacCullogh and Snowden[36] investigated, besides the HCR-20 and VRAG, the predictive validity of the PCL:SV in relation to reconviction of ID offenders for both violent and general offences. In this study, a sample of 145 (118 male and 27 female) forensic ID patients was investigated of which 121 were diagnosed with mild mental retardation (MR), 18 with moderate MR, 5 with severe MR, and one

with unspecified MR. In the ID group, 49 patients had a diagnosis of ID alone, and 96 patients had a comorbid diagnosis of another mental disorder (either mental illness or personality disorder). Mean age at time of discharge was 31.45 years (*SD* = 8.94, Range = 18.84-65.78). The non-ID group (*n* = 996) consisted of all other participants with some form of psychiatric diagnosis without ID. In this ID sample a mean PCL:SV total score of 8.96 (*SD* = 4.79, Range = 0-20) was found, which was significantly higher compared to the non-ID group (*M* = 6.88, *SD* = 4.94, Range = 0-22). Furthermore, the ID group was reconvicted at a slower rate for both violent and general offenses compared to the non-ID group and thus also had a different base rate for reconviction. The PCL:SV showed good predictive validity in the ID sample for both violent (AUC PCL:SV total = .73, *SE* = .10) and general (AUC PCL:SV total = .76, *SE* = .07) recidivism. These AUC s for the ID group did not significantly differ from the non-ID group. In the end these authors conclude that the PCL:SV can be used in offenders with ID without the need for any modification of the items or scoring procedures.

PCL:SV in a Belgian forensic ID sample

Following the abovementioned knowledge about the psychometric properties of the original PCL:SV, inter-rater reliability, Cronbach's alpha and correlates of the Dutch translation of the PCL:SV were investigated in a Belgian ID forensic sample. Furthermore, differences across prison and forensic psychiatry hospital ID groups were explored.

The total sample consisted of sixty male forensic ID patients (so-called internees), of which 5 had borderline intellectual functioning (IQ ranging from 71 to 84) and 55 have mild, moderate or severe mental retardation (IQ ranging from 23 to 70). The forensic ID patients in this sample were residing in pilot projects, which are financed by the *Vlaams Agentschap voor Personen met een Handicap* (VAPH). These projects are located in settings in psychiatric hospitals ('Amanis' – Zoersel, 'Limes' – Sint-Truiden, and 'Itinera' – Beernem), and in prisons (Merksplas – 'A. B.A.G.G.' and Ghent – 'Ontgrendeld'). Internment is a measure carried out by the Belgian government that offers therapeutic care for individuals who committed an offense but cannot be held responsible for it due to psychiatric illness. In the Belgian context, internment is seen as a safety measure, and not as a punishment for the offender. It can be of indefinite duration and is decided upon under criminal law by a judge.

Table 1. Axis-I and Axis-II diagnosis of the forensic ID sample (n = 60)

	Frequency (%)
AXIS – I	**53 (100)**
Adjustment disorder	5 (7.7)
Attention deficit and disruptive behavior disorder	2 (3.1)
Impulse control disorder NOS	1 (1.5)
Mood disorder	3 (4.6)
Paraphilia	24 (36.9)
Pervasive developmental disorder	12 (18.5)
Physical or sexual abuse of adult	1 (1.5)
Physical or sexual abuse or neglect of child	7 (10.8)
Schizophrenia and other psychotic disorders	3 (4.6)
Substance related disorder	7 (10.8)
AXIS – II	**65 (100)**
Antisocial personality disorder	8 (11.1)
Borderline personality disorder	5 (6.9)
Borderline intellectual functioning	2 (2.8)
Mild mental retardation	32 (44.4)
Moderate mental retardation	24 (33.3)
Severe mental retardation	1 (1.4)

The specific frequency and percentage of DSM-IV (American Psychiatric Association, 2000) Axis-I and Axis-II diagnoses of the participants are outlined in Table 1. These diagnoses were retrieved from file studies from the specific institution (hospital – prison) where the participants were residing. As can be seen in Table 1, on Axis I, the most prevalent diagnosis was paraphilia (36.9%) followed by pervasive developmental disorder (18.5%) and physical or sexual abuse or neglect of child (10.8%). On Axis II, the most prevalent personality disorder was borderline PD followed by antisocial PD. The ID classification of the total sample can be seen in Table 2. This classification was done using DSM-IV definitions for intellectual disability. Most of the forensic ID patients in this sample suffered from mild to moderate ID, with only 5 patients within the borderline intellectual functioning category and one within the severe MR category.

Table 2. Classification intellectual functioning of the forensic ID sample (n = 60)

	Frequency (%)
Borderline intellectual functioning (IQ = 71-84)	5 (8.3)
Mild mental retardation (IQ = 53-70)	34 (56.7)
Moderate mental retardation (IQ = 38-52)	20 (33.3)
Severe mental retardation (IQ = 23-37)	1 (1.7)
Total	**60 (100)**

This study was formally approved by the Central Ethical Committee of the University Hospital of Antwerp (Belgium) on August 30, 2010. Informed consent was obtained from the participants and their supervisors. When possible (i.e., mental state, no interference with treatment, no refusal to take part), interviews were done using the semi-structured PCL-R interview. The PCL:SV and PCL-R were scored by four researchers, all certified coders and with experience in coding the PCL-R and PCL:SV, based on the interview and all additional available case file information. Furthermore, demographic and criminological variables were listed.

Of the primarily male forensic ID sample, 80% had no partner and 85% had no children at the time of the offense. With regard to nationality and origin, participants were predominantly Belgian (96.7% and 93.3% respectively). A vast amount of participants (i.e., 36.7%) had previous convictions, 35% was previously interned, 50% either had a previous conviction or internment, and 61.7% had a history of psychiatric hospitalization. Furthermore, although in this research specific data about child abuse or neglect were not included, 21.7% of the sample got into contact with the juvenile court because they were raised in a problematic family situation and 77.6% did not live with both biological parents until the age of 16. At last, 90% of the sample received special education for people with intellectual disabilities ('*Buitengewoon Secundair Onderwijs*').

Table 3 summarizes the different criminological variables related to previous conviction -, internment -, and index offenses committed by the forensic ID sample in this study. As can be seen in this table, most of the index offenses related to sexual "hands-on" offenses against minors. Other more frequent index offenses were violent offenses, property offenses using violence and property offenses.

Table 3. Previous conviction, Internment, and Index offenses of the forensic ID sample

	Previous conviction offenses (%)	***Internment offenses (%)***	***Index offense (%)***
Offense against life	0 (0.0)	2 (0.8)	2 (3.3)
Other offense	13 (12.6)	11 (4.4)	0 (0.0)
Property offense	30 (29.1)	59 (23.4)	6 (10.0)
Property offense using violence	2 (1.9)	24 (9.5)	8 (13.3)
Sexual "hands-off" offense	1 (1.0)	7 (2.8)	1 (1.7)
Sexual "hands-off" offense against minor	0 (0.0)	8 (3.2)	1 (1.7)
Sexual "hands-on" offense	4 (3.9)	11 (4.4)	3 (5.0)
Sexual "hands-on" offense against minor	6 (5.8)	74 (29.4)	30 (50.0)
Traffic offense	35 (34.0)	19 (7.5)	0 (0.0)
Verbal violent offense	0 (0.0)	9 (3.6)	0 (0.0)
Violent offense	12 (11.7)	28 (11.1)	9 (15.0)
Total	**103 (100)**	**252 (100)**	**60 (100)**

We collected PCL-R and PCL:SV scores from 60 forensic ID patients. Mean, median, standard deviations, and range of psychopathy scores and factor scores can be found in Table 4. Furthermore, it can be stated that none of the forensic ID patients scored above the cut-off score of 30 on the PCL-R. The maximum score on the PCL-R was 29.5.

When calculating the psychometric properties of this sample, Cronbach's alpha of the PCL:SV was found to be high ($\alpha = .79$). Inter-rater reliability for the PCL:SV was obtained using PCL:SV scores rated by two independent raters for 24% ($n = 14$) of the total sample. Single measure ICC in this research is .78, which is excellent. Furthermore, Pearson's r correlations between the PCL-R and PCL:SV total scores was .79, $p < .01$ (two-tailed).

Table 4. PCL-R and PCL:SV scores, including factor scores, of the 60 forensic ID patients

	PCL-R total	PCL-R F1	PCL-R F2	PCL:SV total	PCL:SV F1	PCL:SV F2
N	60	60	60	60	60	60
Mean	14.97	6.52	6.51	10.18	5.32	4.77
Median	14.70	6.00	6.60	10.50	5.00	5.00
Standard deviation	5.89	2.76	3.63	4.32	2.42	3.03
Minimum	3	2	0	1.00	1	0
Maximum	29.50	15	14	20.00	12	11

PCL-R and PCL:SV total scores were further compared between the axis II diagnostic groups mild (n = 32) versus moderate (n = 24) mental retardation. For both the PCL-R (Mmild = 15.99, SDmild = 6.34 vs. Mmoderate = 14.10, SDmoderate = 5.56; t (54) = .18, p > .05) and PCL:SV (*M*mild = 10.69, *SD*mild = 4.65 vs. *M*moderate = 10.08, *SD*moderate = 4.65; *t* (54) = .05, *p* > .05), no significant group differences were found.

This study also looked at possible differences in mean psychopathy score, as measured by the PCL:SV, between the two groups in the project: 1. those in the residential settings of the psychiatric hospitals (PCL:SV; $n = 30$) and 2. those in the prisons (PCL:SV; $n = 29$). An independent samples t-test showed that there was a significant difference between PCL:SV scores in both groups (t (57) = 2.31, $p < .05$), with a significantly higher mean PCL:SV score for the hospital group ($M = 11.73$, $SD = 4.15$) compared to the prison group ($M = 9.10$, $SD = 4.59$).

To summarize, it can be concluded that the findings of this study provide initial evidence for the internal consistency and inter-rater reliability of the Dutch version of the PCL:SV (research version)[16] when applied in a forensic sample with ID. We found Cronbach's alpha to be comparable to that obtained in the PCL:SV standardization sample[15] and other international research in non-ID samples. Inter-rater reliability is consistent with those found in the standardization sample

and other international research in non-ID samples. Furthermore, the relationship between the PCL:SV and PCL-R was found to be high, giving construct validity to the PCL:SV

As the use of the Dutch language version of the PCL:SV is likely to increase in forensic populations, with and without ID, there is a need for more psychometric research to further support the scientific status of this instrument.

Conclusion and future

1. Progress has been made in the last years on understanding and assessing risk factors and more in particular psychopathy within forensic ID patients. Given this progress there still is room for improvement on several domains within this field. We will end our chapter with several recommendations for the future: research is still scarce and should focus on the psychometric properties and predictive validity of already developed specialised ID risk assessment tools and their relationship with the standard risk assessment tools. Furthermore explicit descriptions on how intellectual disability was assessed should be clear in those reports in order to facilitate meta-analytic work.
2. As it is for the general offender population, psychopathy is of relevance in this ID patient group, both for risk assessment, risk management and further treatment. In diagnosing psychopathy, caution continues to be indicated in the interpretation of PCL-R scores. Until now, PCL:SV should have the preference given the fact that problematic items for ID patients are left out the PCL:SV item pool. The data presented in this chapter also hint to this message. However, more research is certainly necessary.
3. Research is necessary to establish the psychometric properties of both the PCL-R and PCL:SV in forensic ID patients, in terms of independent inter-rater reliablility of psychopathy diagnoses across clinicians.
4. Careful consideration should be given to applying these labels (i.e., psychopathy and APD), which can have negative consequences for individuals with ID. Instead of stigmatization, future targets on treatment should be useful.
5. It might be interesting to further investigate moral reasoning for offending behaviour in offenders with intellectual disabilities.[34,35] These researchers argue that people with intellectual disabilities may have difficulties in developing moral reasoning and as a consequence, offenders with intellectual disabilities may require appropriate training and treatment to understand the relationship between a lack of moral reasoning and antisocial behaviour.

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Desistance by Social Context in Forensic Psychiatry

Yvonne H.A. Bouman, Moniek van der Logt, (Erik)B.H. Bulten

Introduction

In forensic psychiatry, the main objective is prevention of further criminal behaviour by patients suffering from a psychiatric disorder. In clinical settings, two means of prevention are being used: admission to an enclosed forensic facility and treatment of the dynamic factors related to the criminal behaviour. Within this last means lays the true challenge for forensic psychiatry. So far, many factors have been related to criminal recidivism, the majority of them being static, that is unchangeable. Only some dynamic factors have been consistently related to the risk of reoffending. Most studies which tried to relate dynamic factors to the risk of reoffending lacked a theory of behaviour and used dustbowl empiricism (1). Furthermore, individual and sets of risk factors seem to have limited significant predictive power in relation with criminal recidivism (2-5). New routes of improving knowledge on the subject of diminishing the risk of reoffending by forensic psychiatric patients are being sought, such as neuropsychological research, single subject studies, and the (re)introduction of positive psychology in the forensic field.

Besides individual patient characteristics such as anti-social cognitions, addiction and impulsivity, characteristics of the environment of a patient have been associated with criminal recidivism. One firm protective factor is admission to a secure setting. Because most relevant individual characteristics are static or stable dynamic factors(6), the controlling function of the secure setting should be transferred to other actors after the clinical treatment phase. Combining these pitfalls and new challenges, a theoretical basis for improving risk management for forensic psychiatric patients is explored in this chapter. Before we turn to the central theme of the chapter, we will briefly sketch the current thoughts on best practice.

What works principles

Best Practice can best be described by citing the principles which determine the effectiveness and efficiency of treatment of criminals in general and forensic psychiatric patients in particular. Based on an analysis of effective and efficient

treatment, Bonta and Andrews (7-8) identified various principles which should be followed in order to achieve effective treatment to reduce the risk of criminal recidivism. Besides the five well-known principles which they consider the most important, that is Risk, Need, Responsivity (RNR-principles), Professional discretion and Program delivery or Treatment integrity, they identified four less-known overarching principles (7):

- Respect for the person; which means that services are provided in an ethical, legal, just, moral, humane, and decent manner;
- Theory: in which they proclaim the use of a general personality and cognitive social theory;
- Human service: which advises to introduce human service delivery rather than relying on the severity of the penalty; and
- Crime prevention; by which they advocate that the theoretical and empirical base of RNR-based human service should be disseminated widely for purposes of enhanced crime prevention throughout the justice system and beyond (e.g., general mental health services)

Most of the underlying principles stem directly from the four abovementioned overall principles. They are grouped into RNR-principles, Structured assessment, Program delivery and Organizational. In relation with the general subject of the chapter, we would like to point out two principles named under structured assessment: Strengths and Breadth. Using the term strengths, they advise to assess personal strengths and integrate them into interventions. Breadth refers to the advice to assess specific RNR factors as well as non-criminogenic needs that may be barriers to prosocial change without losing the focus on criminogenic needs. In the Level of Service/Case Management Inventory (LS/CMI; 9), they ask the assessor to assess both criminogenic and non-criminogenic needs and to indicate whether a domain might be considered a strength, and as such function as a protective factor. Adhering to all principles would result in a holistic approach of the patient and his environment and could result in treatment according to best practice.

Protective factors

Although static and dynamic risk factors have shown only limited predictive validity, protective factors have been relatively neglected in risk assessment research (10) or in risk assessment tools. Five recently developed instruments are the exceptions: the Inventory of Offender Risk, Needs, and Strengths (IORNS; 11), the Short Term Assessment of Risk and Treatability (START; 12), the Structured Assessment of PROtective Factors for violence risk (SAPROF; 13-14), the Structured Assessment of Violence Risk in Youth (SAVRY; 15), and the Level of Service/Case Management Inventory (LS/CMI; 9). In the SAPROF,

protective factors are defined as "*Any characteristic of a person, his/her environment or situation which reduces the risk of future violent behavior*" (original italics; 14). Protective factors have been operationalized as the reverse of risk factors (12, 16-17), but they could also function (independently) either as mediator or as buffer for offending behaviour (18).

As mentioned in the definition of protective factors, elements from the environment can have a protective role. In de SAPROF, eight of the 17 factors describe the social or living situation a patient is in. The empirical evidence of the use of protective factors in combination with risk factors in forensic psychiatry is growing (see e.g. 19-30). However, most of these studies lack an integrated theory in which they try to explain the interplay between protective and risk factors, and in which desistance is explored and explained.

Desistance versus persistence

Basically, there are two types of (repeat) offenders: those who cease to commit criminal acts (desisters) and those who not have stopped their criminal behaviour, yet (persisters; 31). Following Serin and Lloyd (32), two elements are necessary for desistance: a history of multiple criminal acts and the subsequent cessation of all criminal behaviour. Others consider offenders who went from an active involvement in crime to a zero or near zero level desisters (33).Although desistance can be defined as occurring after the final criminal act, defining it as a process assists us in understanding it and, perhaps, in being able to influence the process. Desistance is therefore a change process. In order to be able to change, several stages have to be gone through (34): precontemplation, contemplation, preparation, action, and maintenance. Thus, desistance is directly tied to the psychological mechanisms that drive changes in criminal behaviour patterns (32).

Burnet identified three types of desisters (in 31): the avoiders, who are susceptible to punishment and rather take a different route in life; the converts, who denounce their previous criminal lifestyle, due to a inner transformation; and non-starters, who do not consider themselves criminals, but define their criminal behaviour as temporary derailments caused by a misfortunate co-occurrence of circumstances. Sampson and Laub (35) described five mechanisms of desistance: "(1) a "knifing off" of the past from the present; (2) opportunities for investment in new relationships that offer social support, growth, and new social networks; (3) forms of direct and indirect supervision and monitoring of behaviour; (4) structured routines that center more on family life and less on unstructured time with peers; and (5) situations that provide opportunities for identity transformation and that allow for the emergence of a new self or script". According to Maruna (36), these mechanisms by themselves will not result in a successful transformation process. Several intra-personal changes are required,

such as a changed self image, insight in the needs fulfilled by the criminal behaviour, and the discovery of a true self. Also several future oriented changes in opinion are need, for instance finding a socially acceptable goal in life, and a sense of control over one's life and future. Most criminological research aims at 'normal' offenders. In forensic psychiatry, the goal is the same, the route by which the goal will be reached may differ due to illness related characteristics which will interfere with the described mechanisms and possibility for intra-personal changes.

Mentally disordered desisters and persisters

Moffitt (37) made a distinction between life-course persistent offenders and adolescent-limited offenders. Most forensic psychiatric patients have committed their crimes which led to the charge which included forensic treatment as an adult. Furthermore, they can be characterised as either first- or repeat-offenders, and may therefore fall in one of the two mentioned categories or in a group of very late starters. Many of the characteristics associated with life-course persistent offenders (see e.g. 33) are also associated with personality disorders, especially cluster B (38). And many Dutch forensic psychiatric patients suffer from these types of disorders (39). Here, we therefore focus on a third group: the adult desisters. More specifically, we are interested in identifying and understanding desistance and persistence in mentally disordered adults and the mechanisms underlying the process of desistance. Several criminological theories address the problem of criminal persisters and desisters. Whether these theories are also applicable to mentally disordered offenders is unclear. For example, the General Strain Theory (GST; 40) does not seem useful for explaining criminal behaviour of forensic psychiatric patients. In the GST, the presence or absence of negative life events identify criminals who will persist or desist from criminal behaviour. In (forensic) patients with personality disorders, negative life events are very common and persistent (41-42), and can therefore not explain differences in pathways. Furthermore, by definition, positive life events, which have been associated with the process of desistance such as marriage, moving home or getting employed, are often problematic in patients with personality disorders. Because of the influence of the psychiatric disorders on the behaviour and lives of forensic patients, other explanatory routes might be called for. In a study on protective factors in forensic psychiatric outpatients (43), social institutions seemed to play an important role in criminal desistance as did more subjective measures such as satisfaction with health and finances, general psychological well-being and having a goal in life. This led to the idea that a combination of the social control theory with a theory with a base in psychological well-being such as the Good Lives Model might add to our knowledge on criminal desistance in forensic psychiatric patients.

Social Control theory

Using the longitudinal data of the Glueck couple on delinquent and non-delinquent boys in Boston (44), Sampson and Laub (45-46) expanded the data and used it for theoretical development. They added a new measurement (44) and developed a new version of Hirschi's 'Social Bonding Theory' (47), the age-graded theory of informal social control.

Their 'Age-graded Theory of Crime' is based on several assumptions. Sampson and Laub assume that everyone is capable of displaying deviant behaviour. Deviant behaviour is thereby seen as violating social norms and generally accepted standards in a society (45-46). The second major assumption Laub and Sampson (35, 46) make is that people can change as they get older. With respect to continuity in antisocial behaviour over the life course, they combine the ideas of state dependence (48) and cumulative continuity (37). Static factors and a chain of negative events and influences make people start and persist in deviant behaviour. Exploring processes of 'change', they think substantial heterogeneity in desistance from criminal careers cannot be explained by early life factors (35, 49-50). They look at changes in the lives of adult delinquents (51). The adult life course and changes in people's lives can explain changes in antisocial behaviour (49). They examine how the nature of social bonds changes as individuals change. In different stages in life, different social institutions and thus bonds are important (35, 46). Next to these changes, Sampson and Laub (35, 50) refer to an interaction between social context and the individual. The context shapes a person, his capacities and values, and in turn the person shapes its context (52).

With these assumptions, they set up hypotheses as to why people desist from deviant behaviour. Laub and Sampson (50) put socialization less central than Hirschi (53) by looking at both self-control and (in)formal control from social bonds. The probability of displaying deviant behaviour not only depends on the amount of self-control that disputes at the age of twelve like Gottfredson and Hirschi (54) stated (see also 55). Laub and Sampson (50) state that bonds with conventional society provide control and are therefore important in desisting crime. The more bonds one has with the conventional society (like social capital and participation in social institutions), the more involved this individual will be with the general goals and means and the less deviant behaviour he will display. The capacity, stability and quality of the bonds are important (power, conventionality, support and reach; 35, 46, 56-58). It determines the amount of institutional control (50). Re-establishing bonds to conventional society partly explains desistance from crime (45, 50). These bonds can be found in one's living environment, network or pastime. Social contacts can provide routine activities or institutional bonds and the other way around.

Sampson and Laub not only mentioned weak bonds and lack of control as an explanation for criminal behaviour during the life course (59). They also considered life events and human agency(the capacity to have control over

thinking processes, motivation and actions) important aspects (35, 60). Furthermore, they included routine-activities and historical context as important facets in their revised theory. Social control is still the underlying mechanism (35, 59), but turning points are now a central element (61). Changes in life, big or small, can have an enormous impact and become turning points. They can be transitions or (lead to) trajectories, short term or long term (50). Sampson and Laub (35) included these turning points in a life course because they can create new situations that offer opportunities and the chance of getting a different way of life (46, 60, 62).Turning points can 'knife off' the past from the present or offer the possibility to transform one's identity. Furthermore, turning points can provide opportunities to invest in new relationships that foster social support, a new network and growth and opportunities to be under direct or indirect supervision, monitoring and control. For instance, while getting older, unstructured time with friends can be replaced by structured family time. Such a turning point opens up the possibility to engage in conventional routine activities (35, 61).

Besides social capital, social bonds (via social control) and life events, the decision to persist in, or desist from crime depends on human agency. Human agency is the capacity to have control over thinking processes, motivation and actions. Bandura emphasized the role of self-efficacy in choices in behaviour (63). Believing in oneself is important. The external conventional norms that are imposed upon someone can be internalised (64). First, conventional relationships are important. Second, people learn from each other (64, 65) depending on their human agency. Human agency is an interactive concept that determines choices in life. The constraints of the context and the options available and someone's human agency are in constant interaction. The consequences of life events mentioned earlier, also depend on human agency (35, 50), again stressing the importance of the concept of human agency with regard to desistance.

Previous research

Looking at criminal behaviour, static factors are important but do not explain everything (45, 50, 66). The intensity and frequency of criminal paths fluctuate between people. Furthermore, some people start committing crimes at a later age. Static risk factors are predictors for crime, but cannot explain the development of the probability to commit crime during a life time (50, 66). This shows the importance of a life-course vision in research on desistance.

Previous research has shown that dynamic factors like a safe living environment, a job and a non-deviant social network are determinants for non-recidivism (50, 58, 67, 68). On the other hand, especially, the lack of bonds with social institutions later in life, like marriage and the labour market, positively relate with criminal behaviour (69). More specific for forensic patients, Hilterman, Philipse and De Graaf (70) found that a deviant network has a positive influence on the probability to commit serious recidivism during a leave of absence, but not recidivism in general. Recently, the role of life circumstances

in the existence of recidivism has also been studied among out-patient forensic psychiatry (43). In this out-patient population, people with organized leisure reported less criminal behaviour after six months. People with good contacts on the working floor and bonds with a club or union and church reported less violent behaviour (20). In a clinical forensic psychiatric setting, Gijsbers (71) found that patients with a greater network outside the hospital were less involved in physical aggressive incidents. A less supportive network increases the probability to display verbal aggressive behaviour. All these studies stress the importance of considering the role of social institutions in the process of criminal desistance.

Criticism

One of the developers of Social Control Theory, Hirschi (72), concluded that his theory could only to some extend explain criminal behaviour in adolescents. His theory underestimated the role of criminal companions and overestimated the role of involvement in conventional activities. Furthermore, he concluded that "failure to incorporate some notion of what delinquency does *for* the adolescent probably accounts for the failure of the theory in these areas. (original italics). Sampson and Laub did emphasize the individual process, but they did not succeed in individualizing their theory. Although human agency might take that role, the way they explored the concept seems to result in a rather unspecified and vague definition and operationalization of this concept. Other complementary routes are called for. The Good Lives Model (73) might bridge this gap by uncovering the human needs which criminal behaviour fulfilled for the offender, and trying to change the means to achieve those specific needs.

Good Lives Model[1]

In an elaboration on the RNR model, Ward, Melser and Yates (74) stated that a reduction of dynamic risk is "a necessary but not sufficient condition for effective treatment", and that, in conjunction with risk reduction, the promotion of human goods, which "are experiences and activities which are likely to result in enhanced levels of wellbeing" (75), should be taken into account when formulating treatment plans. In line with this critique, Ward and colleagues (73, 75-77) developed a treatment model, the good lives model, which is a strengths-based approach and offers forensic clinicians guidelines to target human goods (valued aspects of human functioning and living; 76). They proposed "that the best way to lower offending recidivism rates is to equip individuals with the tools to live more fulfilling lives rather then [sic] to simply

1 The following is partly derived from Bouman Y. Quality of life and criminal recidivism in forensic outpatients with personality disorders. A good lives approach. PhD thesis. Universiteit Maastricht. Maastricht: Gildeprint drukkerijen; 2009. p. 145-6.

develop increasingly sophisticated risk management measures and strategies" (76).

The risk-needs-responsivity model of treatment of forensic psychiatric (out) patients offers a general method covering treatment targets relevant to patients with personality disorders who are at risk of criminal recidivism. In the good lives model (73), a good or fulfilling life is said to contribute to reducing recidivism (76). According to Ward and colleagues, the risk-needs model "lacks the conceptual resources to adequately guide therapists and to engage offenders" (76) in treatment. They call the risk approach a pincushion model of treatment, with a pin representing a risk factor and treatment aiming at removing each individual pin (75), without considering the need this represents for the patient nor the whole of the patient. Rehabilitation should focus on reducing/avoiding risk and on promoting human goods: the GLM aims at incorporating both treatment aims. A good life becomes possible when an individual possesses the necessary conditions for achieving primary goods, has access to primary goods, lives a life characterized by the instantiation of these goods and when this is achieved in balance with the social obligations of community membership.

They propose that the GLM, among other things, "conceptualizes dynamic risk factors as distortions in the internal and external conditions required for the acquisition of human goods" (76). In the model, two levels of goods are distinguished: primary and secondary (or instrumental) goods. Primary human goods are "defined as actions, states of affaires, characteristics, experiences, and states of mind that are intrinsically beneficial to human beings". Instrumental or secondary goods "provide concrete ways of securing these goods". They list ten (or eleven; see 78) classes of basic human goods: life (including healthy living and functioning), knowledge, excellence in play and work (including mastery experiences), excellence in agency (i.e., autonomy and self-directness), inner peace (i.e., freedom from emotional turmoil and stress), friendship (including intimate, romantic and family relationships), community, spirituality (in the broad sense of finding meaning and purpose in life), happiness, and creativity (74). Ward and colleagues (74) distinguished six phases in the formulation of a treatment plan: (1) Identifying the problems a patient has and what criminogenic needs are evident, related to the offending behaviour (the detection of the clinical phenomena implicated in individuals' [...] offending); (2) Identifying the primary goods that are directly or indirectly linked to the offending behaviour; (3) Identifying the overarching goods and making these the primary focus in the treatment plan; (4) Selection of the secondary goods or values that specify how primary goods will be translated into ways of living and functioning; (5) Identification of the contexts or environments the person is likely to be living in; (6) Construction of a treatment plan based on the previous five phases.

The central assumption underlying the GLM is that "an individual is hypothesized to commit criminal offences because he lacks the capabilities to realize valued outcomes in personally fulfilling and socially acceptable ways" (75).

Every human being, and as such also forensic psychiatric patients, is goal directed and his goal is to achieve psychological well-being by obtaining and keeping primary goods. These goods are "states of affairs, states of mind, personal characteristics, activities, or experiences sought for their own sake" which are likely to increase psychological well-being. The good lives plan aims at realising the human needs which were related with the criminal behaviour in a prosocial manner. In turn, this aims at reduction of criminogenic needs, which may lead to criminal desistance.

Previous research

The empirical foundations for assumptions embedded in the GLM are only recently being built (see 74). Research on the general assumption that a good or fulfilling life diminishes the chance of re-offending has been scare. However, Bouman, Schene and de Ruiter (19) pointed at a possible positive connection between a fulfilling or meaningful life and reduced recidivism rates, which endorses the general GLM assumption. Mann and colleagues (79) found that patients who set their life goals in a positive, approach, manner were more happy, more successful and had a better psychological health than patients who employed an avoidance manner in setting life goals. Other efforts (see 78) are underway and have led to refinements in the model and identification of possible subgroups for whom adopting a good lives model approach might prove useful in preventing future criminal recidivism. They discerned a direct pathway by which the offence was committed in order to secure a particular good and an indirect pathway in which a good is inaccessible due to the absence of the appropriate means to achieve the primary good. Furthermore, the adoption of aspects of GLM into treatment planning has already proven useful with regard to reduction of recidivism in sexual offenders (80).

Criticism

Ward and colleagues consider each human good equally important for every person, despite possible insurmountable barriers to achieve a specific good. Another theory on psychological well-being, the Social Production Function theory (81) describes a mechanism of substitution by which an impossibility to achieve a certain good can be compensated by the achievement of a different good. Although the GLM includes a phase in which criminogenic needs are assessed, the focus in treatment seems to be on non-criminogenic needs. However, modification of non-criminogenic needs does little to alter recidivism risk (82). A dual focus on risk reduction and strengths enhancement seems the logical answer. Following the GLM, criminogenic needs and human needs are, directly, related. Whether non-criminogenic needs as mentioned in for instance the LS/CMI are the same as human needs as mentioned in the GLM should be examined empirically. Furthermore, addressing human needs may be defined as

responsivity in the RNR model, or as potential strengths. So far, adopting a GLM has proven useful, and the debate is still underway (83-85).

Human agency

Human agency, which is the capacity to have control over thinking processes, motivation and actions, is central to the age-graded theory of informal social control of Sampson & Laub (35). It is also one of the primary human goods that should be addressed in a GLM according to Ward and Steward (77). They used autonomy and self-directedness as examples of human agency. Two factors closely related to human agency are life framework and life fulfilment. Briefly, life framework refers to having a goal in life, and life fulfilment refers to the idea that a person is able to reach that goal (86). Both factors were significantly related to short-term violent behaviour or longer term criminal reconvictions in forensic outpatients with personality disorders or personality disorder characteristics (43). Both from a theoretical perspective and empirically founded, human agency merits inclusion in treatment and in risk assessment. One of the factors included in the SAPROF (14) aims at focussing the clinicians' attention to the possible protective function of having a purposeful perspective on the future by the patient and his ability to achieve (socially acceptable) life-goals. Social context also plays a role in human agency: "individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstances." (60). Whether human agency plays an important role in criminal desistance in forensic psychiatric patients needs a more comprehensive approach. The results so far have shown that it merits further attention in research.

Control and/or needs

Central to the Age-graded theory of Sampson and Laub in explaining desistance is (informal) social control through social institutions. The Good Lives Model puts central emphasis on (non)-criminogenic needs. Social institutions can provide means to secure goods, and could therefore be classified as secondary goods. In the GLM however, external control has not been incorporated as possible protective factor. It focuses on the ability of persons to change, despite possible insurmountable barriers. In the Social Control Theory, life events and human agency play important roles in criminal desistance. As mentioned earlier, negative life events occur on a regular basis in the lives of forensic patients with personality disorders. Positive events are far more rare in these patients, and it is unknown if these can surpass the negative events in their effect on behaviour(al

change). The role of human agency in disordered offenders requires further study. All approaches are promising in forensic psychiatric patients for explaining desistance, and all have their lacunae. The basis of the RNR principles might guide us in thinking about steps forward.

The RNR principles are based on Social Learning theory (9). The ability to change behaviour is related with the ability to learn. Central to the Social Learning theory are antecedents of behaviour, such as antecedent stimuli condition, modelling, instigators/facilitators, inhibitors, cognitive 'definitions of situation', expectations, self-regulation skills, self efficacy and self 'talk'/perception. Antecedents are followed by behaviour which results in consequences such as additive or subtractive rewards, additive or subtractive punishments, praise or blame, personal control, self consequation, group control, community control and intrinsic rewards. Consequences lead to feedback, which influences the antecedents. Basically, people learn from the consequences of their behaviour. Changing behaviour in a prosocial direction is strongly related to increasing desistance. Here lays also one of the biggest problems in trying to change the behaviour of some forensic psychiatric patients. For instance, in recent neuropsychological/neurophysiological research, forensic patients with psychopathy did not respond normally in learning situations (87, 88). Explaining or changing behaviour for this important subgroup of forensic psychiatric patients is still in its infancies. Furthermore, a punishment approach has proven contra-productive, both in a 'normal' criminal population as well in preventing recidivism in addicts.

Most criminological studies have focused on when people change, when they start or end their criminal carrier. Several factors co-occurring with desistance have been identified. However, this does not assist clinicians enough in aiding patients to change, because the how is not addressed. The conditions become more clear, which is a step forward. Next, however, attention should be paid to the process. Single subject studies and studies in the field of cognitive neuroscience can be helpful in this quest.

A good life with external control

Despite the abovementioned limitations, combining social control with addressing criminogenic needs in a good lives plan offers clinicians pathways to help forensic psychiatric patients to divert from to criminal path they have taken. Creating external control through participation in prosocial institutions will both replace the protective role of a secure setting, and offer ways of securing primary goods in a prosocial manner. Identification of criminogenic needs and treating them is paramount. Finding prosocial alternative means of securing these human goods likewise. However, we deal with generally very disturbed persons,

with persistent deviant behaviour. Solely addressing needs will not assist them in making different choices in the face of inevitable hardship. Focussing treatment of forensic psychiatric patients on both risk and protective factors, based on individualised theories of behaviour, will improve the chance that these offenders will desist from their criminal paths.

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Explaining Reoffending and Psychiatric Relapse in Youth Forensic Psychiatry from a Good Lives Model Perspective

C.S. Barendregt, A.M. van der Laan, I.L. Bongers, Ch. van Nieuwenhuizen

Introduction

Considerable progress has been made in youth forensic psychiatry with regard to risk assessment of incarcerated juvenile offenders. Risk assessment focuses on mapping the criminogenic risk factors in order to reduce reoffending (1). Until now, most research in youth forensic psychiatry has focused on the prediction or prevention of reoffending (1-6). However, the risk of reoffending is hard to interpret unless a life course perspective is taken into account since, during the life course of youngsters, changes occur in exposure to – and vulnerability for – risk factors (7). Changes related to important life transitions among juvenile offenders (e.g. incarceration, re-socializing, and getting a job after being incarcerated) can affect reoffending, because these transitions change exposure to risk factors (8). In addition, most incarcerated adolescents are diagnosed with (multiple) psychiatric disorders (9-11). Given the impact of psychiatric disorders on daily living, within youth forensic psychiatry the focus should be on reducing the risk of both reoffending and of psychiatric relapse. For example, Capaldi showed that the combination of conduct problems and depressive symptoms during adolescence was associated with poor adjustment outcomes later in life (12). Also, Wiesner et al., showed that depressive symptoms mediate the relationship between developmental risks and reoffending (13).

To understand the relationship between exposure to risk factors, life transitions and reoffending/psychiatric relapse, a broad conceptual framework with a life course perspective is needed. Therefore, the aim of this chapter is to depict such a conceptual framework and to clarify the processes by which exposure to risk and/or promotive factors and life course transitions can affect reoffending and psychiatric relapse. We describe the diverse aspects of the framework and the expected relationships between the concepts.

This chapter is structured as follows. First, we introduce the conceptual framework, which encompasses the Good Lives Model (14), the quality of life concept, risk and promotive factors, and life course transitions. Second, we elaborate on the Good Lives Model, its main component 'quality of life' and the expected relationship with reoffending, psychiatric relapse, and risk and/or

promotive factors. Third, we consider incarceration as a major transition in life. Finally, we outline persistent delinquency and desistance in relation to the Good Lives Model.

Conceptual framework on the development of adolescent offending behavior

Figure 1 presents a conceptual framework. This framework provides insight into the processes by which exposure to risk and/or promotive factors and important life events can affect reoffending and psychiatric relapse. This framework is based on the Good Lives Model-Comprehensive[1] (GLM-C) (14).

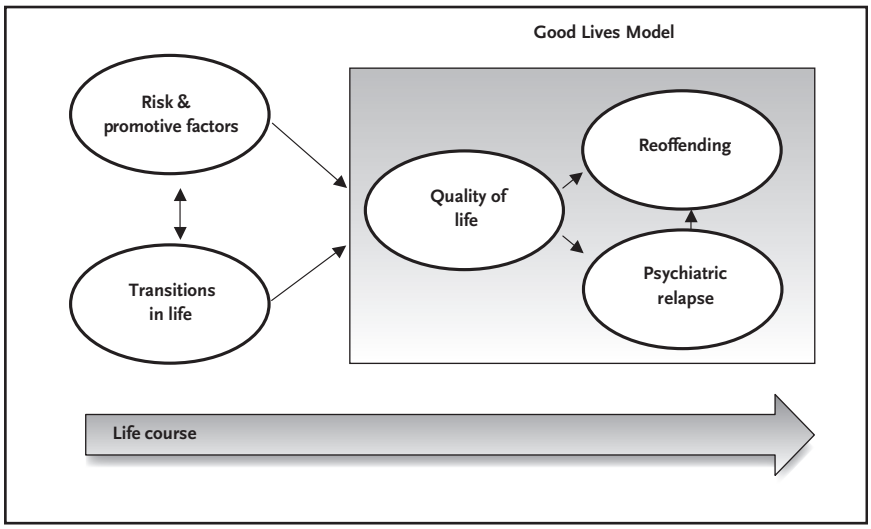

Figure 1. Conceptual framework for the development of offending behavior among adolescents.

The Good Lives Model is a rehabilitation theory which focuses mainly on adult offenders (14-18). The theory is strength-based, and its focus is on promoting human welfare and giving offenders the opportunity to use their personal capacities and skills to fulfill basic human goods (16). Enhancement of these skills and capacities increases an individual's quality of life, and can be used during rehabilitation to reduce reoffending and relapse. According to the Good Lives Model, the offender's quality of life has a direct effect on reoffending and

1 For details on the original Good Lives Model, see e.g. Ward, 2002; Ward & Brown, 2004.

relapse. Since the Good Lives Model is not specifically focused on the development of adolescents, we have added a life course perspective in order to use the framework as an explanation for reoffending and psychiatric relapse of juvenile offenders (See Figure 1). We expect the level of quality of life to mediate both the effects of risk/promotive factors and of life course transitions on reoffending and relapse (See Figure 1: left side). Since the Good Lives Model is used as the theoretical basis of the conceptual framework, the following section outlines the principles of the Good Lives Model.

The Good Lives Model

Introduction

The Good Lives Model is a rehabilitation and strength-based model focusing on the enhancement of offenders' internal and external capabilities (14). The Good Lives Model takes a holistic perspective; its core idea is that the best way to reduce risk of a relapse or reoffending is by helping offenders to change their old criminal lifestyle into a desirable alternative (16). The main aim in the treatment of an offender is to teach that person how to fulfill their personal basic goods in a positive, social and acceptable manner. According to the Good Lives Model, individuals look for ways to fulfill their primary human goods in order to increase their wellbeing. Self-agency is a core principle, since people flourish when making self-directed decisions with regard to their wellbeing (16). Hence, when individuals strive to obtain a high quality of life, they can feel satisfied in several life domains such as in family, school or leisure activities (15). High feelings of perceived quality of life may increase wellbeing, while low feelings of perceived quality of life may increase feelings of stress which may lead to acts of persistent delinquent behavior. In the latter case, conflicting interests may exist between the persistent offender and general society (for details see below: *GLM routes to offending*). According to the Good Lives Model, there is no single perfect life which fits every individual equally. Each individual determines the importance of the primary human goods for themselves (16). The individual importance of every primary human good, and an individual's personal capabilities and goals in life, will ultimately determine a person's own good life.

Primary and secondary human goods

In the Good Lives Model, primary human goods refer to personal characteristics, experiences, actions and states of mind that are beneficial in an intrinsically manner and are likely to increase wellbeing. Ward et al. mention 10 groups of primary human goods: life, knowledge, excellence in work and play, agency, inner peace, relatedness, community, spirituality, happiness and creativity (14, 19, 20). These groups of goods are not, however, exhaustive; some primary

human goods can be divided into different related goods (16). For instance, it is possible to divide the good of 'relatedness' into associated goods such as friendship, intimate relationship and family support.

To fulfill these primary goods, individuals require instrumental goods, also called secondary goods (17). Secondary goods are concrete ways or means to fulfill primary goods, e.g. having a job in order to fulfill the primary human good of 'excellence in work' (16). Secondary goods can be seen as tools to secure the primary human goods. In the Good Lives Model, the primary goods enhance levels of wellbeing, once fulfilled (14). There is not one good way of obtaining a high quality of life; everyone is guided by their own good lives model. From a Good Lives Model perspective, delinquency can be seen as a socially unacceptable and personally frustrating attempt to fulfill primary human goods. Not fulfilling basic goods by means of a socially responsible manner also has consequences for the experienced quality of life in other life domains. As said, the aim of the Good Lives Model is to help offenders to find a meaningful alternative for their old criminal lifestyle (16).

GLM routes to offending

Within the Good Lives Model, criminogenic needs or dynamic risk factors can block or frustrate the fulfillment of primary human goods (16). Individuals may be unable to secure primary goods because they lack the internal abilities or secondary goods. Offenders can experience four types of difficulties in fulfilling their primary human goods (16). First, as mentioned above, offenders may use inappropriate secondary goods to obtain primary goods. For instance, an offender wants to fulfill the primary good of 'relatedness' and to do so socializes with children. Second, offenders may have a lack of scope and therefore focus on a few primary goods, but neglect other goods. Third, conflict may arise by using conflicting secondary goods to secure primary goods, also causing stress. Finally, someone may lack skills, capabilities and/or access to secondary goods to fulfill their primary human goods. These problems that offenders may experience in fulfilling their primary human goods create stress, feelings of unhappiness and, ultimately, a lower perceived quality of life. Also, persistent delinquency may arise due to these problems in securing basic primary goods. Furthermore, these problems may increase the chance of (re-) offending. Bouman et al., showed that engagements in primary goods (e.g. structured leisure activities, good social contacts at work) are related to lower levels of reoffending (21). Thus, the absence of these factors may increase the chance of reoffending.

According to the Good Lives Model, two routes increase the onset and persistence of delinquency (16). The first route is a direct one in which antisocial behavior is a way to achieve a primary human good. For example, a sex offender may have sex with children in order to fulfill his primary good 'intimate friendship'. In the second more indirect route, obtaining a good (or a set of goods) creates stress in the personal circumstances, for instance when there is

conflict between two goods. The stress and frustration resulting from the conflict between two primary goods increases the possibility of antisocial behavior. For example, attachment to delinquent peers can be seen as an indirect route to the onset of offending because it creates a conflict between the primary human goods 'friendship' and 'community'. Thus, stated more generally, securing secondary goods is important in order to fulfill primary goods. That is, secondary goods are used to obtain primary human goods and offenders may use inappropriate strategies.

Empirical evidence for GLM

According to the Good Lives Model, quality of life has a direct effect on reoffending and psychiatric relapse. The occurrence of reoffending or a psychiatric relapse depends on whether the primary human goods are fulfilled and on the experienced quality of life. Whenever appropriate secondary goods are absent the risk of reoffending may increase (22), as can the risk of psychiatric relapse. For example, Willis and Grace compared non-recidivists with recidivists with regard to their personal reintegration plan, to explore whether recidivists would have poorer release planning than non-recidivists (22). They also studied whether secondary goods (defined as strategies to secure primary goods) were present in the reintegration plans. Results showed that recidivists had overall poorer reintegration planning than non-recidivists. Also, non-recidivists had more secondary goods in their reintegration plans and these goods were better targeted than the 10 primary human goods (22). Thus, secondary goods are important in the rehabilitation of offenders. The absence of secondary goods, or the use of inappropriate secondary goods, may lower perceived quality of life and may increase the chance of reoffending and psychiatric relapse.

Limitations of the GLM

The Good Lives Model focuses on enhancing wellbeing through the fulfillment of primary human goods to help offenders find a meaningful alternative for their criminal lifestyle. The (un-)fulfillment of these primary goods corresponds to the experienced quality of life (See Figure 1). Not fulfilling primary goods and/or using inappropriate secondary goods may decrease the quality of life and may ultimately lead to reoffending and/or psychiatric relapse (See Figure 1).

The Good Lives Model is not without flaws. The original Good Lives Model is vague with regard to what causes individuals to offend. In addition to the original Good Lives Model, some recommendations have been made concerning the lack of a theory of etiology. Although the Good Lives Model-Comprehensive gives more insight into the routes to offending, persistent delinquent behavior remains unexplained within these two routes. These routes describe the origin of criminal behavior, but do not explain why some individuals desist while others continue their criminal career. The Good Lives Model is unable to explain persistent delinquent behavior because of a lack of a life course perspective.

Therefore, in Figure 1, the life course perspective is added to the Good Lives Model to explain why some youngsters end their criminal career whereas others do not.

Moreover, the Good Lives Model neglects the influence of life course transitions in the lives of adolescents. For instance, incarceration can be seen as a transition in the life of a delinquent youth. The transition to incarceration may affect experienced quality of life and may increase the risk of reoffending. Therefore, life course transitions have been added to the conceptual framework in Figure 1. Before elaborating on life course transitions, we first discuss to the quality of life concept, since this is a central theme in the Good Lives Model.

Quality of Life

Introduction

In the Good Lives model, quality of life can be seen as a central concept. Quality of life is regarded as a general feeling of wellbeing and satisfaction across life domains (23). Although this concept has received considerable attention in other fields (e.g. medicine), it was not until the 1980s that quality of life was applied in the field of psychiatry (24, 25). Quality of life is multifaceted, composed of both objective and subjective indicators in several life domains (e.g. family relations, leisure activities, and work and education). Objective quality of life can be measured by, for instance, financial income and level of education. Subjective quality of life is assessed by measuring the perceived satisfaction with different parts of life.

Quality of Life in forensic psychiatry

Although quality of life has been increasingly applied in forensic psychiatry, it is applied far less in adolescent forensic psychiatry (26).Van Nieuwenhuizen et al., stated that quality of life is important for forensic psychiatric patients who have served their sentence and return into society (27), since a higher quality of life decreases the chance of reoffending and relapse (28-31). In this way, quality of life can be seen as an outcome measure of treatment (32).

Among adult forensic patients, a high quality of life and mental health are positively associated (33), whereas a low global subjective quality of life may lead to increased feelings of stress (33, 34). Furthermore, Bouman et al. found that among male forensic psychiatric outpatients a high quality of life may be a promotive factor against violent behavior, and this protective effect was found for both low and high risk groups of offenders (34). Moreover, if individuals are more satisfied with the fulfillment of their most important life domains, they are less likely to experience psychiatric relapse. Bastiaansen et al., showed that quality of life reported by self-report, parent report and clinicians, was associated

with child psychopathology (35). The Good Lives Model assumes a similar relation between securing human goods and psychological wellbeing.

As mentioned, in this field, research on quality of life is mainly limited to adults within a forensic psychiatric setting. Among male forensic psychiatric patients, results show a relation between experienced quality of life and offending behavior. From a life course perspective it is valuable to examine whether the relation between quality of life and reoffending and psychiatric relapse also holds true for adolescent offenders. Since adolescence is a period of development in which various changes occur, the perceived quality of life of youngsters differs from those experienced by adults. This developmental period is also seen as one in which antisocial behavior of youngsters can be influenced by providing them with a viable alternative for their criminal lifestyle (36). Moreover, additional factors may affect the relationship between quality of life and reoffending/psychiatric relapse, such as major life transitions, and age-specific risk and promotive factors. These factors are discussed in the following sections.

Reoffending and psychiatric relapse

According to the Good Lives Model, reducing the risk of reoffending and of psychiatric relapse among forensic patients is an important treatment goal (19). In the Good Lives Model, reoffending /psychiatric relapse are outcome measures resulting from difficulties in securing primary human goods. Indicators of reoffending include re-incarceration, re-arrest, probation or parole violations, self-reported offending after an intervention (37), and/or recidivism (38). Reoffending rates among incarcerated juvenile delinquents with severe conduct problems are very high (38-40). The reoffending rates of incarcerated youngsters with conduct problems range from 43% within a period of 2 years (38) up to 80% within a 5-year period (40).

A psychiatric relapse can increase the risk of reoffending. Psychiatric contacts after incarceration provide insight into the psychological development of these youngsters. This is important in order to prevent reoffending, since most acts of criminal behavior are related to some type of psychiatric disorder (9). Conduct disorders at a younger age are known to be a strong predictor of reoffending among juvenile and young adult offenders (41). For instance, Ostrowsky and Messner found that depressive symptoms predict reoffending among young adults (42). In a meta-analysis, Heilbrun et al. found that non-severe pathology was a medium strong predictor of reoffending among youngsters (37). The limited number of studies on the recurrence of psychiatric disorders among juvenile delinquents reveal high rates of relapse within a 1.5 to 3-year period after admission to treatment (43). A psychiatric relapse after admission to treatment may also increase the risk of persistent delinquent behavior corrected for

criminal propensity. Therefore, psychiatric relapse can also be seen as a unique risk factor for future reoffending (13).

In summary, compared to the large body of research with regard to reoffending, research on psychiatric relapse in relation to reoffending is scarce. According to the Good Lives Model, both reoffending and psychiatric relapse are outcome measures directly affected by the experienced quality of life. A high quality of life reduces the odds of reoffending and relapse, whereas a low quality of life increases the likelihood of it. Also, a psychiatric relapse has a mediating effect and increases the odds of reoffending. Since we propose a conceptual framework for the development of delinquency among incarcerated adolescent offenders, it is important to study which factors, besides the Good Lives Model, may have an effect on this development.

Risk and promotive factors

Age-specific risk and promotive factors might be associated with the experienced quality of life of juvenile offenders. With regard to sexual abuse, Ward et al. proposed that this misbehavior occurs as a consequence of a number of interacting causal factors (e.g. biological, ecological and psychological factors) (19). The interaction between these factors increases the likelihood of clinical problems, e.g. emotional problems, social difficulties and problems with empathy (16). These kinds of clinical problems hinder the fulfillment of primary human goods and can lower the experienced quality of life.

Studies have shown which risk factors increase the odds of reoffending and which decrease the odds (44-48). Risk factors are low intelligence, a difficult temperament (44), inconsistent parenting styles, neglect, divorce of parents (49), poor academic performance, low attachment to school (50, 51), associating with delinquent peers, and peer rejection (45). The cumulative risk hypothesis states that the more someone is exposed to risk factors in various life domains, the higher the chance of becoming a persistent or serious delinquent [See, e.g. (52)]. An accumulation of risk factors in several life domains, rather than a risk factor in a single domain, increases the likelihood of persistent and serious delinquent behavior (47). This cumulative risk hypothesis fits into the Good Lives Model.

However, regardless of the presence of risk, not every juvenile offender persists. The development of persistent antisocial behavior also depends on the absence of promotive factors (46-48). Promotive factors are a high socio-economic status neighborhood (47), low parental overprotection (48) and high IQ (53). Stouthamer-Loeber et al., found a counterbalancing effect, i.e. the likelihood of persistent delinquent behavior decreased when multiple promotive factors were present (47). Children with multiple promotive effects were at lower risk for developing persistent antisocial behavior during early adolescence (48).

In sum, to understand the development of (persistent) offending behavior among adolescents, risk and promotive factors are added to the basic conceptual framework. Risk factors may decrease and promotive factors may increase the experienced quality of life of juvenile offenders. It is important to include these factors, since these age-specific factors differ between adolescents and adults. Especially adolescents experience major transitions in their life which may affect their criminal development, incarceration being one of those transitions.

Incarceration as a major transition in life course

Apart from risk and promotive factors affecting the experienced quality of life, transitions in the life course, such as incarceration, have a major impact on quality of life (54-57). During the life course, and during adolescence in particular, individuals experience a variety of transitions which can affect persistence or desistance in crime. Transitions such as changing from primary to secondary school, from school to work, or from being single to married, affect development and have long-term behavioral effects (54). Major life transitions change the fulfillment of primary human goods, and can affect personal well-being on the short or long term. Therefore, transitions should be added to the framework of the Good Lives Model (See Figure 1).

In general, transitions in the life course (e.g. finding a job, being in a romantic relationship) may affect one's quality of life. Transitions in the life course affect the quality of life of an individual and can be a turning point (54). Almost all transitions are stressful, albeit some more than others. Transitions affect the basic goods of individuals through the accessibility of secondary goods. Finding a stable job creates a stable income and is associated with forming conventional bonds; both can have a promotive effect on persistent delinquent behavior (58). Having a romantic partner and establishing a family strengthens conventional bonds which may be promotive and decrease the likelihood of persistent delinquency (54). Strengthening conventional bonds decreases the probability of offending behavior among delinquents (54). A diversity of stressful life transitions can negatively affect basic goods and result in a lower quality of life. Since our focus is on adolescents who have been incarcerated, the transition of incarceration is addressed here in more detail.

Incarceration affects quality of life due to its impact (even on the short term) on primary human goods. First, incarceration itself restricts autonomy or self-directedness (limits agency), or limits contact with significant others (See e.g. 55, 59). Due to its negative effects on fulfilling primary human goods, incarceration can be very stressful and can lower an individual's quality of life. Incarceration is reported to be associated with lower social wellbeing (55-57), higher levels of stress (55, 59) and/or to increased likelihood of suicide attempts (57). Second,

incarceration threatens societal participation and educational opportunities on the long term (54). For example, it is difficult for former prisoners to obtain a certificate of good conduct (60), which diminishes their possibilities on the labor market.

Persistent delinquency, desistance and the Good Lives Model

To date, several theories have attempted to explain the development of (persistent) delinquent behavior during adolescence. These theories all emphasize the impact of risk/promotive factors and life course transitions in a different manner. According to Blokland et al., and Paternoster et al., these criminological theories can be divided into different groups (61, 62).

A first group, so called static theories, state that differences in the development of delinquent behavior are due to biological factors (e.g. personality traits) which remain relatively stable during the life course. From a static perspective, delinquent behavior can be seen as an inherited genetic abnormality. In contrast, dynamic theories, assume that the development of (delinquent) behavior may change over time. Behavior is affected by several factors (e.g. genetic and contextual variables) and the degree of influence may not be equal for all persons. The third group consists of typological theories. These theories assume that different offending trajectories exist and that all individuals can be assigned to either one of these trajectories. Furthermore, most of these theories also assume the existence of two groups; early and late starters of delinquent behavior. The most prominent typological theory is the dual taxonomy of Moffitt (63). The following section discusses these theories in more detail.

Static theories of delinquent behavior

According to static theories, some people are more prone than others to commit delinquent behavior, depending on their psychobiological characteristics. For example, personality traits, which remain stable over the life course, determine whether a person will grow into a delinquent lifestyle (64). Similarly, Gottfredson and Hirschi proposed a 'self-control theory' in which self-control is seen as a stable trait over the life course from age 8 years onwards (65). Individual differences in their proneness to commit delinquent acts depend on their level of self-control (65). People with less self-control have a high propensity for crime, while people with high self-control have a low propensity for delinquent behavior (65). The root cause of low self-control is reported to be inadequate parenting.

Dynamic theories of delinquent behavior

Sampson and Laub argued for a 'life-course theory' in which development is the output of a constant interaction between individuals and their changing environments in which turning points and transitions occur (54). This dynamic theory

suggests that certain changes in a person's life (e.g. life course transitions such as getting a job) can be a turning point and may have a direct effect on the development of offending behavior (54). Important in their theory are bonds that an individual has with conventional others. Sampson and Laub found that social conventional bonds can increase an individual's social capital and can lead to desistance of delinquent behavior (54). Being in a stable work environment can also have altering effects on criminal behavior, in that the more an individual has a connection to his or her job, the less involvement in criminal activities (54). The same is true for marital attachment; individuals with a steady marriage and healthy family ties are less involved in delinquent acts. Human agency also plays a role in the process of desistance in the 'life-course theory', i.e. individuals can choose actively to end their criminal lifestyle. In their studies, Sampson and Laub found considerable variability in the peak ages of criminal behavior; they also found that child and adolescent risk factors (e.g. IQ, temperament, and early onset of antisocial behavior) are not able to accurately predict differences in offending trajectories (54). Furthermore, Sampson and Laub state that all criminal career trajectories show a desistance in crime during the life course (54).

Typological theories of delinquent behavior

In contrast to the static and dynamic theories, which do not assume specific criminal career trajectories, Moffitt argued for a dual taxonomy in the development of delinquent behavior (63). A clear distinction between life-course persistent offenders and adolescence-limited offenders was made. According to a dual taxonomy model, both groups of offenders have a unique history and etiology. Life-course persistent adolescents persist in antisocial behavior throughout their lives; in spite of measures taken to correct their lifestyles, they continue their criminal career. Because these individuals display delinquent behavior at an early age, they had limited opportunities to acquire prosocial behavior. Adolescents in the life-course persistent group are characterized by neuropsychological deficits which interact with the criminogenic environment they are in through their development. This interaction of risk factors causes these individuals to persist in their delinquent behavior. The adolescence-limited category consists of a large group of individuals who only exhibit antisocial behavior during one period of their lives, i.e. during adolescence. This group is characterized by involvement with delinquent peers. Moffitt states that youth can experience a maturity gap, in which a discrepancy exists between their biological age and their social age. When delinquent behavior is no longer profitable or rewarding for them, they can fall back on prosocial behavior learned during childhood and early adolescence. They simply mature out of delinquency because it is no longer rewarding (63). Similarly, Patterson et al., made a clear distinction between early and late-onset offenders; disrupted family processes were a common variable among all early-onset offenders (66). Later research showed that criminal careers are not limited to two groups, but up to six groups. For instance, Moffitt et al.

added a third group, consisting of persons who were aggressive during their childhood but not very delinquent during adolescence (67). Other studies show the existence of multiple (more than two) trajectories within the development of delinquent behavior (68, 69). On average, 3-6 trajectories of criminal careers are generally found (69).

Where criminal career theories and the Good Lives Model meet

The Good Lives Model is a rehabilitation theory originally designed for adult offenders. To use the Good Lives Model as a theoretical background for the explanation of delinquent behavior among youngsters, it is necessary to add several components to the framework. The above-mentioned criminal career theories all tried to explain the development of antisocial behavior. Static theories assume biological characteristics (e.g. certain personality traits) to cause delinquent behavior, whereas life events (e.g. marriage) have no influence. However, Blokland and Nieuwbeerta showed that the development of delinquent behavior is influenced by individual life events (61). Since adolescence is a period in which multiple life events occur, it is important to add transitions in the life course to a model. According to the life-course theory of Sampson and Laub, transitions such as changing schools or getting a stable job can become turning points and have a direct effect on the persistence (or desistance) of delinquent behavior (54). Social bonds, created by life course transitions may create social capital and cause desistance from crime.

The conceptual framework proposed here (See Figure 1) offers more insight into the relation between transitions in the life course and the development of delinquent behavior. Weakening of conventional bonds can lower quality of life and, as a consequence, delinquent behavior may occur. For instance, incarceration may sever conventional bonds, which is a risk factor for persistent delinquency. Also, life course transitions may affect the fulfillment of primary human goods by means of the accessibility of secondary goods. Not fulfilling primary goods, or using inappropriate secondary goods, may lead to a lower quality of life and ultimately to reoffending and/or psychiatric relapse.

Both the dynamic and typological of theories include a life course perspective in which risk and promotive factors are important in persistent delinquent careers. Dynamic theories emphasize the importance of life events and life transitions in the development of delinquent behavior. Typological theories suggest that the criminal careers differ for several groups of offenders, depending on their exposure to risk and promotive factors. Although the Good Lives Model attempts to add elements of desistance to the theory by fulfilling goods that are not directly related to criminal behavior, this is not specifically geared to adolescents. To capture those age-specific risk and promotive factors within the development of criminal behavior, we have added those factors to the framework. The conceptual framework proposed in Figure 1, aims to give more insight into this 'black box' of the development of delinquent behavior by describing the

processes that occur between risk and promotive factors, life course transitions, and quality of life among adolescents. Important life transitions may affect the fulfillment of primary human goods through the accessibility of secondary goods.

Concluding remarks

This chapter aimed to provide more insight into the relationship between exposure to risk and promotive factors, important transitions in life, and reoffending/psychiatric relapse among incarcerated youngsters. To this end, a conceptual framework is proposed using the Good Lives Model as a theoretical basis. To explain the development of delinquent behavior among youngsters, we have added several components to the Good Lives Model. In line with the research of Sampson and Laub, specific life course transitions among adolescents have been added. These transitions may affect the persistence or desistance of offending behavior by having an effect on social bonds. For instance, incarceration may sever social bonds, resulting in the persistence of delinquent behavior. Finally, because age-specific risk and promotive factors may affect the experienced quality of life in various life domains of individuals, they are also added to the conceptual framework. This conceptual framework provides an aid to understanding the possible processes by which exposure to risk and/or promotive factors and life course transitions can affect reoffending and psychiatric relapse.

While most research within youth forensic psychiatry has focused on the mapping of criminogenic risk factors, the Good Lives Model assumes that rehabilitation should incorporate both the reduction of dynamic risk factors and the enhancement of wellbeing. According to the Good Lives Model, individuals look for ways to fulfill their primary human goods in order to increase their wellbeing. The (un-)fulfillment of these primary goods is dependent on secondary goods, and corresponds to the experienced quality of life. According to the Good Lives Model, offenders should acquire those internal/external capabilities and skills that will help them fulfill their needs in a more prosocial and socially accepted manner. Hence, individuals strive to obtain a high quality of life. As a consequence, individuals can then feel satisfied in several domains of their life. On the contrary, a low perceived quality of life increases the chance of reoffending.

Exposure to risk and promotive factors may not only increase the odds of reoffending, but also of psychiatric relapse. Given the influence of psychiatric disorders on multiple life domains, experiencing a psychiatric relapse can be seen as an important outcome measure within youth forensic psychiatry. Also, focusing on psychiatric relapse as an outcome measure is in line with the Good Lives Model. Within the Good Lives Model, the aim is to reduce risk by reducing

dynamic risk factors and enhancing wellbeing by promoting primary human goods. Thus, the Good Lives Model is not limited to those parts of an offender's life that are related to the criminal behavior, but instead covers all areas of life.

In sum, by using the Good Lives Model as a theoretical basis for the new proposed conceptual framework, we focus on the complete lives of incarcerated offenders in order to explain reoffending and psychiatric relapse. In taking this holistic approach to explain delinquent behavior among youngsters, we do not limit ourselves to those factors directly related to criminal behavior but, instead, focus on capacities and skills in all life domains. Like the Good Lives Model that states that sometimes it is better to target non-criminogenic needs, we have added several elements to the proposed framework that may not be directly related to reoffending or psychiatric relapse. These factors can have an impact on reoffending and psychiatric relapse through experienced quality of life. In this way, we expect youngsters with a higher experienced quality of life to desist from crime after discharge, while youngsters with a lower perceived quality of life are more likely to reoffend or to experience a psychiatric relapse.

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The Psyche of Women Committing Neonaticide A Psychological Study of Women who kill their Newborn Children

K.J. de Wijs-Heijlaerts, A.J. Verheugt, T.I. Oei

Introduction

Neonaticide is the biological mother taking the life of the newborn child within 24 hours of its birth. Several times a year in the Netherlands there is an uproar in society when the dead body of a newborn baby is found, wrapped up in a plastic bag, rolled in a towel, sometimes complete with umbilical cord and afterbirth, found under shrubbery, in a park or street, or in a house, in the attic, a bedroom or the basement. If the biological mother is found, she may sometimes say that she kept the pregnancy a secret from her environment, that she gave birth alone and that she subsequently took the life of the child, either passively or actively. Very frequently her environment was unaware of the biological mother's pregnancy, or of the baby's existence. In this day and age, when contraceptives and abortion are available, such a crime provokes not only revulsion and indignation in society, but it also calls forth incomprehension and raises many questions. There are questions about the personality of the culprit, her background, her environment, a possible motive and whether these kind of cases can be prevented. In this chapter we will try to find answers to three essential questions:

1. What is the personality of the person committing neonaticide?
2. What induced her to commit neonaticide?
3. What can be done to prevent neonaticide?

In order to find these answers, in this chapter the most important findings in available scientific psychological and psychiatric literature on neonaticide are outlined. Then the results of this study are reviewed, and recommendations for further research presented.

Review of literature

In order to present a picture of available literature on neonaticide we searched three databases, namely PsycInfo, PubMed and Embase. We used the following keywords: *neonaticide, murder or kill or homicide, newborn or baby/babies or*

neonate/infant, homicide or infanticide or murder. This resulted in 2227 hits, of which we considered 188 to be purely relevant to the review, namely those articles that deal with neonaticide with the emphasis on psycho(patho)logy and the perpetrator's motives. Articles which were not included for the greater part only deal with animal studies, studies of postpartem psychopathology, euthanasia of newborn children, girl killings in China and India, domestic violence during pregnancy, only the pathology relating to the autopsy of the newborn child (and not the psychopathology of the perpetrator), infanticide in the case of children with congenital defects and studies concerning ethical discussions of abortion and infanticide.

Since the denial and concealment of a pregnancy constitute an important part of the entire concept of neonaticide, another literature search was performed in the same databases with the following keywords. A search was performed with the keywords *pregnancy and denial, childbear, deny, denied or denying*, and *conceal*, excluding the hits that were found earlier. This search gave another 1281 hits, after selection leaving 57 hits as purely relevant to the review, as they had to do with denial of pregnancy and concealment of pregnancy in relation to neonaticide or as they dealt with the psychological dynamism behind these phenomena. Those articles that were purely medically oriented as far as pregnancy is concerned, without any link to its denial or concealment, those dealing with animal studies, denial in the sense of (auto) deprivation of proper gynaecological care, those that did not deal with the denial of the pregnancy itself but dealt with other matters during pregnancy (such as cancer, the consumption of alcohol, or smoking), or those dealing with the denial of infertility (during fertility treatments), were not considered.

A review of the relevant articles concerning neonaticide and denial and concealment of pregnancy yields the following picture.

Short historical summary

Neonaticide is a phenomenon of all times which occurred in all corners of the earth and in all layers of society. Already in ancient times people killed newborn children[1] who were not healthy enough in the eyes of the parents, or in times of extreme scarcity of food. In Greek and Roman times the birth of a child did not mean its automatic inclusion in the family. The father had the right to decide whether a child was to live after it was born, whether it would be killed or abandoned. The reasons that children were killed were mostly that they were deformed or illegitimate, or that the parents could not afford a child.[2] Many mythological stories from the period describe the killing or abandoning of newborn babies, as for instance in the legend of Zeus and Cronos, in which Cronos (the ruler of the gods), for fear of being dethroned by a son, would eat

every child his wife bore him, immediately after birth. This made his wife Rhea so unhappy that she thought up a ruse to save her next child from an identical fate and wrapped up a stone instead of her baby in a blanket and offered the package to her husband, who immediately devoured it. In this way her newborn son Zeus managed to escape his father's cruelty.[3] Another example is the story about king Oedipus, who is mainly known as the man who murdered his father and married his mother. This story opens with the father's attempt to kill the infant Oedipus, by abandoning him in the desolate mountains with severed tendons and tied feet.[4]

In the early Middle Ages in 787 AD the first asylum for abandoned infants was founded by Datheus, archbishop of Milan. In Scandinavia it was permissible to kill a child after birth, provided it had had nothing to eat or drink and had not been baptised.[5] In both England, France and China killing newborn girls was a frequent occurrence.[1,6,7,8]

In the Renaissance a change set in regarding child killing. If in the Middle Ages people could still feign ignorance of child killing, stricter legislation was made during the Enlightenment.[9]

However, in Italy many children died in their parental homes or in foster homes through neglect and malnutrition.[10]

In contrast to this, in Germany the penalties for killing a newborn child were far from mild: in Nuremberg between 1513 and 1777, 87 women were executed for infanticide. In England and France stricter laws regarding infanticide also came into effect. Every child killing carried the death penalty, and there was a reverse burden of proof: the person suspected of infanticide was considered guilty from the outset, instead of innocent until proven otherwise. So, the mother of a baby that was found dead was immediately considered to be guilty, unless she could demonstrate that the child had been stillborn or had died of natural causes, which in those days was very difficult to determine.[11]

The colonists witnessed the Indians in America practise infanticide in order to control the growth of the population[1] and both in Japan and India infanticide was principally practised to get rid of deformed children and unwanted girls.[12,13]

In the eighteenth century neonaticide was a prevalent phenomenon among maidservants,[14] who were employed by a family and who were also part of this family. Because of their tender age and the fact that they had to do without the protection of their own family, they were easy prey for the male members of the family. When they turned out to be pregnant, they concealed this pregnancy from their environment, because pregnancy might mean immediate dismissal. For fear of discovery the baby was often killed immediately after birth. In Amsterdam, of the 24 women accused of infanticide between the years 1680 and 1811, no fewer than 22 proved to be maidservants.[15]

In modern times many things have been done (especially in legislation) to promote the protection of (newborn) children, but this does by no means imply that neonaticide is a thing of the past. One important difference in the character

of infanticide in the twentieth century, as compared to preceding times, is found in the rise of (relatively) safe, medically sound and, in many countries also legal, abortion.[1] Generally speaking in a number of countries (among which are England and the Netherlands) legislation dealing with women who kill their newborn child has become milder. In England in 1922 the Infanticide Act was drawn up, which reduced the crime of infanticide from murder to manslaughter, in those cases of the woman killing her newborn child when she had not yet fully recovered from the effects of delivering her child as a result of which the balance of her mind was disturbed. In 1938 the Infanticide Act was widened to include children younger than 12 months killed by their mothers who had not yet fully recovered from the effects of delivery or who had become temporarily insane through the effects of breast-feeding.[1] This Act was widely criticised, because when the same mother killed her child who was older than 12 months, or who killed someone else entirely, it would be called murder instead of infanticide, whereas it would be possible that the mother was suffering from the same insanity.[16, 17]

In the Netherlands there are special sections of law dealing with neonaticide which were changed most recently in 1886. These sections seem to have been written to accommodate the harsh living conditions of the women (often maidservants) who committed such a crime. These are sections 290 and 291 of the Penal Code, dealing respectively with manslaughter and homicide in the case of an infant's death. Section 290 says: 'The mother who, operating under fear of discovery of her pregnancy, deliberately takes her child's life immediately or shortly after it was born, will, if found guilty of infant manslaughter, be punishable with imprisonment for a maximum of six years'. Section 291 of the Penal Code: 'The mother who, in the execution of a decision made while operating under fear of discovery of her approaching delivery, deliberately takes her child's life immediately or shortly after it was born, will, if found guilty of child homicide, be punishable with imprisonment for a maximum of nine years'. The main thing in these sections is the fear of discovery and not, as in the Infanticide Act in England, temporary insanity brought about by the effects of having delivered a baby. In the regular sections in the Dutch Penal Code dealing with manslaughter and homicide (sections 287 and 289 respectively) much higher sentences are laid down, namely a maximum of 20 years for manslaughter and a maximum of 30 years or life for murder. This law has not been changed since 1886, although the living conditions of (young) women have changed on the whole. In today's society, with a changed spirit of the times, in which there is less social disapproval of single and/or extra-marital motherhood and there are various remedies readily available to prevent pregnancy (through contraceptives, preservatives and sexual education) or the option to terminate the pregnancy within the legal time limit (by means of a morning-after pill or through abortion) and in which there is also the option of placing the child in the care of a third

party (by means of adoption), it is true that killing newborns is less frequent than in the past, but has not (yet) left society altogether.

The literature review's results which follow relate to the woman committing neonaticide in our time.

The woman committing neonaticide in present times

Demographic characteristics

Neonaticide is a crime that is almost exclusively committed by women and in which the perpetrator in practically all cases is the biological mother.[18,19] Neonaticide committed by the father is extremely rare. In the Netherlands on average four dead bodies of newborn babies are discovered per year.[20] Resnick was one of the first to describe the phenomenon of neonaticide, and he described, as the typical perpetrator of neonaticide, a generally young (sometimes even underage) woman, who is not in a steady relationship, still lives in the house of her parents, still goes to school, who does not ask for any prenatal assistance and who keeps the pregnancy concealed from her environment.[21] In most cases the victim is the perpetrator's first child. However, in recent years it emerged that neonaticide also occurs among married women who are already the mothers of a number of children.[22,23] Both the single, young women and the women who are in relationships and/or have already had children, generally commit one singular neonaticide, in which one baby is killed before they end up in the hands of justice. There are, however, also cases in which the woman once more becomes pregnant after the first neonaticide and acts in the same fashion as with her first neonaticide.[24,25,26,27]

Perpetrators of neonaticide generally speaking have no judiciary record[25,26] and in those cases where they have been in trouble with the law, this concerns relatively minor offences and only in rare cases acts of violence. Compared to women who kill older children this category is younger, more frequently single, and suffers less from mental disorders.[23]

As regards the pregnancy

It is mostly stated of the pregnancy that it is unplanned and unwanted and concealed from the environment for the entire gravidity. When a third party inquires after the possibility of a pregnancy, this is actively denied.[28,29,30] A number of women claim not to have been aware of the pregnancy, but in most cases they did know and the pregnancy was concealed from the outside world. In many cases the motive that is produced for the concealment of the pregnancy is the fear of discovery of the pregnancy, because – perhaps only in their own minds – this pregnancy would not be acceptable to their immediate environment.[33] Both during the pregnancy and during the delivery no third party

assistance of any kind is asked for. The delivery takes place in absolute isolation, but often in relative proximity to others, who may sometimes even be in the next room.[26] After its birth the baby is killed, mostly fairly rapidly, but in any case within 24 hours, either actively or passively, and the death is caused by the mother's inactivity rather than by her activity.[31] When the child has passed away the dead body is as it were laid aside and in many cases wrapped in several layers (of clothing and/or plastic), and kept in the woman's bedroom, or in an attic, in a basement or storage space. Afterwards no one is informed of the child's birth (and demise) and everyday life is resumed as if nothing has happened. One striking aspect is that some women, when they move home, move the dead body with them into the new abode.[28,31] In other cases the child is put with the garbage or abandoned post mortem in a nature reserve or elsewhere.[32] And then they turn to the order of the day, as if the pregnancy never took place.

Denial and concealment of pregnancy in a general sense

Concealment and denial of the pregnancy is not something that is exclusively found in neonaticide. The literature concerning this subject consists, for the larger part, of descriptions of case studies and has only a few studies of large groups of women who have denied their pregnancies. Denial of pregnancy is mostly defined as "a woman's subjective lack of awareness of being pregnant".[33,34] A distinction is made between the denial of the pregnancy and its concealment, as in the latter case there is an awareness of the pregnancy (often already at an early moment in the pregnancy), but in which the woman tells no one about it and wants to keep the pregnancy hidden to the outside world at all costs.[38,35] Beier et al. suggest in this case to use the term 'negated pregnancy', as an umbrella term for both denying and concealing the pregnancy.[38] A review in Berlin shows that denial of pregnancy after more than 20 weeks' gestation occurs once in 475 pregnancies (0.21%).[36] One in 2500 women (0.04%) keeps up this negation right up to the delivery,[37] a ratio equal to that of eclampsia (a form of toxaemia) during pregnancy.[38] It is an interesting fact that 8% of the women who had kept their pregnancy hidden had earlier already denied a pregnancy in the same way.[41] Denial of pregnancy is linked to potential risks, such as the absence of pre-natal care, ill-treatment of the unborn child in the sense of exposing it to harmful substances during pregnancy, postpartum psychiatric problems in the mother as a reaction to being taken by surprise by the confinement (without any assistance), as well as the risk of neonaticide.[39,40] A review by Wessel et al. of 69 newborns where the pregnancies had been denied by their mothers shows that compared to a group of children whose pregnancies had not been denied, they ran a greater risk of premature birth, lower birth weight, would lag behind in growth for the duration of the pregnancy and would have to stay in a neonatal intensive care unit.[37]

As a possible motive for denying c.q. concealing the pregnancy Nirmal et al. mention the conflict between the desire to have a child and the fear of losing it to

the Child Protection Services.[41] In addition to that an earlier history of substance abuse, early sexual trauma, being of a very tender age, external stressors and an earlier psychiatric history might also be risk factors.[41] Beier et al., however, maintain that in their review group of 66 women who had denied their pregnancy and twelve women who had kept their pregnancies hidden, the risk factors of low socio-economic status, tender age, low intelligence and naivety as regards sexuality and bodily functions do not apply.[38] This last factor is seen as possibly contributory to the occurrence of the denial of pregnancy, but not only women that go through their first pregnancy may deny the pregnancy.

The underlying psychopathology in women denying their pregnancies may be diverse. In many articles a distinction is made between a psychotic and a non-psychotic variant.[42,43,41,42] Psychotic denial frequently occurs with chronically mentally ill (often schizophrenic) women who may experience the physical symptoms of pregnancy but attribute them to delusional causes.[43] The denial of the pregnancy may be so persistent that in a number of cases it continues to exist, even after the birth of the child as 'most persuasive proof' has taken place.[43] Families of psychotic deniers are often aware of the pregnancy, as the patient does not take any trouble whatsoever to conceal her pregnancy.[47] Non-psychotic denial of pregnancy may be divided into three categories: *pervasive denial*, in which not only the emotional meaning but also the entire existence of the pregnancy remains outside the consciousness, *affective denial*, in which the woman is intellectually aware of the pregnancy, but makes only few emotional or physical preparations for the birth, and *persistent denial*, when the woman becomes aware of the pregnancy for the first time in the third trimester, but does not seek out any pre-natal care.[44]

For some considerable time now there have been people advocating the denial of pregnancy to be included as a special category within DSM and ICD classifications. Strauss et al. argued already in 1990 that denial of pregnancy should be considered as an adaptive disorder and should also be classified thus.[45] At the time the suggestion was to refer to this as a 'maladaptive denial of physical disorder' classification within the adaptive disorders in the DSM. Miller made a further differentiation by suggesting that it should be referred to as a 'condition' instead of a 'disorder', because strictly speaking a pregnancy is a physical condition and not a disorder.[46]

At the same time it was advised to specifically include pregnancy in the description of this affliction. It would be regarded as separate from the psychotic forms of denial and of the forms of concealment of pregnancy, in which the pregnancy is not denied by the woman herself.[50] This description of the denial of a physical condition as an adaptive disorder was not included in DSM-IV. Beier et al. suggest regarding the denial of pregnancy as a reproductive dysfunction which is not brought about by an organic disorder or illness and to incorporate it in the chapter 'sexual and gender identity disorders' of the DSM.[38] Still, it is questionable

whether the term 'reproductive dysfunction' is an adequate qualification, as it is not so much the reproductive system of the woman that breaks down, but its mental perception.

Though certainly a number of similarities can be found among women who deny their pregnancy, these women, first and foremost, are a heterogeneous group that does not display an unambiguous mental dynamism that holds good for all women.[39] Beier et al. emphasize therefore the importance of (continuous) observation of the individual presenting this phenomenon, in order to acquire a correct picture of the underlying individual pathology.[38]

Psychopathology of women committing neonaticide

Varying results are found in the literature about the mental health at the time of the offence of women committing neonaticide, but generally it concerns women who are in a mental sense relatively healthy, who at most contend with some personality problems. The majority of women who killed their newborn do not have any psychiatric history preceding the offence.[26,47] The personality problems found in these women are characterized by passivity, the tendency to repress unpleasant matters and to deny the existence of problems.[48] Their personality is further characterized by indecisiveness, emotional immaturity and not assuming their own responsibility. Spinelli describes the personality of the perpetrator of neonaticide as childish and with a certain *belle indifference*, which has no affect, in conformity with the situation in which the woman finds herself.[51] The most prominent characteristic during the pregnancy is that – in contrast to the average woman who is pregnant- no inner bonding with the as yet unborn child develops.[52] The pregnancy is generally felt to be unwanted and many women have stated to have been fearful of reactions to their pregnancy from their environment, and also of being abandoned by their parents and/or partner. The emotional immaturity in their personality gives rise to a form of magical thinking in some women after confrontation with their unwanted pregnancy: they suppose that the pregnancy will magically disappear if they think about it as little as possible.[35] Because of this no action is undertaken to find an adequate solution (for instance in the form of abortion, or adoption or any other way) for their situation. This passivity also leads to no preparation at all being made, neither for the childbirth, nor for the killing of the child. Fear of discovery keeps the pregnancy completely denied and concealed from the outside world. This denial by the mother may be so powerful that it also seems to have effects on the perception of the environment, which goes along in the denial of the pregnancy.[35,49] The strong denial may also lessen the physical presentation of the pregnancy. For example there is a number of cases in which during the pregnancy there was continued monthly loss of blood, very little weight increase and few other pregnancy characteristics such as nausea or increased frequency of mictio.[44]

During the pregnancy no third party assistance is sought, neither as regards the pregnancy in the form of pre-natal assistance, nor as regards their own mental wellbeing in the sense of mental health care.

In labour the approaching confinement becomes an ever increasing reality and many perpetrators of neonaticide become dissociated, and display symptoms of depersonalization and have the feeling that they are in a trance. Some women stated that they had the sensation of watching themselves from a distance, which are also known as autoscopic experiences.[36]

Related to this Nesca and Dalby provided the option that characteristics of a post traumatic stress disorder should also be taken in consideration on account of the dissociative elements at the time of the traumatic confinement, but further study into this has not yet been carried out.[50] Apart from these dissociative phenomena there is frequently no serious psychopathology in a narrower sense,[32,51] although some studies also mention psychotic phenomena.[25,36] There is generally no question of suicidality nor of suicidal intent,[20,26] not in the earlier history, and nor immediately after the offence. After the delivery everyday life is once more resumed and even then the pregnancy or the birth of the child does not play a role of any significance in the mother's perception of the world.

Motives

In most studies the motive for neonaticide is ordinarily classified as that of the 'unwanted child'.[25,32,52] The child being "unwanted" might for instance be based on the fact that it was illegitimately fathered, or because of economic conditions,[23] at the same time suggesting that getting rid of the pregnancy (or its result) might be the only motive. However, this does not explain why they did not resort to abortion at an earlier moment or why some women keep the body close to them for such a long time and, in doing so, seemingly cannot abandon the child post mortem. In the case of these women Oberman also refers to a certain ambivalence about their pregnancies, which contributes to their indecisiveness in action.[53] They live by the day and do not make plans towards the inescapable birth of the child. Pitt & Bale suggest a motive to be found in their relationships, namely that the fear of rejection by the parents or the partner should also be viewed as an important factor.[53]

Quite a few perpetrators of neonaticide claim they were unaware of the pregnancy and were completely taken by surprise when childbirth occurred, but according to Porter & Gavin this does not tally with the behaviour during childbirth.[32] For assistance is not called in, not even when the child is stillborn, whereas also then the normal reaction would be to call in assistance and not to push the child aside or to put it in the bin and to proceed with the order of the day. Putkonen et al. studied 32 cases of neonaticide in Finland over a period of 20 years (1980-2000) and apart from the child being unwanted found other motives: a panic situation, fear of desertion, and an inability to deal with the child.[33] In 66% of the cases the motive was unclear, however. They conclude that

in a prosperous country such as Finland the traditional stigma and economic reasons behind neonaticide are not the prime motives, but suggest that the background reasons are rather to be found in the perpetrator's psychology. Oberman also describes that women feel isolated from their environment and are fearful that they will be deserted when their pregnancy becomes known, whereas afterwards no such fear was justified.[57]

Study in the Netherlands

In the Netherlands the most recent study (2007) of neonaticide was carried out by Verheugt as part of his review of parents who kill their own children.[34] Covering a period of ten years (1994-2003) all cases of neonaticide were reviewed in which the mental faculties of the women involved were examined. Verheugt arrived at the following profile of the perpetrator of neonaticide: the woman who commits neonaticide is generally young, of indigenous origin, is single or has only incidental partner contacts and has very little involvement in intimate relationships with others. Regarding the dynamism the perpetrators of neonaticide display a strong ambivalence: the pregnancy must remain concealed at all costs (often for fear of losing the love of a partner or of the parents) and at the same time there is a strong wish that the pregnancy does get noticed, that searching questions are asked, but when this actually happens, everything is done to deny the pregnancy to the outside world. Verheugt also indicates that the dynamism of becoming pregnant in the testing of mental faculties is often omitted. Generally speaking, at any rate on superficial examination, the women who commit neonaticide function adequately and are mostly not suicidal. The (psychiatric) disorders that exist tend to develop especially in the run-up to the killing. Verheugt's review also indicates that a third of the entire group of parents who kill their own child lost a loved one who was still a child, so a little brother or sister, a (previous) child or a brother or sister of their parents.[34] The statistics for women who commit neonaticide are still to be researched.

Conclusion from literature review

Neonaticide is taking the life of newborns by their biological mothers, within 24 hours after childbirth. It is practised in all eras and in all cultures, mostly because of either harsh living conditions, such as poverty and scarcity of food, or in order to get rid of unwanted (deformed, illegitimate or female) newborns. In this day and age neonaticide is committed by relatively young, emotionally somewhat childish women and is characterized by keeping the pregnancy hidden for the environment, for fear of discovery, and after delivering the child taking its life either actively or passively. Then the mother continues with everyday life.

Denial and concealment of pregnancy are phenomena which – quite apart from neonaticide – more frequently occur in the case of women who are in some

cases already suffering from a psychiatric disorder. The personality problems found in women who commit neonaticide are characterized by passivity, the tendency to suppress difficult matters and to deny the existence of problems. On top of that indecisiveness, emotional immaturity and also an absence of a suitable affect regarding the pregnancy are also frequently identified. No bonding with the as yet unborn child develops and it is sometimes thought that the pregnancy will magically disappear if as little as possible thought is spent on it. During the birth of the child, which takes place in absolute isolation, to a greater or lesser extent dissociative symptoms develop in the mother. In the literature the stock motive for committing neonaticide is mostly given as that of the unwanted child, on account of the illegitimacy of the child or because of economic circumstances. Some studies, however, mention a few other possible motives, such as the fear of desertion, being in a panic situation and an inability to cope with the child. It is suggested to find the background motives in the perpetrator's psychology, rather than in environmental conditions.

Discussion

The available literature concerning neonaticide presents a picture of the demographic and social data of the women who resort to neonaticide, and also the characteristics of the crime and of the historical context of this phenomenon. This sheds a fair amount of light on the 'outside' of the phenomenon of neonaticide, but the present studies still shed too little light on the 'inside' of the perpetrator of neonaticide. Several studies[33,54] suggest that new research should focus on the psychology of the offender, rather than on the (socio-economic) circumstances of the women who commit this crime. In a time when there are many possibilities to prevent pregnancy, and there are also all kinds of alternative solutions available to deal with an unwanted pregnancy, it is most certainly of great importance to determine why a small number of women when confronted with an unwanted pregnancy nevertheless resort to keeping the pregnancy completely hidden from their environment and ultimately to take the life of the newborn child.

Whereas many studies regard neonaticide as a crime in reaction to an unwanted pregnancy, in our view neonaticide should sooner be considered as a 'tragedy in *four* acts': the first act is the (un)desired conception, the second the concealment of the pregnancy, the third the child's birth in isolation and either actively or passively taking its life, and the fourth act concealing the dead body of the newborn child and sometimes keeping it close by. There is sometimes also an epilogue, when the neonaticide comes to light and leads to a court case, but in some cases this is where the tragedy ends and in other cases the tragedy is repeated, when we are dealing with multiple neonaticide. The psychological

dynamism of each act should be examined, paying attention both to the specific dynamism of each individual act and to the psychological dynamism of the phenomenon as a whole.

Also within the group of perpetrators of neonaticide attention should be paid to the fact that this need not be a homogenous group, as Putkonen et al. already suggested,[33] which may be divided in a number of sub-groups. Especially the fact that there are women who are convicted after a single neonaticide and women who only after a series of killings of newborns have to answer for their crimes in court, raises the question whether in neonaticide we are always dealing with potential 'serial killers' or that there are rather two groups: women who do this once and women who will keep doing it unless they are stopped. There should be more longitudinal examination of this, especially with a view to prevention and risk assessment, of which as yet not much is known about this special group of women.

Another element that should be further examined in additional research is the systemic aspect of neonaticide: the environment plays an important part in not noticing the pregnancy and in a number of cases also supplies an additional motive for the killing, namely that the mother's perception is that she dare not make her pregnancy known to her environment. Some women also indicate that they would have liked third parties to ask searching questions when they denied being pregnant. Amon et al. emphasize also the role of the environment; they stress that this role is especially characterized by a certain lack of concern and indifference regarding the woman in question.[58] What dynamism is at play here? From what kind of families do these women come? Is there a fear of losing a relationship with the parents or with a partner? Or is there after all (also) an aspect of revenge on the direct environment which insufficiently notices the pregnancy (and in so doing also the woman concerned)? Many questions regarding the systemic context of neonaticide still remain unanswered and should be more closely addressed in further research.

In most studies of neonaticide the stock diagnosis of the motive for the offence is that of the 'unwanted child'. Although a number of studies also indicate that fear of desertion of a significant other (for instance parents or a partner) also plays a role, only occasionally a study[33] suggests alternative motives for killing the newborn child. The following motives are given: a panic situation, fear of desertion, and inability to cope with the child. Verheugt also mentions the fear of desertion by partner or parents as a possible motive for neonaticide.[34] Extensive further research should be carried out into these alternative motives. For instance in no study up to now was any attention paid to the possibility that concealing the pregnancy and in so doing not acknowledging the life of the child to the outside world might be a motive in itself. In an unconcealed pregnancy the future mother shares the news of the approach of her baby with her environment and thus as it were already slightly detaches the baby from its symbiosis with herself. In this way the baby acquires a meaning also to others and then more

people are looking forward to the birth of the baby. The result is that the baby starts to 'live' for several people before its birth. This 'allowing to live' is something a mother does for her child, in order to create an environment that is receptive and that offers enough support for the child to grow and develop. Nothing even approaching this happens in the behaviour of the perpetrator of neonaticide and even in the woman's own perception the existence of the child is denied. The role of denial of pregnancy and the possibility to regard this as a motive in itself (possibly precisely in those cases where women have committed multiple neonaticide) should be further researched. Also the function of the repetitive aspect needs further (in depth) diagnostics.

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On Forgery and Destruction in Art, Crime and Mental Illness

Frans Koenraadt

1 Introduction

The person who has the sole right, the monopoly, to damage a work of art, is the artist himself. What then makes it necessary or attractive for others to forge or damage a painting? It is true that these are two very different acts of criminal behavior regarding artwork, but to whom does it occur to act in these manners? In order to answer these questions, two remarkable cases will be discussed. The cases themselves and the backgrounds of the two perpetrators, Han van Meegeren (1889-1947), accused of art forgery, and Hans-Joachim B. (1937-2009), accused of repeatedly damaging art, as well as the role experts played in both cases will be elucidated and compared. This is discussed against the backdrop of the role that criminal law plays in these cases.

The attraction of art with regard to criminality unmistakably finds its origin in the big value of objects of art. Certainly not solely their economical value, but also their cultural and emotional value is of importance. The value of art is a perfect example of a result of a social construction, under the influence of an artistic network made up of mostly artists, collectors, museums, auction houses and art scholars (1). With his actions the forger as well as the vandal of art strives to influence the (socially constructed) value. These crimes mostly concern male perpetrators (2). This brings with it power and satisfaction, but additionally signs of triumph can be observed. The uniqueness of the original masterpiece makes it inherently irreplaceable (3). The perpetrator of art forgery defies this uniqueness and the art vandal, especially one who destroys art, proves the irreplaceable character of said art. The criminal law scholar Kelk has pointed out that damaging works of art is viewed as morally worse and a more comprehensive crime than mere vandalizing of property resulting in permanent damage to the object. Rather, people experience art vandalism as a form of art maltreatment or if it concerns destruction as 'art murder' or 'art manslaughter'. Kelk argues that the occurrence of personification of art does not only appear with regard to art vandalism, but also with regard to art forgery: "the feelings for the artwork strongly resemble feelings that one would normally have for important people in their lives. The authenticity of the work means that the artist is connected to his work as the father to his child and that his physical contact with the piece is

experienced in the painting itself. As a carrier of this contact the painting is perceived as an extension of the painter, as a personal and physical manifestation of the painter. Due to the discovery of the forged nature of the painting one undoubtedly is disillusioned regarding the believed integrity of the masterpiece. This is suddenly found to have been tainted by a dark, unknown hand" (4).

Similarities between art and criminal law are numerous. Remmelink discusses art as a criminal instrument (like scornful blasphemy, insult, insulting the Queen and (child) pornography by means of art) and as an object of a legal offense (art theft or art fraud) (5). Precisely the 'art exception' tries to prevent that for example making or exhibiting nudes is qualified as criminal behavior in the sense that it 'is offensive against public morals'. Some other connections between art and crime are those where criminal ideas of delinquents are inspired by art (6) or where delinquent behavior is reproduced in pieces of art.

Between art and psychiatry there is also an existing bond, in several varieties. The soul expresses itself in pictures for example (7), and pathological ideas of patients are reflected in their artwork (8). An entrance into the systematic reconstruction of the processes of esthetic development thus becomes possible (9).

2 Art that was forged

When shortly after World War II, in May 1945, in the art collection belonging to Reichsmarshall Herman Göring *Christ with the Adulteress was* found, it led via middlemen to Han van Meegeren, a painter and dealer in paintings, who was faring not badly indeed. When asked where he acquired his paintings, the answer remained a question, until, when accused of collaboration, he admitted that the work of art is not by Vermeer, but that he himself is in fact the artist. In the Netherlands a few weeks after the liberation from the Germans, on 29 May 1945, Van Meegeren was arrested. Further research revealed that he painted *Christ with the Adulteress* in 1941 and sold it in 1943 to Göring for 1.650.000 Dutch Guilders. But that was not all. After two weeks of incarceration Van Meegeren also confessed having forged *Supper at Emmaus*. He painted *Supper at Emmaus* in 1936-1937, which later on would be identified by famous art expert Bredius as a work of Vermeer and which is praised by Bredius for being the climax of Vermeer's oeuvre. With significant financial help this piece was acquired and on June 18 1938 *Supper at Emmaus* was officially handed over to *Museum Boymans van Beuningen* in Rotterdam. When between June 25 and 16 October 1938 this museum displayed the exhibition *Masterpieces from four centuries 1400-1800, Supper at Emmaus* was its main attraction.

2.1 THE ACCUSATION

Han van Meegeren was accused of fraud by means of selling paintings forged and signed by himself to the Dutch government. He admitted to this accusation (10). It needs to be stressed that Van Meegeren did not in fact copy existing paintings, but that he created paintings that were in line with what experts viewed as typically Vermeer's work in the 1930s (11). So it happened that 'new' work by Vermeer could be added to his oeuvre.

Even though an accused has a right against self-incrimination, Van Meegeren was almost too eager to deliver evidence against himself. During the preliminary judicial investigation he was moved to the top floor of the *Bureau Vermogensvlucht* in Amsterdam, an institute charged with finding goods stolen from the Netherlands during 1943-1948. He promised not to escape and stayed on the top floor, which also functioned as an atelier. Paintings from his atelier were even brought over to get him in the right mood. There, mid 1945, he created a painting in the style of Vermeer's *Young Christ in the temple* under direct scrutiny of judicial employees (12). Shortly hereafter the preventive detention was suspended and he was released awaiting trial.

On top of the forged painting found in Göring's collection, he also confessed to having forged five more paintings allegedly created by Vermeer, (one of which was in the *Museum Boymans van Beuningen*, another in the *Rijksmuseum* in Amsterdam). He also claimed to have painted to 'Pieter de Hooghs'.

To answer the question whether the paintings that Van Meegeren claimed to have made, were created in the seventeenth or in the twentieth century, it was crucial that it could be determined that the paint used contained not drying oil, but an artificial resin, a modern product only used from the twentieth century onwards (13-14). Criminalistic research by Froentjes c.s. confirmed that this criterion was met.

2.2 THE PERPETRATOR

On the tenth of October 1889 Han van Meegeren was born in Deventer, the third child in line. Without any problems he finished elementary school as well as the Higher Vocational School. He went on to study engineering in Delft, but did not graduate since he devoted himself – against his father's wishes – to drawing and painting.

In the spring of 1912 he married Anna de Voogt. In that same year, 1912, his son Jacques was born and in 1914 his daughter Pauline (later Inez) was born. On March 23 1923 Han van Meegeren and Anna de Voogt divorced.

Due to not being properly recognized as an artist Van Meegeren claims to have started making forgeries. On the one hand he wanted his own identity, on the other he wanted to test experts. For these experts played a crucial part in

determining the authenticity and value of these works of art. Others claim that a hunger for money was his true motivator.

From an objective point of view there was no reason for misrecognition, but the discrepancy between his feelings of misrecognition and reality was large. In that period of his life he had few or no intimate relationships, friends. This large discrepancy between his feelings and reality was visible in the bottomless pit of his strive for recognition and in his narcissism. When he was not put forward as Head of the *Haagsche Kunstkring*, an organization for art enthusiasts and artists, he left for the south of France where he worked in relative solitude. Even roommates were denied access to parts of his atelier.

In the many publications on the Van Meegeren case, experts play an important role (15), namely the art experts and the criminalistic experts. With the Van Meegeren case art forging earned a prominent place in Dutch criminalistics. This is mainly because of the efforts made by the later professor in criminalistics W. Froentjes (16-17). A mostly unnoticed part was played by a forensic psychiatric assessment of March 1947 of Han van Meegeren by psychiatrists L. van der Horst and S.P. Tammenoms Bakker as ordered by the investigative judge for the purpose of the criminal trial. The report confirms officially several characteristics that laymen had already described in psychiatric and psychological areas, before as well as after the conviction.

Phenomena of a psychotic nature were not found during the assessment. The reporting psychiatrists note furthermore that he did encounter exceptional situations in his personal history. Visionairy experiences, whereby his strong visual imagination had a great influence upon the content of the consciousness, also occur.

About his mood the reporters note that this was tidy and always about the same, whereby he leans towards the humorous, but in a cynical and sarcastic sense. His mental faculties are estimated as having developed exceptionally well, whilst having a high level of ready knowledge, a very good memory and ditto imprinting. They call him erudite regarding literary.

On the basis of his personal history and results of the inquiry the experts decide that the subject has psychopathological characteristics pointing towards psychopathy. He is a narcissist. They conclude that they are dealing with 'a very sensible personality, whose affections are swayed easily and who lived in an environment, in which rivalry played a big role.' They state that for these personalities opportunities easily lead to rancor. The overrated ideas, that then come to life, lead to a state without criticism, causing the subject not to recognize his unsocial behavior.

He does not suffer a mental disorder or a defective development of his mental abilities, meaning he is not rendered insane, according to the forensic psychiatric experts. They do regard him 'a person who on the basis of his predisposition, his distorted attitude to life, his unharmonious and socially unadapted expressions like an unbalanced, neurotic, insufficiently integrated personality with a strong

tendency toward vegetative and vasomotoric disorders, that therefore easily comes to unsocial actions and situations of conflict.' Finally they add to their report that of such a constitution it is expected that he will react badly to incarceration, as proved in the past.

Because strictly taken there was nothing new in forensic psychiatric sense and criminalistic expertise was vital in this case, the part forensic psychiatry played remained small, especially when compared to criminalistics. However, the psychiatric estimation that he would have great difficulty with incarceration, would prove to be very crucial indeed.

2.3 THE JUDGMENT

On October 29 1947, Han van Meegeren stands trial before the Amsterdam court. On November 12 1947 he is convicted of fraud, his punishment is one year of unconditional imprisonment, according to articles 326 and 326bis of the Dutch Criminal Code. For making *Supper at Emmaus* Van Meegeren could not be convicted since the fact had exceeded the statute of limitations in 1947 (18). Shortly after having been convicted by the Court, he is moved to the Valerius mental hospital in Amsterdam due to psychiatric deterioration, as predicted by the psychiatric reporters, where he deceases on 30 December 1947. The cause of death remains unclear.

2.4 COMMENT

In his psychopathological analysis of *The swindler*, the Dutch forensic psychiatrist Zeegers (1959) describes the perpetrator from an anthropological perspective. He states that committing deception offenses requires a certain achievement, different from that in other crimes. In cases of theft and embezzlement the offender appropriates any good, but in the rule he does not meet his victim. In contrast, the swindler has primarily to do with a person, he tries to move to an act; and then still an act that is against the interest of that victim. The victim in this crime plays an active role too, and the offender can never go unnoticed. Here the methods are of a more subtle nature. No violence, threat or coercion are the weapons of the swindler. He should be able to acquire unearned trust (19). For the swindler the contact with the victim is necessary, a contact where he tries to convince the victim. A playful and manipulative contact where the victim is fooled by the weak spot. This affective contact between swindler and his victim remains unauthentic. Although the swindler is mostly socially very competent there remains a lack of empathy.

Lenain (2012) states that van Meegeren condemned himself to an inescapable frustration. It was impossible for him to share the delectation of being so right against those consecrated experts whose next of kin, the art critics, had openly despised him at the beginning of his career. The author considers Van

Meegeren's case as "the typical story of the loner defying the establishment, and winning. Last but not least, Van Meegeren declared that his initial intention was to reveal the secret side of things: he wanted to expose the pompous imbecility of the so-called specialists and, by the same token, prove his own excellence as an artist. During his trial he explained that financial gain was not a consideration, at least not in the beginning. Of' course he had to set the price high enough, but he claimed that his initial project was to disclose the truth himself afterwards, which would have meant returning the money as well." (20)

A remarkable change appears in the attention for Van Meegeren: during the time of his arrest his attitude toward the Germans and his alleged collaboration is the focal point of the investigation, only to be replaced by his forgeries merely one year later. Van Meegeren and his case have, mostly posthumously, been a model for various literary (21) (22) (23) (24) (25) and scientific publications. Also in public debate the Van Meegeren case has become well-known to people in favor or against, believers and non-believers, concerning the genuine nature of the challenged works of art. Jo Spier drew two distinguished gentlemen in *Op de valreep* (at the last minute), both inspecting a painting critically, accompanied by the following text: "I have bought it as a Van Meegeren, but sometimes I fear it is a plain Vermeer." (26)

In 1996 the *Kunsthal* in Rotterdam and the *Museum Bredius* in The Hague dedicated exhibitions to Van Meegeren's art work.

3 Art that has been damaged

Where youths commit vandalism in groups, art vandals and iconoclasts usually work alone (27). They are mostly older and act alone. Empirical research in England reveals that these perpetrators often suffer from psychological problems (28).

On June 25 2006 the Netherlands was struck by surprise when an elderly man damaged the *Banquet of the Amsterdam Civic Guard in Celebration of the Peace of Münster*, a 1648 painting by Bartholomeus van der Helst (1613-1670) housed in the Philips Wing of the Rijksmuseum in Amsterdam. He sprayed lighter fluid on the painting and lit it up. The museum's surveillance personnel caught Hans-Joachim B. and handed him over to the police. A surface area of half a meter by a meter and a half was severely damaged: the coat of paint was damaged and the varnish was charred. Due to the use of water to extinguish the fire other parts of the painting were also damaged. Finally the frame also suffered damage.

3.1 A SERIES OF DAMAGES

Between 1977 and 1988 Hans-Joachim B. damages more than fifty pieces of art in German museums, public exhibitions, parks, churches and cemeteries resulting into a total estimated cost of 130 million euro.

His first target was the painting *Golden Fish* by Paul Klee in the Kunsthalle Hamburg. Further attacks followed in Lübeck, Hannover (on Rubens' *Archduke Albrecht*), Düsseldorf, Lüneburg, Essen, Bochum and Kassel. In Kassel, he managed to damage three masterpieces by Rembrandt and three by other Dutch painters, causing over 25 million Dutch Guilders of damage. In 1977 he was sentenced to five years of imprisonment by the *Landesgericht* in Hamburg.

Shortly after his release in 1984 Hans-Joachim B. lit a construction machine on fire resulting in three more years of imprisonment. During his probation on April 21, 1988 he corroded three masterpieces by Albrecht Dürer with hydrochloric acid in the *Alte Pinokothek* in Munich. They were: *Mater Dolarosa, Paumgartner-Altar* and the *Lamentation for Christ*, adding a further 50 million euro of destruction to his total. Hans-Joachim B. was sentenced to two years of imprisonment with psychiatric treatment. The Regional Court in Munich assumed that his crimes were motivated by feelings of hate and resentment towards society. He was diagnosed with anxiety disorders and obsessive compulsive disorders.

The perpetrator often damaged paintings using acidic or corrosive substances. Through his modus operandus he acquired several names in the (foreign) press such as 'Acid Assassin' or 'Säureattentäter' and 'Säurespritzer' (acid sprayer), in Dutch media he was baptized similarly: the 'zuurvandaal' (acid vandal). A perpetrator of these crimes is not concerned with striking the painter of these masterpieces. He is concerned with the authority of the art, the object of his affection or hate. On the moment of the attack the perpetrator is equal to the prominence and power of the piece of art he is destroying (29).

3.2 THE PERPETRATOR

Hans Joachim B. was born in 1937 in Breslau, Germany. He was the second child in a family of four. Initially he was in good contact with his father, but he developed a severe anxiety towards this strict man. Often there was marital strife between the parents which Hans Joachim and his siblings often witnessed. He was neglected by his mother, for instance, she forgot to enlist him in elementary school, resulting in Hans Joachim attending school for the first time several years too late. At the age of two he barely made it out of a well alive, after falling in and being rescued just in time. As a result of the war his father had a prolonged absence. Starting in his puberty he has had an indescribable and incomprehensible anxiety, a stress anxiety, surrounded by doubt, which he has to regain control on regardless of the consequences. From the age of seventeen

onwards he is admitted to psychiatric hospitals several times, including regarding depression, severe anxieties, suicidal tendencies, incontrollable compulsions and compulsive thoughts. As early as in 1960 a neurotic development is diagnosed showing compulsive rituals.

Following his first admission in a psychiatric unit, he was banned from returning home, resulting in a homeless existence leading to more contact with psychiatrists. During this time he had a few jobs for a short duration. At 32 he marries and works in a company dealing in coffee for several years. His severe anxieties are proved by his grave fear for exploding coffee bags and for water escaping the women's toilets. His compulsive behavior also increases until he starts psychiatric treatment.

3.3 UNDER THE WING OF (FORENSIC) PSYCHIATRY

In 1974 Hans Joachim B. received an irreversible psychosurgery through stereotactic neurosurgery. With the help of electrodes inserted into the brain, small pieces of the brain are destroyed in targeted areas. This was a method of treatment for patients with serious psychiatric disorders, such as severe compulsive disorders. In the seventies prof. Dieter Müller was regarded an expert in the area of treating compulsive disorders by means of a stereotactic leucotomy.

Six months after the operation it was assessed that even though the symptoms had decreased, he had become evidently more aggressive. Forensic psychiatrist Henning Sass, who would later on assess Hans-Joachim B. as ordered by the Regional Court in Munich, determined that the surgery was obsolete and that it had drastically altered Hans-Joachim's behavior as well as further deteriorating his condition.

In 1977 his spouse falls out of the window frame whilst cleaning the windows, she dies fourteen days later as a result of her injuries. During her final days, he damages his first painting out of revenge and anger. This is extensively covered by the media. In the same year he damages 23 more paintings and is admitted in a psychiatric unit.

When he is forensic psychiatrically assessed, the psychiatrists discards his compusive disorders as not forensically relevant and diagnoses him with the controversial 'anankastic psychopathy'. Even though he has not been in contact with criminal law authorities in 37 years.

He remains for several years in the psychiatric hospital in Munich, later for a long time in Hamburg. In 1998 he abuses the loosening of the regime by the Regional Court Hamburg, to flee the forensic psychiatric hospital in Hamburg-Ochsenzoll. Two days later he is arrested. In 2001 he also manages to escape for two days.

After sixteen years of detention the Regional Court in Hamburg decides that he can go on probation. The Court motivates this by weighing the concerns of the Prosecutor, that there is a great risk of recidivism, lighter than *de facto* result of

him being incarcerated for life in a psychiatric hospital following vandalism. As a result according to the Court the guarantee of his rights prevails over the protection of cultural heritage. As of 2005 he got parole with a duty to report, a museum ban and he is not allowed to leave Hamburg.

3.4 DAMAGE IN THE NETHERLANDS

A year later, on Sunday June 25, 2006, Hans Joachim B. violated a masterpiece by Van der Helst in Amsterdam. He came to the Netherlands because of his acquired status as a serial art vandal in Germany, making it impossible for him to enter German museums and galleries due to him instantly being recognized and because in Germany, more than in the Netherlands, paintings were put behind glass. In the Netherlands it is more believed that the vulnerability of the painting adds to the aura of the artwork itself.

Three experts, a psychologist, a behavioral neurologist and a psychiatrist each make a pre trial forensic report (30-31). Together with a neuropsychologist and a neuroradiologist they make a forensic mental health report on an out patient basis. They conclude that the accused suffers from a severe personality disorder with compulsive and narcissistic features, a frontal syndrome with organic personality alterations as a result of the stereotactic leucotomy, with a negative interaction existing between the defective development of the personality and the pathological disorder. The experts regard him as severely diminished accountable for his crimes.

The Court considered him guilty of purposefully committing arson whilst there was a risk of grievous bodily harm for others, and to purposefully and illegally vandalizing the paintings, and holds him severely diminished accountable for his actions. He is sentenced to one year of imprisonment, special sanction *Terbeschikkingstelling (tbs)* with forced treatment and payment of damages of nearly 18.000 euro. In appeal he received a lower sentence and no *tbs order*.

In 2006 he had declared to the Regional Court of Amsterdam that he did not intend to burn the painting, merely to damage it. In the restoration atelier of the Rijksmuseum the painting has been restored behind closed doors and once again hangs on its former place in the museum as of mid-October 2007. In 2007 it is found that Hans Joachim B. is extremely ill: he is diagnosed with lung cancer. For chemo treatment he stays in the Penitentiary Hospital in Scheveningen. In June 2008 he is released from prison and returns to Hamburg, where he died in January 2009.

4 A short comparison

Even though *prima facie* one sees a big contrast between both cases discussed, a few similarities also stand out. Both perpetrators ached for a stage to express their discontent. Both were able to acquire national as well as international attention, with the difference that Van Meegeren gathered astonished reactions bordering on admiration and Hans-Joachim B.'s behavior evoked indignation and disapproval. In Van Meegeren's case the reactions reversed shortly after his arrest, initial indignation about his alleged collaboration changed into profound astonishment because he had been able to fool so many, even experts.

Both perpetrators lived relatively isolated and felt un(der)appreciated. Van Meegeren lived in the south of France for some time, from the fall of 1932 after his controversy with the *Haagsche Kunstkring*, an organization for art admirers and artists, until the threat of war arose in the fall of 1939. During his stay in psychiatric and penitentiary institutions Hans-Joachim B. did have contact with professionals, but he had little contact with close relations.

Whereas Van Meegeren resided in France during the time leading up to the Second World War and lived through the occupation by the Germans in the Netherlands, Hans-Joachim B. was born in Germany just prior to the Second World War, making Van Meegeren more than fifty years his senior. Their socio-political mindset is unmistakable, be it in different ways, influenced by national-socialistic developments.

The crucial role played by the experts in both cases differs greatly. Public opinion played a greater part in the Van Meegeren case during his trial, because his criminal acts occurred during the occupation of the Netherlands, and during investigations the question arose whether he had been collaborating with the Germans. Only when Van Meegeren confessed to being a forger and therefore not a collaborator, the experts entered into the picture to investigate whether Van Meegeren was being truthful. Due to this criminalistic interest, the psychiatric interest vanished into the background. The part that psychiatry played in this case could be called modest, which contrasts with its role in the Hans-Joachim B. case, where it was intrusive, lengthy and increasingly controversial. (For a relatively recent case in which a manic depression contributed to art forgery and the subsequent admission into psychiatric institutions and the treatment there using electroshocks see the autobiography by Behrman, 2003) (32).

The damaging of artworks possibly reflects the damage done to Hans-Joachim B. by the stereotactic surgery performed on his brain by psychiatric/neurological professionals.

Both perpetrators acted out in violence against the art world in their own manner- one directly, the other indirectly-, concerning millions in a financial sense. Criminal law can only play a minor role here, due to its nature (33). Even though nowadays within western societies voices call for a strong interference by means of criminal law, Kelk's argument in favor of the use of *criminal law in*

moderation remains most valid. If one thing emerges from both cases, it is that criminal law is always one step behind. The essence of criminal law is after all primarily repressive. Even if prevention in full is possible, then this cannot be expected from criminal law, its scope is too narrow to serve that purpose. The alleged necessity that both perpetrators felt to commit their crimes, required from criminal law something it could not sufficiently deliver. Both cases do show to what extent experts play their own prominent, but sometimes doubtful role. On the shoulders of the criminal judge rests the responsibility to ensure that the experts remain within the margins of criminal law (procedure).

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Progression in Forensic Psychiatry

Impulsive Violent Sexual Behaviour: Antilibidinal Hormonal Treatment Considerations in Mentally Disabled Perpetrators

Rob C. Brouwers, Jelle A. Troelstra

Introduction

Antilibidinal hormonal treatments, such as steroidal antiandrogens and gonadotrophin-releasing hormone (GnRH) analogues, seem to be effective in paraphilic disorders (1, 2). In this paper we like to discuss when to consider antilibinal hormonal treatment in mentally disabled perpetrators with recurrent impulsive violent sexual behaviour. First we give a short description of cases that are in our viewpoint illustrative for the dilemma's associated with this kind of treatment especially when more permission outside the clinic is at stake. Then we will give an introduction of pharmacologic evidence and introduce the Dutch guideline about this topic. Finally we will discuss for and against arguments in general.

In risk assessment in offenders with intellectual disability there is no research evidence that current forensic assessment tools are valid or invalid in this population (3). It is proposed to use a practical guide of risk factors that are identified in the research as being related to sexual re-offense (4). Risk rating in which research-based items are linked to sexual recidivism, either conceptually or empirically reveal eight broad categories: global, diagnostic, social skills, behavioural, knowledge, treatment progress, release and acute factors. When the base rate of sexual recidivism is low, the ability of the clinician to differentiate a recidivist from a no recidivist accurately is also low, and the risk of false labelling a recidivist is therefore greater.

Paraphilic disorders are sexual disorders and most of the time not accompanied with violence and victims. It can be misleading to talk about disorder and in forensic psychiatry the focus is on violent sexual behaviour with victims. A legal term is forcible sexual offence and includes any sexual act directed against another person forcibly and/or against that person's will or not forcibly or against the person's will in which the injured party is incapable of giving consent (5). When the victim is a child perpetrators commonly justify and minimize their actions by stating that the act had educational value or that the child derived pleasure from the act(s) or that the child was provocative and encouraged the act(s) in some way.

In this paper we focus on impulsive violent sexual behaviour in contrast to instrumental violent sexual behaviour with much more planning and control over the situation. Impulsive violent sexual behaviour is not planned and

happens when a situation is within reach of the perpetrator in progress. Impulsivity has two different subtypes namely deficits in delay aversion and deficits of response inhibition (6). The first is the result of an inability to wait for gratification and the second is difficulty in shielding planned or ongoing behaviour from disruption by irrelevant stimuli. Perpetrators with the first type have difficulty in resisting the urge to have sex, they know that it can happen and most of the time they can resist there urges but then there is a week moment and the sexual drive is overflowing them. The second type perpetrators are not hypersexual but do not think first before doing. Suddenly there is a situation and before they realised the sexual assault is a fact.

So the question is whether antilibidinal hormonal treatments are helpful in diminishing recurrent impulsive violent sexual behaviour by improving ability to wait or response inhibition.

Description of cases

Case one. This is a man of 32 years old who had sex with his children from their very young age. He also hit them on daily basis and masturbated frequently. He is mentally disabled, understands that what he did is not right and feels sorry for his children but would do it again if he had the chance. He held his behaviour secret for his wife. After starting with cyproterone the frequency of masturbating diminished from eight times a day to zero or one time a day but his sexual fantasies did not decline.

Case two. A mentally disabled man, 49 years old, abused his children from school age. He gets exited seeing his children naked. When he had sex with his wife he forced the children to look that made him more exited. Later on he abused also the girl and boyfriends of his children. He knows that it is wrong and he did try to stop it but after several times there was a moment he could not resist his urges. After his conviction he started with fluvoxamine and his urge to look for porno sites and frequency of masturbation diminished.

Case three. Is an 18-year-old man who, during visiting his family, tried to touch the genitals of a six-year-old girl when he was alone with her. He tried to lock himself up in the bathroom when he saw the girl up stairs. He did not think about his action and was to aroused to stop. It was an action on impulse when he saw the opportunity and got sexually aroused by seeing the girl in the bathroom. After the fifth time such sexual offensive behaviour occurred with different victims, triptorelin was prescribed with no recidivism as result but he lives in a 24 our care unit with only small periods of no supervision.

Psychopharmacological evidence

The magnitude of sexual violence as an expression of aggression in humans is clearly strongly influenced by multiple genes (7) but environmental factors are important as well. The impact of heritability to aggression changes with time so that in childhood genetic and environmental factors are equally important but genetic factors become predominant in adulthood. Certain brain regions like hypothalamus, amygdala, prefrontal cortex, anterior cingulated cortex and neurotransmitters like serotonin, dopamine and other like cortisol, glucose, play a key role in aggressive responses. Polymorphism influences expression of genes and several receptors like androgen receptor and serotonin receptor can change in function. Overall imbalance in testosterone and serotonin and testosterone and cortisol ratios increases the likelihood of violent behaviour because of the reduced activation of the neural circuitry of impulse control and self-regulation. Sex steroid hormones (including testosterone) are involved in shaping the (adolescent) brain (8) and have been implicated in the pathogenesis of neurodevelopmental disorders including mental illness. Although this was a study in mice this study suggest an influence of adolescent androgens on forebrain neurotrophic expression. Moreover in a study with boys salivary testosterone was significantly correlated with fluid intelligence (9).

For the purpose of this chapter, three relations are considered: testosterone and violence, testosterone and impulsivity and impulsivity and (sexual) violence.

Testosterone and violence. The role of testosterone in human aggression is less clear and it is probable that there is a bidirectional relationship in which androgen levels may be both cause and consequence of aggressive behaviour (10). Male prisoners with a history of violent crime had higher testosterone levels than those convicted of nonviolent crimes (11). High free testosterone levels in the cerebrospinal fluid discriminated violent from nonviolent alcoholic offenders (12). There is a relationship between basal levels of cerebrospinal fluid testosterone and a form of sensation seeking, venturesomeness (13). This study was done in male personality disordered subjects and found no relation between testosterone and overt aggression or impulsiveness. However in a meta–analysis in a combined sample size of 9760 subjects (14) the mean correlation was significant but of small magnitude (r=.14). Testosterone has a positive influence on the amount of violence if violent behaviour is used. It alters the probability that particular (violent) behaviour will occur in the presence of a particular sex stimulus (15).

The experience of intense rage, the male flash of anger, in response to transgression, probably consists of two discrete motivational components (16) the competitively aggressive component that is the desire to dominate others and the risk indifference component, the willingness to subject oneself to danger. Immediate aggressive responses to transgression are more effective than delayed ones, they do not allow the actor to control the circumstances surrounding the

action to the same degree as delayed responses but immediate responses entail greater risk. One of the substrates involved in the male flash of anger is probably testosterone.

In a recent study (17) androgen levels were assessed in 90 nine-year-old children (44 boys and 46 girls) in relation to impulsivity, anger and levels of physical, verbal and indirect aggression. After sex, testosterone was found to be the best predictor of all three types of aggressive behaviour however androstenedione had a tendency to act as an inhibitor of the effects of anger on these behaviours. Androstenedione is the common precursor of male and female sex hormones, produced in the adrenal glands and gonads, secreted in to the plasma as an intermediate step in the pathway to testosterone (and estrogens). As a dietary supplement androstenedione is banned and placed under the category of androgenic anabolic steroids.

Impulsivity and violence. Neither impulsivity itself nor its interactions with hormone measures were found to have any predictor role for aggression in this group of children. However it is pointed out that dysfunctional impulsivity, deficits in response inhibition (shielding), is associated with aggression (18) with impulsivity being related to emotional (impulsive) and instrumental aspects of aggression. Within the group of offenders with intellectual disability sex offenders were less impulsive compared to non-sex offenders (19). This suggests a considerable ability to delay gratification, which is precisely opposite to the features of impulsiveness.

Testosterone and impulsivity. The results of diverse studies suggest a positive relationship between androgens and impulsivity. However the way in which the impulsivity variable is operationalized differs according to delay aversion or response inhibition. A study related to response inhibition using the continuous performance test found a positive correlation between testosterone levels and commission errors in the distracter variant (20). This means a relation between doing without thinking and testosterone level. High testosterone levels further augmented rates and intensity of aggression in subject with low CSF 5-HIAA and leads to the testosterone serotonin link (21). Testosterone is presumably stimulating frontal 5-HT1a receptors leading to a reduced down stream control in more aggressive subjects (22). In other words higher testosterone stimulates 5-HT1a activity in the frontal cortices and that leads to a loss of prefrontal control over limbic centres like the amygdala.

To summarise this short review sexual offenders with intellectual disability seem to be less impulsive as we thought and if there is a direct relation between testosterone and violence, 5HT-1a could play a relevant role.

Dutch Guidelines

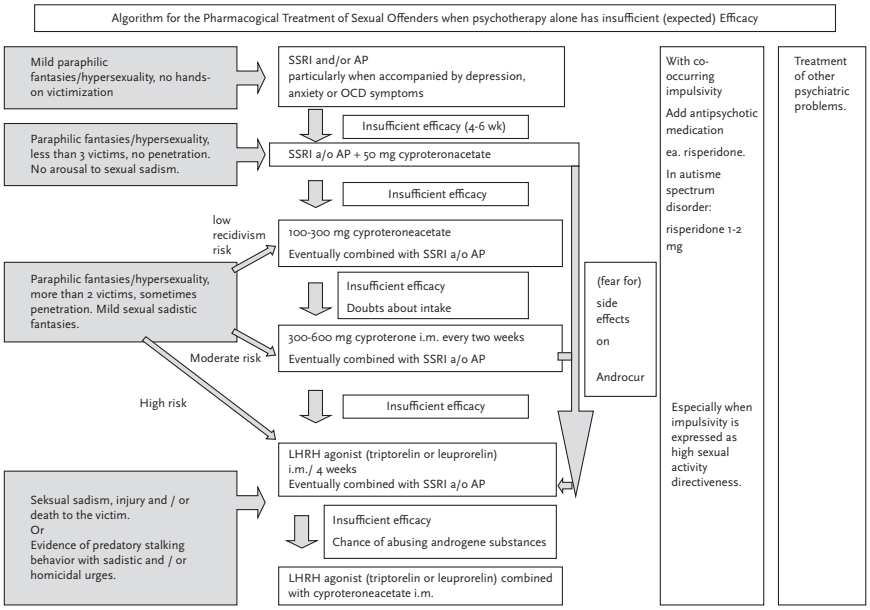

Figure 1.

Dutch guidelines are based on the algorithm for pharmacological treatment of sexual offenders (23, 24, 25, 26)(see figure 1). Leading are paraphilic fantasies and hyper sexuality followed by the number of victims and recidivism risk. Finally sadism, injury and predatory stalking are at stake but also when impulsivity is expressed as high sexual activity directiveness. So both predatory or instrumental and impulsive sexual violence can be a reason for antilibidinal hormonal treatment.

The guideline presented by the Taskforce on Sexual disorders (27) begins at level one with the aim to control paraphilic sexual fantasies, compulsions and behaviours without impact on conventional sexual activity. At level two, behaviour is unconventional (exhibitionism) and at level three, behaviour is hands-on without penetration. At level four, behaviour is more severe with penetration but a limited number of victims and no sexual sadism. At level five the perpetrator has sadistic sexual fantasies and high risk of violent recidivism. Level six is for the most severe cases. In this algorithm the severity and frequency of sexual violence are guiding.

In contrast the conclusion of a Dutch expert meeting (28) the role for antilibidinal hormonal treatment was small: A pharmacological treatment that decreases the possibility of committing a sexual offense is only suited for a

limited group of relatively harmless sexual offenders. And even then they must then accept the treatment as long as they stay out of the clinic, having been informed about the side effects and the damage to their health. Moreover, they must then remain under permanent medical surveillance, for which there is only limited juridical ground at the moment. In addition, they must be medically screened and supported permanently, in order to be immediately readmitted into the clinic when the side effects become too serious to continue the medication.

According to the scheme above only when impulsivity is co-occurring it is advised to add antipsychotic medication but it is not clear which type of impulsivity so these guidelines give no answer when to use antilibidinal hormonal treatment in diminishing recurrent impulsive violent sexual behaviour by improving ability to wait or response inhibition.

Discussion

Is antilibidinal hormonal treatment in mentally disabled sex offenders a blessing or curse, treatment or punishment? Anyway an algorithm with different levels of severity of violence and frequency for pharmacological treatment for different categories of paraphilias is guiding (26, 27).

It should be kept in mind that the term "sex offender" is not a diagnosis. Pharmacological interventions should be part of a treatment plan including psychotherapy and interventions on the ward in clinical settings. Some perpetrators have clearly an inability to resist their sexual urges, which have a compulsive element. SSRIs can be effective especially in those who have co morbidity with OCD and depression (2).

Based on the bimodal model of violence (29) and the two types of impulsivity there are three prototypes of sexual violence. First the instrumental type characterised by well-planned sexual violence, sexual fantasies and urges can be controlled, and victims can be chosen carefully. Caught red-handed the perpetrator still denies even if evidence is robust. Antilibidinal hormonal treatment could have effect in diminishing sexual urges and violence but will probably have no or less contribution in diminishing fantasies. The planning of the sexual offence will go on with the slightest arousal. This may require thorough pharmacological intervention with an LHRH agonist. To receive adequate results in this type of offender it is necessary to reach commitment to the treatment goals. Motivational interviewing and cognitive behavioural psychotherapy are recommended to achieve this (30).

Second, impulsive sexual violence delay aversion type, characterised by fast sexual arousal, high sexual urge, unable to delay personal gratification or poor control over inhibition, no serious planning but when there is an opportunity resistance fails. Perpetrators with this type of sexual violence can have advantage

of antilibidinal hormonal treatment because testosterone reduction diminish sexual urge and improves control. Combination with SSRIs may even reinforce this effect.

Third, impulsive sexual violence response inhibition type, characterized by deficit in information processing, there is no planning, no hyper sexuality; by coincidence suddenly the opportunity is there, just doing without thinking. Antilibidinal hormonal treatment is helpful in diminishing sexual urges and lengthening time to become aroused. Lower testosterone level may stimulate control to withhold if the offender is familiar with social sexual manners.

So there is some evidence that antilibidinal hormonal treatment can be helpful in diminishing recidivism of impulsive violent sexual offences in mentally disabled perpetrators through delay and improvement of impulse control. Unfortunately it seems that the majority of offences by mentally disabled perpetrators are not impulsive in nature. Even the slightest sexual arousal will flourish sexual fantasies and planning behaviour. The question is if pharmacological treatment with antilibidinal hormonal treatment alone is sufficient for this kind of instrumental violence. Clinical trials should be undertaken with antilibidinal hormonal treatment in combination with SSRIs, neuroleptics or cortisol with different actions on different parts of the brain to influence different psychological mechanisms like executive functions and arousal (31). But if supervision is needed or the only way to prevent recidivism, the question is how far you want to go with antilibidinal hormonal treatment. With genetic and non-genetic factors contribution to risk factors and a probability of recidivism, a potential perpetrator needs a potential victim. In a twenty-four our seven days a week supervision setting with no possibility of getting to a potential victim the question is what antilibidinal hormonal treatment will add.

The aim of treatment is to control sexual fantasies, arousal and behaviour. Cognitive behavioural therapy is effective but must be adapted for people with intellectual disabilities (32, 33, 34). Education, repeating again and again of what is good and what is wrong. Establish improvement in sex knowledge and socialization skills. They may have limited control over their everyday lives and limited opportunity to negotiate change.

In the guidelines above antilibidinal hormonal treatment is recommended for the last levels in which severity of violence and frequency is enhancing. It could be suggested that severity of violence legalize punishment with pharmacologic testosterone decrease, but that is of course not true. However if we can identify relevant factors in relation with phathofysiological mechanisms, antilibidinal hormonal treatment can be used different and more accurate. If we apply the bimodal model of violence then antilibidinal hormonal treatment can be used in an earlier phase of treatment. Lowering of testosterone will diminish sexual arousal, decrease amount of violence, enhance control and decrease perhaps

anger responses (inhibiting dominance and risk taking) in the impulsive violent mentally disabled perpetrator.

In contrast to these favourable effects, antilibidinal hormonal treatment has some serious side effects. If the testosterone level declines, a man produces less estrogen. In men, testosterone is the only raw material for estrogen production. The resulting drop in estrogen production leads to mental and physical complaints. These are complaints that resemble climacteric complaints: mood swings with depressive complaints, sweat attacks (hot flushes) and osteoporosis. The decline in testosterone can reduce muscle mass and may cause fatigue complaints. Using progestagene substances (resembling progesterone, the pregnancy maintaining hormone) such as cyproterone-acetate can cause weight gain and breast enlargement (gynecomastia) as adverse side effects (35). On the long term osteoporosis with a greater chance of fractures is certain something to be avoided. Bone metabolism in males is regulated by androgens and a low level of testosterone is associated with bone loss. Results of our research (will be published later) shows that vitamin D level declines in wintertime in almost all inhabitants of our clinic and in some suppletion is needed. Those whit antilibidinal hormonal treatment receive according to the protocol vitamin D, calcium suppletion and a biphosphonate like alendronate that specifically inhibits bone resorption. Although some mentally disabled perpetrators have a better discipline in drugtherapy most of them are on this subject the same as the normal population or even worse. They must be supported in taking every day calcium and vitamin D. Biphosphonate is given once a week and on that day the resorption of alendronate is decreased by calcium supplement. At least half an hour should pass after intake of alendronate before taking the supplement.

All these considerations should be taken into account when antilibidinal hormonal treatment is under discussion. But what do patients understand from their treatment program (36) and are they able to make a proper discision in this complex matter. If more freedome is possible with antilibidinal hormonal treatment, it will be hard to refuse. Because it is difficult to understand all these considerations for the mentally disabled perpetrator and this kind of treatment is an ethical minefield we recommend a special multidiscipline committee that is not involved in the treatment and can give a independent advise. In the two years experience we have with this kind of expert advice we noticed that not allways an antilibidinal hormonal treatment is necessary especially in those cases when twentyfour our supervision is demanded.

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Improving Services for the Mentally Ill at Risk of Being Violent

K.R. Goethals

Introduction

Since the 1980s, there is a growing body of evidence that mentally ill people are at risk of being violent. These patients are characterised by a high prevalence of comorbid disorders, such as a personality disorder and substance misuse disorders, and several circumstantial risks, such as poverty and a violent neighbourhood. Therefore it is extremely important that these patients at high risk for violence need to be recognised at an early stage, and treated in an appropriate way in general and forensic psychiatry. In this chapter, we will discuss these issues with a focus on possible approaches to improve services in general and forensic psychiatry.

Is mental illness associated with an increased risk of violence?

In order to answer this extremely relevant question, it is necessary to have a look at the research on this topic. There are two main ways that this question has been investigated:

1. studies of rates of violence within those with mental illness
2. studies of rates of mental illness within those known to have committed a violent offence.

First of all, cross-sectional studies showed that there is an increased rate of violence among the mentally ill when compared with the general population. Swanson et al. (1) used data from the Epidemiologic Catchment Area study. Violence was reported by eight percent of those with schizophrenia and even thirteen percent of those with schizophrenia and comorbid substance abuse, versus two percent in the general population with no psychiatric disorder. It is striking that these findings have been confirmed in a variety of cultures and countries all over the world (2). The important MacArthur Violence Risk Assessment Study (3) investigated the rates of violence in discharged patients for a year. At least one violent act was committed during the first 20 weeks after discharge from hospital by 18.7% of all patients. Once again, a diagnosis of substance abuse was associated with the highest prevalence of violence, followed

by a diagnosis of a personality disorder, and other psychotic disorders. Schizophrenia was associated with the lowest prevalence of violent acts towards others, but was significantly increased compared to those without a mental illness. Also birth cohort studies showed that those who later will develop a mental illness (schizophrenia spectrum disorders, personality disorders, and substance abuse) have an increased risk of violence. For example, an unselected birth cohort in Denmark (4) including more than 12,000 people showed that schizophrenic male patients were 4.6 more likely to commit a violent offence. In females, this odds ratio was even much higher, namely 23.2. These rates remained stable even when controlling for demographic factors, substance abuse, and personality disorders.

Next, in studies of rates of mental illness within those known to have committed a violent offence, robust data can also be found. In prisons throughout the Western world, five to ten percent of those awaiting trial for murder will have a schizophrenic disorder (5). In studies of community samples assessing the rates of mental illness in those who have committed serious violence, schizophrenia is over represented (6, 7).

Finally, the majority of patients with a mental illness will not commit violence, but in many western societies, between five to ten percent of all homicides and over five percent of serious violence are committed by those with a schizophrenic spectrum disorder. And about ten percent of the schizophrenic population are at high risk of violence. That is why these patients at high risk need to be recognized and given an appropriately high priority for management of their illness. In the next heading, we will have a look at some characteristics of those mentally ill at risk of being violent.

Characteristics of the mentally ill at risk of being violent

A distinction has to be made here between static and dynamic risk factors. Static risk factors are factors that typically cannot be changed by treatment interventions, e.g. age at first offence, male sex, sociodemographic background, and history of a conduct disorder. With regard to substance abuse, it can be said that this is both a static or historical factor and a dynamic factor. Dynamic risk factors, contrary to static risk factors, are subject to change over time and can indeed be a target for treatment in daily practice. Examples of these dynamic factors are active psychotic symptoms, insight, anger, hostility, social circumstances, and personality traits. First of all, important psychotic symptoms are persecutory delusions (8), suspiciousness, hallucinations, more particularly command hallucinations (7), and threat control override symptoms (9). However, in the literature there is no consensus about the importance of these threat control override symptoms. The identification of these positive psychotic symptoms are

important targets of treatment in forensic psychiatry and in general psychiatry (3, 7, 10). Next, those patients with a comorbid antisocial personality disorder showed more behaviour problems in childhood and adolescence, and more psychopathic traits (4, 11, 12, 13). A useful differentiation in the criminal pathways of psychotic offenders was elaborated by Hodgins et al. (14). Early starters began their criminal career in childhood (under age 18), have a comorbidity with a personality disorder, and displaced violent behaviour before the onset of the psychosis. Late starters started their criminal career after the onset of the psychosis and have less comorbidity with a personality disorder. With regard to psychopathy, an association between a personality disorder and alcohol abuse or dependence and the 'Deficient Affective Experience' can be found. The Deficient Affective Experience is the sum of four items of the PCL-R (15), namely shallow affect, lack of remorse, lack of empathy, and 'doesn't accept responsibility'. Male schizophrenic patients who had committed an offence before their first contact with psychiatric services had a significant higher score on the Deficient Affective Experience, compared to those who did not.

Finally, only a few circumstantial risks will be mentioned here. In schizophrenia and comorbid substance abuse, more (violent) criminal behaviour can be found (1, 16). Alcohol is the most prevalent substance, and more violence will take place in the alcohol and amphetamines subgroups (17, 18). Early starters are more often intoxicated at the time of the offence (12, 14, 19), and grew up more often from dysfunctional families (14, 19).

A typical mentally ill patient who is at risk of being violent has a variety of the following characteristics: a diagnosis of schizophrenia, poor insight, antisocial behaviour since childhood, substance misuse since age 14, non-violent offending since age 15, violent offending since age 18, few pro-social skills, no employment skills, patents and siblings with substance abuse and/or criminality, acquaintances who use drugs and engage in crimes, or living in a neighbourhood with easy access to drugs and to other criminal activities. In conclusion, this is a patient with multiple problems each of which interacts with the others.

Improving services

In this heading we will consider the following issues:
- what improvements do we need to our forensic services?
- enhancing general psychiatric services: how can that be done?
- is there need for more skills, more resources, and a better liaison between general and specialist forensic services?
- enhancing the relationship between general and forensic psychiatric services: how can that be done?
- and what are the mechanisms for improvement?

What improvements do we need to our forensic services?
Several unmet needs and/or gaps in services can be raised here. First of all, the transition from criminal to civil law legal status if very difficult to obtain, in case of indigent care patients. Next, the gap between adolescent and adult (forensic) services is big. Above that, in most countries juvenile court orders end at age 18. In forensic psychiatry there is insufficient knowledge of substance abuse, and especially managing substance abuse in an appropriate way is not often met. Another gap can be found between caregivers on the one hand, and judges and probation officers on the other hand. Law professionals have little knowledge of forensic psychiatry, and caregivers have little knowledge of law. Probation officers often have an excessive caseload, so there is less time for improving their knowledge about forensic psychiatry.

Little attention is paid to somatic health problems in forensic patients, and the use of hormonal treatment in sex offenders is not common. Reasons for that can be a lack of knowledge about chemical castration in the psychiatric profession, or ethical objections.

With regard to Belgian forensic psychiatry, a severe gap between regular psychiatric care and the deficient penitentiary forensic care still exists. The main reason for that is the fact that prisoners are excluded from the Belgian health care system. It is the responsibility of the justice department to organize health care within jails and prisons. Other reasons are the chronic overcrowding in prisons, and that most of the buildings stem from the 19th century. Considering the Netherlands, the Dutch Entrustment Act (TBS) does not mean compulsory treatment, meaning that only acute dangerous patients can be forced to be treated. The new category of longstay TBS-detainees can be seen as an 'erosion' of the judicial TBS-continuation. In the TBS-field, there is an increased capacity, leading to an increased security and a larger distance between management and forensic psychiatric wards. The unlimited duration of the TBS-measure causes uncertainty of the detainee's destiny. Also there is no independent committee for leaves, but the Minister of Justice is responsible for all leaves of all TBS-detainees.

Of course, several things go well and should be maintained and extended in forensic services. Treatment in forensic psychiatry is also aimed at rewarding patients. This means much more than only the punishment of mentally disordered offenders. For example, there is a very human approach towards mentally disordered offenders in the Netherlands. Well equipped Dutch inpatient services (TBS-hospitals, medium security wards) do exist, beside this human approach. Also a forensic network with several chain partners are available. In some countries such as Germany and the Netherlands, a combination of punishment (imprisonment) and treatment (hospitalization) exists. Five degrees of responsibility can be seen as an advantage in the Netherlands. Contrary to that, no combination can be found in Belgium. Belgian psychiatrists have always stated that treatment can never be a modality of punishment.

Enhancing general psychiatric services: how can that be done?
On the one hand, patients who move from general to forensic psychiatry have a more severe disorder than those who remain in general adult services as indicated by the presence of conduct problems since childhood, higher scores on the trait of the Deficient Affective Experience, and the absence of intimate relationships, in addition to repeated aggressive behaviour. If there has been an increase in the incidence of patients with schizophrenia who display persistent aggressive behaviour, little empathy, failure to take responsibility for their own actions, and poor interpersonal skills, or, alternately, if general adult services are no longer able to provide such patients with services designed specifically to target these deficits and to reduce violent behaviour, then complexity of disorder may be a factor contributing to the increase in the numbers of forensic beds (20). On the other hand, men experiencing their first episode of schizophrenia or schizoaffective disorder should be assessed for conduct disorder in childhood (prior to age 15) and for antisocial personality disorder and substance use disorders. Once psychotic symptoms are reduced, patients with a history of antisocial behaviour require cognitive-behavioural interventions aimed at changing antisocial behaviours and the associated attitudes and ways of thinking. This means that these men require long-term care in communities that limit access to drugs and offenders and that support newly learned prosocial behaviours, attitudes and ways of thinking (21).

Therefore, risk assessment and risk management should become a real issue in general psychiatry. Aggression should be anticipated in general psychiatry. A different attitude towards violent behaviour is highly necessary. Violent behaviour should be an integrated of daily psychiatric practice. Further developments of pathways should be elaborated, in order to describe how a patient goes through forensic and general psychiatric systems. More resources and more staff is needed. And finally, a closer gap is desirable between forensic and general psychiatry.

Is there need for more skills, more resources, and a better liaison between general and specialist forensic services?
The answer here is 'yes', because most of the people who have a mental disorder and become violent have been in contact with general psychiatric services at some stage. Several ways to achieve these aims can be raised here: a better identification of people at risk, e.g. those with high DAE scores or those with much externalising behaviour (22), and acquiring 'forensic' skills, such as developing 'healthy' suspicion, tolerating to be abused by forensic patients, risk management thinking, and considering justice and society as important actors. We may not forget the importance of more funding in general psychiatry, and more communication between general and specialist forensic psychiatry.

Enhancing the relationship between general and forensic psychiatry: how can that be done?

In order to find answers to these questions, we can look to countries and jurisdictions which hardly separate their specialities and services (e.g. Denmark), and to those that have full specialist training and a separate specialist forensic psychiatric system (e.g. UK).

In Denmark, forensic psychiatry is – or should be- part of general psychiatry. In their view, forensic patients suffer from the same diseases as general psychiatric patients and should be treated in the same way. Further, separating forensic psychiatry from general psychiatry should imply that general psychiatrists loose experience in treating the most difficult and ill patients, and then these patients become forensic patients. In Denmark, being 'labelled' as a forensic patients is an extra stigma. Nowadays, forensic psychiatry becomes more and more a specialty. General psychiatrists say that they are not able – or do not have resources – to write court reports, and consequently this function is increasingly centralised. About eighty percent of all Danish forensic patients are treated in general psychiatry, but often the special needs for this group are not met. As a consequence, one of the five regions in Denmark has decided that all forensic patients will be treated by this regional forensic service. This policy change has not yet been evaluated, but the regional forensic psychiatrists say that it works better.

The Netherlands and the UK have a separate specialist forensic psychiatric system. In the UK there is even a full specialist training. What can be learned from these countries? First of all, tensions between general and forensic psychiatric services are considerable. Next, the moving on from a forensic hospital to a general psychiatric hospital is bad. Many general psychiatrists resist the idea that they have a role with repetitively or seriously violent patients. These two separate systems lead to island formation. Pronounced specialisation leads to a reduction of skills in forensic psychiatry by general psychiatrists. And finally, it is plausible that pronounced specialisation leads to a reduction of general psychiatric knowledge by forensic psychiatrists.

What are the mechanisms for improvement?

Different improvements can be raised. Teaching and training should be improved, from a very early stage in medical school. Improving teaching and training leads to better knowledge and skills about forensic psychiatric patients. Improving research can be achieved by dealing in international collaborations. Forensic psychiatry should be more 'evidence based'. Here the importance of outcome measurements in forensic psychiatry can be stressed. Maybe psychiatrists should communicate more with politicians and other policy makers.

Ways forward

A lot of work still has to be done for the mentally ill patient who is at risk of being violent. Some final recommendations can be made here. Further elaboration of development trajectories in people at risk of being violent is necessary, from childhood to adulthood.

These trajectories are relevant to practice and scientific research. In hospitals, a staff exchange between forensic and non-forensic wards should be organised. This could be extremely helpful to decrease prejudices towards forensic psychiatry, and to learn more about each other's work in forensic and in general psychiatry. Several liaisons should be created or intensified, e.g. between justice and psychiatry, between child and adolescent psychiatry and forensic psychiatry, between addiction psychiatry and forensic psychiatry, and between general psychiatry and forensic psychiatry. And finally, the word 'forensic' has perhaps too much negative connotations. Maybe the field should think about another, less stigmatising term.

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Do we (have to) Care, or just say 'Beware'?

Relational Ethics and Relational Research in Forensic Psychiatry: Two Birds with One Stone?

Swanny Kremer, Lydia Pomp

"We have the word 'to be'
What I propose is the word 'to interbe'
Because it is not possible to be on your own, by yourself
You need other people in order to be
You need other beings in order to be
(...) so it is impossible to be on yourself, alone
You have to interbe with everything and anyone else"

Thich Nhat Hahn

There is practically no tolerance in society relating to errors made in TBS-treatment. Especially when those errors result in a repeated offence. Therefore, potential risks of a patient must be as well known as possible. The current standard in forensic hospitals is risk assessment based on group data (1). And indeed, group data is very useful. But do we do justice to the person in question? Should we not take a closer look, and consider other persons as individuals, with their own unique story and unique characteristics? And to do so, can we use a different approach?

In this paper, we argue that relational ethics will be helpful in forensic psychiatry.

Relational ethics, also known as ethics of care or care ethics, focuses on values that are important within (care) relationships (2-3). This corresponds with a method used in forensic psychiatry, Forensic Social Network Analysis (FSNA) (4). The idea that relational ethics and FSNA are mutually reinforcing is developed in this essay. Care ethics focuses on quality care for an individual. A person needs others to be as autonomous as possible and to do so, he creates his own network. Those two basic thoughts are what relational ethics and FSNA have in common. Often there is an asymmetric relation between patients, employees of a forensic clinic and the further social network members of a patient. Attention is needed for the social well-being of the patient when one wants to give 'good care'. At the same time, present risk factors of the patient must not be forgotten. The FSNA supports both factors. FSNA is developed in Forensic Psychiatric Centre Dr. S. van Mesdag and originated from collaboration between researchers and social workers. FSNA analyzes a social network with attention to two factors, risk factors and protective factors. After that, one determines which network members can play a more active role in a patient's

life concerning treatment, rehabilitation and beyond. Care ethics seems to seek 'the good' but seems a bit too woolly for forensic psychiatry. What is 'the good' and how can you achieve this? And FSNA is a way to analyze a social network, but by linking it to relational ethics it acquires a vision on care in forensic psychiatry.

This paper has been divided into six parts. The first section introduces a case study. This case study is the leading thread running through this essay. The second section focuses on autonomy in forensic psychiatry. How autonomous is someone with a TBS-status? The classical view on autonomy, that of a rational and reasonable individual who makes sensible choices, does not stand in forensic psychiatry. Therefore, we look for an ethical basis that is applicable in forensic psychiatry. Relational ethics is introduced in the third section. Relational ethics offers a view on autonomy that differs from the classic view on autonomy. It looks at man in dependency relations to others. It focuses on 'care' within these relationships. That sounds good but also woolly. Therefore, the fourth section introduces the FSNA approach. FSNA shakes off the woolliness of relational ethics. In the fifth section, the reinforcing cooperation between relational ethics and the FSNA is explained through an FSNA case study. Finally, the sixth section discusses the conclusions.

1 Introduction to the case study

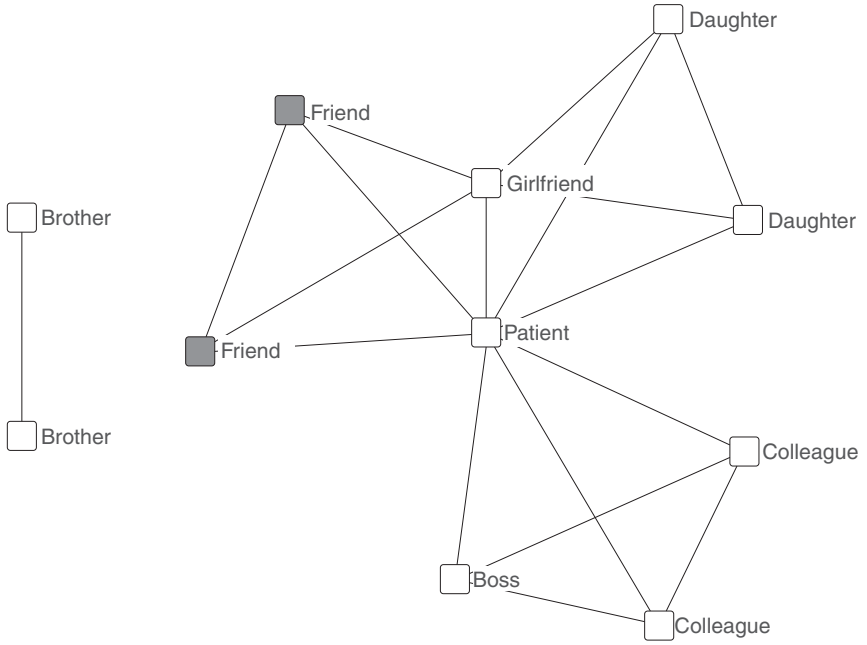
A case study about patient X is used to show the benefits of combining relational ethics with the forensic social network analysis approach. The case study is constructed from different cases, so traceability to persons or situations is not possible.

This first part describes the patient's (social) situation at the moment of crime.

Patient X – at the moment of crime

Patient X was diagnosed with a psychotic disorder (DSM IV Axis-I). Patient X did not use antipsychotic medication, but he used a lot of drugs and alcohol. Patient X has committed two murders. The first murder:*patient X was psychotic and he was convinced that criminals wanted to kill him. He thought that two persons were planning to murder him and he had to act quickly. So he killed the presumed murderer. X had no relationship with the victim; it was an unknown person who played a role in his psychotic perception. Patient X was not caught.* The second murder:*a few years later patient X was incarcerated as a result of committing a burglary together with two friends. Serving a prison sentence he was psychotic and based on hallucinations he thought his eldest daughter was sexually abused. Although his girlfriend did not share the suspicions and his daughter denied abuse, his suspicions grew. After his sentence, he*

*had a job and a colleague told him that another employee was a pedo-sexual. After that X started to see signs, which indicated that he in fact was ordered to kill this man. And so he did. X went home and continued with his usual activities. In the afternoon, he was arrested. At the trial he confessed also the first, never solved murder. At the moment of the crimes, patient X had a small personal social network. He was in an intimate relationship in which tension, partly by the psychosis, was running high. Patient X had two daughters with his girlfriend. Patient had two criminal friends. He was not in contact with his family members (his two brothers; both parents are deceased). Figure 1 shows the patient's social network. Patient was in contact with criminal friends, his girlfriend, his daughters and his boss and colleagues.*Figure 1: social network at the moment of crimes.



This case shows that patient X lost contact with reality at the time of his crimes, and that his social network was not able to serve as a buffer against committing an offense. X was psychotic, there was tension in the relationship with his girlfriend and concerning his eldest daughter there was also stress.

In the next sections, especially section 5, more information about patient X is given to discuss relational ethics and FSNA in relation to each other.

2 Autonomy in forensic psychiatry

It is not possible to reason from 'mainstream ethics' in forensic psychiatry. A care ethics approach of autonomy is appropriate. In this paragraph we first explain what TBS is. Second, we discuss what 'having TBS' implicates for the autonomy concept of an individual in forensic psychiatry.

In the Netherlands, mentally disturbed violent offenders can be sentenced to the so called TBS-order. The TBS-order (art 37 a, b of The Netherlands Criminal Code) is considered for offenders who suffer from a personality disorder and/or a severe mental illness and it is only intended for offenders who have committed an offence with a criminal threat of four years or more (5). The aim of TBS is to protect society and its citizens against mentally disturbed offenders and to provide effective treatments to prevent future recidivism (6). Most offenders go to prison first before they start treatment in forensic psychiatric hospitals (FPC's). As part of this treatment a number of fundamental rights are restricted. The nursing or the 'nursing-care' is forced treatment, and 'therapy' is voluntary. The aim of TBS is a gradual return to society, but only if the nursing care and treatment have decreased the risk of recidivism sufficiently (6).

If patients have been sent to forensic psychiatric centers, many dimensions of their life undergo significant changes that affect their autonomy. In literature, autonomy is understood as self-imposed laws, freedom and the opportunity to choose what to do (7). A distinction should be made between free will and freedom of action. Free will is the ability of rational individuals to control their own decisions and actions. (7) Freedom of action infers nothing about the will. Individuals with a TBS status are ultimately dependent on decisions of others. Not only are they separated from society, the duration of this separation is not certain; every two years, there is a re-evaluation whether or not extension of the measure for the individual patient is necessary. These aspects due to the TBS order have a negative impact on the patient's free will and freedom of action. A TBS-patient may have the will or desire to go for a jog in the park, but it is not possible to realize because he has no freedom of action. An example where both the will and freedom of action is limited is a psychotic TBS-patient who is refusing to take anti-psychotic medication. An autonomous choice must meet certain conditions. There must be an identifiable volition or choice, the person must have sufficient insight into his own situation and the choice made should be voluntary (8). Many patients are unable or do not have the opportunity to make such a choice. For an autonomous choice, one has to be in particular circumstances, but one also has to possess certain (mental and physical) capabilities. For example, the patient's freedom of action can be limited because the hospital decides to force medication. The TBS-patients are in a way dependent on the rules set by the clinic and the law. To guarantee high quality of care, every Dutch forensic psychiatric hospital has to define its own document about the vision on care. For example, the Dutch Forensic Psychiatric Center

(FPC) Dr. S. van Mesdag states that mutual respect is required between staff, between staff and patients and between patients (9). Respect is understood as mutual recognition of the other as an individual with his own responsibilities. There should be an attempt to achieve a meaningful life within the walls of an FPC. This implies that the clinic has to think about meaningfulness and values within 'the walls of a total institution'. It is also needed, based on the vision of care, to take the personality of the patient into account and the vulnerability of his existence. To generate more discussion about ethical dilemmas and to improve the quality of care, employees of the Dr. S van Mesdag have formed a discussion group[1] about ethical dilemmas. Patient and staff are confronted with different dilemmas. For example, employees (need to) consider what it means to give care and to 'have to' receive care. The patient is at the mercy of involuntary professional care. And especially in this ultimately dependent situation it is important that humanity is kept constantly in sight (10).

An important paradox in forensic psychiatry is internal versus external coercion / compulsion (11). Many forms of coercion and compulsion are not aimed at limiting patients' autonomy, but at mobilizing autonomy. In other words, external pressure is used to start the needed treatment. As a result, treatment reduces the internal coercion. It is a quest for a balance between the right to self-determination of the patient and the right to appropriate care. This means that autonomy is a central value, but that the assumption that everyone is or can be autonomous cannot be a central value within forensic psychiatry.

It is probably clear by now, that the classical description of autonomy cannot be applied to patients with a TBS status. Not only can it be questioned whether they had 'free will' at the time of the offence, TBS patients are also restricted in their freedom of action. All forms of ethics based on the classical notion of autonomy are not compatible within forensic psychiatry. The question arises as to whether it is possible to find a better suitable approach. In the next section, we argue that relational ethics will be helpful for a better understanding of the concept of autonomy in the forensic psychiatric context.

3 Relational ethics

Relational ethics, also known as ethics of care, seems to be particularly suitable for forensic psychiatry. It focuses on values that are important within (care) relationships (2-3). Autonomy in relational ethics is something very different from being independent. Autonomy can only be properly designed in relationships with others. This is why care or relational ethicists also speak of relational autonomy. Tronto specifies that within the ethics of care attention is drawn to the view that

1 The leader of this discussion group is Swanny Kremer.

human life only exists in a web of relationships that should constantly be maintained by our care (12).

Ethics of care focuses on *values* that are important within (care) relationships. Like ethics in general, care ethics asks very fundamental questions: 'What ought I to do?' and 'How will I live?' Care ethics has its own perspective. A basic principle is the concern of people for each other. Care ethics presupposes dependence, asymmetry within (care) relationships. Care is a primary and normative form of interaction between people. Care ethics is best known in health care but it is not (exclusively) designed for the care sector. In every situation within people care for each other, care ethics can be used. This can be also within a company or within a family.

For care ethicists, 'care' is an essential part of being human. The care relationship is always part of a network in which responsibilities play an important role. It covers the responsibilities of all persons engaged in the network of relationships and who are involved in care or a care-relationship. Thus, the 'care recipient', family, social workers and so on.

Held describes five characteristics of 'ethics of care' to define and qualify it as a better alternative to other 'dominant' theoretical approaches (2). The first is the scope of care ethics that is focused on meeting and fulfilling the needs of others for whom we take responsibility; 'Every person needs care for at least his early years' and 'most persons will become ill and dependent for some periods of their later lives(..)' (13). In relation to the case study of patient X one could say he needed care during his psychosis. He needed someone who would give him his medication. But he has not received this care. Second, care ethics tries to understand what the best morally thing to do would be within the actual interpersonal contexts from an epistemological perspective. 'Ethics of care values emotions rather than rejects it (...) moral emotions (...) need to be cultivated, not only to help in the implementation of the dictates of reason but also to better ascertain what morality recommends' (14). Third, ethics of care rejects the dominant conception of moral theories that suggest that the more abstract reasoning about a moral issue is the better it is to prevent prejudice and arbitrariness to achieve greater impartiality. Ethics of care focuses directly on certain others with whom we share real relationships. In the case of patient X for example, it is important to know who are the people in his social network. Then it is important to find out which contacts could be 'caring-relations', and which contacts should make us concerned. Fourth, care ethics is a new conceptualization of the distinction between 'the private' and 'the public' domain, and their respective importance. 'Dominant moral theories have seen 'public' life as relevant to morality, while missing the more significance of the 'private' domains of family and friendship' (15). Patient X was especially concerned about the violation of morality in the private domain. He feared that his daughter was abused. This resulted in the fact he also violated a moral and legal law in the private domain: 'thou shalt not kill'. Finally, care ethics has a relational conception of persons; this is in sharp contrast to liberal individualism. Ethics of care has a

'conception of persons as relational, rather than as the self-sufficient, independent individuals of the dominant moral theories' (16). In other words: 'it often calls on us to take responsibility, while liberal individualist morality focuses on how we should leave each other alone' (17). A relational vision on autonomy fits much better in patients with a TBS status.

A central notion of ethics of care is that it assumes all humans to be vulnerable and relational, as opposed to autonomous independent individuals. Autonomy is shaped in relationships; a person creates his own network. Therefore, autonomy consists of relationship to others; it is bound in relationship to the other. Jean Keller says care ethics takes 'the insight that the moral agent is an 'encumbered self,' who is always embedded in relations with flesh and blood to others and is partly constituted by these relations' (18).

In relational ethics, it is important to understand what the other feels and experiences, by putting yourself in that situation. Every person has his own sets of learnt dispositions, (social) skills and ways of responding to the other. It is important to 'put on the shoes of the other', to draw attention of the other ones *hexis* or *habitus* (19-20). Noddings uses the term 'engrossment', which refers to thinking about someone in order to understand him or her better (21). In other words, it is about 'real attention'. Engrossment is necessary for good care, because someone's personal and physical situation must be understood before proper care can be given. There must be reciprocity in communicating back and forth. Relational ethics is about a caring relationship between the person who gives, 'one-caring', and the one who receives, the one being 'cared for' (21). Reciprocity as a 'demand' in a care relationship does encourage dependence. The 'one-caring', and the 'cared-for' need each other to achieve quality care.

But what is actually good care? What is reciprocity? What is attention? And how can we achieve all this? Relational ethics is somewhat vague on these questions. However, relational ethics is concerned with questions different from those asked in traditional ethical theories. Relational ethics has the name to 'seek for good care', but is also seems a bit fuzzy and unclear. And how fuzzy can we be and do we dare to be when it comes to patients with severe criminal backgrounds and with risk of recidivism? The next section introduces a forensic social network analysis approach. Social network approaches are helpful in defining significant (care) relationships.

4 Forensic Social Network Analysis (FSNA)

The TBS-measure is aiming at rehabilitating the patient in society. Thereby, risks must be minimized. With the current generation of risk assessment instruments (eg HKT-30, HCR-20, SVR-20) it remains difficult to find the insights on group level and translate them to the individual situation of a patient (22). According to

the 'thinkgroup' Riskassessment Forensic Psychiatry (werkgroep Risicotaxatie Forensische Psychiatrie) it is possible that a particular feature does exist in a risk assessment tool, but that this characteristic might weigh relatively heavier than other items, while the instrument gives no opportunity for such differences in weighing in individual casuistic (23). It is also possible that a particular feature is important in a particular case, but that this feature is not included in the instrument (23).

To include characteristics of the individual (social) situation of a patient in risk assessment, the Forensic Social Network Analysis (FSNA) is developed as a tool for forensic social work (4). The FSNA is generally based on Social Network Analyses research (SNA) and has focused on the forensic aspect, the 'F'. FSNA has been developed within the TBS context, but it is also useful for forensic social work outside the TBS sector. The FSNA method is developed based on scientific findings and practical experiences of forensic social work. Researchers and social workers have worked together to ensure that FSNA is a scientifically method that can be used in practice. It is important to pay attention to contextual and environmental factors and underlying mechanisms. This in order to explore possibilities for treatment and for managing the risks specific to the *individual* patient when he might return to society. The FSNA method focuses at the specific social, cultural and relational circumstances of each individual patient at the time of the offence, comparing this with present time and then appoints potential positive as well as negative influences on future behaviour. The comparison of the 'crime network' with the 'return network' is the basis of an FSNA analysis. 'Crime network' means the collection of (meaningful) people (and their relationships) the patient knew at the time of the crime and the social contexts which the patient dealt with at this time. The 'return network' is defined as significant persons (and their relationships) with whom the patient has contact during the treatment phase and with whom he probably will have contact in the future. In addition, the return network consists of various social contexts in which the patient is likely to play a role. For example, a patient may meet some 'old friends' at the birthday party of his brother.

The three fundamental questions of FSNA (based on theories of Bem and Funder) are 1) Which network developments (relational and social dynamics) in combination with the crime context, were specific for the patient?, 2) What are the expected network developments (relational and social dynamics) in the current situation and the near future? and 3)What are the similarities and differences between these networks? (24)

The FSNA uses a structured method (methodologically sound) to collect information about the social network of the individual patient. Data processing is conducted by forensic social work. The FSNA method uses three different sources: file study, patient- and network interview.

File study: Relevant background information is collected, such as about the crime(s), life history, psychiatric diagnosis, social/relational, and offence history.

The file study focuses especially on the crime situation and the potential influence of people in the environment on the patient's criminal behaviour. Attention is also paid to how the patient during treatment behaves himself concerning people in the clinic and concerning his network members. It is investigated whether or not this observed behaviour is offence-related. Finally, reading the file, general information about the characteristics of the network members is collected.

Patient interview: a structured questionnaire is used during a patient interview in order to obtain patient information about the network at the time of the offence, the current network, and the network the patient will return to. For each period a systematically assessment of which people in what contexts maintain contact with the patient is executed. Patients are asked to list a maximum of 40 names of people who they considered as network members in their crime network, current network and return network. The FSNA uses a name generator: network members are identified in different domains. The questions are designed to identify network members with whom the patient is likely to have significant contacts, regardless of the frequency of interaction (25). After the names are inventoried, variables regarding the content of the contacts are gatherered on all indentified network members: personal variables of the network members (occupation, education, marital status, memberships), variables regarding the relationship (the duration, origin, context, frequency, initiatives of contact, etcetera.) and variables that show potential risks (criminal record, psychiatric problems, drug-usage, alcoholism, aggression or problematic way of life). A series of questions is asked about the social support system: the patient is asked to give the names of people from whom he has received social support: companionship support (spending time with), financial support (borrowing money), practical support (domestic help) and emotional support (seeking advice from, talking when troubled). The patient is also requested to nominate the network members with whom he had/have a tense relationship and whom he ask(ed) for help if he could get in trouble. Finally, the patient is requested for information about the relationships between the network members.

The network members interview: Unlike the new generation of dynamic risk management tools such as START or SORM, the FSNA not only weighs the opinion of the experts in the clinic, but also weighs the view of network members on the (risky) behaviour of the patient (26). The patient is asked whether his network members may be approached for a network interview. An important aspect is that the social worker, and not the patient, determines which people are visited. This approach is chosen because the network members of a patient do meet him in social situations and circumstances where the clinic does not. Thereby, one can more sufficiently assess whether the patient is applying learned skills in an uncontrolled environment. Another benefit of approaching patient's network members is that they may specify information given by patient in FSNA

research. Those people, who can supply the most essential information concerning the patient, are selected. Ideally, from every domain a network member is interviewed. For instance, a family member, a friend, a colleague, a neighbor, and so on. The disadvantage of potentially socially desirable answers given by the network members can be solved by approaching persons for an interview who have a close relationship with the patient, as well as network members who have a less close relationship with the client (27).

The FSNA-interview for network members includes a number of structured questions designed to measure clinical and future items of the HKT-30. Recent studies showed that the dynamic indicators of the HKT-30 have a reasonable to good predictive value, in terms of withdrawal of leave (28). Other research suggests that the clinical and future indicators of the HKT-30 predict the risk of recidivism after discharge of TBS reasonably well (29). The FSNA method uses the clinical items of the HKT-30 to assess whether the patient might end up in risky situations soon after discharge. Concerning the clinical item 'attitude towards treatment', for example network members are asked whether the patient spoke mainly positive or negative about his treatment in the last year. A patient can tell his network that he sees no further use of his treatment and can be supported in this by his network, while in the clinic he is known as a motivated patient. In contrast, the future/prospective (T) items of the HKT-30 are used to clarify if the patient will be able to achieve a stable and risk free environment in the future. The influence of the social network on the HKT-30 risk indicators will be described.

In summary, it is important to know who is involved in a patient's social network, and it is also important to know what we can expect from these people. It is important, from the forensic perspective, to discover the (im)possibilities of the social network members to stimulate the patient not to commit (new) crimes and in some cases to stop using alcohol or drugs. For instance, patient X used alcohol and drugs and didn't use any anti-psychotic medication. His girlfriend was not able to let him stay off booze and drugs (she did drink alcohol and used drugs in his presence) and she was also not able to give him his medication. When contact with network members reveals an increase of risk in a patient's behaviour, it is adequately identified by an FSNA and individual risk management may therefore been drawn up. And it is important to know as well whether there are 'protective network members'. Precisely these contacts should be attempted to be activated so that they can support the TBS patient during his treatment and rehabilitation. In other words, we need to know if social network members can be protective or posses potential risk factors. The next section shows that relational ethics and the FSNA have a lot in common. To clarify this, both concepts, relational ethics and relational research (FSNA) will be applied to the case of patient X.

5 Relational ethics and Forensic Social Network Analysis

Relational ethics and the FSNA have a lot in common and they reinforce each other.

Individual focus– Relational ethics and FSNA focus on the individual with his own individual (social) context and his own story as a theme running through his life

The individual context can only be understood by identifying the social context and vice versa - The view that human life only exists in a web of relationships (social context) that constantly should be maintained with 'care' is a vision that FSNA and care ethics share. Both concepts formulate significant questions related to the individual context.

People create their own social network - The thought that people create their own social network is supported by both positions.

The individual can only be understood by 'put on the shoes of that person' - Every person has his own sets of learnt dispositions, (social) skills and ways of responding to the other. It is important to 'put on the shoes of the other' in order to understand him or her better. This is necessary for good care and risk management, because someone's personal and physical situation must be understood before proper care can be given.

Reciprocity is a key element – Both concepts demonstrated that reciprocity is needed for stable long-lasting (care) relationships. To have true contact with each other, reciprocity is necessary. Although, professional contacts are not chosen voluntarily. The 'worker' must remember this is a joint process between care-provider and care-receiver. The care relationship is always part of a network in which responsibilities play an important role.

Relational autonomy - The care ethicists' description of autonomy matches that of FSNA. This concept of autonomy is a relational version, because autonomy can only be properly designed in relationships with others.

To show the common nature between relational ethics and FSNA, we discuss the last part of the case study.

Back to patient X...***Patient X- current treatment situation***
Patient X was imposed to the TBS order. He was not entirely 'responsible' for his acts, because he was psychotic during his committed crimes. The last years, patient X is stable and he seems to have made progress in his treatment. According to the TBS treatment, returning an offender to society can be achieved only by gradually granting the patient more liberties. Steps to more liberties are first supervised leave, then unsupervised leaves; after these steps, "transmural" leave may be granted (this involves the person's staying outside the clinic under the supervision and responsibility of the clinic). Finally, a probationary leave may

be granted. In the case of probationary leave, patients can return to society under certain conditions (6).

In the current situation, patient X has received treatment for five years and his status is "transmural". There is a lot of contact between X and TBS -practitioners. He is friendly and seems to be open and honest. But there is need for external control, structure and guidance. Concerning his psychotic vulnerability he is put on anti-psychotic medication. He has his medication in his own possession and takes it according to prescription. This is checked by monthly blood levels. These checks have always been positive. The prognosis is that X will probably need a certain degree of guidance and care for the rest of his life or at least for a very long while. A traject directing 'assisted living' is designed.

Last year, the treatment team, the task of the treatment team was to determine opportunities for risk assessment: How can the necessary care, structure and supervision adequately designed? They noticed that there were some significant issues related to the patient's social network at the time of the offence: patient was in contact with criminal friends, his girlfriend, his daughters and his boss and colleagues. Despite his psychotic symptoms he seemed relatively well to the outside world. For instance, his employer was very pleased with his attitude and commitment. But in a relatively short time, a few days, his psychotic perception grew. His boss never noticed. Also, patient's girlfriend was not aware of his psychotic symptoms. Even the day of the second murder she had seen nothing special, patient responded like he always did. He had no contact with family members at the moment of offences. To be specific, he had no contact with his two brothers. The treatment team recommended focusing on social network interventions motivated by the fact that in the current situation, the patient has no contact with his family.

Patient X- FSNA research

Patient X was invited to an FSNA interview. Patient X was asked to describe his network members of 1) his past network at the moment of the crime, 2) his current network, and 3) his return network. Patient X mentioned he has a small social return network. His social network consists his ex-girlfriend, their two daughters, his boss and one colleague.

About his relationship with his ex-girlfriend he said that they have children together and therefore they will always have a relationship.

Patient X told that his two brothers are very important to him. Patient X is feeling sad, because he has no contact with his brothers for a long time (the last contact was a year before his first committed crime). Patient X has always felt connected with his brothers even when they did not see each other. Figure 2 shows the current social network in patient's perception.

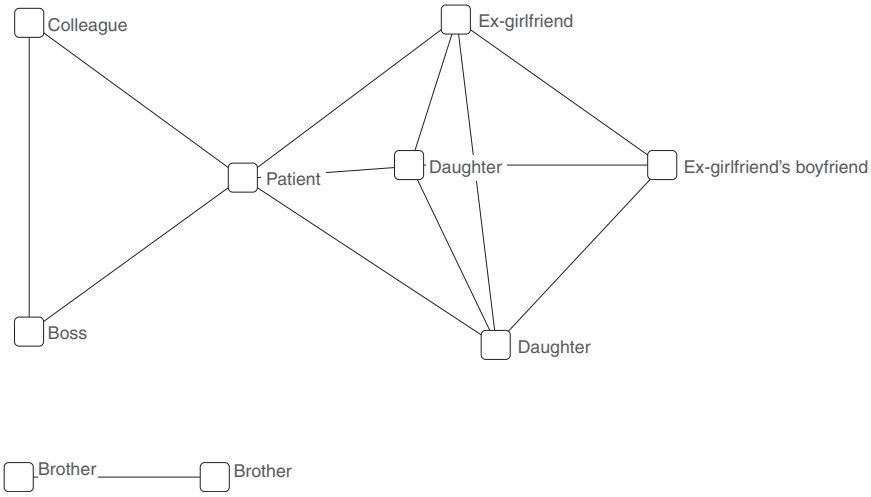


Figure 2

As a part of the FSNA method the ex-girlfriend, the two brothers and patient's boss were visited and interviewed.

The ex-girlfriend stated that when she met patient X she was 16 years old, patient X was 18. She was heavily in love and she was under the impression he loved her deeply. At 17 she was pregnant. At 19 again. She had a relationship for about 10 years with patient X. During these years the relationship was regularly broken by patient X. Sometimes because he had enough of her, sometimes because he was detained. He was jealous and suspicious and became more and more aggressive and violent in the relationship. In contact with their children he was brutal and harsh. Nowadays she still loves him even though the relationship is 'over': 'I feel as if we have become adults together, like we are family'. At the same time she is afraid of him. When patient X goes on leave the FPC informs her about this on her request. She wants only supervised visits to the children. Otherwise he could 'miss' the train. Then he must spend the night with her, she says. 'And you never know what happens'. Ex- girl-friend has a new relationship. She does not want her ex to meet her new partner because she is worried the two men will fight.

The brothers told the interviewer that they have not maintained contact with patient X because he was continuously in and out detention and that he also never listened to their advice. They tried to convince him to go to a psychiatric hospital voluntarily which had failed. They did not know what to do. And frankly, they were fed up with him. They were unaware of the psychiatric problems of patient X.

Patient X's boss told during the FSNA interview that he is satisfied with patient X; X is a highly valued employee. Patient X gets along with his boss and his immediate colleagues. He is friendly and is always willing to help others. The

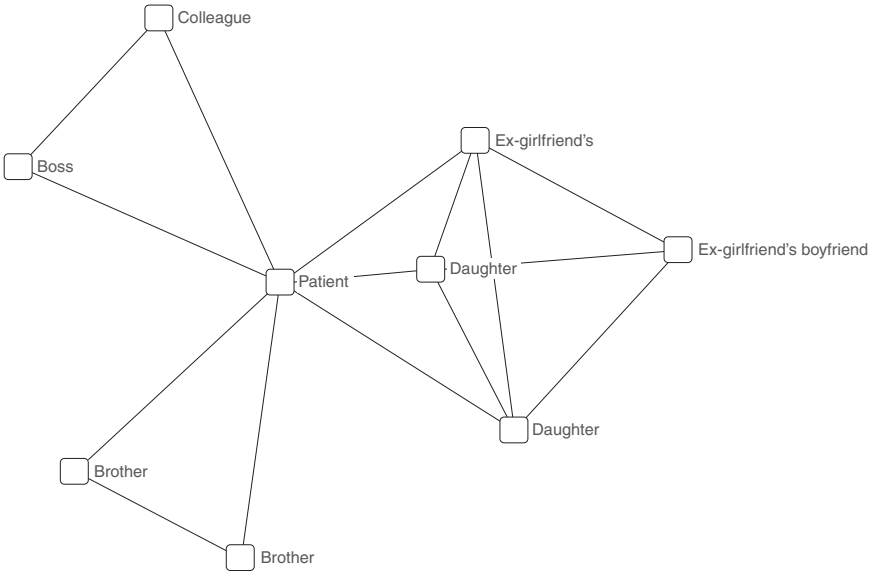
only concern is that patient X is sometimes a bit too assertive: 'When he gives his opinion, he ignores the feelings of others.'

Table 1 shows the answers of patient X about what he expects for support from his social network members. The answers of patient X are compared with the answers of his social network members.

Table 1: table of expected social support

Social Support	Practical support	Financial support	Emotional support
Patient Ex-girlfriend	Yes No	Yes No	Yes No
Patient Brother 1	Yes Yes	No Yes	No Yes
Patient Brother 2	Yes Yes	No Yes	No Yes
Patient Boss	Yes Yes	No No	No No

The interviews showed patient X has no good perception of the support he can expect in the future from his ex-girlfriend and his brothers. Patient underestimates the amount of social support given by his two brothers. He expects practical-, financial and emotional support from his ex-girlfriend, while she says 'no' to any form of support. Figure 3 shows the current social network after interviewing the network members. An assumption of the FSNA is that each existing misperception may lead to stress when the patient reenters society. Social support can be significant to care relationships, because it influences a person's mental health, and vice versa (30-31). Nel Noddings makes the distinction between 'caring-for' and 'caring-about' (32). Caring-for does culminate in caring relations. Caring-about is something more general. We can care about poor people in Africa and think we ought to give some money. One could say patient X' ex-girlfriend still cares-about patient X because she lets him visit the children, but she refuses tot care-for. Even though she still has warm feelings for him, somewhere. She is too scared. It is important to know if there is overestimation of expected social support. If clinicians are aware of this information during treatment, interventions become possible, such as telling the patient about his or her "real" social support system and helping her or him to build and expand a social support system.Figure 3: current social network after network interviews



Patient X - FSNA intervention

A positive finding is the willingness of the brothers to support patient X. Patient X did not expect this. Because the brothers are ready to 'care-for' patient X, they are approached for an intervention: psycho-education.

After the brothers have received psycho-education about patient X, as part of risk management suggestions from the FSNA research, they restored contact with patient X. They consider him now as a psychiatric patient who needs others for support and they understand better why their brother acts like he does. There are agreements made between patient, his brothers and the forensic clinic. For example, an appointment made is when brothers would see something special about the behaviour of their brother, they will inform the forensic hospital immediately.

Patient X visits his brothers regularly when he is on leave. On average, he is staying over two nights per month by one of his brothers. It seemed to go very well with patient X. At the transmural home of the FPC, an outside of the clinic placed residence, he is doing well. Monthly blood tests allow the treatment team to monitor patient's medicine use.

At work he is an appreciated colleague and his boss is satisfied with his work. His ex-girlfriend sees him when he visits her and their daughters. These visits are accompanied.

And then there is a phone call... The eldest brother of patient X calls the clinic. He and his brother are worried about patient X. Their brother seems to have lost grip on reality the last two days. X seems to be suspicious about the new boyfriend of his ex-girlfriend. Patient X is immediately picked up by his mentor

and brought back to the FPC. In a very short time, patient X had become psychotic again. And in his psychosis patient X found evidence that the current boyfriend of his ex-girlfriend would sexual abuse his daughters. A new, but very familiar, risk situation does his entry.

Thanks to the FSNA research contact between patient X and his brothers is restored. The brothers see patient outside the clinic, and were able to observe him outside the clinical setting. By means of the psycho education they recognised signals of a new psychosis. And because of their care relation with patient X they ensured that their brother could get the care that he needs. Fortunately, patient X was this time housed in a caring-situation before an offence has occurred.

Patient returned back to the FPC. He confessed that he did not take his medication in the last weeks. Because his ex-girlfriend had a new boy-friend he had felt unconfident. Patient X suffered from male erectile disorder most likely as a result of his medication use, and said; 'A real man does not use any medication.' The treatment team has to decide about the patient's future, his prospects are uncertain. The brothers will be involved in future treatment plans.

To conclude: good personal networks help you to meet other people, but *really* good personal care networks also help you to avoid people and situations which can bring you into trouble.

Discussion and future directions

This study has examined the extent to which relational ethics can play a significant role in forensic psychiatry, and how a forensic instrument, the forensic social network analysis (FSNA), can help to get rid of the fuzziness of relational ethics.

We stated that the classical view on autonomy, that of a rational and reasonable individual who makes sensible choices, does not stand in forensic psychiatry. We have to focus on the care ethicists' description of autonomy. This concept of autonomy is a relational version, because autonomy can only be properly designed in relationships with others. Relational ethics looks at individuals in dependency relations to others. It focuses on 'care' within these relationships. To not solely focus on care relationships but also to interpret this relationships in a forensic psychiatric context, the FSNA was introduced. FSNA activates the social network of a patient in the context of risk and protective factors. Also, FSNA provides additional information for risk assessment, as well as tools for possible intervention (risk management) purposes.

The case study about patient X was the the leading thread running through this essay and has shown us that relational ethics and FSNA together give us possibilities to give the patient the needed care within an individual oriented risk management approach. For example, patient's brothers were ready to 'care-for' their brother. Thanks to the psycho- education they recognised signals of patient's new psychosis.

The common nature of relational ethics and FSNA is motivated by some key elements; A shared focus on the individual with his own individual (social) context and his own story as a theme running through his life; The individual context can only be understood by identifying the social context and vice versa; Every person has his own sets of learnt dispositions, (social) skills and ways of responding to the other. It is important to 'put on the shoes of the other' in order to understand him or her better. This is necessary for good care and risk management, because someone's personal and physical situation must be understood before proper care can be given; To have true contact with each other, reciprocity is necessary. Although, professional contacts are not chosen voluntarily in forensic psychiatry, there will be only a therapeutic *relation*ship if there is reciprocity between patient and clinician. Thus, for the future, we would like to develop a care ethical autonomy concept for the forensic sector. An autonomy concept that includes *forced* contacts within the social network.

The care relationship is always part of the patient's network in which responsibilities play an important role.

FSNA disposes relational ethics in forensic psychiatry of 'fuzzyness', and FSNA becomes much more than a risk management tool: FSNA has become a method that does more justice to an individual, a method that has a vision on forensic psychiatric patients, a care ethical approach. We do catch two birds with one stone. To answer the question 'Do we (have to) care, or just say 'beware'?', with this care ethical social network approach, we can do both.

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Senior Citizen Criminality and Mental Disorder in the Netherlands*

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Summary

Possible reasons why first time offenders aged sixty or older commit crimes include psychiatric problems which, we think, are sometimes linked to addiction, socio-economic issues, and/or legal aspects of psycho-social explanations seen from the perspective of old age. This article will address specific aspects of criminality and psychiatric disorders among Dutch seniors by a literature search and data-analyses of Dutch older offenders suffering from a psychiatric disorder, because of the plea for that specific detention for elders in the Netherlands.

Our literature search has revealed that with increasing age crimes are in general increasingly less severe. As a rule, the elderly generally commit minor crimes such as petty theft, fraud or minor assault. Furthermore, when in some cases senior citizens commit more serious crimes there is a greater chance of sexual offenses, in particular child abuse. Finally, we found that little research has been conducted into the motives behind why the elderly commit crimes.

Our data of Dutch older offenders suffering from a psychiatric disorder reveal that the number of reports on those 55 and older has risen in recent years, and remains relatively low (± 3%) compared to younger age groups. In case of serious crimes among these elderly, we found homicide, assault and arson. This population shows a relatively frequent incidence of organic cerebral disorders.

We recommend therefore that (follow-up) research should be directed at psychiatric disorders and criminal behavior in old age as well as the influence of deprivation among the elderly, in order to study whether as concerns crimes against property, it is possible to establish a link between issues of loneliness and petty theft.

1 Introduction

Statistics released by the Dutch Ministry of Justice (*Dienst Justitiële Inrichtingen* or DJI) show that the number of individuals over the age of 60 in Dutch prisons has

* For permission to publish the DJI statistics we thank Mr. K. Swierstra, Head of the DJI's Department of Information Analysis and Documentation in The Hague. We also extend our gratitude to Dr. Edwin de Beurs for allowing the NIFP statistics to be used.

gradually increased since 1994. In that year there were only 60 inmates over 60 years of age, in 2002 this number had risen to 138, by the end of 2006 it stood at 228 and by 2008 at 232 (1) The number of senior citizen inmates rose substantially in 2002-2003 (see illustration 1). This trend can be partially explained by the rise in the total number of inmates which began in 2002. Yet while the total number of inmates since 2002 has declined slightly, the number of inmates over the age of 60 has not followed suit.

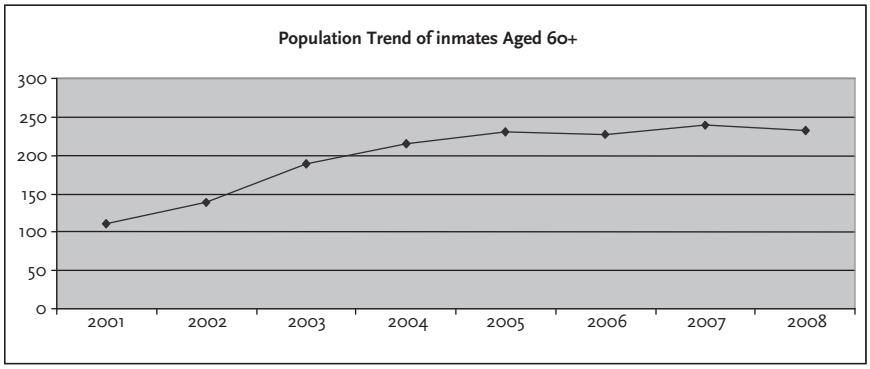

Illustration 1: Number of Inmates Aged 60+ 2001-2009 (Source: DJI; TULP GW)

Having this in mind, we aimed to this literature search and data-analyses of Dutch older offenders to describing the possible sources of criminality among Dutch seniors. The rise of committed crimes by elders in recent years prompt us to look for more reasons to facilitate the institution of specific detentions for elderly criminals, too. Not only socio-economical, and legal aspects, but also psychiatric and psychological and psychosocial aspects. Is there a need for a specific criminal law for elders in the Netherlands, like there is a specific youth law? And if this need is not necessary at the moment, should it anyway be of thought to establish specific treatment detention centers elders with psychic problems?

What kind of crimes are we dealing with? Why is the number of crimes committed by people over the age of sixty increasing in the Netherlands? How do they compare to the larger group of Dutch senior citizens?

Thinking of the establishment of specific detention centers for elders (2) an investigative report into senior crime was recently prepared for the supervisory board of the Dutch Public Prosecutor's office (3). This investigation consisted of three parts. The first deals with the scope and nature of the influx of Dutch elderly (65+) into the criminal justice system as well as with how the Public Prosecutor actually tracks down and prosecutes the elderly. The second part consists of a comparative legal inquiry and the third part deals with the cognitive

consequences of aging of the brain. These thorough studies show that the increase in the number of elderly can be principally explained by an increase in police efficiency and the aging of the general Dutch population (first part of the study). It also appears that there exists no legislation for seniors in any of the investigated jurisdictions and that current Dutch penal statute thus do not deviate from the international norm (second part of the study). Finally, the Public Prosecutor's report reveals that current research does not indicate a link between normal aging of the brain and an ailing intellect or criminal behavior (third part of the study). The report's general conclusion is that there is insufficient cause to introduce senior criminal law in the Netherlands (3).

Although the Public Prosecutor's report very thoroughly addresses a number of this issue's facets, this investigative inquiry, we found, hardly deals with the psychiatric, psychological and psycho-social factors of senior criminality. Yet, of course we then can face the need for specific psychiatric treatment and care. Furthermore, the various aspects of senior criminality examined, excepting the comparative legal study, were not placed in an international perspective. This study emphasises the factors missing from the Public Prosecutor's report. First, a number of hypotheses will be formulated regarding the causes of '60+ criminality' in the Netherlands; then with the aid of a literature search the issues will be more closely examined from an international perspective. Thereafter an overview of elderly suspects and inmates suffering from psychiatric disturbances in the Netherlands between 2000 and 2007 will be provided. Finally, the question whether there should be plan for senior criminality regarding legislation or special prisons for the elderly will be discussed.

2 Hypotheses and reasons regarding the causes of 60+ criminality

There are a number of reasons why first time offenders aged sixty or older commit crimes; these include psychiatric problems which are, we feel, sometimes linked to addiction, socio-economic issues, and/or legal aspects of psychosocial explanations seen from the perspective of the third or fourth phase of life. The following section sets forth the possible causes of 60+ criminality, some of which partially overlap (4-5). We look particularly at issues regarding criminal offences and psychiatric morbidity, and legal aspects, because we feel, that in those issues (together with factors which are connected to psychiatric problems, like socioeconomic, psychological and psychosocial issues) the problems at stake are relatively pinpointed.

Psychiatric issues include a (fronto-temporal) dementia syndrome concluded the Americans Hucker and Ben-Aron (6). Their study showed that 69% of violent elderly offenders suffered from a degenerative brain disease or functional

psychosis. Among non-violent elderly offenders this figure was 19% and among the younger control group 0%. Older violent offenders also included significantly more cases of schizophrenia and bipolar disorder. It was also remarkable that of these violent elderly offenders half were first time offenders while among the younger violent offenders this was merely 25%. Similar studies have been conducted however in which the share of older offenders with organic cerebral problems is marginal. In this kind of research it is important to differentiate between various offences (7).

The aging of the population in the Netherlands between 1990 and 2004 produced an increase in both the total number of patients with dementia and the number of new patients per year. Yet if these figures are corrected for these demographic developments is there still an increase? One must also reckon with improved detection of the signs of these neurodegenerative disorders, such as valid psychological tests and advanced imaging.

Addiction problems among the elderly might be a possible explanation for the increase in '60+ criminality'. Recent figures from the Dutch Central Bureau for Statistics (CBS) show that 8% of senior citizens drink three or more glasses of alcohol per day (8). Addiction among the elderly is increasing; in addition to increased alcohol use, there is also an increase in the use of hard drugs in the Netherlands. For this reason there are now a number of special places for older users in shelters. Dependence upon for the most part expensive narcotics along with a lack of money may prompt delinquent behavior such as theft and violence. We have not yet been able to locate any literature on aging and hard drug use.

Socio-economic reasons or the possibility of financial gain are other plausible explanations for the increase in criminal behavior among the elderly. According to the Dutch Social and Cultural Planning Bureau (SCP), the position of senior citizens over the last fifteen years has developed favorably. The percentage of low incomes among those aged 65 or older is lower than among those still working. When compared to younger people, those over the age of 65 suffer less from material want, government agency access problems, and unsafe housing conditions (9). Evidently this is not the case for every elderly person. For example, there is a group of people in the Netherlands that receives nothing more than a general old age benefit. Furthermore, SCP figures indicate that two hundred thousand elderly over the age of 65 in the Netherlands live below the poverty line.

In addition, relative deprivation may also offer an explanation. Relative deprivation refers to the fact that subjective satisfaction is not determined so much by the objective situation in which an individual finds him or herself, but indeed by the relative position of that individual vis-à-vis other relevant people with whom he or she compares him or herself. In other words, these senior citizens believe that the environment progresses more materially than their own situation. Several practical examples have been displayed in a Dutch tv documentary about elders who have committed crimes (2). In that documentary

elders committed crimes, too, consequently for economic reasons. Supplementary income from, for example, the illegal sale of soft-drugs may be an alternative to these senior citizens. It is possible that today's blurring of moral standards in the Netherlands has now also reached the oldest cohorts and has lowered the threshold as regards the trade in narcotics. Although the blurring of norms is difficult to assess, research into the nature and motives behind the crimes committed by senior citizens can provide more clarity.

Legal aspects can also explain the increase in '60+ criminality' in the Netherlands. For instance, criminal investigation for the elderly in recent years has been intensified, and fewer criminal cases (involving the elderly) have been dismissed.

A fourth explanation is of a *psycho-social nature*. The problem of loneliness has steadily increased among the elderly, in part as a consequence of the "double aging" of society. In other words, the proportion of people among the Dutch population over the age of 65 is not only increasing, but the elderly are also increasingly older. On January 1st, 2007 the Netherlands had an estimated population of 2.4 million senior citizens, roughly 14% of the population. We then refer to the "double aging" by which we refer to the fact that within the group of people over the age of 65 the number over the age of 80 has increased the most. On January 1st, 2007 there were almost 601,000 people aged 80 or older in the Netherlands, roughly 4% of the population. The proportion of the population living alone increases considerably over the age of 70; this group principally consists of elderly women who have been widowed (8). Boredom and social isolation by virtue of the loss of or conflict with neighbors may also be motives behind why some people commit crimes for the first time late in life. In these situations such crimes chiefly consist of repeated petty theft commonly of inexpensive items in supermarkets and shops. The crimes are committed not for financial gain, but to break out of daily routine. This probably also plays a role in sexual offences, including those with minors.

3 Specific search

More specific literature search was designed to chart the differences in criminality between young adults and the elderly (> 60 years) in order to be able to compare nations such as the United States, Japan, Israel, Great Britain, Germany, Sweden and the Netherlands. Why these countries? Because of their actual detention facilities for elders, or their specific criminal law procedures for elders, and actual news in the media about it. The following search terms were employed: crime offenders, mental disorders, prevalence, older adults, elderly, detention, imprisonment. These terms were searched in various combinations which produced in total 45 usable hits. The questions we posed during this investigation were: How many of those accused of a crime that are older than 60

are first time offenders? What crimes do they commit? What kind of psychiatric disorders are found in this group? What kind of sentences do they receive and how many turn out to be non compos mentis?

This literature search demonstrates that on average half of senior citizens convicted of a crime were first time offenders. (10-13) Furthermore, it appears that older people are more likely to commit sexual crimes. The motives behind this were appeared to be concerns, (social) isolation, relationship problems, and altered role patterns, such as retirement in which responsibility for a job is lost (11).

The elderly end up in prison less frequently, however. Less than 1% of those incarcerated are over 65 (14). Similar results gave the Wyomissing Borough report (15): 4% of those arrested are 55 or older and only 1% is over 65. Yorston (16) reported that shoplifting is the most frequent crime committed by the elderly (more than 80%). In general those over the age of 50 commit less serious crimes. For example, only 1-4% of murders are committed by people over the age of 50. (14, 16-18) Dunlop's et al. study (18) analyzed criminal behavior among the elderly in five nations (Germany, Japan, Israel, Great Britain and the United States). On average 1.2% of offenders in these five countries are 65 or older; their most common crimes are petty theft and fraud.

As regards serious offences, senior citizens chiefly commit sexual crimes, mostly child abuse, as demonstrated in multiple studies (10-12, 17, 19-20) The motives behind these sexual crimes (especially against children) are: (social) isolation, relationship problems and changing role patterns. (11) It also appears that murder and violent crimes are rarely committed by those over 60. For example, only 2% of all American serial killers in 2004 were older than fifty. (21) The motives for such crimes are relationship problems Senior citizens who commit murder are more likely to thereafter commit suicide than younger people (22). Our search revealed that most studies into senior citizen criminality deal with the more serious crimes. One should note that these studies utilize sample surveying which is not representative for the entire group of those over the age of sixty that have committed a crime.

Roughly 1 to 5% of convicted criminals are sixty or older (14). Criminality among the elderly is increasing in Germany as well (23-24). We are dealing here chiefly with petty theft, fare-dodging, fraud and property damage. This kind of criminality is motivated by financial problems, boredom and loneliness. One study in Japan also reported an increase in criminality among the elderly: one in seven crimes in that country is committed by someone over the age of 65. The crimes committed by Japanese senior citizens are chiefly (criminal) assault, assault and battering, petty theft and pick-pocketing. The motives for these crimes are (again) loneliness, frustration and financial problems (25).

The most common psychiatric disorders among elderly convicts are alcohol abuse, depression and dementia (10-11, 13-14, 19-20, 26-28).

Personality disorders, schizophrenia and drug abuse are less common among the elderly as compared to younger groups (10, 19, 27). In contrast, alcohol abuse and dementia are more common among the elderly (10, 12, 14, 26-28).

Compared to younger age groups, senior citizens are more likely to receive a suspended sentence. This is explained by the assumption that the elderly commit less serious crimes and that their recidivism rates are low (14, 16, 18). Their increased vulnerability also contributes to their receiving less severe sentences. Studies have shown that sentences differ by nation. Thus in general England and Japan hand out stiffer sentences to senior citizens than Israel (18). A comprehensive account of international penal law can be found in the recent Public Prosecutor's report on senior citizen crime (3).

Two studies took 'non compos mentis' as a variable. Lewis' study shows that of the 99 elderly offenders 42% were declared non compos mentis or not criminally responsible (13). In this study being declared of unsound mind is associated with dementia. Fazel's study (27) indicates that of the 213 offenders aged 60 or over, 62% were non compos mentis and of the 103 offenders aged 65 or over this figure was 65%. Among the elderly it is men who are more often declared non compos mentis. This contrasts with younger groups in which women are more often so reported. Half of those senior citizens declared non compos mentis had a psychotic disorder, 12% suffered from dementia and 7% from personality disorders (27).

In sum, this specific literature search, based on findings in the United States, Japan, Israel, Great Britain, Germany, Sweden and the Netherlands, has revealed that with increasing age crimes are in general increasingly less severe. As a rule, the elderly generally commit minor crimes such as petty theft, fraud or minor assault. Furthermore, when senior citizens commit more serious crimes there is a greater chance of sexual offenses, in particular child abuse. Finally, little research has been conducted into the motives behind why the elderly commit crimes. We were interested in some data regarding elder offenders suffering from a psychiatric disorder in the Netherlands in recent years, which will be discussed next.

4 Some investigative statistics regarding older offenders suffering from a psychiatric disorder in the Netherlands, 2000-2007

The studied population is part of all suspects and those already convicted of having committed a crime in the period. A number of these individuals are released, some are held over for trial and some are in prison serving sentences. The overview presented here addresses those in this group older than 55 years during the period 2000-2007 who were assessed or treated for a psychiatric

disorder. If there is reason to believe that the accused or convicted when committing the crime, or later in the trial process, suffered or suffers from a psychiatric disorder, that individual is then assessed and, if necessary, treated by a psychiatrist or psychologist from the Dutch Institute for Forensic Psychiatry and Psychology (NIFP). This examination is conducted at the request of the Public Prosecutor or the Court for the benefit of the trial, and results in a legal report. In other cases it is a question of diagnosis and/or treatment at the request of the prison physician and then we are dealing with a consult.

Those detainees, who by virtue of psychiatric disorder find themselves in a crisis and cannot be sent to a psychiatric hospital on account of the seriousness of their crime or required security, are transferred to the Forensic Observation and Counseling Division of the Amsterdam penitentiary (Foba).

Between 2003 and 2007 the NIFP issued 1203 reports on individuals in trouble with the law over the age of 55 (see Table 1). In the same period NIFP psychiatrists were consulted 1017 times for detainees in this age group. There is an overlap of about 30% between these two groups by virtue of the fact that the same persons may have a report written up on them (at the request of a judge) as well as receive a consult on request of the institute physician/psychologist.

Table 1: Number of NIFP reports and consults 2000-2007

	2000-2002	*M/F*	2003-2007	*M/F*
Reports	513	*13/1*	1203	*14/1*
Consults	219	*14/1*	1017	*10/1*

In total the NIFP registered contact with some 1500 individuals in the criminal justice system 55 years of age or older in this period. That is 300 per year on average. In the period 2000 to 2002 there were roughly 200. The total number of reports per year in the Netherlands was 3500 in 1996 and 9000 in 2007. In 2007 those over the age of 55 constituted 3.3% of the number of reports per year. In Sweden (19) 7297 reports per year were recorded between 1998 and 2007 of which 210 were on individuals 55 or older (2.9%). Of the 10,292 detainees in the Netherlands in the year 2000 2.8% were 55 years old or older. During the last two decades yearly three to five detainees from this age group suffered a serious psychiatric crisis that necessitated referral to the Foba.

In the period 2000 to 2002 7% of those accused or convicted of a crime 55 years of age or over were women. In the period 2003 to 2007 this rose to 10% on average.

Most of these senior citizens belong to the 'younger old'; those above the age of 75 are an exception (see Table 2). Foba almost never houses anyone over 75 years of age.

Table 2: Age NIFP consults and reports 2000-2007	
55-64	75%
65-74	20%
75+	<5%

The NIFP data in Table 3 demonstrates that homicide and violent crimes are most frequent. (Pedo-) sexual crime is the second frequent type of crime, and almost exclusively committed by men.

Among Foba patients aged 55 and older, however, arson is the crime committed most frequently: 30% annually. Sex crimes are encountered less frequently in the Foba population (10%) and child sex crimes not at all. In contrast, among this group we find more individuals who have broken narcotics laws (12%). Probably sexual crime leads to more alternative sentences in this age group Note that Foba is for people in detention only, the NIFP reports regard individuals in detention, but also suspects not in custody.

Table 3: Percentage of crimes NIFP reports and consults 2000-2007 (N=2962)		
	55+	*M/F*
Homicide & assault	40%	*8/1*
Arson	6%	*2/1*
Fraud	7%	*3/1*
Sex crimes	21%	*130/1*
Child sex crimes	15%	*70/1*
Drug offenses	0,7%	*3/1*
Other	10.3%	–

Table 4: Percentage mental disorders 55+ NIFP 2000-2007 (N=2962) and Foba 1992-2007 (N=57)			
	Report	**Consult**	**Foba**
Axis I			
psychosis	10	14	45
mood disorder	12	21	10
organic mental disorder	7	8	28
sexual perversion	10	5	–
no clinical picture	32	38	2
Axis II			
personality disorder	36	40	6

Table 4 shows that psychotic disorders in the Foba population are relatively more prominent. However this is the case among older Foba patients far less than among 18 to 55-year-olds (80%). Organic mental disorders are relatively prominent and here too mostly among the Foba population.

Note that there is no illness detected in a third of the NIFP population. This is a possible sign of too broad rather than too narrows referring and makes it less

likely for psychiatric disorders to go undetected in these suspects. The small proportion of Axis II disorders among the Foba group is probably related to the gravity of the Axis I disorders. Personality disorders can be hidden by these.

Part of the pro justitia report is a recommendation to the Court. This recommendation can be related to the degree in which the mental disorder influenced culpability during the crime, to the suspect's need for treatment, and to the type of sentence. A total of 1716 reports were issued between 2000 and 2007 regarding people 55 years old and older. Of these 71% contained a recommendation regarding culpability (N=1252); 67% contained a treatment recommendation (N=1172); and 26.5% contained a sentencing recommendation (N=468). These data are presented below in Tables 5, 6 and 7.

Table 5: Culpability recommendations 55+ (reports 2000-2007, N=1252)	
	N
non compos mentis	110
diminished culpability	671
fully responsible	471

Table 6: Treatment recommendations 55+ (reports 2000-2007, N=1172)	
	N
polyclinic and outpatient treatment	402
assisted living	45
psychiatric hospital	105
medication	47

In 599 of these cases (±30%) an explicit treatment recommendation (of ambulant and/or clinical psychiatric treatment) was supplied.

Table 7: Sentence Recommendations for those 55 and older (reports 2003-2007, N=468)	
	N
community service	38
conditional sentence	379
not to be punished	38
transfer to a psychiatric hospital (art. 37)	13

An explicit recommendation for a sentence other than prison was made in almost a quarter of the reports on those aged 55 or older.

Finally, what happens to older Foba patients after the crisis intervention?

Table 8: Foba: destination of 55+ patients after treatment (1992-2007, N=57)	
	N
inside the prison system	
regular custody	15
care facility	30
outside the prison system	
nursing home	4
psychiatric hospital	20
sentence served/parole	25
suicide	2
data missing	2

As might be expected a significant number or patients are admitted to nursing homes and (geriatric wings) of psychiatric hospitals. It is interesting to see that almost half of these patients are able to return to a prison setting.

In summary, the data listed above reveal that the number of assessments on court order (NIFP reports) on suspects 55 years and older has risen in recent years, but remains relatively low (± 3% compared to younger age groups). The NIFP reports, that if only a small part of the total group of elderly, who committed a serious crime and having a psychiatric disorder, indicate that the most common crimes among these elderly are homicide and assault, and (pedo-) sexual crime in men. In contrast, among elderly suspects in custody (Foba patients) aged 55 or older arson is seen more frequently, while (pedo-) sexual crime is practically nonexistent. Both groups have a relatively frequent incidence of organic cerebral disorders.

5 Discussion

At the moment senior citizen criminality is a popular, sometimes even comic subject in the Dutch media (2). Yet this has also brought the subject to the attention of the Public Prosecutor's office, which led to the production of series of scientific monographs on senior citizen crime, based on literature search and data-analyses (3).

Our own study of the international literature together with data on clinical and court-order assessments has extended the subject to include the role of mental disorder in senior criminality. The combined data demonstrate that with increasing age the crimes committed are on the whole less severe. The elderly generally commit crimes such as petty theft, fraud or minor assault. As far as serious crimes among the elderly are concerned, child abuse is the most common. Furthermore, when corrected for an aging population, we do not find a relative increase in senior citizen crime in the Netherlands. In the Public

Prosecutor's report discussed above the increase in senior citizen crime is also explained by the increased effectiveness of police work (3). The Public Prosecutor's report states that Dutch senior citizens most often commit traffic crimes, in particular leaving the scene of an accident, followed on a distance by assault and crimes against property. Increased traffic crime among the elderly is probably (or at least largely) explained by the increased mobility of senior citizens (3). The aging of the populations of western nations has led to a customary division of old age into two phases. The first of these begins after (increasingly early) retirement, and is known as the 'third phase of life'; in which people are still vital and can continue to develop after they have finished with career and family. Over the last thirty years this phase has grown longer as a consequence of increased life spans. The second phase of old age, i.e., the 'fourth phase of life', is the period of increasing physical and mental deterioration as well as social dependence, ending with death. On account of good health care and modern means to compensate for immobility and other handicaps, this phase is lasting increasing shorter long. Since the 1970s the border between the third and four phases of life in the Netherlands has shifted from 65 to 85. It is probable that the living conditions of most of those who are charged and/or convicted of a crime are by and large less favorable, resulting in the third phase of life being shorter on average. This may explain in part why the old-old (75 and older) are very rare in the Dutch prisons. Other possible explanations include: less (serious) crime and/or a less stringent prosecution policy for the very elderly. Statistics covering the period 1995 to 2009 from the *Dienst Justitiële Inrichtingen* (DJI), the Dutch prison system, on inmates 65 or older evidence that the younger of the two elderly groups (65 to 69) is twice as big as the older group. The group of inmates 75 years and older remained the same between 1995 and March 2009 (3).

Should the Netherlands now anticipate on the absolute increase of criminality among the elderly by drafting new legislation? Do we need special prisons for senior citizens, as there are in England, Germany and Japan? (29) Considering that the population the group comprising those of 75 or older is hardly represented in the Dutch penal system, and that senior citizens under age 75 are usually not in need of care and special (housing) provisions, it has been argued that special senior prisons are not needed in the Netherlands (30).

The introduction of a penal code for senior citizens, for example for those 75 years old and older, not only stigmatizes, but is difficult to implement on account of the great differences between senior citizens described earlier (Oei, 2007) (5). In addition, in the Netherlands sufficient legal options already exist to ensure that during a criminal trial those issues specific to the third and fourth phases of life are taken into sufficient account. The Public Prosecutor's report as well stated that there were insufficient grounds to draft criminal laws especially for the elderly (3).

We recommend further research into the relationship of psychiatric disorders and criminal behavior in old age, as well as on the relationship of (social-deprivation and petty crime in the elderly. Closer examination of aspects of the phases of later life also constitutes an interesting research subject. In a word, the elderly constitute a relatively young and dynamic field of forensic research.

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What can Family Law do in Case of Maltreatment of Elderly?[1]

Paul Vlaardingerbroek

1 Introduction

Due to the growing number of older persons new issues draw the attention. Questions with regard to (flexible) housing, health (care) issues, caring, financial problems, pension rights, etc. draw the full attention of politicians, caregivers, doctors, financial experts, etc. But also family members may have concerns about their (grand)parents' health and the way they live. Especially in western societies there are great concerns about the growing and growing number of elderly and the decline of new born children. In this paper I will not focus on these issues, although they are very important and highly debated, but there are many experts working in this field who can better describe the problems and the interaction between the different aspects of these issues. Therefore, I will focus on the subject of maltreatment of elder persons and what can be done to prevent this from a family law perspective.

In the last decade a lot of literature and research has been published on the subject of maltreatment of the elderly. The main focus in literature is the research on elderly maltreatment from psychologists, sociologists and medical experts. Books and papers on maltreatment by caregivers, the financial abuse of elderly, sexual abuse etc. can easily be found. The question arises why the attention for maltreatment of the elderly is so popular now, because this rather new phenomenon is not quite new. Maltreatment of vulnerable people, like children, elderly people and disabled persons will surely have taken place as long as we have these groups in our society. So it is not the maltreatment itself, but the attention for it at a societal level. What has been kept for many decades as a family secret or as an incident in the residential homes or hospitals, has now become to an issue what also has drawn the attention from governments and politicians. In the Netherlands, the subject of maltreatment of elderly has got more and more attention, even from the Ministry of Health, Welfare and Sport. In May 2012 our Secretary of State, Mrs. Veldhuijzen van Zanten, has announced that she made a financial reservation of 10 million Euros to tackle this problem. She announced this with the start of the action plan "Elderly in safe hands". It is expected that the number of maltreated elderly in the Netherlands

1 This is a strongly revised version of my contribution to the liber amicorum for Professor P. Agallopoulou, Protection of adult persons, a family law issue? In: Essays in Honour of Penelope Agallopoulou, Volume II, Ant. N. Sakkoulas Publishers, Piraeus (Gr.), (ISBN: 978-960-15-2511-2), 2011: P. 1477-1495.

(appr. 200.000) is even higher than the number of maltreated children (120.000). Therefore, it is interesting to try to find solutions how it is possible to better protect the elderly in our families and in society and how to better protect their legal rights. In the decades ahead of us the number of elderly will grow more and more, so the need for better treatment and care of elderly persons is evident. From a family law perspective it is interesting to see what families can do to better protect their parents and grandparents if they have become of age or if they are handicapped or ill.

To deal with this subject, I will first give some figures on this topic, then I will describe the rights of the elderly and the Convention on the Rights of Persons with Disabilities and its Optional Protocol and its consequences for governments and others to respect the rights of the elderly. Finally, I will focus on the question what (family) law can do to help to protect the rights of the elderly within the family and what we can learn from the prevention of child protection.

2 The issue of ageing in western societies

In the years after the Second World War many babies were born, due to the reunion of families after the World War II and the feeling of freedom. The last decades, the human life span in most (developed) states has continued to lengthen (good health care, other labour activities), accompanied by a corresponding increase in the illnesses attaching to old age. The Economic and Social Council has forecasted that in the two coming decades the number of persons *above the age of sixty* will increase from 600 million in 2001 till 1.2 billion in 2023. The total number of the real elderly (the fourth generation), those who are *eighty years old or older*, will increase to almost 140 million in 2025 (in 2001 600 million). This means that in almost all countries we can expect a growing number of persons who are suffering from infirmities of old age, such as physical and mental problems and diseases. Besides this, we also see that a growing number of elderly, those who were born in the thirties, forties and fifties of last century are well-to-do persons, who have more money to spend because of good pension arrangements, property, etc. Many elderly go on (long) vacations abroad or have a second home in a country with a warmer climate and enjoy the warmth and good life there. However, unfortunately for these elderly this happy life does not last forever. The older people are, the more physical and mental health problems will show up. The Hague Convention of 13 January 2000 on the International Protection of Adults provides in the problems when adult persons need a provision for the protection in international situations of adults who, by reason of an impairment or insufficiency of their personal faculties, are not in a position to protect their interests.

Besides the growing number of elderly with mental problems, there is a reasonable number of adults who need (financial) protection because of incapacity. Such is the case with those who are mentally handicapped (e.g. Down syndrome) or who have serious psychiatric problems.

The Council of Europe's European Commissioner Thomas Hammarberg wrote in his Human Right's comment: "*... The elderly is one of the vulnerable groups that have been deeply affected by the economic crises. In Europe especially, ageing persons in the so-called transition countries have been hit hard. The number of elderly people begging in the streets goes to prove that their human right to an adequate standard of living is not respected. The term 'lost generation' is sadly appropriate.*

Within the vulnerable group of elderly people, there are those who are particularly at risk. Elderly women often receive a reduced pension allowance because they have cared for family members rather than being professionally active. With a growing immigrant population the number of older migrants is also increasing. Their wellbeing is a challenge for which the authorities in European countries seem to be grossly unprepared.

..... (...., PV)

The number of people in the EU aged 65 and above is expected to grow by 70% by 2050, and the number of people aged over 80 by 170%, according to the EU Health Directorate. This will not only require new social security strategies, but it will also have strong implications for health care systems. Age-friendly policies and more focus on the prevention of chronic diseases, which actually cause more disability than ageing itself, will be necessary.[2]

Therefore, the issue of aging of the population becomes more and more important. On the one hand we see a growing number of elderly, on the other hand there is a decline of new born babies. With less youngsters and a growing number of elderly, of which many will no longer be able to take care of themselves or will suffer from great health problems and diseases like Alzheimer, it is to be expected that these two different developments (ageing of society and less youngsters) will heavily crash in the near future. In this respect a big issue is already how to take care of those elderly who have become dependent of others. In European countries this is especially the group of those who are 80 years or older.

Because of this growing number of elderly who need (medical) care, it is easy to understand that this will raise very important challenges in the field of (health)care. New health systems need to be developed in the near future, to get adapted to the needs of these older persons, especially when it is to be expected that we shall deal with a smaller workforce and less caretakers in the near future. Of course, it is already a fact that people stay longer active in life, because they live longer and live healthier. However, at a certain point in ones' life there will surely come a time that living becomes much more difficult because of problems

2 http://commissioner.cws.coe.int/tiki-view_blog_post.php?postId=65.

that are related to the aging. To my opinion, it is extremely necessary that our ageing population will be in good health as long as possible, because this will lead to less strain on health care and health systems and because this will be less stressful for their children and their families who will usually have to work both and cannot afford to have an extra job in caring for the parent(s). Besides this, healthy people can work longer. We must also bear in mind that with a strong growing number of elderly of a high age, it will be impossible to have enough nursery homes and caregivers for all of them. This means that this problem will have to be tackled by the elderly themselves by hiring private caretakers, nurses, etc., that will allow them to live at their selves as long as possible. The longer persons work, the better financial means they usually will have. With this money they can invest in their home to be longer able to live in their house because of adaptations for a saver living (elevator, shower/bath, domotica, alarm system etc.). Parents at age can also ask their children for assistance, although if parents at eighty years or older their children will be older too and nowadays it is more usually that families do not live in the same town or village. In cases where older people cannot properly take care of themselves the risks of financial mismanagement, inadequate care, neglect, abuse and maltreatment can become much higher.

In those cases the question arises what can be done to help these elderly in need, even if they do not ask for help.

3 Financial protection of the elderly

In case an adult person is no longer capable to take care of himself, especially when there are financial risks, the judge may order a kind of protection measure for the person involved, such as a *supervision order*, a *guardianship order* and/or a *mentor order*. Of course, when deciding the judge has to take into account the basic principles of subsidiary and proportionality. The consequences of these measures may vary from total legal incapacity for the person involved to a certain incapacity (e.g.: the supervised person is only incapable of acting independently in view of certain assets). Besides these financial protection measures, there are also other ways to represent the incapable person with regard to their immaterial interests (e.g. for questions of care, nursing, treatment and support).

But who should be appointed as supervisor, guardian or mentor? Should he preferably be a professional or is it better to give priority to the spouse or partner, or one of the other family members (parents, children, brothers, sisters)? Is it preferably to appoint two supervisors? And what to do if it is not quite sure if they can co-operate in the guidance of the person involved? What are or should be the criteria for the court to appoint a family member as supervisor?

These are important questions to be answered, because for the persons involved it can be very important who will be the legal representative, because

this representation will usually last for a longer period and they must closely work together. In the past years we see growing conflicts between close family members with regards to the issue of (usually financial) protection of the parent (s). Therefore, in case of the nomination by a judge of a family member as legal representative of the older parent(s), it is very important that the judge carefully looks at the best interests of the person involved and really tries to find out, how the relations between the family members are. The judge must also try to find out whether the nomination of one of the family members or a third person as curator, supervisor or mentor will be accepted by the parties and the family involved. Of course, this may be difficult when family members have different views how to give the best protection to the parent(s). Therefore, the role of the judge is to figure out if there is a conflict in the family with regard to the caring of the parent(s) and if conflicts between them are to be expected in the near future. In case of disagreement between the family members with regard to protection of the parents or others or about the nomination of one or more supervisors for the elderly, it is better to nominate a professional agency or a third person as a curator, supervisor or mentor. It must be noticed that this procedure will take much time for the judge, because it is essential that his decision will be carefully taken. This demands a quite new approach by the judge, because – although his decision must be based on the law - he must be able to deal with opposite family members. Just giving a legal decision will not always make an end to the fight in the family on the issue who must become the curator or mentor for the parents. And if the fight between brothers and sisters continues or even becomes harder and harder, it are usually the parents who suffer most from it.

4 Maltreatment of elder persons

Due to the increasing population of people at age, more and more elderly are in need of quality care from either family members, friends or care and health facilities[3]. It is to be expected (and feared) that – with this increase – the number of abuse cases of elderly will also raise. Until now there is not much known about how and why people can commit such a crime against other persons in need. Therefore, further sociological and psychological research is necessary to find out why vulnerable persons are abused and maltreated. Only by identifying the causes of abuse against the elderly and by looking at the criminological theory behind why one would commit such a crime, we can start to focus at those areas that can be changed in order to tackle this growing problem. With regard to the

3 A survey of nursing-home staff in the United States of America suggests rates may be high:
- 36% witnessed at least one incident of physical abuse of an elderly patient in the previous year;
- 10% committed at least one act of physical abuse towards an elderly patient;
- 40% admitted to psychologically abusing patients (WHO, Elder maltreatment, Fact sheet N°357, August 2011.

prevention and elimination of this problem of maltreatment, it can be very helpful to know the background of these crimes and to have more knowledge of the (background of the) actors of these crimes.

Because we do not know exactly how caregivers and family members come to these crimes against elderly, there are no standardized definitions yet. A consistent definition is needed to monitor the incidence of elder maltreatment and to be able to examine trends over time and to be able to better tackle the problem.

The following descriptive definition of maltreatment of elderly can be given:

Maltreatment of elderly is any abuse and neglect of vulnerable persons of age by a caregiver or another person in a relationship involving an expectation of trust. However, this definition does not cover all sorts of taking advantage of the vulnerable position of the elderly. E.g., is (an oral) threat or blackmail of the elderly maltreatment? Probably not in the pure sense of the word, but taking into account that elderly usually are vulnerable persons, it may be said that this is also a form of maltreatment.

In some definitions the age is mentioned, e.g. 60 or 65 years or older, but to my opinion it is better not to mention concrete ages. A person of age can already be threatened at the age of 40 or 50 (in some cases young parents are maltreated by their children and sometimes forced to financially support the children for buying drugs, or to give the child more freedom than is good for them, etc.). In daily language the term 'older people' is mostly used for the over fifty-fives. However, someone of fifty-five is in an entirely different situation than someone of eighty-five years old. Therefore, more differentiation will have to be made between sorts of elderly, e.g. in a division of generations or capacities.

When we speak of elderly maltreatment we usually think of the maltreatment of people who – because of their old age – cannot no longer take good care of themselves and who have become (partly or totally) dependent of others (family members, caretakers etc.).[4] In the following I focus on this specific age group.

Forms of *elder maltreatment* include:[5]

- *Physical Abuse*: an elder is injured (e.g. by scratching, biting, slapping, pushing, hitting, burning, etc.), assaulted or threatened with a weapon (e.g., knife, gun, or other object), or inappropriately restrained.
- *Sexual Abuse or Abusive Sexual Contact*: any sexual contact against an elder's will. This also includes acts in which the elder is unable to understand the act or is unable to communicate. Abusive sexual contact is defined as intentional

4 Of course domestic violence from children towards their children happens too, but I will not define this as maltreatment of elderly, but as a sort of 'domestic violence'.

5 http://www.nysna.org/practice/positions/position3_10.htm

touching (either directly or through the clothing), of the genitalia, anus, groin, breast, mouth, inner thigh, or buttocks.

- *Emotional (or Psychological) Abuse*: this occurs when an elder experiences trauma after exposure to threatening acts or coercive tactics. Examples of emotional abuse include humiliation or embarrassment, controlling behavior (e.g., prohibiting or limiting access to transportation, telephone, money or other resources), social isolation, disregarding or trivializing needs, or damaging or destroying property.
- *Neglect*: the failure or refusal of a caregiver or other responsible person to provide for an elder's basic physical, emotional, or social needs, or failure to protect them from harm. Examples include not providing adequate nutrition, hygiene, clothing, shelter, or access to necessary health care; or failure to prevent exposure to unsafe activities and environments.
- *Abandonmen*t: the willful desertion of an elderly person by caregiver or other responsible person.[6]
- *Financial Abuse or Exploitation:* the unauthorized or improper use of the resources of an elder for monetary or personal benefit, profit, or gain. Examples include forgery, misuse or theft of money or possessions; use of coercion or deception to surrender finances or property; or improper use of guardianship or power of attorney.

In some articles also self-neglect is mentioned as a form of elder maltreatment, but in my opinion elder maltreatment and self-neglect are two separated forms of behavior. Self-neglect occurs when vulnerable persons fail or refuse to address their own basic physical, emotional and/or social needs. Examples of self-neglect are forms of not taking good care of nourishment, clothing, hygiene, housing and shelter. But also no proper or appropriate use of medications; and a failure in managing or administering one's finances are forms of self-neglect too. In these cases the client may suffer from mental and/or psychiatric problems. In those cases it may be necessary to intervene in one's private life. In hard cases it can even be necessary to force someone – by court order – to be placed in a (closed) nursery or psychiatric home (with Compulsory Mental Care). Maltreatment of elderly differs from self-neglect, because this maltreatment is caused by others than the older person himself. Yet, the two forms are closely related, because both have a great impact on the well-being and health of the person. Hence, self-neglect – when noticed and neglected/tolerated by third persons – can be seen as a form of abandonment. According to Dutch research[7] it are usually professionals who report elderly maltreatment. Not well given professional care is

6 When I stayed in St. Petersburg in Florida (USA) for research, I heard from the phenomenon "parent-dropping". Elderly, cared for by their child, who are severely suffering from Alzheimer are driven to a nursery home in another (neighbor state), where they are left behind in front of the nursery home, after having removed all the possible ways to identify (the background/origin of) the older person.

7 Het Landelijk Platform Bestrijding Ouderenmishandeling (Dutch National Platform to Combat Maltreatment of the Elderly.

reported in one third of all cases, but in two third of all cases the maltreatment has been done on purpose. It was shown that in 43% of the reported cases children and grandchildren maltreated their (grand)parents.[8]

In the report "*Legislation in the member states of the Council of Europe in the Field of Violence against Women. Volume II, Italy to United Kingdom*" it is said that Nordic studies show that between 2%-4% of elderly women are abused by close relatives (p. 87). In The Netherlands in 2006-2007, a campaign to stop elderly abuse distributed a leaflet entitled 'you only have see it once to believe it'. The number of Dutch municipalities that have a contact point for information and referral concerning abuse of the elderly increased from 31% (150 municipalities) to 94% (416 municipalities) during the campaign period. One third of all municipalities now have professional help networks and there are agreements with cooperating organizations on combating elder abuse. Now, every region and greater local community has its own network/center where people can ask for help/support in case of domestic violence.[9] Since 2008, the number of municipalities with help networks has increased.

A form of (emotional) maltreatment, that can be very harsh, is to forbid grandparents to have contact with their (grand)children or vice versa. If a spouse forbids his wife to visit and/or help) her parent, this is a form of maltreatment of several persons.

To mention *a Dutch case*:
In the Netherlands a husband of a spouse (63 years old) who suffered from Alzheimer did not allow his 61 years old sister-in-law to visit her sister in his home. Although the right of access is not applicable for access with adult persons, the sister sued her brother-in-law with a tort action and the judge allowed her to see her sister in her home, where she still lived with her husband. The district court in Groningen ordered that the man had to allow his sister-in-law for three hours a month to have personal contact with his wife (her sister), because otherwise this would be an infringement of the family life of both sisters.[10]

But we also have jurisprudence in which the courts ordered that there were no access rights between the adult persons, although the petitioner was referred to the magistrate (in the Netherlands: kantonrechter) to ask for a decision with regard to the rightfulness of the practice of the defendant (the one who forbid the access) of his/her mentorship. This is a problem that needs to be tackled in family law. I will come back to this later.

8 Action Plan "Elderly in Safe Hands", Kamerstukken II, 2011–2012, 29 389, nr. 30.
9 Domestic Violence, Ministry of Justice, August 2008/F&A 8840 ()
10 Rechtbank Groningen 11 juli 2007, LJN:BA9520.

5 How to discover abuse and maltreatment or neglect of elderly?

It is very hard to discover elderly abuse or neglect of elderly persons in those cases where the person is suffering from dementia or cannot speak for him/herself. Therefore, it is crucial for registered professional nurses and caretakers who work with elderly patients, to be aware of the problem and the implications of this phenomenon to nursing practice. This includes not only knowledge of the problem and the related assessment criteria and interventions, but also knowledge of related laws.[11] Those who work with elderly persons and take care of them in their private homes or nursery homes are in contact with them and so they are in a unique position to identify abuse or the potential for abuse. Whether in the home, hospital or various community and long-term care agencies, the aging client requires comprehensive care including promotion and maintenance of health, assessment, timely intervention, rehabilitation, ongoing education and referral as necessary.[12]

There are several risk factors for elder maltreatment, and they may be on the individual, relationship, community, and society levels. If the caregiver (that can be a family member) has problems with depression, alcohol abuse, or other mental disorders, this will place him or her at risk for mistreatment of the elderly person. Caregivers with high degrees of hostility and poor coping skills may abuse the client.

Also caregivers who in their childhood suffered maltreatment may not be effective in the care of elderly people. If the caregiver has not received adequate training to manage the affairs of these clients, or if he or she becomes responsible for the elderly person at an early age, there is risk of maltreatment too. Besides this, the relationship between the caregiver and the elderly person can pose a difficult situation. If the caregiver is financially dependent on the elderly client/patient, there is risk of an abusive relationship. Lack of social support further complicates the stressful situation. The expectation that family members care for elderly persons without assistance may cause extra stress, because the caregiver thinks that he has to meet all the expectations. Therefore, support and control in these situations shall be very helpful.

Elderly who suffer from dementia or cannot stand up for themselves are in a dependent and vulnerable position. Actually, they are in the same position as young children or handicapped persons. But, is there a universal right of elderly to be protected against violence, maltreatment, abuse or neglect, like the UN-Convention on Children's Rights?

11 Brandl, B., & Horan, D. L. (2002). Domestic violence in later life: An overview for health care providers. Women & Health, 35(2/3), 41-54.

12 American Nurses Association. (2001a). Scope and standards of gerontological nursing practice. Washington, DC.

6 Human Rights and the protection of elderly

Every person, including elder persons, is protected in his private and family life and according to international human rights conventions and treaties. The most important convention in this respect is the European Convention on Human Rights, but also the Convention on Civil and Political Rights is important for the position of elderly. Another convention that has to be mentioned, is the *Convention on the Rights of Persons with Disabilities*, that was adopted by the United Nations General Assembly at 13th December 2006, opened for signature at 30th March 2007 end entered into force at 3rd May 2008. According to Article 1 the purpose of this Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The Convention does not explicitly define what 'disability' means, but the Preamble of the Convention states that 'Disability is an evolving concept, and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others'. Furthermore, Article 1 of the Convention states that 'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'. Persons with disabilities are not viewed as 'objects' of charity, caring, medical treatment and social protection, but rather as 'subjects' with own rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society. So, the Convention gives universal recognition to the dignity of persons with disabilities. For the elderly this is a helpful instrument, because usually elderly also suffer from different sorts of disabilities. In this field, I think the actions of the United Nations, such as the Vienna International Plan of Action on Ageing, the first international instrument on ageing, that was endorsed by UNGA Resolution 37/51, must be mentioned too. The Plan promotes international co-operation to strengthen the capacities of states to contend with the ageing of populations and to address the developmental potential and dependency needs of older persons. It addresses research, training and education and makes recommendations in the following areas: a) education; b) health and nutrition; c) family; d) protection of elderly consumers; e) income security and employment; f) housing and environment; and g) social welfare.

Besides UN-Conventions and Rules, it is important, as I mentioned before, that – in Europe – elderly may also search protection in the *European conventions and treaties, such as the important European Convention on Human rights.* The European Court, for instance, has dealt with several cases concerning elderly persons. I will only mention the decision with regard to neglect of elderly,

although the ECHR has decided in more cases in which the (especially financial) rights of elderly where in conflict.

In the case of *Dodov v. Bulgaria* the applicant complained that the events surrounding the disappearance of his mother disclosed violations of Articles 2, 13 and 17 of the European Convention. In particular, his mother's life had been put at risk through inexcusable negligence on the part of nursing home staff and deficient regulations. Moreover, the ensuing investigation had not resulted in criminal or disciplinary sanctions and the applicant's attempt to obtain compensation in civil proceedings had been frustrated by the dilatory approach of the defendant State authorities and delays imputable to the courts. The applicant also complained that the police had not undertaken all necessary measures to search for the applicant's mother immediately after her disappearance. The Government contested the applicant's arguments. The Court, however, considered in these circumstances, that the legal system as a whole, faced with an arguable case of negligent acts endangering human life, failed to provide an adequate and timely response consonant with the state's procedural obligations under Article 2 (right to life).[13]

To avoid conflicts of law in case and to provide for the protection in *international situations* of adults who, by reason of an impairment or insufficiency of their personal faculties, are not in a position to protect their interests, the *Hague Convention on the international Protection of Adults*, concluded at 13 January 2000, was made. The objects of this convention are:

a) to determine the State whose authorities have jurisdiction to take measures[14] directed to the protection of the person or property of the adult;
b) to determine which law is to be applied by such authorities in exercising their jurisdiction;
c) to determine the law applicable to representation of the adult;
d) to provide for the recognition and enforcement of such measures of protection in all Contracting States;
e) to establish such co-operation between the authorities of the Contracting States as may be necessary in order to achieve the purposes of this Convention.[15]

13 ECHR 17 January 2008, *Application no. 59548/00.*
14 The measures referred to in Article 1 of the convention deal in particular with

a) the determination of incapacity and the institution of a protective regime;
b) the placing of the adult under the protection of a judicial or administrative authority;
c) guardianship, curatorship and analogous institutions;
d) the designation and functions of any person or body having charge of the adult's person or property, representing or assisting the adult;
e) the placement of the adult in an establishment or other place where protection can be provided;
f) the administration, conservation or disposal of the adult's property;
g) the authorisation of a specific intervention for the protection of the person or property of the adult.

15 See *www.hcch.com*: 35: Convention of 13 January 2000 on the International Protection of Adults (Entry into force: 1-I-2009).

The Netherlands have signed, but not yet ratified, this Hague convention. Until now, the Hague Convention on the International Protection of Adults has been signed by thirteen and ratified by six countries[16]

7 Should protection of elderly be part of family law?

Most jurisdictions do not have specific regulations for the protection of elderly in case of maltreatment or sexual abuse by family members. Of course, the perpetrators can be prosecuted and punished, but usually – especially in the case of family members who are the perpetrators – it is also necessary to look for other solutions. Usually, the protection of family members is concentrated on minor children. One may think of child protection services if a child is endangered because of maltreatment, (sexual) abuse and/or neglect. It is broadly accepted that in case children are in danger the child protection agencies will come into action, even if this means an interference in the private life of families. However, when elderly are concerned it is a different case, because in many countries there are no specific agencies for the maltreatment of elder persons. One of the problems in this field, is that it is also often thought that elderly can well take care of themselves and that – if they do not mention a case of maltreatment – everything is all right with them (see § 5). Many cases are not reported because of fear to get a conflict with the caregiver, the institution, nursery home, doctor or with other family members. Besides this, the question arises what can be done in case of maltreatment of old persons. Actually, they have the full capacity to perform legal acts and that is quite different than in the case of young children, because they have parents or guardians who have to take care of them. Parents have the parental authority and guardians may have guardianship. If they maltreat the children, their authority can be restricted by a sort of supervision order or a relief or dismissal of parental authority can take place. But what if an elder person is maltreated by (one of) the children? In case the elder persons live with these children they can be protected by placing the elderly elsewhere, e.g. in a private home or in a nursery home. We also have seen that a growing number of elderly, those who were born in the thirties, forties and fifties of last century are well-to-do persons, who have money to spend because of good pension arrangements, property, etc. Many elderly go on (long) vacations abroad or have a second home in a country with a warmer climate and enjoy the warmth and life there.

But, unfortunately this happy life does not last forever, and the older people are, the more physical and mental health problems will show up. The Hague Convention of 13 January 2000 on the International Protection of Adults provides in the problems when adult persons need a provision for the protection

16 http://www.hcch.net/index_en.php?act=conventions.status&cid=71

in international situations of adults who, by reason of an impairment or insufficiency of their personal faculties, are not in a position to protect their interests.

Fortunately, in most families there is a good atmosphere and good social contact between the family members. Social support and caring for the older persons, from family and friends, will surely be of help to promote healthy aging, but although this is usually the situation we must not close our eyes and ears for those situations in which this care-giving in the family results in maltreatment, abuse or neglect. Indeed, offences against elderly often occurs within the family and it is generally known that care-giving can also create multiple occasions for conflicts. Existing problems in family relationships will – as we all know -sometimes also lead also to abusing episodes.

Besides the growing number of elderly with mental problems, there is reasonable number of adults who need (financial) protection because of (growing) incapacity. Such is the case with those who are mentally handicapped (e.g. Down syndrome) or who have serious psychiatric problems.

Finally, loneliness can form a real problem for elderly too. Older people who are single, have lost a loved one, have problems with their health and those over eighty run an extra risk of being lonely. For parents who have lost the contact with their children or other family members, this may cause extra (emotional) problems, but also the risk that an older person will be neglected and/or isolated with all its negative consequences.

In all these cases the judge may order a kind of protection measure for the person involved, such as a *supervision order*, a *guardianship order* or a *mentor order*. Of course, when deciding the principles of subsidiary and proportionality have to be taken into account. The consequences of these measures may vary from total legal incapacity for the person involved to a certain incapacity (e.g.: the supervised person is only incapable of acting independently in view of certain assets). Besides these financial protection, measures can be found for the representation of the incapable person for immaterial interests (e.g. for questions of care, nursing, treatment and support).

But who has to be appointed as supervisor, guardian or mentor? Should he preferably be a professional or is it better to give priority to the spouse, partner or to other family members (parents, children, brothers, sisters)? Is it preferably to appoint two supervisors? But what if it is not quite sure if they can co-operate in the guidance of the person involved? What are or should be the criteria for the court to appoint a family member as supervisor?

These are important questions to be answered, because for the person involved it can be very important who his/her legal representative will be, because this representation will usually last for a longer period and they must closely work together.

Looking at possibilities in *the Netherlands* to protect the elderly, three different protection measures can be taken.[17]

1. So, an adult person may be made ward of court for mental disturbance, dissipation or alcoholism (not for other addictions like drugs). For the person concerned tutelage means that he is in a legal situation very similar to that of a minor less than twelve years of age. A curator appointed by the Magistrate will represent him in his financial affairs, but also in health care issues, such caring, nursing, treatment and support. This legal supervision is especially meant to help those persons who cannot always know how to act in taking decisions about their own health and care (Art. 1:450 et cetera). This curator acts as the administrator of the property of the person in ward (Arts. 1:383 and 386) and as a mentor. The ward himself is only capable of performing legal acts with the consent of the curator (Arts. 1:381 and 383). But the curator has the duty to take into consideration the opinions of the person in ward himself and not only look exclusively after the material interests of his ward (Art. 1:384 para 4). The Magistrate may terminate the tutelage, if the grounds no longer exist (Art. 1:389).
2. If an adult person, so also in case of an elderly person, is unable, as a consequence of his physical or mental situation, either temporarily or permanently, to look after his own *financial interests* adequately, the Magistrate can give a supervision order (also: administration) (Art. 1:413).
   As supervisor the court may appoint the spouse or the person with whom the supervised person is living, but to whom he/she is not married (Art. 1:432). The official supervisor is representing the person under supervision and he is the one to make suitable and appropriate investments.
   The supervision order resembles a bit the tutelage (see chapter 16), but there is an important difference. A ward is, like a minor under twelve years of age, unable to and incapable of performing any legal act. The supervised person, however, is only incapable of acting independently in view of certain assets. In all other respects the supervised person is to be regarded as any other adult.
3. If an adult person, because of his mental or physical situation (e.g. in the case of a mental handicap, dementia, coma, etc.) either temporarily or permanently is incapable to look after his *immaterial interests* himself, the Kantonrechter can appoint a 'mentor' i.e. a kind of guardian or supervisor. With immaterial interests the law means questions of care, nursing, treatment and support. This legal supervision is especially meant to help those persons who cannot always know how to act in taking decisions about their own health and care (Art. 1:450 et cetera).

17 Apart from the measure to place someone in a psychiatric hospital in case of psychiatric problems. In case of severe psychiatric problems that cause danger to the person himself, to others or to the goods of others the zourt may order the placement in a psychiatric hospital behind closed doors.

A Bill to modernize the measures to protect adult persons

In case of the nomination of a curator or mentor until now in the Netherlands only a natural person can be nominated. However, at the end of November 2011 the Secretary of State for Security & Justice sent a bill to Parliament in which quality standards must be met by professional administrators, curators and guardians in order to qualify for appointment. This bill will also bring some important changes in Book 1 of the Civil Code with regard to the protection measures for adult persons (including elderly).[18] Although, this new act is not specifically meant for elderly, they will surely profit from it, because a great number of elderly, suffering from Alzheimer, will have an administrator/supervisor. As we have seen, these individuals or agencies take financial and personal decisions for people who can no longer (fully) take care of their own affairs. Guardianship, administration and curatorship are measures that are primarily meant as protection against abuse by others. The tasks of a guardian are the most far-reaching. A person who is placed under guardianship loses his/her legal competency. The guardian must give permission for just about every act and decision. In the case of curatorship and administration, the person concerned is still legally competent. The administrator decides about money and goods, whereas the curator takes decisions about care, nursing, treatment and guidance.

Currently the district court may still appoint any adult as administrator, guardian or curator, unless there are well-founded reasons to decide not to. Usually a relative will perform this task, but it may also be a professional administrator such as a foundation or a natural person. In most cases, privilege should be given to the appointment of a family member, but is case of conflicts (or to be expected) it is better to appoint an agency.

By ensuring that quality requirements in this field are, as a guarantee, enshrined in the law, the Dutch Minister wants to prevent abuse as much as possible. The economic situation and business operations of professional administrators, curators and guardians will also be watched more closely. This means that the day-to-day management and the recruitment, training and guidance of staff will be monitored. An auditor must certify each year that the quality standards are met. The supervisory task of the district court will not change, but will become more clear because of the additional monitoring of business operations. For example, the district court will grant authorizations for expenses on behalf of the entitled party, and will check whether the expenses incurred by the administrator are justified.

In future, legal entities may also be considered for appointment as curators and guardians. There is a need for this possibility in practice. Legal entities, such as

18 Kamerstukken II, 33 054, nrs. 1-3. The unauthorised actions of a foundation charged with the protective guardianship and entrusted with the administration of the money and goods of a few dozen entitled parties formed the immediate reason for the measure. Liquidation followed, and many people suffered damage and losses

foundations or associations, can guarantee the continuation of the activities more easily, because the performance of the duties of a curator or guardian no longer depends on one particular (natural) person.

In addition, the legislative proposal provides that two guardians may represent the person placed under guardianship. This was already possible on the basis of a decision of the Dutch Supreme Court in 2000, but will now be explicitly laid down in the law. This concerns, for instance, parents who continued to exercise parental authority after their divorce and wish to continue their responsibilities after their child has become of age. As in the case of guardians, it will also become possible to appoint two curators.

In addition, there will be a ministerial regulation for remunerating administrators, guardians and curators, in order to ensure that a uniform remuneration system is used nationally.

Another new measure is that the district court will have jurisdiction to terminate the regime of administration, if this is no longer necessary or if continuation no longer serves a purpose. This concerns, for instance, an entitled party who continues to incur debts and couldn't care less about the administrator. In the current situation, the administration can only be terminated if the reasons for imposing the measure no longer exist.

The law will also specifically provide that from now on an administrator "may perform all acts that contribute to a proper administration". This more accurately reflects the broad interpretation of the administrator's duties that exists in everyday practice. It also emphasizes that a proactive attitude is expected of the administrator. He should, for instance, check which provision can be relied on, and ensure that the required application – for example, an application for a personal budget (PGB) or an identity document – is filed in time.

As a final point, the court will also be authorized to publicly disclose the decision to impose the administration by inclusion in a register. This also applies to the possible appointment, suspension or dismissal of the administrator. To that end, the existing guardianship register will be extended and renamed. The register can be consulted via the Internet, and is publicly accessible. So, in the near future – after the enactment of this Bill – it will (finally) also be possible to nominate an agency instead of a natural person. To my opinion, this can be very useful in cases where the family members disagree about the measure of protection or about the person(s) who should be nominated as legal representatives of the older person, except a neutral third person. But also a third person, being a professional, will visit the older client and he – if he is well trained in observing – will have the possibility to notice from an objective perspective how the situation of the elder client really is, and to ask (or even report) if he thinks something is wrong in the care, given by family members of the client or by an institute.

8 Some final remarks

Due to the 'baby boom', shortly after the second world war, in many countries the aging of the populations will lead to severe problems. In order to respond to the increasing demand for care for people with dementia and to continue to expand the range of available choices, it is necessary that no time will be spoiled in the search for good solutions to meet these problems (decline of pension rights, more care-takers, less caregivers, more nursery homes for those who suffer from Alzheimer or other diseases, etc.). Fortunately, the majority of elderly persons is doing well. Many of them are in the midst of their communities, as evidenced by their involvement in voluntary work and informal care provision. Some of them study (Philosophy is very popular), many travel abroad, stay for a long period in warm countries (Spain, Turkey and Thailand are popular). In addition, more older people than in the past are working, and not always because of the expected decline in their pension rights. Their healthy life expectancy and (mostly more) favorable socio-economic position opens the way to a relatively long social life, also due to better medical treatments and better medical care.

Yet, despite this positive tendency, there are and will be also more and more vulnerable elderly persons who are unable to fully participate in society. These older persons must and can count on support. Examples include poor physical or psychological health, undergoing major life events, poverty, total or virtual inability to read and write, or limited digital skills. Elderly persons who would want to participate in society, but who do not do so, also deserve extra attention. Primarily, this attention should be given by family members, friends and neighbors. If these latter persons do not meet the problems of the older persons, the question arises who will take care of these vulnerable neglected persons. To my opinion, in a welfare state it will ultimately be the State who must take care of this elderly neglected persons. The State also has an important task to protect as far as possible, vulnerable persons in case of maltreatment, neglect or abuse. Of course the State cannot be aware of dramatic situations, but it can and must organize all possible (effective) means to prevent domestic violence, to prosecute the perpetrators and to help the victims and to restore the family ties. It is typically, that e.g. in the Netherlands we do have a Child Protection Board and child protection agencies and special child protection institutes. The Child Protection Board falls under the authority of the Ministry of Security & Justice, although it has an own management and staff.[19] In case of maltreatment of elderly, we do not have a special protection agency for elderly in need, although they (or someone else) can always call the "Steunpunt Huiselijk Geweld" (Support Office for Domestic Violence). The staff members are experienced counselors who can give advice and put the person in need in contact with social workers in the area that can best help in this situation. Of course, a call to the

19 With about 2200 employees and located in 22 towns.

emergency number of the Police is also possible. But it is always better to prevent domestic violence and maltreatment of elderly. Prevention is the keyword in this. Therefore, it is necessary to be alert at forms of maltreatment, abuse or neglect. To my opinion it might be interesting to look at the possibility of creating an *Elderly Protection Board* and elderly protection agencies, because most cases of elderly maltreatment happen in families, so we need an agency that has the right an possibility to take a look behind the front door and to report elderly maltreatment cases to the courts in order to get a supervision order or another kind of protection measure for the elderly in need.

Recognizing maltreatment, especially of vulnerable persons (e.g. children and elderly), does not only require more (forensic) knowledge on the part of doctors, nurses and care-givers, but also another attitude towards elderly in general. To prevent this public health and legal problem, members of the community need to listen to elderly people and their caregivers. If elder persons (and probably their caregivers too) live a social isolated position, it might be useful to visit them regularly to see how things are going. Not because of suspicion, but because of real interest in and concern about the persons involved. If there is real suspicion of abuse, one should discuss this with the persons involved (if this is without risk) and report it to an agency (the Elderly Protection Board?), that is specialized in domestic violence, or even better, specialized in cases of maltreatment of elderly. The report of this suspicion is crucial if one really aims to prevent maltreatment or to make an end to this as soon as possible.

For civilians and professionals it is important to comprehend how the normal aging process differs from the signs of elder abuse. In any event, caregivers should seek help from family, friends, or local relief care groups.

Once, it has been confirmed that the older person has really been maltreated, abused or neglected, action must be undertaken to help and assist the older person (and probably the other persons involved (i.e. family members, other caregivers, etc,). In case the person involved is a vulnerable person, a measure of protection must be taken if necessary. In the field of Family Law it is necessary to find good solutions to help these elderly in the best way. In case a measure must be taken, the court must take the best subsidiary and proportional measure that is in the best interests of the elderly, e.g. a kind of supervision order (with the possibility of a placement elsewhere) as we know in Child Law. Therefore, a continuous search and research for the best measures in case of infringement in the private and family life of the elderly is necessary. Also, we need to search for help to the perpetrator(s), because if they maltreat an older person (e.g. a parent) there is a need for help for this person too.

Moreover, we need to find better solutions in case of conflicts between family members about which of them can best be nominated as a representative (administrator, guardian or curator) for the older person and/or how to make an end to these conflicts in or beyond the courtroom, by appointing a mediator or social worker.

If we do not take good care of vulnerable persons and elder people who are in a difficult situation, we will lose traditional values and norms that we have to take care of the elderly.

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Ethnic Identity[1]

Jaap Ubbels

In the WIS (Werkgroep Interculturele Samenwerking van het Nederlands Psychoanalytisch Instituut [Working Party on Intercultural affairs in psychoanalysis]) discussions of clinical cases habitual, psychoanalytically based, theoretical and technical tools often proved to be inadequate. At least, that is how it felt at first. On closer examination it is perhaps more correct to say that the habitual tools should be interpreted in a different way, used differently, with other accentuations. Of course knowledge of the development of the child, of life events, of personalitystructure and defenceorganization, of traumatization within this group of patients is just as relevant, but the context within which these data present themselves deviates from what we are used to. Often unaccustomed, uncomfortable feelings are provoked; frequently you don't know and understand. New, conflicting meanings arise that are hard to thrash out. You are faced with so much impotence within yourself. The psychoanalytical attitude towards therapy which is focused on empathy, on the security within which subjectivity may get its full scope, so often clashes with the reality of our patients. From our point of view their subjectivity is curtailed by the environment or there is a constant threat of infringement of the integrity of the developing subject. This involves patterns that have existed for a long time already, that are not infrequently carried over into contacts with the Dutch society: waiting for a residence permit, the despair which the linguistic character of the bureaucracy may bring about, an immanent animosity. The helplessness which this calls forth fairly often leads to a far-reaching rift between public and private. Clinical examples have been in abundance in our discussions. Merely the countless misunderstandings we have come across demand a continuous vigilance which justifies the existence of a study group like WIS.

A coloured gentleman who had lived in the Netherlands for the past ten years had performed the incredible feat of fully mastering the Dutch language. He had also done his studies again in order to acquire the necessary certificates and had managed to obtain a position of responsibility in a government agency. He came in with the complaint that he was uninterruptedly dealing with the question of how he came across to the other person, whether he was more or

1 Treatment of a text from a presentation at the scientific meeting of the Dutch Psycho-analytical Institute (NPI) of 6 February 2012. The vignettes are fictitious, but the clinical constellations and presentations of questions are authentic.

less. At practically every level as he was processed through the mental health institution difficulties cropped up of the kind 'forgotten to return your call', a 'long waiting list', and being subjected to a rigid, formalist examination. In his contacts with his therapist he once again provoked an uncomfortable feeling of irritation caused by impotence because he never dared commit himself in any way. This forever being on his guard even went so far that on the basis of the psychological examination the psychologist wondered whether he might be dealing with a paranoid psychosis. It was only gradually that this patient dared show somewhat more of what was hidden by his fearful mistrust: pain, very concrete pain, feeling constricted, feeling cold. His fantasy: 'going to another country, to Canada where his brother lived', the reality that all his efforts in the Netherlands then would have been for nothing. He stated that he had to drag himself to the sessions because he was so afraid to show himself and 'people like him could not be helped anyway'.

In this contribution I will dwell in greater detail on the problems of a large group of highly educated NPI patients who at first sight are examples of successful integration. Inwardly, however, they are struggling with deep confusion or conflict. It concerns people who are part of family systems which experience radical processes of change within a short space of time. Wouter Gomperts (1) described what one might imagine in such a cultural process of change. With the transition from a 'command structure' to more room for negotiation, with the acceptance of other possibilities and models, other patterns of self control and affect regulation develop.[2] This means that for the younger generation other subjectivities, other meanings, become available. At the same time in their emotional life it is often still 'too much' to provide an inward place for the change. In such situations the expectations from the inner world are no longer in accordance with those from the outside world. A crisis easily develops in psychic reality[3] with a strong tendency to discover themselves in the eyes of the other by 'acting' ('acting out').[4] This group starts looking for help when they start experiencing a greater distance to their original environment (2). There is a great need for acceptance and recognition in what this process of change means in psychic reality.

An example is Fatma, who, after completing her HBO education[5] had a variety of jobs all over the world. She was in a series of relationships with 'white men'

2 Julia Kristeva (11) points out that we tend to place individuality within groups, whereas individuality essentially develops within the triangular, transgenerational context of men and women. So within oedipal relationships which are variously defined in various cultures.

3 Freud referred by 'psychic reality' to everything which has in the psyche of a person the same power and consistency as material reality.

4 'Acting out' is a psychoanalytic term for action in which a person relives emotions, unconscious wishes and fantasies in the immediacy of the present without being aware of, or refusing to acknowledge, their affective source. From an intersubjective point of view 'acting out' may be considered as a form of unconscious communication between two subjects. On closer examination the unconscious meaning may be revealed.

5 HBO: College.

which would invariably end in violence. She got pregnant twice and, pressurized by her partner, underwent two abortions, although she herself was diametrically opposed to this. Such a pattern we have regularly come across in our discussions of actual cases. Our explanation is that the violence is combined with defencelessness clinical and paralysing fear when the primary environment does not provide any 'containment' for the new area of experience which these women enter. Exhausted, Fatma had returned to her parents: "There is too much shame, too much ignominy to be true. My parents will never know about me, for I think they will never trust me again." In this loss I could offer a new perspective by providing another meaning, the recognition "that she wanted to feel accepted in her struggle to build an independent existence as a 'modern' woman." I tried to see this and to make her see this within the context of processes of change in a family who only a few decades ago had migrated from a faraway isolated mountain area. Fatma told me for instance how panicky the reaction of her parents was to a letter from the building corporation that they could buy the house they lived in. "I said that I would certainly do this later, but then outside of Amsterdam. Mother started grumbling and shouting that this was nothing for them. She had been baking traditional pancakes but I was not allowed any because I was going to buy a house later on. My father said that I had only said it to goad her and that my mother should stop making a spectacle of herself, but my mother knows that I will do this and that is why she got angry."

This vignette illustrates an enormous step ahead because shame and humiliation make way for a sense of bondage and love, whereas simultaneously she feels recognized in her wish to be 'different'.

I will explain why the term 'ethnic identity' is clarifying in this clinical issue. Identities are formed concept within an inter-subjective relationship. An identity, inwardly aspired to, must also be seen by the outside world in order to achieve 'real' meaning. An identity that is imposed from the outside must also be inwardly accepted to form part of the mental reality. It is inescapable that the provision of what lies and what does not lie within the collectivity bears the stamp of the deciding power. In contrast to these 'adjectival' identities the 'feeling of identity' has no quality. It is a balance that emerges and is maintained by endless processes of intra and inter-mental reflective comparisons, a process for which Bohleber (3) coined the phrase 'Identitäts Arbeit'. It is important to be well aware of the fact that in adolescence the growing awareness of identity acquires a regulating function, as a subjective unity, an inner balance of the subject[6] linked to the outside world as in an open system. Identity becomes the subject's

6 The term 'subject' refers to the complex nature of the adult, with all levels of experience, history and ambiguity that have accumulated. Subjectivity incorporates both intrapsychic as intersubjective positions. 'Being a subject' may be summarized as someone who recognizes herself as an 'I', as having her own peculiar perspective, and to assume responsibility for herself and some of her actions. Identity is the key concept in intersubjective theory, just as sexuality is in former drive theory.

organizer. All sorts of life experiences attain a subjective meaning from this balance which centres on the feeling of identity. Identity is as it were the focal point of the various positions from which the subject approaches the world (4).

That is why pronouncements about the identity of others are often senseless or plainly abject. This kind of pronouncements is made within power relationships or imagined power relationships with the intention to be provocative. Such pronouncements are vindictive feints only intended to whip up sentiment, which, when and if they manage to reach the heart of the other party, may be so injurious as to destroy even the merest budding of inter-subjective recognition or dialogue.

The following is in order to show the different dimensions of the concept: The baby boomers of the sixties who celebrated their 'identity crisis' had quite an energetic, lively sense of identity on account of the fact that they found an identity of their own within the context of the identity of the post-war Western society. The debate about identity that was being carried on ever since the nineties is determined by the fear of global migration and fragmentation of society. South African Marlène Dumas (5) writes that every time she hears the word 'identity', she is certain that a fearful nation is scaring its own people. In the case of the borderline patient it concerns quite a different dimension of the complex notion of identity. The borderline patient is struggling with a recurring panic when it is impossible to hang on to the sense of identity. For us in WIS the diagnosis 'borderline' is one of the most important sources of confusion within mental health vocabulary, being based on DSM-IV classification.

Within power relations, negotiations among groups about identity are all the time going on. These negotiations are being conducted in many fields so that an identity consists of a multitude of economic, political, cultural and mental aspects. All these aspects coalesce in the concept of ethnicity as one of the profoundest and most fundamental of all possible identities. Positions of power are all-encompassing. After all, when negotiating about identity, there are far fewer possibilities for choice and there is less leeway for young people from minority groups. The importance of the power that is derived from the 'mother' tongue, the mastery of the language with all its hidden and implicit meanings is immense (6). Their social position is often more difficult and as for the development of an identity of their own they are faced with a far more demanding task. We should not think lightly of this. Forming an identity is a developmental phase and the sense of identity develops by trial and error. I am afraid that among challenge youngsters of foreign birth there are quite a number who, after having stumbled once, will never fully seize the opportunity to get up again. The far higher percentage of patients with a schizophrenia diagnosis points in that direction. I will give an example of sudden loss of the sense of identity in a young adolescent.

During his summer holidays in the mountain village Abdul had been cheered by his relatives.

Grinning widely he said that girls were offered him as wedding partners and that many a lad had asked him if he did not know a girl for them. Back in Holland he had sunk in a deep pit. There is no obvious reason. Perhaps the reason is that last summer when he should have transferred from the juniors to the seniors, he had given up football on first division level. Training four times a week could no longer be combined with his studies and there had been too many conflicts regarding his absenteeism. From his earliest youth he had been part of this club, together with his father. Abdul describes the rich Amsterdam history of this club, but over the past few years 'too many blacks' have joined the club. Abdul talks about his situation in football terms: I can only move forward, I can play a ball back, I cannot link up with the others. I have no choice." Now he has become so scared that there are signs of dementia. All sorts of weird things are going on inside his head, he is brooding all day that 'everything has been in vain' and he would like nothing better than an MRI scan. The parents who come to the surgery with him speak of 'the evil eye', there is too much envy surrounding them. Abdul mumbles something about 'an abstract thing'. During therapy the word 'abstract' is mentioned again. Abdul can think in 'an abstract way' his daily environment can only think 'in a concrete way'. Then it suddenly occurs to me that he also used the word to explain what his mother meant when she referred to the evil eye. I ask Abdul to elucidate. To his mother and his father 'the evil eye' is quite concrete. When there is lots of envy and ill feeling, the person who is the object of this may be struck by fate. Abdul's mother, his father and Abdul himself have become mortally afraid. And when you are afraid, you can no longer think 'in an abstract way'. Nor can Abdul.

An image goes through my mind from a Turkish-German movie 'Bal' (which in Turkish means 'honey') in which a young Turkish boy is struggling with his fantasies, death wishes and his jealousy. His father tells him that he is not allowed to discuss these things aloud; he can only whisper them into his father's ear. The result is that the boy can now only whisper, or speak in a frightful stutter. He is sent to the Imam to pray together that the evil is driven out of the 'whisperer'. In a wonderful scene parts of the Koran are recited aloud, providing an opportunity for the fearful boy to put his fearful fantasies in them. I mention this at such length because a whole world of books, films, video art, internet sites, Biennales has been created in which the modern world of migration is magnificently portrayed. And what a powerful, vibrant identity this is: the portrayal of 'change'.

In the psychoanalytical treatment of this group of patients it is often so difficult for the analyst to indulge in this kind of 'rêverie'. The imagination of the analyst's unconscious, the 'rêverie', in which he dreams himself his patient, is burdened with all sorts of vague, conscious and unconscious fantasies and

emotions surrounding 'wretchedness', impotence, fear of not-knowing and 'a sense of guilt'. Subsequently this may in its turn lead to all sorts of well-intentioned actions, but which are essentially felt as belittling (a form of so called 'counter-acting out')

Back to Abdul. When I asked him, he told me that he too went to see the Imam. He read bits from the Koran and they prayed together. The Imam said that from now on Abdul had to take charge himself by completely disregarding 'the evil eye'. I ask Abdul how he sees the future. On his 25th? Yes. Then he will be certified business administrator and lawyer and he will still be living at home. There are no further ideas of how he could build an independent life. But in a more limited field, there is some movement. He is going to join another football club where perhaps there is not such a high frequency of training. His father is now taking his younger cousin to football, so he has a new target, Abdul says with a grin. The fear and loneliness Abdul feels cannot easily be overestimated. Abdul has entered a different world. In the therapy the fear which has affected the entire system is acknowledged. In therapy, within this group identity, Abdul feels recognized in his being 'different', his ability to think 'in an abstract way'. Thus in the therapy some 'mentalization'[7] has been regained and along with that taking his own responsibility, at any rate regarding some aspects of life.

Being able to make your own inner choices is of crucial importance for a vital sense of identity. Inequality of power, lack of choices and the impossibility to negotiate about these matters is on the other hand felt as submission and humiliation. Abdul is caught between two negatives. The more his relatives feel threatened, the stronger the inclination to retreat within the familiar social system that avoids the confrontation with differences. There is, however, one positive sign: his mother wants to leave the neighbourhood where they live now, there are too many high-rises, it is 'too black', she wants to return to her old neighbourhood in Amsterdam where she felt much more at home. So mother is also looking for change and may therefore also somewhat understand the changes that Abdul is looking for. But when he accepts the therapy too much he is afraid that he will lose his own original identity. Identities have a core of belonging, security and containment. At the same time he feels that the bonding with his background gives him little scope for expanding his ownness and autonomy. That is why it is so important that there is some more scope for him in two small aspects of life: abstract thinking and football. In the WIS discussions we have often been racking our brains about the question why psycho-analytically oriented therapy in this group is often short-lived and why sometimes therapy that goes well is abruptly stopped. It seems to me that the answer is that it

7 Mentalizing is the on going conscious and mostly unconscious mental process of reading one's own mind and the mind of the other, as well as the integrative role played by such a capacity in a person's self-organization.

concerns therapy which, just as child therapy or child analysis, is embedded in a system. Just as in child analysis the threat of one-sided termination provokes fearful emotions in the countertransference which may lead to urging to continue or an inclination to increase the frequency which is then counter productive. Assuming that this group of patients turns up when they feel a separation from their environment of origin, their interests will be perfectly served when there is slightly more scope for ownness and negotiation. In that case further development is possible without 'wanting to be different' being equal to 'no longer being part of'. I will always shy away from trying to decode intercultural messages –whose meanings I never can fully estimate anyway- and will try not to be focused on the old, but on the 'new' that is being created inside and outside the therapeutic relationship.

At one point in her adolescence Aziza had wriggled out of all the hassle of matchmaking with cousins by refusing to go on holiday to North Africa any longer with her family. The psychotherapy that followed was a drastic experience for her: Her weekly discussions with an older, Dutch man about her most intimate emotional life were absolutely unthinkable in her original environment. In therapy she had come to realize one thing quite well: that she constantly lived in the reality of 'being a foreigner in the Netherlands'. This was a feeling that she wished to be rid of, but that never went away. She sometimes said that I am a German, because I look 'so German'. I must admit that I did not feel really comfortable with this remark, and was intuitively inclined to reject this suggestion. When I inquired these remarks after the meaning of the attribution she said that then I might also feel what it is like to be addressed as a Moroccan, or a Turk, an Irani or Antillean. She was trying desperately to find a husband in the Netherlands within her own ethnic group. Desperately because in the point of view of her environment she was already old, desperately because she had no set of tools with which she could create some latitude with young men. She fared somewhat better on the Internet, although she often mentioned this with shame. When she met the young man in question in the flesh, 'giving a kiss' would immediately mean a promise of marriage. I told her that in this way she would repeat exactly what she had always been protesting against: when you were introduced to a man, you had to marry him. I tried to demonstrate how it would be possible to be flirtatious without immediately chasing the man off. All of a sudden Aziza informed me by e-mail that she had terminated the therapy. When later she visited me once again, she told me how relieved she was that she had managed after all to be matched with a second cousin in her country of origin.

When trying to find the background of 'misunderstandings', in WIS we also came across situations that we could interpret like a dream or language. An eight-year-old boy shows me his reality by being intensely involved in the game of Monopoly: produshion... produshion he lisps, while the dice roll across the board. His father

has an important position and is 'Saving up... saving up for presents', while he indicates that he too would rather save his money than invest in the houses of the game. Every year they travel to the village where his relatives live, but that means nothing to him: they talk to you on the first day and then they ignore you, what is more, he cannot understand them. It is even worse with the Koran school he attends every week He looks down his nose and makes it clear that this is not for him. He likes to talk about football; he insists that the name of the footballer Van Persie shows that he has a Persian or Afghan father. He himself plays football in a club that has a membership that is mainly foreign, where he goes with his father. It is a nice outing for his father for there he can speak his own language with other men. From then on I call the boy by the name of the club and realize that in so doing I give him an identity. A phenomenon Wouter Gomperts (7) so often warned against in WIS: taking your dominance for granted it is so easy to hurt people in a weaker position with remarks about their ethnic identity. It is so easy to unwittingly impose an identity on another person which that other person in a minority position perceives as burdensome (8).

In the therapy something remarkable happens: the boy reports that together with his mother he intends to go to *Swift*, the football club located at Olympiaplein across from the NPI, to enrol. Mother comes from the Stadion neighbourhood where her family still lives. This boy, who has a firm latent identity, imagines that he will take the bus to his aunt and then continue on foot to *Swift*. What happens after this remarkable development is rather disappointing: I hear hardly anything about it any more. When I ask him about it he mumbles something about being too young and that *Swift* has a full membership and is not accepting any new players. When I talk to the parents somewhat later it becomes apparent how important the old club is for the father. As a young man he came to the Netherlands for an arranged marriage with the mother and he never learned Dutch properly. Now traumatic moments come to the fore as we so often encountered them in WIS discussions. A constellation of memories concerning a traumatic event which acts as a cover memory for everything that has been 'too much' in the process of migration and rapid changes or that profoundly affected a basic aspect of the sense of security: 'belonging' (9-10). In his work on the assembly line the father is still troubled by a chronic bronchial infection resulting from an accident. The mother herself wants therapy, a type of treatment that is represented by one of the most beautiful buildings in the Berlage site on the 'good' side of Zijlstraat and Marathonweg. The results are minimal. Although the mother has the position of the greatest power, power in the sense that she has the most options, is best able to juggle various points of view and was also the one who started the negotiations vis à vis 'the NPI', it appears that the outer limits of the inter-cultural system have now been reached because the mother as well is struggling with a need to be seen and accepted and the profound fear that

once she exceeds the possibilities of the system, she will lose herself and may never find herself again.

In this contribution it is my intention to show how we in the WIS have started to think within an inter-subjective theoretical framework, a framework extended with a dimension of 'ethnic identity': all those aspects of the problems surrounding identity and the feeling of identity that are to do with the situation of being part of an ethnic group within a dominant western, in this case Dutch, culture. This viewpoint forces mental health workers to reflect on aspects one is not normally accustomed to reflect on. Reflections on the specific emotions concerning the themes of migration, rapid social changes, fears and resistance to change and last but not least the importance of dominance, positions of power and the resulting manipulations among ethnic groups.

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Conflict and Coping by Clients and Group Workers in Secure Residential Facilities

G.H.P. van der Helm, G.J.J.M Stams

1 Introduction

In Holland and most western countries, the aim of secure residential treatment for adolescents and adults with severe psychiatric and behavioural problems, designated as clients, is problem stabilization, recovery and rehabilitation (1). Clients are treated in living groups by trained group workers. Mandated treatment in groups, however, is not without problems: forced treatment and loss of control by clients and unequal distribution of power at the living group result almost inevitable in conflict and dysfunctional conflict handling strategies by clients (2). Group workers can react to conflict with dysfunctional conflict handling strategies too, often resulting in escalation of many conflicts and suboptimal treatment outcomes. These conflict handling strategies, characterized by using force or avoiding conflict, often cause aggression and lack of treatment motivation of incarcerated clients in a secure environment, where clients are unable to leave the situation, which can easily aggravate problems (1). Direct aggression by clients is not tolerated by group workers and is punished, indirect aggression is often reflected in manipulative behaviour and may therefore be hard to detect by group workers, resulting in negative group dynamics that hamper effective treatment of behaviour problems in secure residential facilities (2). Nevertheless, recent research shows that clients can profit from secure residential treatment (3, 4, 6).

Recent research on secure residential treatment shows that an open living group climate is crucial for stabilization, growth and recovery of incarcerated clients. Characteristics of an open living group climate are safety and structure on the one hand and flexibility and contact with group workers on the other hand, which has been shown to promote social learning and recovery (1, 5). Another characteristic of an open living group climate is active problem solving by group workers, as a therapeutic way of conflict handling, and clients who eagerly try to actively solve their problems as well, supported by group workers who are responsive to the needs of their clients.

An open living group climate is hard to establish in practice, because import problems of clients, such as mental disorders, and deprivation due to incarceration can easily lead to a closed climate, which is characterized by great power imbalance between group workers and clients and among clients themselves,

repression as well as negative group dynamics and dysfunctional ways of conflict handling by both group workers and clients (1, 2). Consequences of a closed living group climate are suboptimal or even negative treatment outcomes, including recidivism (3,6). Therefore, Marshall and Burton urgently call for a research-based framework of living group dynamics (7).

This chapter aims to provide the first empirical input in order to sketch the contours of a framework of group dynamics in mandated treatment in secure residential facilities. We will first focus on importation problems, which can aggravate problems with living together in the institution, and subsequently turn to the fundamentals of conflict handling, its influences on brains, emotions, cognition and behaviour of clients and group workers, and we will finally highlight the influence of living group climate on recovery.

2 Importation problems

Clients entering a secure residential facility often bring with them many 'importation' problems, such as aggression and criminal behaviour, substance abuse, and psychiatric problems, often coupled with a mild intellectual disability (8, 9). These problems mostly start at an early age after a history of neglect, maltreatment or deprivation, and have often resulted in failed youth care trajectories, social isolation and avoidance behaviour (9, 10).

A gradual accumulation of individual and social problems, such as social backwardness, unemployment and debts, aggression, substance abuse and depression often follows. Social isolation can lead to joining deviant groups, marginalization, negative social information processing, instrumental and egocentric behaviour and lack of moral attitudes (1, 9, 10, 11). Stress, accompanied by social and psychiatric problems, can lead to changes in size and functioning of the brain, negatively affecting cortical functioning, resulting in a shift from rational to emotional thinking (12, 13). Emotional thinking is highly influenced by brain stem structures on behaviour, which leads to a focus on immediate gratification, problematic impulse control, thinking errors and strong mood fluctuations (14). Emotional thinking also leads to defects in executive functioning and a shift in the stress system (HpA axis), which results in less sensitivity to punishment and heightened susceptibility for environmental stimuli and loss of regulation capacity (13, 14, 15). This is called 'field dependent behaviour' by Goldman, which further aggravates individual and societal problems and may cause an accumulation of conflicts and deviant behaviours, which in the end can lead to secure residential treatment enforced by civil or criminal law (14).

3 Conflict handling by clients

A disposition to work together with people (approach or assimilation) and solving interpersonal problems is essential for efficacious conflict handling and building supportive and meaningful relationships (16). Four main strategies of conflict handling can be discerned, depending on whether the individual follows only his own interest or also takes the others' interest into account (16). Forcing means imposing your will on the other and it is associated with competition, yielding means unduly giving in to the others' wishes. Neither forcing nor yielding occurs when avoiding conflicts; when the conflict is of no importance or there is no future contact, yielding or avoiding can be a sensible option. In general, however, these strategies can be counterproductive in human relations. Finally, taking the interest of both parties into account is the defining feature of active problem solving. In general, to engage in active problem solving is considered the most adaptive way of conflict handling, because it requires cooperation and fosters adequate social solutions. Less adaptive conflict handling strategies, like forcing, avoiding and yielding, are associated with avoidance behaviour, competition and exploitative relationships (16).

Conflict handling cannot be isolated from conflict type (17). In general, task conflicts can be solved more easily by means of active problem solving, whereas social emotional conflicts are harder to solve and often require a combination of forcing and active problem solving (16). Forcing without active problem solving often results in resentment, reactance, and indirect or covert aggression, conflict escalation, emotional thinking and stress (2, 16, 17). Active problem solving can be difficult, because one needs to take into account differences in point of view (often finding out which is important for the other person as part of an integrative solution), different interests and some patience in working out a solution and getting this accepted by all parties. Problem solving needs well-developed executive functioning, impulse control and integrative reasoning (i.e., to be able to share profit), which is a higher brain function of the Anterior Cingulate Cortex and the Dorsolateral Prefrontal Cortex (14, 18). Even in 'normal' populations, impulse control and sharing can be quite difficult, especially when the conflict is social emotional in nature, which can make zero-sum solutions attractive. Such requirements often lack in clients residing in secure institutions (1). Inhibition of negative impulses is often problematic in clients, and as a consequence conflict handling strategies are more often assertive (fighting), submissive (yielding) or avoidant (fleeing), strategies that are mainly under the influence of the brain stem, which results in a shift from cognitive to emotional influences (17, 18).

Limited executive functioning and conflict handling often result in 'moral blindness', lack of empathy and learning behaviour that constitutes a pronounced 'survival' attitude, which accompanied by avoidance behaviour can create a negative feedback cycle in response to environmental stimuli (17, 18).

Research by De Jong shows conflict handling in deviant groups to be associated with a need for control and dominance, which results in positioning behaviour[1], bullying, harassment, humiliation and extortion (19, 20, 21). Positioning behaviour can be seen as a coping response to an unsafe and unstructured environment, which often leads to further avoidance behaviour and reinforcement of problem behaviour by group members rewarding antisocial behaviour of their peers (i.e., deviancy training), which can be seen in secure living groups as well (22).

4 Institutional climate, conflict and coping

An open living group climate in a secure residential setting diminishes the need for competition and is characterized by safety and structure, which leads to stabilisation of problems and individual balance (homeostasis). Responsivity from group workers and possibilities for learning and change promote less emotional thinking, impulse control, approach behaviour, assimilation and active problem solving. Goldberg calls this 'cognitive rehabilitation', a process in which improvement in executive functioning can lead to growth in cortical neurons as well as improved social functioning and active social problem solving (14, 18).

Such growth and learning is difficult to achieve in a prison environment, where the focus on personal survival predominates social functioning, triggering competition, emotional thinking and avoidant ways of conflict solving, which is characteristic of a closed or repressive living group climate.

The cumulative effects of importation problems and deprivational characteristics in secure residential facilities often result in destabilisation of the client. Incarceration effects of job-loss and hedonistic gratification, loss of supportive social contacts and loss of status are combined with a loss of control and diminished self-worth (1). Conflict and emotional thinking lead to hyper arousal, depression, rumination and anxiety. (This can add to existing psychiatric problems, cause less cognitive flexibility, resistance to change and thinking errors (14). Thinking errors are emotional and self-centered thinking ('I am not getting what I deserve'), blaming others ('he walked into my knife'), minimising/mislabelling ('he doesn't need the money I stole from him') and assuming the worst ('everyone is always after me') (14).

Recent research on deviant social information processing shows hostile attributions (hostility bias) in social problem situations to be at the heart of thinking errors (23). Key social problem situations are the inability to cope with disadvantage (being laughed at), the inability to compete with others, the inability to accept authority and the inability to accept or give help. Emotional reactions to

1 Positioning behaviour refers to a natural tendency in human and animal groups to structure group dynamics by assuming hierarchical defined roles (14).

social problem situations mirror emotional conflict handling strategies and are often aggressive behaviour (forcing), avoiding or fleeing (14, 23).

Coping with a closed and repressive living group climate hampers social information processing, empathy development and promotes instrumental relationships, lower levels of moral reasoning, focusing on survival and dominance, limiting possibilities for rehabilitation (13, 17, 18).

Emotional thinking, which is one of the most negative consequences of a repressive living group climate, can be contagious to other group members in whom relatively small task conflicts (who puts dinner on table?) regularly shift to social emotional conflicts and aggression due to negative social information processing, including hostility bias. The hyper arousal, associated with persistent anger, fear and depression further fuel small conflicts, and can lead to health problems, such as depression and immune problems (13). Avoidance and yielding can produce learned helplessness in the long term (1). Indirect aggression also leads to 'playing the system', in which the need for dominance and positioning behaviour produces identical behaviour with group workers, who avoid contact at the group or unduly give in: clients may even take over power at the living group from group workers (2).

5 Transactional processes between group workers and clients

Emotional thinking is associated with a need for control and power, instrumental relationships and loss of impulse control (13, 14). Clients as well as group workers cannot leave the situation at will, and group dynamics or transactional processes tend to intensify at a secure living group: a group-dynamical pressure cooker. Negative group dynamics have a deleterious effect on clients as well as on group workers (24).

Group workers can react to conflict with anger and fighting (forcing and punitive behaviour) or fear (avoidant behaviour or yielding) (2). Social emotional conflicts, associated with forcing, can also lead to positioning behaviour ('because I tell you so'), thinking errors, resistance to change and rule enforcing (making more rules). The reactance by clients, associated with loss of control, results in a coercive cycle of aggressive behaviour (25). Avoidant behaviour by group workers can result in clients taking over power at the living group, and a closed living climate as a result of dominance and positioning behaviour of clients. Group workers face a difficult task in controlling these negative group dynamics, because in avoiding conflicts or unduly giving in (yielding) they co-create these dynamics. It is hard to understand group dynamics, the impact of your own behaviour, and its consequences for group climate, when you have detached yourself from it.

Thinking errors by group workers or the entire team can result in egocentrism and blaming others ('team members are always right, clients always are to blame'). Mislabelling and assuming the worst often lead to euphemisms describing violent behaviour of group workers, e.g. forcibly ending discussion with clients like 'working to the ground' or 'end of the day' in order to 'break them or teach them a lesson'.[2] 'Collecting night-kisses' was a common referral to sexual abuse by group workers in some Dutch forensic institutions. Having an intimate relationship with a group worker was often a consequence of positioning behaviour among the girls, trading protection and favours for sex, a habit often acquired by sexual abuse in the family or living on the streets. Now and then, avoidant behaviour or yielding is sometimes mislabelled by referring to 'it keeps them quiet' (in the case of drug use) or: 'giving clients more responsibility'.

Moral disengagement in group workers, as a consequence of survival and emotional thinking, can lead to demotivation, burn-out problems and even aggression at home. Lambert remarks: 'it spills over' (24).

Treatment outcomes in a closed living group climate turn out to be negative for incarcerated clients, but may also have negative consequences for group workers. Anger, fear of incidents, feelings of hopelessness and inadequacy, hyper arousal, and negative team functioning may lead to a rapid turn-over of group workers, which can aggravate conflicts, as clients have to learn to accept new group workers (2).

There is recent evidence that an open living group climate, with its emphasis on responsivity by group workers, safety and structure and ample opportunities for growth can stabilize incarcerated clients, create mutual trust, often starting with group workers, followed by treatment motivation, approach behaviour and recovery of clients.

Although research on this topic is urgently needed, recovery probably is associated with positive interpersonal contact, improvements in prefrontal- and executive functioning, active problem solving, less field dependent behaviour, resulting in more control and empathy, and less avoidance or yielding (12, 13,). Improved social information processing will lead to efficacious conflict handling in social problem situations and less direct or indirect aggressive behaviour.

It is reasonable to assume that enhanced social control and cooperative behaviour will result in less need for dominance and positioning behaviour (with clients and group workers) at the living group; positive transactional processes at the living group with group workers can result in a positive feedback cycle and better treatment outcomes (26).

2 Examples are derived from interviews with group workers in the national Dutch climate research.

6 Discussion

Cognitive and social rehabilitation in a secure setting, as a result of negative consequences of mandated treatment, is being debated (27). Punitive power can destroy a therapeutic relationship because of reactance, avoidance behaviour and mistrust (28). Social psychological research on group dynamics and conflict handling often shows that power–imbalance leads to unprofessional behaviour by workers; Baumeister even concludes after ample research that 'bad is stronger than good' (29). Nevertheless, this article looks at requirements for maintaining an open living climate and professional behaviour within a secure residential setting.

6.1 CONTACT

Contact with clients by group workers is one of the main aspects of approach behaviour, even with extremely decompensated clients (30). Contact requires responsivity of group workers and *being there in person*. Group workers who abstain from contact pose a possible threat to clients due to lack of predictability and control, which can result in aggression.

Recent longitudinal research by Ros and Van der Helm shows a lack of contact to be predictive of violent incidents, something that Fluttert also found in his research on precursors of aggression at the living group (30, 31). To remain responsive, even in the face of aggression, avoidance or extreme manipulating behaviour of inmates, is one of the main tasks of group workers.

6.2 ATMOSPHERE AND REPRESSION

A balance between structure (safety) and flexibility results in less repressive behaviour by group workers. Stabilisation of incarcerated clients requires an atmosphere, characterized by safety and structure at the living group. On the other hand: too much safety and structure causes repression and reactance and hampers social learning. This thin line is one of the hardest tasks of group workers and is often very hard to grasp, especially when facing critical incidents.

In the face of aggression, it may be easy to think that more rules and forcing increases safety and compliance, but in practice this turns out to be a thinking error.

Introducing more rules and punishing small infractions diminishes contact between group workers and clients, and promotes giving in for peace's sake or avoiding conflicts. Avoiding by group workers is often accomplished by doing paperwork at the office. Yielding or avoiding by group workers leads to more positioning behaviour by clients to counteract loss of security and structure. Although safety and structure result in stabilisation, without individual growth recovery and rehabilitation is not possible.

6.3 GROWTH

Growth pertains to giving meaning to life in the residential institution, rehabilitation and hope for an acceptable future, preferably outside. Flexibility, again, is necessary for social learning and growth to attend to individual needs of clients (1). But educational learning too is important for cognitive rehabilitation, perspective taking and opportunities at the labour market after release (32). Some studies show simple reading lessons to be effective for diminishing recidivism (33, 34). Activation of higher cortical functions though is dependent on the environment and quality of conflict handling.

6.4 EFFICACIOUS CONFLICT HANDLING BY GROUP WORKERS

In handling conflicts at the living group the group workers should maintain emotional stability and try to actively solve problems (34). This is needed to prevent reactance, emotional thinking and small task conflicts growing into difficult to handle social-emotional conflicts. Sometimes forcing is required in order to maintain structure and safety at the living group. Forcing, however, should always be followed by active problem solving to maintain flexibility and possibilities for growth. Group workers should be aware of dysfunctional conflict handling strategies for living group climate, like yielding or avoiding, because these strategies give way for 'playing the system' and clients taking over the group. Conflict handling by group workers requires personal stability, adequate professional education and organisational stability.

6.5 PROFESSIONAL GROUP WORKERS

To be able to handle conflicts at the living group, group workers should be stable persons, and able to reflect on their own and their fellow team workers' professional behaviour.

As mentioned in the previous paragraph, emotional stability is very important to counteract tendencies of emotional thinking and dysfunctional conflict handling. Emotional stability is not only a characteristic of the individual group workers, but is influenced by team functioning and team leadership as well, and should not lead to lack of responsiveness and loss of flexibility. Fear of incidents result in group workers being less responsive and less flexible and less able to reflect on their own professional behaviour and of their team members (avoidant behaviour) (2).

Maintaining stability and flexibility is only possible when team functioning and team leadership provide for adequate safety and support (2). Self-managing teams are in fact neglected teams in a secure residential setting. It should be noted that here we describe 'parallel' processes in conflict handling and coping.

Group workers who, like clients, perceive a lack of support by their staff are prone to emotional thinking and dysfunctional conflict handling.

Professional education and training (preferable 'on the job') still remain necessary to help group workers handle their difficult tasks. For these purpose a special training ('TOP Group Workers') was developed in the Netherlands.[3] Results are very encouraging in that after training violent incidents and formal complaints from clients fell dramatically at the group.

Measuring living group climate quality on a regular basis can help training and organizational change in the shape of a 'plan-do check-act' cycle, but also gives a 'voice' to incarcerated clients. For this purpose the 'Prison Group Climate Inventory' for clients and the 'Living Group Work Climate Inventory' for group workers were developed and validated; free access instruments, with English, German and Papiamento versions are now available (5).

7 Conclusion

Active problem solving instead of forcing, yielding or avoiding is essential in order for group workers to create an open living group climate. Only together, teams of social workers, staff, and inmates, can prevent a coercive cycle of antisocial and positioning behaviour. But conflicts do not stop within the confinement of a secure institution. In society, emotional thinking and dysfunctional conflict handling often prevail, as many temptations, instant gratification and lack of impulse control are part of every day life.

Recovery and rehabilitation can only be successful when treatment immediately starts upon entrance in the institution, with a realistic exit programme (education, work, relationships, housing) and professional help with the many conflicts ex-clients usually face when re-entering the outside world.

Secure forensic institutions should adopt the moral responsibility to care for their employees (group workers), the work climate and for their clients (living group climate) within and outside the institutional walls to create optimal possibilities for recovery and rehabilitation. Results from recent research on transactional processes in secure residential care show promising possibilities for practical and scientific improvements of secure residential treatment.

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Psychopaths "R" (among) Us – How Companies are being Destroyed (and Repaired again)

J.C. Goorden

I Introduction

A few years ago, Jaap van Vliet wrote a doctorate on what I would like to call a black spot. The reason for this is that it concerned (and still concerns) an underestimated issue, but with dramatic consequences. He described the situation in which people who are in need of psychological support are more or less evading contacts with the organisations that are appointed to take care of such support.

The fact that there seems to be a dramatic lack of communication between the abovementioned organisations certainly does not help these persons any further.

The reason that I mention this is that I found another black spot albeit that I will not be the only one, which I found out after some careful scrutiny.

It concerns ***companies***. Hare and Babiak already wrote a book about what they describe as "Snakes in Suits". It describes what could happen if psychopaths take over important management positions within companies, and the devastating effects this may have on such companies.

It must be underlined that, despite the popular tone of Hare's and Babiak's work, they definitely use the official definition of a psychopath as described earlier by Hare. I refer to his standard PCL tests and all other tests that followed to find out whether or not a given person can be considered to be a psychopath.

This is extremely important since a) far too much people use the term psychopath merely as an insult, all too often referring to infamous characters like Dr. Hannibal Lecter and other unpleasant persons, and b) there is an important difference between Hare's psychopaths and the persons described in the different versions of the DSM standard.

II Companies – another black spot

Companies play an important role in society. After all, they generate money and provide employment. This needs no further introduction.

But there is an issue on-going that is massively underestimated in my opinion. While it is very easy to find antisocial characters and even psychopaths in the more traditional environments such as any given poor neighbourhood in the big cities all over the world, it seems a bit more complicated to find them within organisations such as companies. This seems perfectly logic in the light of the fact that it is not hard to find and sue antisocial and psychopathic persons in environments that are considered to be useless, and also these persons will normally not be capable of defending themselves. So it does not really come as a surprise that there is a vast population of persons with the abovementioned character traits in jails and psychiatric hospitals.

So there is a part of the psychopathic population that is perfectly able to find a more comfortable environment, in lieu of ending up in jail. Of course, this also depends on the definition. If we use the DSM definition of somebody with antisocial traits, it is not surprising that many of these persons will not be capable of maintaining their position in this modern society.

But if we look at Hare's definition of a psychopath, we can easily draw the conclusion that a person who is considered to be a psychopath according to the various PCL-tests could be perfectly capable of avoiding prosecution et cetera. For instance, one of the features that are mentioned in the PCL-tests but not in the DSM-definition is ***glibness***, while ASPD often goes hand in hand with a (certain) ***lack of verbal skills***.

This makes a world of difference. Where the "DSM-psychopath" will not be able to save himself if and when (potentially) in trouble, the "Hare-psychopath" will be perfectly capable of finding a way out when the going gets tough. He or she will even enjoy this, it is all part of the game.

And this is exactly the reason that such psychopaths enjoy their stay within companies. Modern companies are, more than in the past, fast moving organisations where dynamic persons are more than welcome. Unfortunately, the qualities required by these companies are often confused with the character traits of a classic (Hare) psychopath.

For instance, any "normal" person would be concerned or even anxious if he or she has to make an important decision, and it even gets worse if this involves unpopular decisions such as laying off staff.

A few qualities that are required here ***in reality*** are qualities such as the ability to keep a given distance ("a good manager is friendly but never too familiar"), a given lack of fear (regarding the consequences such as the confrontation with the staff in question, or with the unions), and the ability to actually make the decision

itself. Such qualities can be described as positive if the manager in question is (to keep it short) sane, also in the social sense of the word.

It gets more complicated if the abovementioned manager is a psychopath. He or she certainly will be capable of keeping a certain distance (because of his or her callousness), he or she will not be very anxious (because of his or her thrill/ novelty seeking) and (also in the light of a general absence of fear in combination with a total disrespect of the negative consequences for the staff involved, e.g. in case of an important reorganisation) he or she will be perfectly able to make hard decisions on a very short notice.

As an example and as an example only since I did not have the chance to assess the persons in question, I refer to the following (actual) situation.

A family company that had been taken over by an international group of companies was being reorganised, as it happens quite often. One of the managers of the family company unfortunately got saddled with the unpleasant task of laying off staff. He is considered to be -and generally known as- a correct, friendly and empathic person, one could describe him as "soft".

He discusses the problems that he has with firing people that he has been working with for a very long time, and this with one of my family members, stating that he cannot sleep and that he cannot make the decision which staff members to make redundant and which staff members not. For him this is a real nightmare and he decides to involve his cousin. I want to underline that this person (the cousin) is not known to me as a psychopath but what followed at least gives rise to the assumption that the person in question could possibly be antisocial or even psychopathic.

The cousin having moral problems with the reorganisation process decided to discuss the list of employees with the other cousin, who had no problems with this issue - the latter simply took the list and started striking the names of people to be fired. It did not take him very long. It must be said that the second cousin also commented his work by saying, every time he struck the name of an employee, "he goes", "he goes" et cetera.

After quite some years in the survey and oil & gas industry, I can only confirm that this is not an isolated case.

III The psychopathic company

Now we are left with the question whether or not a company can be "psychopathic". I dare to state yes. Of course, as a moral person, a company cannot have a psyche of its own as it is merely an organisation that exists in writing. But this does not mean, for instance, that a company cannot commit crimes. In the Netherlands, a few interesting cases found their way to the Supreme Court (Hoge Raad) during the last century (IJzerdraad-arrest and V&D-arrest) in which cases the Dutch supreme court decided that, given the fact that the company itself can only act through physical persons acting on behalf of such a company, it must be established to which degree such persons can be found guilty for criminal offenses committed by the company. The Supreme Court developed criteria which can be translated in English as "***factually*** leading the company". The term "factual(-ly)" is of key importance here, as it clearly indicated that not only the official representatives of a company could be responsible and thus guilty of offences/crimes committed by a given company (which makes perfectly sense) but also persons who are, given the factual position they have within the company, to be considered as leading persons within such a company. According to the Supreme Court, the facts play an important role here, since the impression that the outside world has can be decisive here. It means, among others, that if an outsider (this could be a company) gets the (justified) impression that a given person has the power to represent that company (formally or not), such a company is legally bound by the acts of that person, also in criminal matters.

This is very interesting, since we already know that the percentage of psychopaths within the realm of companies is higher than the average percentage in the "normal" world. Where most authors assume that about 2% of the population is psychopathic according to PCL criteria, it is estimated by the same and/or other authors that this percentage could be several per cents (some mention over 5% and higher) within the ranks of company top managers.

IV Some antisocial and psychopathic traits of the company

Also referring to Anne van den Berg's work on management styles and mental disorders of top managers being reflected in the organisation, I am inclined to follow the same route with regard to psychopathic behaviour and/or treats.

Montague Ullman (Corporate Psychopathy) refers to the DSM-criteria whereas I think it might be better to refer to Hare's definition - in light of what I discussed earlier.

Ullman refers to:

- *1. Failure to confirm to social norms with regard to lawful behaviour as indicated by repeatedly performing acts that are grounds for arrest.* The author correctly states that this could apply to corporations as well, unfortunately referring to the term "psychopaths" where DSM does not use this term of course, but at least it is a good start. I agree with Ullman that not every culprit will be arrested ("ground for arrest" does indeed not mean that the person or company in question is being sued) but he correctly refers to the fact that companies often try to manipulate stock shares or engage in illegal accounting practices.
- *2. Deceitfulness as indicated by repeated lying, use of aliases or conning others for personal profit or pleasure.* It is indeed obvious that a corporation can be perfectly capable of showing this kind of behaviour, the author states "Corrupt corporations are out for money and power and manoeuvre the agencies of government in pursuit of their goals".
- *3. Impulsivity or failure to plan ahead.* Here Ullman refers to the Iraq war. More in general, and referring to companies, I would like to refer to companies where decisions are not made on a long term (strategy), but more on an ad hoc basis, and without any thorough thinking.
- *4. Irritability and aggressiveness as indicated in repeated physical fights or assaults.* Comment: "There is aggression and fighting in the world of corporate psychopathy but this is acted out in the court in order to save or expand its own turf". I would like to refer to verbal aggression, mobbing and stalking which are very common in psychopathic companies.
- *5. Reckless disregard for safety of self or others.* Again, the author refers to the Iraq war. With regard to company psychopathy, I think about an existing example that clarifies this. A company taking samples from the sea bottom used a drilling device. After testing the device the certification authority decided not to issue a certificate that it was safe. Since time is money, the operations manager did not really bother and decided to use the equipment. Moreover, after a few hours or days the company was officially warned by the national organisation governing gas pipelines that it never received any notification, which is mandatory if and when drilling. It appeared that the operations (possibly) took place only a few metres from a gas pipeline.
- *6. Reckless disregard for safety for self or others consistent with irresponsibility as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.*

  Comment: the author refers to financial security when referring to corporate psychopathy. Indeed, this makes sense. I witnessed how financial and accountancy laws were ignored. For instance, in the country in question there is a mandatory "alarm bell procedure" that has to be followed by any company that encounters financial problems. While it became clear to me that all legal requirements had been fulfilled to sound the alarm, it remained silent. Moreover, after the refusal of the financial auditor to give his approval

regarding the companies' figures (resulting in an official notification from the auditor to the authorities) the authorities started a procedure that is being used regarding companies encountering financial problems, a procedure that (theoretically) can end up in a bankruptcy.
The directors were not impressed, gathered some information, and convinced the court that there were no problems at all (a new investor was found) and the procedure was stopped for the time being. Eventually, the investor injected the necessary millions into the company, but given the structural problems within the organisation, the whole story started again afterwards. This company has also a history of late payments. Many financial obligations were (and this repeatedly) only fulfilled after lawyers issued official letters. In one case, a so-called Statutory Demand under English law was issued, meaning that the company was in extremely deep trouble and ready to be declared bankrupt within a few weeks only. The person who caused this (and caused many other problems before and afterwards) jeopardised the jobs of about 60 to 70 persons by his reckless and irresponsible behaviour.

– *7. Lack of remorse as indicated by being indifferent to or rationalising having hurt, or mistreated or stolen from another*. The author states that the company cannot feel remorse but the people that run it can. I can only confirm this. The people I did observe in the company that I referred to above never seemed to be concerned about the damage done. It was never their fault either.

The author correctly states that "the criteria as noted in the manual do not go far enough in capturing the essence of psychopathy (....)".

Now I will discuss the PCL-R items in relation to companies.

V The PCL-R Checklist: 20 items

Hare's PCL-R Checklists consists of 20 items:
– Glib/superficial charm
– Grandiose sense of self-worth
– Need for stimulation
– Lying
– Manipulative
– No remorse
– Shallow affect
– Lack of empathy
– Failure to take responsibility for own actions
– Parasitic lifestyle
– Poor behavioural controls
– Promiscuous
– Early behavioural problems

– Lack of realistic, long-term goals
– Impulsivity
– Irresponsibility
– Juvenile delinquency
– Revocation of conditional release
– Many short-term marital relationships
– Criminal versatility

One can "score" 0, 1 or 2 points on each item. For obvious reasons, this is not meant to be a self-test, as a real psychopath would not be honest enough to answer each item sincerely.

The cutoff (meaning, in short, how many points are decisive to conclude that a given person is a psychopath) differs from country to country and is 30 for the USA and 25 for Canada and the UK.

Now I will try to find out whether or not it would make sense to test a company in the same way as a physical person in order to call a corporation psychopathic.

VI The 20 PCL-R items applied to the company

Let us see what happens if we apply the 20 PCL-R items to companies:

– Glib/superficial charm: Especially glibness certainly seems to be applicable to companies, at least potentially. I refer to the team of accountants involved in an official survey. The language used in reports can be decisive here. If companies face massive problems that the outside world is not aware of and there is a danger that this will change due to any official survey by the authorities, glibness can really save the company in question. Suppose that such a company is managed by a management team that is verbally not capable of giving a "good" explanation (lack of verbal skills) for say severe financial problems, there is a substantial risk that the authorities will declare such a company bankrupt. But if this team is run by persons that are really eloquent and capable of filing a brilliant report to the authorities (also known as "window-dressing" in the financial world, at least where this refers to manipulating figures) it certainly helps of course if the manipulated figures are elucidated by an attractive text rather than by a clumsy set of words.
– Grandiose sense of self-worth: I think it is obvious that companies can show a grandiose sense of self-worth without any problem. I only have to refer to impressive websites showing all the big achievements of the company in question, including the names of important clients, pictures of expensive equipment, smiling faces of succesful staff et cetera.

- Need for stimulation: Obviously there are different sorts of companies. There are rather quiet accountancy offices for example, and small factories where the employees do their job without any disturbance. Contrary to this, there are companies that are more "exciting" like the companies that are active in the off-shore industry or corporations trading stocks. The latter category of companies is rather attractive to psychopaths and I dare to state that these companies (in a way) are in need of stimulation by their nature. It can and will be part of these companies' culture. I think everybody will know examples of such "adventurous" companies.
- Lying: It is self-evident that companies can lie. Again I refer to corporations cheating clients, manipulating official records to deceit the authorities, providing false statements to banks in order to get loans et cetera.
- Manipulative: This comes close to lying of course. Suppose that a company desperately needs new projects in order to survive. It is not unusual that potential clients will require the company to provide them with information referring to earlier projects, witness statements of earlier clients et cetera. Or a client wants to visit the premises of the company and there are certain parts of these premises that are in a deplorable condition (broken machines, dangerous situations). Then it may not come as a surprise that the company could manipulate the client by keeping the latter away from these locations ("under construction", "off-limits") or, in case we refer to mobile equipment (cars, trucks, aircraft, vessels), you just make sure that the equipment will be mobile indeed in the most literal sense of the word.

  Of course, a more classic example of manipulating is the accountancy department showing banks, clients and authorities the figures that they want to see rather than the real figures that (naturally) are less promising.
- No remorse: This could also apply to companies. I just refer to companies that are being found guilty of oil spillages, reckless actions with regard to clients' savings (investments) et cetera. Afterwards, an official press conference is being organised to explain the situation and of course, nobody present (Board members, Directors, Senior Managers) will state that he or she is responsible. Investigations take place and all necessary information will be provided if available. Of course, this can take a while. But we did not do it, somebody else did.
- Shallow affect: Suppose a staff member passes away. This can go either way. The company can get really involved, showing sincere interest in the person in question and his or her family, or the companies' reaction can simply be limited to sending a formal card to the family of the deceased. Why should we be bothered, people come and go.
- Lack of empathy: This relates to the item "shallow affect" as well. Of course, there are many wise words for managers (do not be too familiar, keep a certain distance) to make sure that they can make the right decisions. Sometimes (I refer to my example involving the two cousins who were forced

to dismiss staff) this can be useful. Too much empathy can be counter-productive in many situations. But empathy certainly remains important within companies. It is important to be aware of what is going on and if top management is not capable of feeling what people within the lower ranks of the company think and feel, it runs the risk of losing control. Just a possible example. Twelve employees of a UK based transport company recently won a few million Euros after buying a winning "Euro Millions" lottery ticket. The day after, they resigned. All twelve of them. That day, the company in question lost about 25% of its workforce. Strange, because normally, the average lottery winner declares to be very happy of course, but in most cases he or she just wants to continue daily life including his or her job. Maybe these twelve employees were not happy with their job(s) at all, just waiting for the opportunity to resign. And this could be the result of top management not being aware of their dissatisfaction. In short, such situations could be the result of top managers lacking empathy. This also goes for clients. I remember a case of a client calling a company on a regular basis, always barking and swearing at the lady in the call centre. This lasted until the general manager had enough of this and he called the client in question in order to find out what appeared to be the problem. Also, he clearly stated that the conversation would be ended if the client would raise his voice to him as well, client or not.

This worked and after a while it became clear to the general manager what the problem was, and eventually it was solved. This solution was only possible with the help of empathy.

- Failure to take responsibility for own actions: It is clear that companies can fail to do so. Many companies only take responsibility for their actions after being forced by (e.g.) a court decision.
- Parasitic lifestyle: Again, it is no problem to imagine that corporate entities can be parasitic. There is no fundamental difference between the physical person who deliberately loans money from others without paying it back, and a company that loans (even more) money from the banks (and shareholders, by issuing stocks), knowing that such company cannot pay the money back, and subsequently goes bankrupt, leaving all stakeholders with empty hands (and pockets).
- Poor behavioural controls: This is more difficult. A company as such can hardly be impulsive in the same way as a physical person (which can be a neurological issue) but as a company acts through persons who can show poor behavioural controls one can imagine that a company can act impulsively accordingly. For example, if top management within a given company has an issue with a third party (e.g. an outstanding invoice involving a significant amount) it has to decide what to do. It might be that the other company has only temporary problems and that this company happens to be an important business partner. In such case it would not make sense to sue the company in question, for in most cases this would mean the end of a fruitful relationship.

- Promiscuous: Although a company cannot be promiscuous in the same way as a human being, one must look at the behaviour behind promiscuity to realise that companies can actually behave in the same way (but without the physical pleasure of course). Psychopaths are known for being unable to maintain stable relationships, which logically leads to promiscuity in many cases. If we look at corporate entities, we actually can find similar situations. It is, after all, of key importance to companies to build stable relationships with all stakeholders (clients, shareholders, banks, people living in the vicinity of the premises if any, governmental organisations et cetera). In my opinion, there is not much difference between the person who is promiscuous in the more classical sense of the word and a company that constantly ruins its relations with (e.g.) clients. In both cases it will have a potentially disastrous effect on the persons and/or the companies involved.
- Early behavioural problems: I also refer to my comments under "juvenile delinquency". I think it is clear that a company can show "behavioural problems" in an early stage of its existence. A corporation can be organised badly, a lack of skills and experience can result in poor communications with clients and the government, et cetera. For instance, a young company does not have enough staff yet but it is growing fast. Clients are being neglected, meetings forgotten, and due to a lack of bookkeepers/accountants invoices are overdue (or not paid at all), and tax reports are filed too late or not at all due to the same problems. Of course, this does not always happen intentionally but sometimes it is the result of a negative attitude and in such cases this could be described as problematic behaviour.
- Lack of realistic, long-term goals: Companies must take strategic decisions, where the term "strategic" traditionally refers to long-term goals in business terms. This also means that the company in question must decide which projects are too dangerous to start with. Risk analysis forms a part of this procedure. An (actual) example. A young and fast growing company normally got jobs worth about € 5 million. This was never a problem and risks were carefully covered, among others with bank guarantees and insurances. Now this company received an invitation to tender (ITT) for a job in the Middle East, worth about € 10-15 million. Legally, the proposed terms and conditions (T&C) of the project (part of the tender) were found to be unacceptable already. As a consequence of these (extremely one-sided) T&C, payment conditions were a real threat to the company as well. Despite all warnings, the company in question started the project totally unprepared and nearly got bankrupt, and it could only be saved by new investments afterwards. This catastrophic outcome was the direct result of a total lack of long-term goals. In fact, the job was accepted impulsively.
- Impulsivity: I refer to the above, where a company only with the financial help of new investors could be saved after entering into a very dangerous project, which ended dramatically in all respects (legally, financially and operationally). Top

management was simply too gung ho to start the project and never realised what the risks on the long run could be. This behaviour can only be described as impulsive.

- Irresponsibility: The structural late or even non-payment of invoices, entering into agreements involving obligations that cannot be fulfilled, drilling near gas pipelines without even notifying the authorities. These are all (actual) clear examples of irresponsible behaviour by a company.
- Juvenile delinquency: Mutatis mutandis, this item can be applicable to companies. New companies sometimes (often) have problems such as a lack of finances, or a lack of knowledge with regard to the obligations that have to be fulfilled. This can easily result in criminal behaviour. Moreover, in many cases starters even know that they are breaking the rules, but they take this for granted because otherwise they cannot survive. It happens quite often (for example) that the monies earned in the beginning are not being reported to the tax authorities. Normally, this behaviour often stops when business starts to go well and the company in question gets organised, e.g. when there is enough money to engage a bookkeeper and/or an accountant. Of course, when young organisations break the rules intentionally or unintentionally, there is always a risk that this behaviour starts again if the company meets problems later on. At least, top management (if this is still the original management) knows from the past how to "deal" with problems if necessary. This does not differ much from juvenile delinquency, where youngsters often learned to cope with the daily problems, and in such cases there will always be a certain danger if such a person meets severe problems later, because in that case he or she still has these basic "skills" to deal with certain issues if the going gets tough.
- Revocation of conditional release: Obviously, a corporation cannot be incarcerated. But it can be condemned, and the subsequent penalty can be suspended. Suppose a company does not pay taxes, clearly a serious offence. The company is being sued and the judge decides that a fine must be paid, but given the fact that this is the first offence he or she also decides that the payment of the fine shall be conditional, of course if the company does not commit the same offence within a given period. The fact that a company cannot be jailed does not play an important role here in my opinion. Important is the fact that such a company does not (or does not want to) learn from its mistakes.
- Many short-term marital relationships: Although a company cannot be married in the strict sense of the word, it can engage in long-term relationships with other parties, such as joint ventures (based on equality), and the various contracts with the employees of course (albeit that there is no real equality here since employees have to obey unless the "employee" is self-employed in which case there is more reason to assume at least some equality, e.g. in case of top managers who happen to be powerful consultants, able to impose their conditions to the company if and when negotiating the

T&C of their contract with such company). If the company breaks or terminates its (intended) long-term formal (contractual) relationships on a regular basis one can compare this behaviour (again, mutatis mutandis) with the psychopath who leaves a trail of ex-spouses. Pacta sunt servanda is the rule and this generally goes for all agreements, certainly regarding important long-term agreements.

– Criminal versatility: Companies can easily be versatile if and when committing crimes. For example, a company can spill toxic waste or oil, and at the same time it can commit tax fraud, cheat banks when applying for loans et cetera.

VII And how to repair companies again: Leadership

There is a big difference between a manager and a leader. Not every manager has the personality and/or the skills of a real leader. Too many (top) managers destroyed or are destroying sound companies. Leadership is a term that is currently embraced by many authors, especially those with what we could call a "New Age" background. Earlier, Kets de Vries wrote a book about the different management styles that can ruin a company potentially. He describes five "styles" that can be problematic albeit that sometimes it is necessary to involve a "problematic" manager (crisis management).

Narcissism plays an important role here. For example, there is the dramatic leader, who likes to take excessive risks and does everything to overpower his competitors. Or the suspicious one, being more concerned about his defence strategies than leading the company.

Eventually, Kets de Vries concludes that true leadership should be a ***servant leadership***. In fact, the true leader is more or less invisible. If he or she acts correctly, the people surrounding him or her will complete a task or project successfully, stating that "we did a good job". And although this kind of leader (being human) likes to receive compliments, he or she will not have problems with this "invisibility".

Servant leadership is also a key element of Jaworski's works. As a former top lawyer, he was quite familiar with the sweet taste of success. His law firm used to be one of the USA's top law firms and losing cases was not an option. Every success was a good reason to celebrate. A personal crisis ended this story. Jaworski realised that the kind of success he had was in fact not "real" and he started a personal quest, following his intuition, guided by meaningful coincidences (earlier described by Jung as "synchronicity" which is far more than just sheer coincidence).

Jaworski met several top managers during his journey and most of these leaders had problems with the traditional management styles, although many of these styles certainly would be good for their Ego.

Eventually, Jaworski had an important meeting with the top manager of a well-known oil company. They decided to form project groups, guided by Jaworski's ideas. Participation was of key importance here and these groups involved persons with different backgrounds, even artists were invited to participate. There were no leaders in the traditional sense of the word. Every group worked as a team.

This approach resulted in a totally new way of tackling strategic issues (including, as stated above, long-term decisions), and for many years the "scenarios" which used to be the results of the work of these project groups played an important role within this corporation.

It needs no further explanation that this totally new approach would not allow psychopathic elements to play their destructive games.

VIII Conclusions

My review is only a start. Provisionally, I wanted to point out that companies can act like psychopaths. This does not have to come as a shock for companies have to act through natural persons. If a given amount of persons (a critical mass) within top management acts in a psychopathic way, it can (and mostly will) affect the whole organisation. I would like to join Dr. Ketola who refers to a "Prince of Virtues" who would be able to awake them "from a 100-year sleep" but this prince will have to be a powerful one, showing guts. And I can guarantee that the awakening could be a rather painful one.

I agree with those who would like to introduce a set of tests for top managers, including the PCL-R test. This certainly will not be applauded by many of these potential managers, but the key stakeholders, such as the shareholders who invested their money in the company in question, are entitled to know if the managers in question have the qualities they need in spite of qualities that are in reality the "qualities" of a hard-core psychopath rather than the qualities of a top manager. After all, such a manager could destroy the whole company and thus the investments of all shareholders, including the "small" investor who simply invests his or her precious savings in the company.

Structure is also a key word here. Kets de Vries refers to a certain basic structure, including well-defined roles/authorities and clear procedures as a possible

solution, should problems rise regarding problematic leaders and their respective management styles.

Indeed, a well-organised corporation with a given set of basic rules (checks and balances) is not the favourite place for psychopaths. Regular audits can reveal unpleasant issues long before the bomb bursts. These audits should include ISO 9001 audits as well.

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Therapeutic Jurisprudence and the Victim of Crime

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This article deals with the issue of *therapeutic jurisprudence (TJ)* and how the role of the victim in criminal proceedings is looked upon within that legal ideology.[1] The principal conclusion is that the victim of crime's position in criminal proceedings is generally too weak, and that the absence of an active role and of real influence is harmful to his or her well-being. As a way to tackle this problem, mediation – a process that will not be evaluated in this article – could be an alternative or complement to the ordinary process, but in general terms the main objective is to meet the victim's need to be heard and to give him or her the chance to explain the serious consequences of the crime to the community (and not least to the perpetrator).

In Sweden, there have been positive developments during the last 20 years in supporting victims of crime. Every victim of a serious offence gets a lawyer for his or her support (a victim's counsel, "målsägandebiträde"), every convicted criminal has to pay a contribution (of approximately 50 euros) to victimology research, and every victim of crime can get damages paid by the state if no offender can be identified or if the offender cannot pay (unless the victim has insurance coverage). The victim is present throughout the trial, acting (through his or her lawyer) as a party beside the prosecutor, and has a chance to present charges, claims, evidence and arguments. One reason for the opportunity to create this strong position in the criminal process is the fact that, in Sweden, the victim of crime always has been regarded as a party, and not just as a witness. During one period of the last century the position of the prosecutor overshadowed this position of the victim, but since the 1980s the procedural position and the interests of the latter have been restored. Another reason for this development is the strong crime victim support movement (linked to the women's liberation movement), which opposed the official policies of the 1970s under which all attention was given to the rehabilitation of criminals.

1 A Swedish version of this article is available in Lernestedt & Tham (Eds.) "Brottsoffret och kriminalpolitiken", Stockholm 2011. Therapeutic jurisprudence from a Swedish perspective is presented in the monography C.Diesen *Terapeutisk juridik*: Malmö; Liber; 2011.

The present procedural system provides a good balance between the suspect and the victim, giving the victim a chance to participate in and influence the trial. From an international perspective, it seems important to discuss these Swedish reforms and experiences. However, good procedural rules and regulations guarantee neither an adequate response to the needs of the victim of crime, nor a high quality of justice. To be able to accomplish these aims requires knowledge – which is often to be found within the behavioural sciences – about the consequences of a crime for its victim. This is the mission and task for therapeutic jurisprudence.

1 What is therapeutic jurisprudence?

"Therapeutic jurisprudence" can be defined as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects" (1). This definition may give the impression that TJ is a form of sociology studies or at least an instrument for empirical research. That impression is misleading: the main focus of TJ is on legal practice, although the analysis of that practice can lead to the conclusion that the law is not functioning as it ought, and should be changed. From that point of view TJ can be considered *a legal ideology*. If society creates laws and practices that make the situation worse for all affected persons, this is a societal failure.

A TJ-lawyer uses this ideology, this approach to legal situations, as a complementary working tool (2). The idea is that *lawyers have to use the theories and findings of social sciences that improve legal practice*. As legal conflicts always have social implications, a good lawyer needs a broader perspective than just the legal effects of that conflict. By studying socio-psychological aspects, i.e. how laws and legal practices influence the lives of citizens and, in particular, of individuals involved in legal processes, a lawyer can avoid future mistakes. In a macro-perspective, TJ can be used to evaluate whether a certain law fulfils its purposes or, instead, functions in a counter-productive way. On an individual level, lawyers – through a more holistic approach to problems – can try to minimise the damage caused by a conflict. The purpose of a trial should not just be to solve the actual conflict, but should also be to solve the human and social problems that created the conflict (3). By analysing the underlying problems, and by choosing long-term solutions, it might be possible to prevent the occurrence of new conflicts and problems.

In short, TJ signifies a broader and deeper approach than the traditional, more instrumental, way of solving legal conflicts; social elements represent a wider

foundation for decisions.[2] This approach does not mean that a lawyer who practises TJ should become a therapist, or that the court has to abandon traditional justice in favour of making choices within a spectrum of social solutions. TJ is only meant to be a subsidiary, normative approach – not a substitution for judicial norms, like due process, fair trial or burden of proof, or judicial purposes such as punishment, protection and compensation. But through analyses from a TJ point of view – generally considering the type of conflict and individual aspects of the specific case – lawyers and judges can discover values other than the legal ones. The insights provided by TJ analysis are important for measuring and balancing conflicting interests and interfering norms. The analysis might produce a well-balanced policy for the type of conflict, and a functioning strategy for finding the best solution in an individual case (5).

These ideas are not new. In fact today there are many "schools" of legal ideology and practice which have a similar platform (6). One such school, which is very close to TJ, is *Restorative Justice (RJ)*, a philosophy which aims to use legislation, legal practice and the treatment of offenders in order to repair the damage caused by crime and to prevent reoffending (7). Mediation is particularly recommended as an instrument for creating a better balance between victims and perpetrators, for giving deeper insights into the dynamics of a conflict and for finding more efficient solutions. Restorative Justice can be regarded as one side of TJ, the ideological side, but the other side of TJ lies in its close link to the social sciences. That link makes TJ more universal than RJ, but the main difference between the two schools is that RJ is (mostly) focused on criminal law, while TJ can be used – and is used – for all legal situations and problems.

The main factor that distinguishes TJ from other schools of legal doctrine is the close connection between legal practice and psychosocial findings. Decisions that are to be made in a legal context must, if possible, be based on verified scientific results. The idea behind TJ is not merely to analyse legal rules, comparing the aims of the law with its expected effects, but also to find out what answers the social sciences have to this question (8). The standpoint that law and legal practice are based on ethics, and result in an expression of values, does not prevent lawyers from seeking knowledge about the consequences of alternative decisions – of different evaluations.

2 Sometimes the metaphor "wide angle lens" is used, see Wexler & Winick i *Law in a Therapeutic Key* at vii (4).

2 History

Many of the central elements in TJ – both theoretical and practical – can be found in older ideas and practices. You can find some of these elements in the *ting* of the Vikings or the clan-meetings of the Navajo Indians (9), in the works of Max Weber and Michel Foucault, in the American legal realism of Roscoe Pound, in the "treatment ideology" of the 1970s,[3] and in Danish jurisprudence of polycentric legal sources. More recent ideas about a more holistic approach to legal practice can be found in the Restorative Justice movement and in the South African Truth and Reconciliation Commission. In short, the ideas of TJ are not revolutionary, nor even new. But what makes TJ special in this context is the close link between legal practice and the social sciences, between theory and a very fast breakthrough in American legal practice.

Trying to describe TJ as the product of an historical development that started with, let's say, Salomo, was interrupted by Montesquieu but had a renaissance with legal realism, and so on, does not seem adequate in a short presentation. But a brief summary of the history of TJ does have a place here. TJ started in the late 1980s in the USA with an analysis of practice in mental health cases. In a federal study of the laws and legal practice in this field, two legal scholars, Bruce Winick, a professor in Florida (who died in 2011), and David B. Wexler, then a professor in Arizona, began a long-term co-operation. Their analysis of the legal situation of the mentally disturbed ended with a critical conclusion about a gap between the aims of the law and its practice. The declared purpose of labelling someone as mentally disturbed was to grant him or her better opportunities to use his or her civil and human rights. The law should guarantee the mentally ill equality and fair treatment, whether the legal circumstances are criminal law, custodial care or civil rights. A person who does not realise what he is doing should not be punished, a person who does not understand his need of cure and treatment can – for his own benefit – be forced to have a cure or treatment, and a person who cannot deal with his own affairs needs a guardian. Under this special system, the mentally disturbed will get compensation for their handicaps. Winick and Wexler (10) found that, in practice, the labelling of citizens as mentally ill expressed a paternalistic, protective and repressive idea. It leads to negative, sometimes devastating, consequences for the individual; the mentally ill are deprived of their civil rights and human dignity, people are declared incompetent and will be stigmatized by the community, and this in turn leads to a loss of self-confidence and self-esteem. Considering all these negative effects, the legal system must be very careful and restrained in labelling someone as mentally

3 The treatment ideology – that criminality is a product of unfavourable circumstances and should be treated with individual rehabilitation programmes – was an international tendency during that period, and in Sweden it was particularly strong (as a policy of the governing party, the Social Democrats).

disturbed, especially since the legal criteria for that label are difficult to evaluate and since the psychological problems could be temporary.

From mental health law Wexler and Winick went on to other legal fields, and then other legal scholars, from universities all around the USA, joined them in the idea of legal practice being more focused on proactive and rehabilitating measures. In 1990 the first collection of articles based on the new ideas, edited by Wexler ("Therapeutic Jurisprudence: The law as a therapeutic agent") appeared, and the year after that Wexler and Winick published the first anthology on the subject, "Essays in Therapeutic Jurisprudence". At that point most of the articles emanated from the original analysis of mental health law, but issues of punishment and compulsory care are now discussed from a broader perspective. The discussion is not limited to the question of how to get a closer connection to behavioural sciences, but it also contains critical views on the legal system and on legal principles and proceedings that prevent more constructive solutions being found. The criticism is also about the need in the USA to use international experience in situations where problems seem too hard to handle in a traditional way. Overcrowded prisons and the frustratingly high frequency of reoffending have not been least among the incitements for change (11).

The most important factor for the success of the TJ movement was the American reality, a reality that demanded changes in legal practice. The fast development of TJ in American theory and practice depended on the fact that the ideas did not remain at the universities, but were soon adapted by many practitioners. For reasons that are self-evident, there was also fertile soil for new ideas among legislators. Parallel to the evolution of TJ, there was an evolving insight that you cannot fight drug abuse with imprisonment, that prison sentences for drug addicts only postpone problems and that cure of drug abuse is a much better solution both for the individual and for society. Following this conclusion, on the initiative of the state attorney Janet Reno (later Minister of Justice), the first *drug treatment court* (DTC) was set up in 1989. Drug abusers accused of a crime could choose between a traditional court trial (with jail as a consequence if they were convicted) and a DTC trial with contract cure as a consequence. Now, twenty years later, there are DTCs in all states of the USA, and the reform has been a great success. Reoffending rates have decreased and costs have been reduced to 15% per conviction compared to jail sentence (12).

Through the connection between legal ideology and trial reform the TJ movement took a strong position on the American legal scene. Without the ongoing reforms of the courts it would have been much more difficult for TJ to find a base for its ideas – but now TJ is the ideological backbone of modern legal practice. The successful outcome of the DTC reform has led to the introduction of other special courts in the USA, using the same idea of special treatment for conflicts

with a certain social dimension. The most common of these courts so far are the domestic violence courts and the mental health courts.[4]

On the theoretical side TJ has been broadened step by step and now *includes all fields of legal practice*. In 1996 another anthology by Wexler and Winick, "Law in a Therapeutic Key", was published, and more than 50 authors contributed to that 1000 page book. The subjects range from social law and penal law to civil law, tort law, administrative law, etc. A significant part of that book deals with therapeutic jurisprudence as a method both to analyse the positive and negative consequences of alternative solutions and to make recommendations for therapeutic legal practice.

The issue of best practice is developed in the next anthology: Stolle, Wexler & Winick's "Practicing Therapeutic Jurisprudence: Law as a helping profession"(13) was published in 2000 and deals with the relationship between the lawyer and the client. Therapeutic judging, with a focus on the new problem-solving courts, is dealt with in "Judging in a therapeutic key: Therapeutic jurisprudence and the courts", which was published in 2003. The latest anthology, "Rehabilitating lawyers", from 2008 and edited by Wexler (14), develops the therapeutic attorney-client relationship further, showing how the defence lawyer can function as a change agent for his client.

The TJ movement is organised by the International Network on Therapeutic Jurisprudence, and practitioners participate in the biennial conferences of the IALMH (International Academy of Law and Mental Health). The home page *therapeuticjurisprudence.org* has a growing bibliography, now (2012) containing more than 2,000 articles from more than 500 different authors (most of whom are from the USA, but including contributors from all over the world).

In a short time a movement, in co-operation with other comprehensive law schools (including Restorative Justice), has had such an impact on legal ideas that it has reformed the judicial system in the USA. The reason is the strength of the message, in combination with the need for changes to deal with current problems. The reforms influenced by TJ are not primarily directed towards a change of court organisation, with specialisation and differentiation, but are based on a change of perspective. Through knowledge obtained from the social sciences it is possible to find better ways to prevent and solve social conflicts than the traditional, narrow and instrumental approach.

Summing up, therapeutic jurisprudence rests on three pillars. *The first pillar* deals with the lawyer's need for behavioural knowledge in order to do a good job.

4 About this development, see Winick & Wexler *Judging in a Therapeutic Key ps*.21-72 (3).

As being a lawyer is about preventing and solving social conflicts, you need a certain knowledge of the grounds and dynamics of these conflicts to be able to solve them. *The second pillar* deals with the question of how lawyers can gain this knowledge; one alternative is to widen the competence of the lawyer, while the other is to cooperate with people representing other disciplines. *The third pillar* deals with the therapeutic and anti-therapeutic effects of lawyering, i.e. how different solutions affect the lives of the people involved. A natural starting point for a TJ lawyer is that the legal procedure should not ruin the possibilities of rehabilitation, and a natural aim is to seek long-term solutions. On a higher level TJ is about using legal skills to prevent and solve conflicts in an efficient way.

3 Victimology

Therapeutic jurisprudence deals with the rehabilitation of both parties in the criminal process. On the victim's side, an important conclusion is that the victim should be guaranteed more influence than he or she was given in the traditional process and trial. In different ways the participation of the victim is important, both in the proceedings and in the rehabilitation of the offender. It is unsatisfactory that the person suffering from the effects of the crime has no influence on the closure of the case or on a decision to accept a settlement.[5] The power of the prosecutor today is unacceptably great if the prosecutor can take away all opportunities for the victim to be part of the decisions.[6] On one hand it can be legitimate for the prosecutor to bring the alleged perpetrator of a serious crime, e.g. rape, to court without the consent of the victim, because this prevents the victim from being a target of pressure and extortion. On the other hand, being excluded from influence and participation makes it more difficult for the victim to tackle the trauma and suffering caused by the crime. Another important aspect of this lack of influence is that the legal system does not use the experiences of the victim as a resource (an instrument to make the offender understand the severe consequences of his acts) in the rehabilitation of the offender.

To be able to accept the needs and rights of the victim, it is essential to accept fully that a crime, especially when it is physically directed towards a person, creates negative psychological effects. In addition to the immediate reactions of fear, loss of security and reduced self-confidence, the crime can lead to long-lasting and deep disturbances in the psychosocial life of the victim, which will

5 This is most evident in legal systems that accept plea bargain, eg. the USA. Most American states have rulings that require contact with the victim before a settlement, but in practice this seldom happens (15).

6 In former times it was the crime victim, not the state, that "owned" the process, but with the Magna Carta (1215) – or with the entrance of the feudal era in each nation – that right was, step by step, taken away (16).

reduce his or her quality of life: depression, anxiety, PTSD,[7] disturbances in perception (e.g. flashbacks and nightmares), drug abuse, problems in social relations, and even somatic diseases (e.g. high blood pressure and stomach problems) are common consequences (18). In more serious cases, the experience of being the victim of a crime can lead to suicidal tendencies, aggressive behaviour (most common amongst men) and to taking on the role of perpetrator.[8] There is also a risk of revictimisation, i.e. of becoming a victim again.[9]

It is a fact that victims of crime have more psychosocial problems than average people, but the individual variations are so many that it is not possible to foresee who will be affected, in what form and to what degree. Nor is it possible, if effects occur, to make a prognosis about the time and means needed to get over the problems (20). Support from the family and others can ease the pain, but – if the victim does not get professional help – he or she will often choose avoidance strategies (e.g. changing his or her phone number, not attending parties, staying at home or choosing isolation), strategies which may increase the psychological problems (20). The overall result of being a victim of crime can be an entry into a state of "learned helplessness" in which the victim identifies himself or herself with the role of a victim. With these insights *the therapeutic approach must be to turn the victim into a "survivor"* (15).

4 The risk of secondary traumatisation

Throughout the process, to strengthen the victim of crime, in a psychological and in a legal sense, is an important ambition for modern society. Neglecting that ambition means risking continuing suffering for the victim. Not giving him or her enough support means there is a risk of *secondary traumatisation*, in which the trial itself makes the trauma worse and emphasises the victim's role as victim. The result is that the risk of *secondary victimisation* increases too, meaning that the victim has to suffer other negative psychosocial effects, such as being treated in a particular way by the community, failing to manage his or her work, losing his or her sexual appetite, and so on.[10]

Secondary traumatisation is of particular interest from a TJ perspective, as the ambitions of this perspective must include minimising the negative effects for the victim. It can hardly be in the interests of the legal system – or even in the

7 57% of rape victims in a 1987 study suffered from PTSD, and for 16% the problems remained 17 years (the median) after the assault (17).
8 Being a victim increases the risk of becoming a perpetrator (of a similar crime) (18), but there is no direct correlation – too many factors (especially in the social environment) influence the risk (19).
9 It is not rare that victims of incest become victims of rape as adults (18).
10 The terms "secondary traumatisation" and "secondary victimisation" are often used synonymously, but here a distinction is made between the experience of the crime (psychological effect) and the additional negative consequences (social effect).

interests of the defendant – that the suffering of the victim increases as a consequence of the trial. On the contrary, it is essential that the proceedings, without interfering with the rights of the defendant, reduce the negative effects to a minimum. In order to follow that ambition, it is important to know about the different elements in the process that can produce these negative effects.

Being a victim of a crime creates stress. Sometimes this stress is minor, but even a burglary at home can be a stressful factor for a long time. In other cases, particularly when it comes to violent and sexual crimes, the experience can lead to PTSD or other more severe disturbances. The stress that the investigation, and especially an upcoming trial, creates can make it hard for the victim to focus on going back to normal everyday life. In more serious cases, it can be very difficult to start rehabilitation before the trial is over. But it is not primarily the *continuing* stress that is covered by the term 'secondary traumatisation'; instead, it is the fact that the investigation and the trial can be experienced as another abuse. This second encroachment can revoke or fixate the trauma of the victim.

Different elements of the proceedings can cause this effect, but in general it is caused by an *accumulation of unpleasant experiences*. Mistrust by the police can be the first and most determining step in this mental development. Then meeting with the offender in court causes worries, and the stress is increased by the nervousness connected to the cross-examination that the defence lawyer will perform. Not knowing what will happen in court, or the outcome of the trial, exacerbates the tension. To tell the court about the experience is, to many victims, to revive the suffering caused by the criminal act – in particular, the giving of testimony is emotionally demanding. In that situation it is easy to become tongue-tied, and the frustration of not being able to tell the story well enough can create even more negative energy. When the defence attorney, during cross-examination, starts to question the victim's credibility, his or her suffering reaches its peak. The negative experience is complete if, in addition to all the other factors, the defendant's attitude is indifferent, spiteful or even threatening. The final result is that the victim gets stuck in his or her role as victim. The trial is not a liberation, a step on the road to a normal life, but a trauma in itself.

To avoid all these negative effects, the victim of crime needs *support in many different forms*, both legal and psychological. It is also important that the support is continuous, combined and not limited to separate efforts. A common consequence of becoming a crime victim is a loss of self-confidence and security, making everyday life darkened by fear or anxiety. Also common is a tendency to blame oneself, feeling that the crime was the result of taking unnecessary risks. To help the victim to cope with these insecurities, rebuilding confidence and self-confidence must be an essential part of the preparations for the trial. If these

needs are underestimated, there is a major risk that the negative effects will increase and become long-term problems.

Although there are these common features, it is also important to handle the problems on an individual basis. As we said above, the effects differ according to the character and severity of the crime (18), and depend on the relationship to the perpetrator (whether he or she was unknown there was already a relationship). The effects also differ between people with different social backgrounds and family situations – the strengths of the victim's social networks. The access to support can also depend on how close the person is to the concept of "the ideal victim" (21), and on many other factors in the environment or the personality of the victim. A hypothesis is that the crime victim who acts in an "expected" way (a stereotype), and expresses his or her suffering in an emotive way, has better chances of getting adequate support (22). As a result, the risk of secondary traumatisation to such a victim is less: an emotional victim is more often easily trusted and treated with empathy, both in court and by the community.[11] People who are more reluctant to admit their trauma have more difficulties in getting the support they need.

It is essential to pay attention to the difficult situation of the crime victim and his or her fragility. The idea that it is necessary – in the name of a fair trial for the defendant – to torment the crime victim during cross-examination in order to discover deception is often based on prejudice. The risk of false allegations cannot be a general platform for cross-examination, and the general credibility of a witness is seldom of substantial relevance for a rational evaluation of the evidence. As an example, it is, in all aspects, a destructive strategy to examine the sexual history of a rape victim and to "run her over with horse and cart" to test her credibility.[12] The truth of the matter can be reached by a good investigation, by focusing on the alleged criminal act, by encouraging a free narration and by testing alternative interpretations, not by accusing the victim of telling lies or by putting the blame on him or her.[13] It is too common today that the crime witness feels himself or herself to be the accused at the trial.

From a TJ point of view it is essential that all professionals representing crime victims get to know about the risks of secondary traumatisation. In order to support the crime victim in the best possible way, it is important to be aware of the psychological risks and complications. Without this knowledge, it can be very

11 The fact that an emotional person is more easily trusted may tempt the victim's counsel to encourage the victim to act emotionally (and to cry) in court. But the correct position of the supporting counsel is to encourage the victim to be as genuine and sincere as possible. On a higher level, a TJ lawyer opposes all stereotypic myths of credibility and deception.

12 Temkin (23) quoting a police commissioner's advice to the interrogators.

13 In jury trials the defence lawyer often uses prejudices as bases of mistrust – and often succeeds in doing so; e.g. in a majority of rape cases in England, Ireland and Norway the defendant is acquitted (24, 25).

hard to handle unforeseen situations, such as the victim breaking down or not being able to deliver his or her testimony, during the trial. To communicate security before and during the trial is one of the main tasks of the lawyer representing the victim of crime, and is a task that cannot be transferred to social services. The lawyer has to make good contact with the victim, and to evaluate his or her strengths and weaknesses and need for psychosocial support to withstand the difficulties of the trial.

The philosophy of TJ is simple in this aspect: it is not acceptable for the life of the victim of crime to be ruined, if it is possible to avoid this. The aim of therapeutic jurisprudence is to make lawyers aware of these risks and of how to tackle them.

5 Supporting the victim of crime

As there are so many problems and stress factors connected with an appearance in court, a general position for the victim of a crime might be to avoid trial. But in most prosecuted cases a trial cannot be avoided, and trying to minimise participation in that trial might be counter-productive. Not appearing in court (by, for example, only giving testimony through a video recording) can lead to a weaker position in the evaluation of the evidence. If the defence lawyer and judge do not have an opportunity to put suggestions or complementary questions to the victim, the value of his or her testimony will be reduced, and the victim will not have the opportunity to refute new statements by the defendant. The general position must therefore be to appear in court – and to take as much time as is needed to express his or her rights and claims.

In the long run, the trial, in spite of the stress it creates, can be a turning point, a way out of the victim status that has been inflicted. A condition for such a change is that the victim is treated well during the proceedings, and that it is a fair trial. This aspect, that the trial is fair, is often more important to the victim of the crime than the legal outcome of the trial. To be listened to, and to be trusted sufficiently by society to get the accusation tried in court, are the most important factors for rehabilitation (26). For the same reason, it is important for victims of a violent or sexual crime to report it to the police; not to do so, because of fear or a lack of evidence, will often create worries and long-term regrets. Refusing to accept the attack, making it public, is normally a better basis for going on than trying to forget it.

In that context it is important to distinguish different outcomes of the investigation. In a criminal trial, when the perpetrator is identified and charged, the victim of crime has an opportunity to get some compensation for his or her sufferings. But most crimes never lead to a trial: the offender cannot be found,

the case is closed for lack of evidence, or the evidential burden cannot be fulfilled. Whether or not the victim in that case can get some economic compensation is often dependent on his or her insurance situation,[14] but any such limited restitution appears anonymous and does not give the victim full recognition of what he or she needs. From that perspective, it is often important to get psychosocial help from a crime victim support group, and legal support from a lawyer. To meet this need, every victim of a felony in Sweden has the right to have support from a lawyer, which is paid for by the state, from the start of the process, i.e. when the crime is recorded. If the crime never reaches the courts, the victim has still had legal support throughout the investigation, which is a factor that can prevent him or her from feeling abandoned.

In less severe cases, and if the offender admits the crime, there might be a possibility (in Sweden and in most other modern jurisdictions) of solving the conflict – and promoting the rehabilitation of both parties – through mediation. The pre-requisite for that solution is that the victim of the crime is willing to participate. Most surveys on mediation show that both parties in the majority of cases are satisfied with mediation (27, 28), but it must be underlined that if the victim feels a pressure to be part of the process – or if forgiveness is expected – it can be better to reject the proposal. In other cases, where the alleged offender denies the crime or where the crime is more serious, a trial will be held, regardless of the will of the victim. In that situation *the trial must be regarded as a therapeutic platform for the crime victim.*

A trial is, to the victim, not only a chance to get economic and legal redress, but it is also a social ritual that channels the needs for vindication, respect, excuse, forgiveness and other feelings connected to the crime. This more invisible part of the trial can have a life of its own, outside the formal proceedings and outcome, and concerns the parties and how they handle the crime and the trial emotionally (29). From the point of view of the victim, it is important that the trial functions as an instrument for leaving the past behind and moving on. From the point of view of the offender, it is important for the future that he is able to understand the consequences of his acts. How these "emotional dynamics" function depends on many factors: the design of the procedure, the type and severity of the crime, the outcome, the relationship between the parties, and the parties' personalities and experiences. However, no matter how the dynamics are constituted there are often possibilities of finding ways towards rehabilitation for both parties. In that drama, shame and respect represent two major ingredients that should be recognised and used, and in order to promote the therapeutic effects of the

14 In Sweden, the Swedish Crime Victim Support and Compensation Authority pays damages if the case is not covered by insurance.

process it is essential to lead the parties to the core of the conflict which was manifested by the crime.

In that aspect it is important that both parties have an active participation in the proceedings. If the defendant remains silent, and if the crime victim is regarded as just a witness, the therapeutic side of the trial will be reduced or missing. Sometimes this consequence must be accepted, but at the same time it must be noted that if this happens then a traditional aspect of the trial – the "negotiation" between parties – is missing as well. If this valuable dialogue between the parties is going to have a renaissance (as it has in mediation reforms), the starting point must be a recognition of the rights and needs of the crime victim. Without this, the trial does not serve all its possible functions.

To support the idea of the trial as a conflict-solving process that can be therapeutic, it is important that the needs of the victim of the crime are recognised. The legal system must organise the proceedings in a way that gives the victim of the crime a legitimate place. Changes in the procedural design might require public opinion to be in favour of the interests of victims of crime, but it is vital for such reforms that they are directly related to procedural rules; otherwise, the collective demands of victims risk being reduced to a plea for more severe punishments (30). The reform that seems most appropriate for securing the rights of the victim of crime is probably the appointment of a victim's lawyer, an advocate who (free of charge) represents the victim from report to verdict. During the last decade many countries in Europe have followed the Swedish example and – at least in the case of sexual crimes (and crimes against children) – allow the victim to have his or her own lawyer during the process (31). Some European countries, like Sweden, have even given the victim of crime a position as a party in the trial (beside the prosecutor).[15] These reforms sit very well with the ideas of the TJ movement: *working for a stronger consideration of the rights and needs of the crime victim is one of the main ambitions of therapeutic jurisprudence* (15).

As we said above, to accomplish the therapeutic effects the victim normally needs to be active throughout the proceedings. To be able to do that, and not least to be able to confront the defendant in court, a certain mental strength is needed. To get that strength, legal support is not enough – the victim often needs psychosocial support as well. In the USA, the procedural rights of the victim have been neglected for a long time, but in contrast the Americans have worked a lot with social support. For cases of violence or sexual crimes against women and children, in particular, many programmes for victim support have been

15 In some jurisdictions the possibility of having a victim's counsel depends on the crime and on the income of the victim, and in some jurisdictions it is only possible to have a private lawyer for compensation claims in criminal trials.

developed, mostly by NGOs.[16] The supporting resources are partly focused on social needs, but their main purpose is to strengthen the victim so that he or she can withstand interrogation in court.

To be able to give testimony and to be prepared for cross-examination, legal support is important – and so is the support of family and friends. But often there is also a need for psychological support from professionals who have the insights needed to understand the problems and stress which the crime victim has to cope with. The long-term need for rehabilitation is also best achieved with help from professionals.

The need for a cure varies – as does the suffering – from person to person. Generally, it seems that younger people, men, and people with higher social status have less need of supportive efforts than older people, women and people with lower social status (32). One explanation might be a resistance in the former group to accepting the need for support (connected, for example, to the male stereotype), but another might be that people in the latter group take fewer risks and therefore feel a bigger loss of security as consequence of a crime (30). In addition, women are more often victims of serial crimes against their personal integrity, e.g. rape and assault within a relationship.

In terms of content, *psychosocial support* is about preparing the victim for the trial, treating the trauma before and after the trial, and helping the victim to get back to a normal life. The aim is to put the victim in the same (or a better) position than he or she was in before the crime. In long-term rehabilitation, there are no universal methods that can guarantee success; in contrast, American studies show that methods chosen individually are the most likely to be successful (30).

It goes without saying that the victim of crime also needs financial support. The victim should never be placed in the situation where he or she has to pay for rehabilitation (or forgo salary for attending therapy). To make rehabilitation successful, the victim needs full compensation for the losses caused by the crime – economic loss is a counter-productive factor to the normalisation process. But the economic compensation in itself is seldom the complete solution for the victim of crime (33).

16 A good example, now spreading all over the world, are the *Children's Advocacy Centers*, where children suspected to be victims of abuse come to be investigated and treated by multi-disciplinary teams (police, prosecutors, psychologists, physicians and social workers).

6 The balance between victim and defendant

If victimology is looked upon as *a question of rights*, it is evident, according to TJ, that the victim has had too limited a role in the criminal trial. One can be justified in concluding that the state has deprived the victim of the control of the moral responsibility that the offender created (34). And in the same way as a suspect has the right to have the accusation tried in court, the victim of the crime should have the right to a trial. It is not right that a person victimized by a criminal act has no access to the criminal courts if the state – for some (more or less legitimate) reason – decides not to proceed against the suspect. Alternative expensive means of justice are not fair, and nor is a plea bargain agreement between the suspect and the prosecutor which is made without considering the interests of the victim.

Having influence in the process is important for the well-being of all parties in court. That statement is also true for the victim of the crime. During the last two decades, several proposals to improve the position of the victim have been discussed in the USA (35). In that debate some prominent legal scholars, mostly within the feminist movement, have argued that victims are better off if they sue the perpetrator in a civil case and claim compensation than if they are reduced to the position of a witness in a criminal trial (36).[17] The psychological gain is that it becomes possible for the victim of, for example, rape, to leave the passive role of a victim and become an active and accusing actor. This change of perspective is considered favourable for the victim's psychological well-being (37).[18]

In the same debate it has been argued that the victim's need for more influence in the criminal process, and the concept of revenge, can be harmful for the defendant and his rights (38). Too great an influence for the crime victim can make it harder to get a fair trial and a reasonable punishment. As a result of the debate about the rights of the victim there is a tendency in the USA to give extended space at trial for the victim, but to meet the critics most of this space is given *after* the decision on the question of guilt. Before sentencing, or when the court is deciding on probation, the crime victim in the USA today has a certain influence. Many states have introduced *victim impact statements* before sentencing, giving the victim a chance to give his or her view on the effects of the crime.[19]

17 The alternative of a civil action is often dependant on the prosecutor deciding not to prosecute.
18 The psychological outcome may depend on the outcome of the process (33), but the chances may be better in a civil case as the burden of proof is less demanding.
19 If the victim has been killed (or severely injured) the court permits the family to show a video portraying the victim (39).

The tendency to strengthen the position of the victim of crime is clear, not only in the USA, but also in Europe.[20] In the EU the need for legal support, especially for victims of sexual crimes, has been an object for declarations and reforms – the general policy is expressed in the European Council Framework Decision 2001/220 on the standing of victims in criminal proceedings.[21] In the USA, the main contribution to this development in favour of the interests of the crime victim is the conclusion that special knowledge is needed in court when dealing with crimes within relationships (or caused by drug abuse or mental illness). The establishment of problem-solving courts, where all the lawyers (judges, attorneys and prosecutors) and social workers are specialized in the field, gives the courts a better possibility than in traditional courts of understanding the causes of the crime. In that ambience the chances of preventing reoffending and of improving the psychosocial situation of the victim are much better.

An obstacle to "pure" problem-solving is the repressive character of criminal law. The verdict is a sanction (sometimes very harsh) against the offender, and in that light it is difficult to make the process therapeutic overall. In some areas of criminal law – those where crime is against the state, such as tax evasion or drunk driving – a therapeutic approach might be to minimise the role of the verdict as a warning example for others and to focus on proactive means of prevention and on avoiding reoffending. But in cases where there is an individual who is suffering the effects of the crime, it is necessary to consider aspects other than the needs of the perpetrator: through the trial, the victim of the crime is to be given the chance of renewal, compensation and a new start. *Since the victim is the offended party, it must be the interests of that party which come first*, at least when considering therapeutic purposes. The well-being of the offender is a concept that must be set in relation to the interests of the victim – and the promotion of the welfare of the offender should not be carried out without having regard to the victim.

One of the crucial issues in criminal law is how to create a functioning balance between the security of the citizen and the rights of the suspect, between the victim and the offender. Part of this issue is how to find a balance between the state (the prosecutor) and the victim. Since the French Revolution, the rights of the defendant and the aspects of a fair trial have been the major concern, but – as described above – in recent decades there has been a tendency to give the victim a stronger position. It is crucial that these reforms do not lessen the rights of the defendant, but the argument that giving the victim a legal adviser makes the trial unbalanced is not valid. So long as the prosecutor retains the burden of proof,

20 An anthology, mirroring the international trends and discussions from a TJ perspective, has recently been published; Erez, Kilchling & Wemmers (eds) "Therapeutic Jurisprudence and victim participation in justice" (2011) (40).

21 See also the Council Conclusions on a strategy to ensure the fulfilment of the rights of and improved support to persons who fall victim to crime in the European Union (41).

there is no risk of the trial becoming a two-against-one situation. The fact that the victim's lawyer and the prosecutor are standing together on the same side does not mean that the position of the defence has been weakened. On the contrary, the stronger position of the victim is an expression of *equality of arms*: if the defendant has the chance of expressing his point of view throughout the process, then the victim should have the same chance. Being reduced to a witness in the trial makes the victim a spectator, not an actor. Limiting the role of the victim makes her feel a pawn in the game, without space to act or react.

The stronger position of the victim is favourable to the rehabilitation process for the victim as well for the offender. If the trial is going to be a platform for renewal and a new start, is it essential that the victim feels that he or she is a protagonist, not merely a piece of evidence. Although the trial can be a very tense experience, with cross-examination by the defence lawyer and scrutiny by the court, the relief of giving evidence often gives the victim a restored sense of self-esteem. To have been listened to, seriously and publicly, can give him or her enough strength to go on in life. And, as we said before, that satisfaction is often more important than the outcome of the trial.[22] For the defendant the more obvious presence of the victim at the trial creates a need for a deeper contemplation on the causes and effects of the criminal act, which favours regret, remorse and rehabilitation.

7 Summary: TJ and support for victims of crime

Therapeutic jurisprudence requires lawyers to deal with solving social conflicts, and in that task a broader and deeper perspective than the traditional one is needed. Traditional legal methods are often limited, in the sense that their results are instantaneous solutions of instantaneous occurrences – lawyers are not interested in why a conflict occurred or in what will happen in the future. The risk of such an instrumental approach to the problem is that patterns will remain, conflicts and destructive behaviour will reappear, perpetrators will reoffend, and so on. To avoid such negative effects, *the legal procedure (and the trial) should be regarded as the chance for a new start*. To the offender, this can mean treatment or therapy, and to the victim it means (or, at least, it should mean) putting him or her in the same position as he or she was in before the crime. This more profound approach demands insights and knowledge that must be sought in disciplines other than jurisprudence and must, according to TJ, be considered both in legislation and in practice.

22 After the trial it is important – especially after an acquittal of the defendant – that the victim's counsel takes time to discuss the outcome with the client, and also discusses the need for further support (appeal, protection, rehabilitation). It may be a problem to get paid for this part of the job, but it is necessary for the victim not to feel abandoned in that situation.

From a victimological perspective, this approach means more emphasis on the rights and needs of the victim of crime. In most jurisdictions – with some exceptions for Sweden (and Finland) – and for a long time the victim has had too weak a position in criminal proceedings. According to TJ it is important to give the victim a stronger influence. This influence can be created in different ways – through a role as a party at the trial, through other legal representation or through mediation – but *the important aspect is participation*. To have been reduced to playing a passive part, and maybe not getting full compensation for his or her suffering, is an anti-therapeutic force which prevents or complicates getting back to normal life. To make victims feel secure, have control over their own lives and be able to live that life as everybody else, must be a main aim of the criminal procedure.

The psychosocial effects of being a victim of crime are underestimated, and as long as that is a fact, it is a handicap to be one (or to risk being one). Greater efforts must be made to implement proactive measures, but also to improve the support and rehabilitation of victims. *Understanding, participation and responsibility* are keywords in that support – and the same is true for the offender.

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Prison Mental Health

J.B. Gorter,J. Wesselius

Introduction

In 2008 two psychiatrists and the then director of the Forensic Observation and Guidance Unit (FOBA) took the bold step of attempting to describe forensic care within the penal system in the year 2018 (1). They stated that, despite the many unexpected events that could occur over ten years, it was possible to sketch a realistic picture of the future based on the present and based on experience encountered in and knowledge of the field. They referred to it as an 'educated guess'.

Four years have now gone by and it would be a good idea to carry out an interim review.

In this section we shall describe, along the same lines taken by our colleagues in 2008, the current reality of Dutch Prison Mental Health and whether the future perspective formulated then still holds.

That a lot can change in a short period of time can be seen from the fact that the name of the Ministry bearing the final responsibility changed as of October 2010. The Directorate-General for Security has been transferred from the Ministry of the Interior and Kingdom Relations to the 'old' Ministry of Justice, which now goes by the name of the Ministry of Security and Justice.

Although the term 'forensic care in a criminal framework' refers to all care that is provided within such a framework (from ambulatory care to detention under a hospital order, or TBS, with compulsory psychiatric treatment), this section focuses mainly on forensic care provided within prison institutions.

1 Forensic care within a criminal framework, a matter of justice

1.1 ORGANIZATION OF CARE

Since the 1970s, there has been a growing awareness that people with a psychiatric disorder are better off if they are hospitalized within their own district, and preferably for the shortest time possible. The aim of the Dutch Mental Healthcare Association then should be to enable these people to lead as normal a life as possible within society (2). Deinstitutionalization of the provided mental healthcare (GGZ) was initiated. The large institutions outside cities were

closed and replaced by GGZ institutions that offer patients clinical and ambulatory assistance and counseling while leading as normal a life as possible.

The expected advantages of this deinstitutionalization were: fewer restrictions could reduce aggression; more involvement in treatment on the part of the networks of patients; and, possibly, more rapid and more flexible reintegration of patients in their original living environment (3). However, disadvantages were also expected. For instance, there was the fear of excessive burden on the home situation, increased medicinal intake and an increased need of crisis support.

Deinstitutionalization worked well for a lot of patients, but not for all of them, and it presented a number of challenges in relation to cooperation with the various civil institutions and organizations in our society. After all, in the past, psychiatric patients were 'safely hidden away' in institutions, but now these patients are back in society. Some of them have encounters with the judiciary and the police, sometimes regularly so, and they do not always receive the care that is necessary in order to protect both them and society(4).

In the past, the prison system was not designed to provide psychiatric patients with supervision, let alone treatment. Separate departments for their care gradually came into being. For example, the first department of the FOBA was opened in April 1981 and it was followed by a number of individual supervision units (IBAs) at the start of the 1990s (5).

At the present, the care and treatment of prisoners with a psychiatric disorder has become concentrated in five regional Penitentiary Psychiatric Centers (PPCs). The indication for placement in one of these centers is established by a Psycho-Medical Team (PMO) in the institution where a prisoner is staying and examined independently (immediately or afterwards) by the Indications for Forensic Care (IFZ) department of the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP). The 'rules of the game' relating to placement are laid down in the 'Forensic Care Implementation Protocol 2011' (6).

The funding of psychiatric care and treatment during detention currently takes place according to the 'standard price funding' used within prison institutions. This involves budget funding in advance and it is actually unsuited to this care, as the method was developed for the prison system. The idea is that the psychiatric care and treatment provided in the five PPCs will be financed by means of Diagnosis Treatment Security Combinations (DBBCs) as of 2014.

Its implementation will form the realization of all the recommendations made earlier by both the temporary 'committee of inquiry into detention under a hospital order' (the Visser committee, 2006) and the Houtman interdepartmental working group (7):

- Centralization, and professionalization, of psychiatric care and treatment within the prison system,
- Independent care assessment,
- Funding in the same way as within the healthcare system: in arrears and by means of DBBCs

In 2008 our colleagues concluded that during the past 20 years the judiciary had learned to cope with problematic psychiatric patients within the prison system and that it had developed a vision relating to care within a criminal framework.

By the year 2011, the policy developed for the future – based on that vision – is slowly being translated into responsible, transparent care and treatment for psychiatric patients within the prison system.

1.2 EPIDEMIOLOGY

During the past few years, not a lot has changed in the epidemiological characteristics of the psychiatric prison population. When addiction is included, more than 80% of the prison population suffer from some form of psychiatric disorder; more than 6% suffer from a psychotic disorder, about 15% suffer from a mood disorder and 20% have a limited mental capacity (8).

Contrary to a number of different prognoses made at the start of this century indicating an increased demand for cell capacity, the total cell capacity has fallen. The capacity fell by 14,963 in 2006 to 12,633 in 2010; the annual intake of the prison system also fell from 44,799 in 2006 to 39,293 in 2010 (9).

In view of the above-mentioned statistics, the conclusion drawn in 2008, that in the Netherlands the prison system contains the population of a very large psychiatric hospital of the old style, can still be endorsed (8).

1.3 CARE VISION

The mission of the Custodial Institutions Agency in the Netherlands (DJI) is as follows:

'The Custodial Institutions Agency contributes to the safety of society by executing custodial sentences and custodial punishment and by offering people entrusted into our care a chance to build an acceptable life in society.'

The care vision of the five PPCs relates to a particular aspect of the DJI's mission. Their task is to 'provide responsible care' for prisoners with severe psychiatric problems. They therefore provide specialized, high-quality psychiatric care.

The PPC, including the PPCs' national crisis department, is called upon as a sanctuary in the event of a crisis if a referring institution can no longer carry out its DJI mission in relation to a prisoner within its walls as a result of unmanageable and/or untreatable behaviour that is beyond the coping and supervising capacity of the institution concerned. It always, or at least nearly always, concerns a crisis in the *system* (i.e., the referring institution), caused by interaction between the problem behaviour of the prisoner and his immediate environment.

The regional PPC (five PPCs in various locations in the country) are called upon following an indication from the psychologist and/or psychiatrist in the referring institution, such in relation to the psycho-medical team (PMO). This will be because the existence of a psychiatric disorder has been established or is

suspected, which is beyond the capacity of the basic care provided in regular penitentiaries. Generally it concerns psychotic disorders.

The medical-psychiatric, multidisciplinary treatment organized in a PPC takes place in accordance with current psychiatric state of the art and is based on best practices within the GGZ and forensic psychiatry (10).

1.4 EQUIVALENT CARE

In response to a motion passed in 2004 in the Dutch Senate, (11) an inter-departmental working group was set up which was earlier mentioned in this chapter (Houtman). The advice of this group – together with recommendation 17 of the (also already mentioned) parliamentary committee of inquiry into detention under a hospital order (12) – led to the Reforming Forensic Care programme (6). (see also paragraph 4).

One of the results of starting this programme is that 5 PPCs have been developed within the prison system since 2009. In addition, more than 350 places have been purchased in GGZ facilities for forensic psychiatric patients.

The original proposal under the new care program spoke of psychiatric care and treatment *equivalent* to that within the GGZ, such within the limitations set by the detention situation. The idea was that prisoners who suffer from a psychiatric disorder would, in principle, be transferred to a GGZ institution, *unless* there were grounds for this not being possible. This could involve, for example, the seriousness of the charge (social disquiet) and suchlike. Prisoners for which this was the case would be transferred to one of the PPCs.

In fact, it transpired that the term 'equivalent care' was not useful for describing the boundaries of the care and treatment provided in the PPC. It proved not possible to fully synchronize mental health care in- and outside the prison system. Eventually, in 2010, the term 'equivalent care' was therefore replaced by 'responsible care' (13). When the Forensic Care legislative proposal was debated in the House of Representatives, the State Secretary for Security and Justice provided the following reply in answer to questions from the SP political group:

'I interpret the equivalence principle as meaning that responsible care is being provided. Prisoners receive care in the PPCs, such within the limitations presented by their detention situation. The circumstance of detention must be taken into account, which means it is not possible to provide treatment that is entirely comparable with treatment in normal society. Objectives of care within a detention situation are the recovery of the forensic patient by providing responsible care, reducing criminal recidivism by focused interventions and increasing safety in society' (14).

In the autumn of 2010, the Healthcare Inspectorate (IGZ) carried out an initial inspection of the five PPCs. The PPCs were examined on the basis of nine maintenance criteria as well as nine growth criteria. A second inspection took

place in the spring of 2011. The title of its report, 'Penitentiary Psychiatric Centers provide responsible care soon after being opened', shows that the inspectorate regarded the psychiatric care and treatment within the Prison system as adequate (15).

The following tables provide an overview of the Inspectorate's findings in relation to both of the inspections carried out in the PPCs.

1. Quality policy

	Operational first inspection	Operational second inspection	Non-operational second inspection
Professional statute	0	5	0
Department/staff consultation	2	4	1
General expertise	5	5	0
Coercive treatment policy expertise	0	5	0
Quality committee	2	5	0
Quality of personnel	3	4	1
Registration of coercive medical actions	0	5	0

2. Psychiatric and psychosocial therapy and treatment

	Operational first inspection	Operational second inspection	Non-operational second inspection
Vision on therapy and treatment	3	5	0
Use of guidelines	1	4	1
Policy on assessment	5	5	0
Protocol on grounds for admittance	1	5	0
Interdisciplinary and multidisciplinary collaboration	4	5	0
Case history	2	5	0
Treatment and care plan	3	5	0
Somatic screening	3	5	0

3. Pharmaceutical process

	Operational first inspection	Operational second inspection	Non-operational second inspection
Pharmaceutical consultation/ medicine committee formulary	5	5	0
Medicine prescription policy	3	5	0
Medicine distribution protocol	2	5	0

2 The future demand for forensic care and policy

2.1 TRENDS IN DEVELOPMENTS

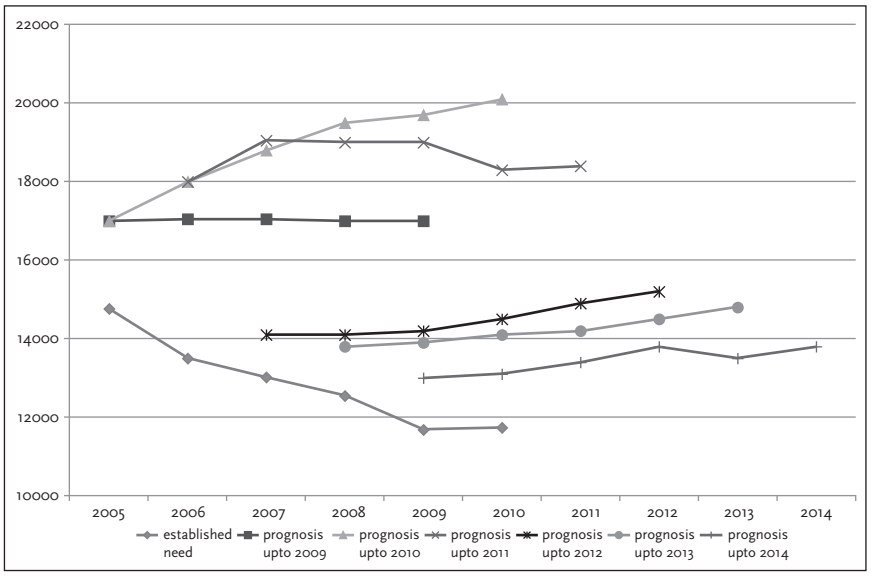
The Reforming Forensic Care programme made the following assumptions in determining the required care capacity:

1. In 2006 more than 600 places were reserved in the prison system for so-called 'special groups'. This includes the capacity of the Forensic Observation and Guidance Unit (FOBA), the Forensic Bridging Unit (FSU), the Individual Supervision Unit (IBA) and the Secure Individual Supervision Unit (BIBA).
2. On the grounds of scientific research, about 10% of the total prison population is thought to suffer from a serious psychiatric disorder and some 6% from a psychotic disorder (16). In 2006 the total capacity was about 14,000, which means that there were about 1,400 people in detention who had a serious psychiatric disorder.

On the basis of this, it was established that the capacity for care and treatment would have to be expanded by 700 places. An arbitrary decision was made that half of these extra places would be purchased in GGZ facilities outside prison and the other half would have to be found within the existing capacity of the prison system.

A prognosis for the required detention capacity is carried out annually by the Research and Documentation Centre (WODC) of the Ministry of Security and Justice, making use of the judicial institutions prognosis model (PMJ). This prognosis model estimates the capacity requirements (for the next 6 years) in various judicial spheres of activity. Its purpose is to substantiate, as far as possible, the budget of the Ministry of Security and Justice and increase its transparency.

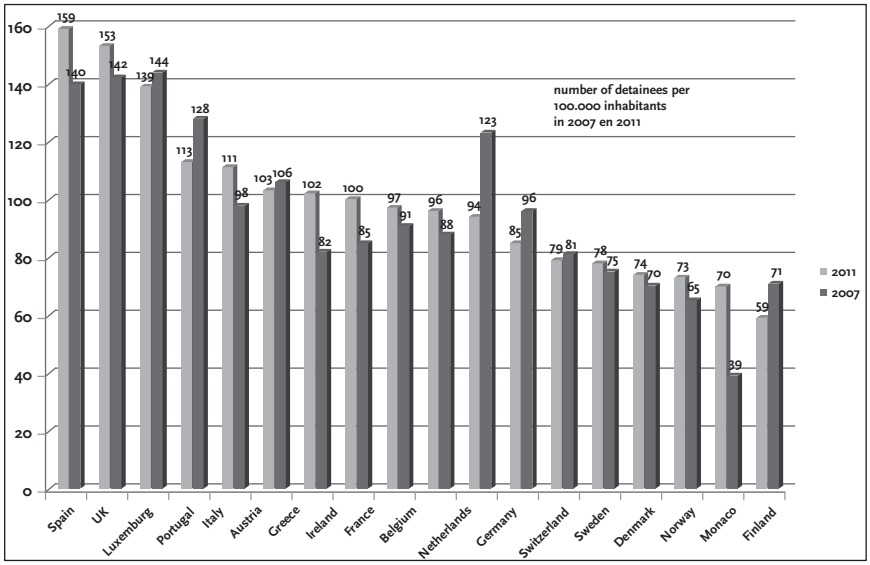
Since the middle of this decade, the demand for detention capacity has undergone drastic change. The prognoses of the WODC have not always been able to meet this altered demand: during the past few years differences have been evident between the prognoses and actual developments in the demand for detention capacity (17). This can be seen in the following figure.



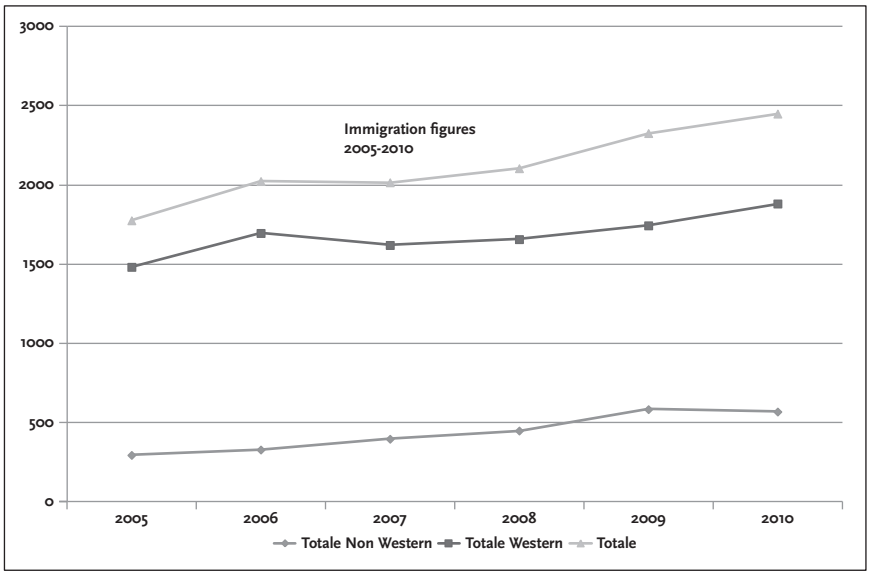
The changing prognoses in capacity requirements also led to a downward adjustment in the care capacity within the prison system: 700 places in 2012, while in 2008 a capacity of 900 places was expected to be needed (18).

It is as yet difficult to predict the extent to which this reduction in capacity is justified. Assuming a total capacity of 12,000, based on the above-mentioned prevalence statistics, there should still be 1,200 people with a moderate to serious psychiatric disorder staying within the prison system. The total care capacity, including beds purchased from the GGZ, is 1,050. This means that for 150 people no place is available. This is referred to as the so-called 'hidden' psychiatry. People with a psychiatric disorder who become noticeable within a detention situation because of their deviant behaviour (for example, verbal and/or physical aggression, suicidal and auto-mutilating behaviour, noise disturbance, self-neglect, arson, etc.) generally tend to 'surface'. Prisoners who do have a psychiatric disorder but who do not display deviant behaviour, and who often stay for only a short period (sometimes only a few weeks), tend to 'miss the boat' as it were. They are not necessarily detected. In all probability, this group of prisoners makes a sizeable contribution to the recidivism rate. The screening instrument that has been developed for detecting patients from this group has not yet been fully implemented. The expectation is that starting the Prison System Reform programme (16), of which this screening is a part, will enable us to provide a better picture of this group in 2012/13.

The reduced capacity translates into a lower level of detention in the Netherlands in comparison with five years ago. In 2007 the Netherlands took fifth place among the countries in Western Europe; this had become eleventh place by 2011 (19).



In 2008 our colleagues concluded that the relatively rapid growth in non-Western immigrants could explain the growth in capacity requirements, because a relatively large percentage of – in particular – the young immigrant population comes into conflict with the criminal justice system. However, the statistics suggest that immigration growth is stabilizing, as can be seen from the following figure (20).



Predicting remains difficult: the political landscape has altered drastically in comparison with 2008. In 2010 the Rutte Administration was installed, a centre/right-wing minority coalition of the People's Party for Freedom and Democracy (VVD) and the Christian Democratic Appeal (CDA) with backbench support from the Party for Freedom (PPV). It remains to be seen how a number of measures announced – and partly already implemented – by this administration will influence the demand for capacity for prisoners with a psychiatric disorder. For example, it is possible that introducing the personal contribution for the GGZ (as of 1 January 2012) will negatively affect exactly those people who are mainly found at the interface between the judiciary and GGZ. Moreover, the call for heavier and longer punishments will – if converted into policy – have an effect on the demand for capacity.

3 The involvement and the vision of the professional group of psychiatrists

For some years now, forensic psychiatry is clearly what is known as a 'booming industry'. Whilst in the 1990s, the District Psychiatric Service (DPD) of the prison system only comprised 40 psychiatrists, who all worked part-time for the Ministry of Justice, the current NIFP (Dutch Institute of Forensic Psychiatry and Psychology) has grown to become a professional organization with 72 FTE psychiatrists(5, 21).

In 2010, the forensic psychiatry department was created within the Dutch Association for Psychiatry (22).

The department has set itself the following objective:

- Promoting the scientific development and quality of forensic psychiatry in the Netherlands, both in the field of forensic diagnostics and in the field of forensic care (in the prison system) and treatment (in TBS clinics, Young Offenders Institutions, Penitentiary Psychiatric Centers and forensic GGZ).
- Promoting the expertise of psychiatrists and youth psychiatrists who work in the forensic field (via accredited refresher courses), but also of trainee psychiatrists (via providing forensic psychiatry courses within the basic training).
- Promoting the interests of – and improving the position of – psychiatrists and youth psychiatrists who work in the forensic field.

This seems to largely confirm the vision of the future of our colleagues in 2008: the forensic professionals will be able to bridge the gap between the judiciary and general mental healthcare, a gap which has been very disadvantageous for the treatment of patients.

4 The Reforming Forensic Care Project

After the Government had decided, in 2006, to follow up the advice of the parliamentary committee of inquiry into the system of detention under a hospital order, and to extend care for detainees with psychiatric disorders, the Ministry of Justice decided to reform forensic care in its entirety. This project was given the name Reforming Forensic Care (VFZ).

4.1 REGIONAL CARE CENTERS

Organizations that were in first instance referred to as 'Regional Care Centers' became operational Penitentiary Psychiatric Centers as of 2009. In total, five PPCs have been set up:

1. PPC Amsterdam
2. PPC Maastricht
3. PPC Scheveningen
4. PPC Vught
5. PPC Zwolle

Two of the PPCs are further specialized, PPC Amsterdam in national crisis intervention and PPC Zwolle in women. For the rest, the five PPCs are equivalent to one another and operate regionally, each one covering one of the five Court of Appeal jurisdictions.

Based on the registration of patients' characteristics in PPC Amsterdam (23), a picture can be formed of the PPC population, although it should be noted that this picture can vary per PPC location due to regional differences. The PPCs' assessment is, though, that differences in the psychopathology of the patient population are slight.

The PPC population is not an exact reflection of society. In 2010, a total of 59 different nationalities were recorded in the PPC. The nationality of a large majority of the population is Dutch (69.2%), though a percentage of these did not originally come from the Netherlands: 52.4% of the population were born in the Netherlands. The average age of the patients is 34.5 years for men and 35.1 years for women.

A large majority of the patients were still in preventive detention during their stay in the PPC: 61.9% of the population of the crisis ward and 55.9% of the regular ward. A prison sentence forms the ground for imprisonment of 15 to 20% of the population and for the others this ground is a treatment measure (TBS, Article 37 of the Penal code and a custodial order for repeat offenders (ISD))

The largest group of patients in the PPCs are diagnosed (DSM-IV, Axis I) as having a psychotic disorder: 66.9%, 36.5% of whom suffer from schizophrenia; 10.5% of the diagnoses concern mood disorders and 5% autism spectrum disorders.

From a diagnostic point of view, no significant difference has been observed between the PPC population of the crisis and regular wards except where it concerns schizo-affective disorders: this diagnosis is established significantly more often at the crisis ward.

A diagnosis on the DSM-IV Axis II is delayed for a large majority of the population: 73.5%. A cluster-B personality disorder was established in 7.7% of the population and a limited mental capacity in 5.5%.

One of the goals of the PPCs is to transfer at least 30% of its population to the GGZ; this will involve placements within the framework of a criminal-law basis (Article 37 of the Penal Code, placement within the framework of exceptional conditions, TBS and Article 15(5) of the Custodial Institutions Act), as well as placement in a GGZ facility subsequent to a stay in the prison system. The statistics for 2010 suggest that this is being achieved: about 34% of the out-placements were made to a GGZ institution. Of the placements in a GGZ institution, 71.3% were intramural, 28.7% related to ambulatory care.

During the next few years, the PPCs must continue to develop, particularly in the field of extending diagnostics and broadening the range of treatments.

4.2 LEGISLATIVE AMENDMENTS

In 2006, a start was made in preparing a number of legislative amendments that are necessary within the framework of reforming forensic care and providing a different financial system.

– Healthcare (Market Regulation) Act

Act of 7 July 2006, containing rules relating to market regulation, efficiency and controlled cost developments in the field of healthcare. This Act stipulates the powers and responsibilities of the Dutch Healthcare Authority (NZa) (24).

The NZa was established in connection with changes in the healthcare insurance system that came into force in the Netherlands on 1 January 2006. The NZa was formed by combining the National Health Tariffs Authority (CTG) and the Healthcare Insurance Supervisory Board (CTZ) to create a single organization for supervising the implementation of the Healthcare Insurance Act and the Exceptional Medical Expenses Act (AWBZ). The NZa has taken on the task of promoting accessible, affordable and high-quality healthcare for everyone. Within the healthcare system introduced in 2006, patients and insured clients must be able to choose their care provider and health insurer, and this requires the provision of proper information. The NZa ensures that hospitals, insurers and doctors provide proper, honest and understandable information about their prices, policies and achievements. The new healthcare system is based on 'regulated market forces'. The NZa has to ensure that the transition to a market with more stimuli takes place properly and that health insurers implement the Healthcare Insurance Act and the AWBZ properly. On areas where there are no market forces active in healthcare, the NZa installs fixed tariffs. At this moment, NZa's parameters form the basis for GGZ funding by means of the Diagnose Treatment Combination (DBC); the idea is that as of 2014, the Diagnosis Treatment and Security Combination (DBBC) will form the basis for funding the PPCs. The DBBCs should lead to greater transparency in care products and improved comparability of prices and products. In addition it should also facilitate harmonization with healthcare in the regular GGZ.

– Compulsory Mental Healthcare Act (WVGGZ)

The Psychiatric Hospitals (Compulsory Admissions) Act (BOPZ Act) is soon to be replaced by the Compulsory Mental Healthcare Act (25). This new Act wants to make the compulsory treatment of people with mental problems less difficult. An important difference is that it will soon be possible to impose compulsory care, medicinal or otherwise, outside institutions. The legislative proposal was submitted to the House of Representatives for debate in January 2012.

– Forensic Care Act (WFZ)

In June 2010, the then Minister of Justice submitted the Forensic Care legislative proposal to the House of Representatives (26). Reforming forensic care can prevent placement of people with a psychiatric disorder (or whose mental capacity is limited) in a judicial institution when they really do not belong there. The legislative proposal provides the public prosecutor with various options for providing a person with mental care, outside the prison system.

The legislative proposal was first debated in the House of Representatives in December 2011.

The WFZ will alter the possibility of compulsory treatment within the prison. Currently, compulsory treatment within a penitentiary institution is laid down in the Custodial Institutions Act (PBW) and is limited to rapid tranquilization in a case involving acute danger to the patient or his environment (27). Long-term treatment is not allowed and patients who experience high levels of suffering and neglect, but who are in no acute danger, can currently not be forced to undergo treatment, unlike those patients staying in a GGZ institution. The introduction of the WFZ will correct this inequality in treatment options and also reinforce the legal position of a psychiatric patient who is admitted involuntarily to a PPC.

– Correlation between the WVGGZ and the WFZ

The Ministry of Security and Justice and the Ministry of Public Health, Welfare and Sport are attempting to achieve correlation in both these legislative proposals. This in order to remove the statutory obstacles that stand in the way of providing efficient care. Furthermore to harmonize treatment options inside the prison system with those in the GGZ. The forensic care legislative proposal Article 2.3 ensures close harmonization between the WFZ and the BOPZ Act (and its proposed successor, the WVGGZ). The criminal court judge will be given an independent power to impose a care authorization, in combination with a criminal charge or otherwise. This should lead to a stream of patients leaving forensic care to go to GGZ. Which will in turn lead to questions about the availability of adequate treatment facilities outside prison for this particular patient group, whether people with and without criminal charges should be placed together in the same institution and other problems such as, for example, the level of security of the GGZ institutions.

In 2008, our colleagues suggested that '*the Reforming Forensic Care project was a well-considered and properly substantiated reform of the care of prisoners with psychiatric problems, which places the focus on patients and removes the organizational obstacles to providing efficient care. It is a long-range programme that connects seamlessly with the developments in modernizing the funding of the mental healthcare system. It seems to have everything that is necessary in order to have a long-term effect on the structure of care within a criminal framework, and will therefore probably still be noticeable in 2018'*.

The above-mentioned description of the current state of affairs in relation to care for prisoners with a psychiatric disorder shows that it is indeed the case that the project had already realized one of its most important objectives in a relatively short period of time, i.e. providing responsible, transparent psychiatric care and treatment within a forensic framework that is organized in a method equivalent to that of the GGZ.

5 The DBBC system

One of the aspects of the VFZ project is to standardize the healthcare funding methods of the Ministry of Security and Justice and the Ministry of Health, Welfare and Sport. For this reason it was decided to allow forensic care to take place by means of invoicing by way of DBCs, just as within the GGZ. As the security component of the DBCs plays next to no role in the GGZ, but it does in forensic care, this cost item was added to the DBC for forensic care to form a Diagnosis Treatment Security Combination (DBBC). The population that is treated within a forensic environment is not completely comparable with that of the GGZ. A number of new combinations will have to be developed for this. This could relate, for example, to the treatment, clinical or otherwise, of personality disorders, sexual disorders and disorders relating to impulse control and aggressive behaviour.

This method of funding has been used since 2008 within Forensic Psychiatric Centers (formerly: TBS clinics). There is a delay in introducing DBBC funding for the PPCs, and it is currently planned for 2014. An important reason for this delay was the lack of a PPC product specification. The product specification describes the care and treatment in a PPC on an operational level, e.g. what and who do you need to run such things as a daily programme, treatment activities, etc.

The PPCs themselves are currently developing the product specification. In addition, there is still a lack of clarity about how certain costs, which relate to detention rather than to care, will be funded. These can be the most trivial of matters: *'do the costs of the prisoners' meals fall under the DBBC or under regular prison system funding'*?

It has been established that the DBBC system will eventually be implemented within the PPCs. It remains to be seen whether this will actually take place in 2014; time is getting short.

In spite of delays the optimism of our colleagues in 2008 still holds firm: the continuity of treatment for the difficult category of patients that tend to withdraw from – or do not fit in – regular forms of treatment and guidance can be improved and made more efficient by introducing the DBBC system. Furthermore, statistics on placements in GGZ institutions and after-care subsequent to detention shows an encouraging development: Continuity of care

across the line that divides the prison system from the GGZ improves more and more due to the VFZ project.

6 Conclusion

Although it seemed an ambitious proposition in 2008 to sketch forensic care in the year 2018, almost halfway through the period covered by the 'prediction', the conclusion must be that we have come quite far in the right direction and that the picture of the future that was sketched at the time still relates well to current reality.

A number of the objectives of the VFZ project were achieved within a short period of time. The psychiatric care and treatment of people with a psychiatric disorder who are being detained is currently concentrated in five specialized centers (PPCs), which – according to the Inspectorate – provide responsible care. Placement of psychiatric patients from the prison system in GGZ institutions is taking place more flexibly than at the start of this century, partly because the judiciary purchased beds from the GGZ, partly because the GGZ is increasingly able to manage the category of patients involved, who often have complicated and disruptive problems. This also means that the continuity of care is becoming increasingly more common then before, due to the blurring of the line that divided the judiciary and the GGZ for so many years.

Psychiatric care has now become a formal aspect of the Ministry of Security and Justice's policy.

The care provided in detention in 2012 is responsible; it is not yet equivalent to the care provided in the GGZ. Then again, the question is whether 'equivalent' is the right term for comparing care in the two systems. Both have advantages and disadvantages and it would be better if the prison system and the GGZ were to be, and were expected to be, supplementary, not competitive.

Furthermore, proposed new legislation will equalize the legal position of patients admitted under the prison system and those admitted via the GGZ. And steps are made to harmonize the legal possibilities for treatment in and outside prison. From a professionals' viewpoint, both are important steps that needed to be taken to improve forensic healthcare as we move in the direction of 2018.

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The Autonomy of Criminal Judges in Determining the Disorder and the Risk of Recidivism – Some Reflections on the Hoogerheide Case[1]

Anne Ruth Mackor

1 Introduction

Judges are autonomous professionals 'par excellence'. They are autonomous in the Kantian sense that they are reasonable moral subjects who can submit themselves to standards and who can account for their behaviour (1). Within the boundaries of law judges are autonomous when they interpret rules and qualify facts in the process of making decisions in individual cases. Moreover, judges are, again pre-eminently, professionals who can and should account for their behaviour, viz by offering reasons for their decisions.

The foregoing applies to criminal judges too. Within the boundaries of law they have autonomy in concrete cases. Again, this holds for the interpretation of the rules, and thus for decisions about the applicability of the rules, as well as for the identification and the qualification of the facts, and thus for the relevance of the facts. Especially when it comes to the identification and qualification of the facts the latitude of criminal judges is noticeable. Whereas the Dutch criminal law of evidence is quite elaborate and detailed as far as the *lawfulness* of evidence is concerned, the Code of Criminal Procedure (CCRP) offers remarkably little guidance when it comes to the *reliability* of evidence. Although formally speaking the Dutch criminal law of evidence is negative and statutory, many legal scholars claim that in fact it is a free system allowing judges to choose and weigh evidence as they see fitting.[2]

1 This paper is a revised translation of 'Grenzen aan de autonomie van strafrechters: wie bewijst de stoornis en het recidiverisico?', Ontmoetingen, Voordrachtenreeks van het Lutje Psychiatrisch-Juridisch Genootschap nr 17 mei 2012, pp 55-67.

2 The Dutch criminal law of evidence is a statutory system because the court can only allow evidence that is explicitly mentioned in the Code of Criminal Procedure (article 339 Code of Criminal Procedure, CCRP from now on); it is negative since judges are not allowed to decide that the defendant is guilty of the charge if they are not convinced that the defendant has committed the crime, even if there is sufficient statutory evidence (article 339 CCRP). A free system of evidence implies that judges are not bound by any legal rules on the matter; they are free in their choice and their weighing of the evidence. Since the CCRP offers very few restrictions, it is said that the Dutch criminal law of evidence is in fact a free system.

Not only does the CCRP offer very few restrictions, the Dutch Supreme Court has further scooped out the statutory rules about evidence, among others in decisions about hearsay and about the demand that proof of the indictment is based on more than one witness (the unus testis nullus testis rule).[3] Moreover, Dutch criminal courts are free both in the selection and the weighing of evidence and until recently they had only a very limited obligation to motivate their choices and decisions. Dreissen (2) and Knigge (3) among others argue that as a consequence a doctrine of evidence has hardly been developed.[4] In recent years there have been some changes, however. In 2005 the obligation to motivate has been tightened in article 359 paragraph 2 CCRP, which states that the court must offer a motivated rebuttal when the prosecution or the defendant offer an 'explicitly motivated point of view'. Until 2005 the court could leave such objections unaddressed. Moreover, since 2009 the Supreme Court seems to advocate a more strict interpretation of the unus testis rule. Nevertheless, these changes have definitely not yet resulted in a *doctrine* of criminal evidence. Borgers for example criticises 'the casuistic character' of the rulings of the Supreme Court on the unus testis rule.[5]

2 Autonomy and competence

It is remarkable, to say the least, that criminal judges have the greatest liberties when it comes to deciding on matters about which they are the least competent, viz the *reliability* of evidence. I deliberately use the term "liberty" instead of "autonomy" because we can even wonder whether criminal judges are able to operate as reasonable subjects, whether they can offer sound reasons for their decisions, given the fact that analysing and assessing the reliability of evidence is not part and parcel of their professional training (1,4). The question is: should judges act upon their own conviction as article 338 CCRP tells them to? Are they allowed to make their own 'reliability rules'? Or should they rely on the advices of

3 In the hearsay or de auditu case (HR December 20th, 1926, NJ 1927, 85) the Dutch Supreme Court has declared that courts are allowed to ground their decision on what a witness has heard from someone else (hearsay or de auditu). This decision is at odds with articles 342 paragraph 1 and 344 paragraph 1 sub 2 CCRP that only allow direct observation as evidence. The Supreme Court also offers a loose interpretation of the unus testis nullus testis rule. According to this reading, even though courts are not allowed to ground the charge as a whole on the statement of one witness, they are allowed to ground important parts of the charge on the statement of just one witness.

4 Also see Advocate General Knigge in his opinion delivered to the Supreme Court (HR February 2th 2010, *LJN*: BJ7266).

5 See HR June 30th 2009, *LJN* BH3704 and BG7746 and Borgers in his annotation to a decision of the Supreme Court (HR July 13th 2010, *LJN* BM2452 sub 4).

experts and conform themselves to the scientific theories and the guidelines for reliable evidence that experts commit themselves to?[6]

In response to several recent miscarriages of justice[7] psychologists, judges and legal scholars have started a debate about truth finding in criminal law (9, 10, 11, 12, 13). Psychologists have criticised the role that (subjective) 'judicial convictions' (article 339 CCRP) are allowed to play and they have argued against claims of lawyers and legal scholars that there are important differences between judicial and scientific methods of truth finding. Lawyers in turn have argued that experts do not understand the unique character of evidence and truth finding in criminal trials and that they incorrectly try to impose the aims and methods of science upon the criminal trial. For an analysis of the debate see (14,15).

The debate has focussed on the reliability of the judicial proof of the *criminal fact*. In this paper, however, I argue that this discussion should also be conducted about the way in which the Dutch *order of tbs* is imposed.[8] Tbs is an order that can be imposed on defendants that are deemed not or diminished criminally responsible. The crucial thing to note is that the judge can convict the defendant to tbs only if he suffered from a *disorder* at the time of the crime and if he poses a *threat* to the general safety or the safety of others.[9]

It should be noted that strictly speaking articles 338 CCRP and further only apply to the proof of the criminal fact as charged. The articles do not apply to the question whether the defendant is criminally responsible and thus punishable nor to the question exactly which punishment or order should be imposed.[10] However, the claim put forward in this paper is that the debate about the reliability of criminal evidence should analogously be conducted about the way in which the disorder and the risk of recidivism are determined in the context of the decision whether or not tbs should be imposed. The question about the reliability of the assessment of the disorder and the risk of recidivism is just as pressing as the question whether or not the defendant committed the crime as charged since many defendants abhor the idea of being sentenced to tbs. They consider the assessment of 'madness' an affront to their dignity as a normal person and,

6 I will not discuss another troubling question, viz who count as experts. Experts quite often disagree among themselves. They sometimes disagree on the level of the theories they adhere to. Even when they agree on the level of theory, they quite often disagree about the relevance and the weight of the evidence in a particular case. For an analysis of a tbs-case in which there was disagreement, mainly between experts among themselves, about the presence and the nature of the disorder as well as about the risk of recidivism, see (5,6,7,8).

7 Some infamous cases are: Lucia de Berk, the Puttense murder, Schiedammer Park-murder and Ina Post.

8 Tbs is an abbreviation of "terbeschikkingstelling van de regering", i.e. "to be put at the disposal of the government".

9 See article 37a paragraph 1 sub 2 Code of Criminal Law (CCRL from now on), also see the Supreme Court (HR January 9th 2001, *LJN* AD 4678).

10 For this reason I make a distinction in this paper between the legal proof of the criminal fact and the legal 'proof' of the disorder and the risk of recidivism.

moreover, they are deeply worried about the fact that the duration of tbs, unlike the duration of the punishment of imprisonment, can be indeterminate. In other words, there is a lot at stake. Therefore the assessment of the disorder and the risk of recidivism should be as reliable as possible.

3 Reliable judgments about disorder and risk of recidivism

The central question of article 37 of the Code of Criminal Law (CCRL), whether the criminal fact can be imputed to the defendant, is largely a *normative* question and therefore typically a legal question that belongs to the 'core business' of criminal judges. This is less so when it comes to the question whether the order of tbs should be imposed because the order can only be imposed when the defendant, at the time of committing the criminal fact, suffered from a defective development or mental disorder and, moreover, the general safety or the safety of other persons demands the imposition of this order (article 37a paragraph 1 sub 2 CCRL). Obviously the questions whether the defendant has a disorder and whether he is a danger to the safety, are by and large a *factual matter*.

The legislator too seems to be of the opinion that the determination of a disorder is a factual question that demands a specific professional competence. Articles 37a paragraph 3 and 37 paragraph 2 CCRL state that before the judge can legitimately impose tbs he should be advised by at least two behavioural experts, at least one of them being a psychiatrist. The advices should answer both questions, viz whether the defendant was suffering from a defective development or mental disorder at the time of the crime and what the risk of recidivism is.

However, if the defendant is unwilling to co-operate with the investigations of the behavioural experts, such an advice is not obligatory (articles 37a paragraph 3 and 37 paragraph 3 CCRL). In such a case not only the partly normative decision about the imposition of tbs, but also the largely factual decision about the disorder can be made by the court on its own. In an answer to questions of the parliament about the so-called Reparation bill that was meant to offer a 'solution' to the problem of the so-called refusing defendant the Minister of Justice states:

'The decision of the judge about the imposition of the tbs-order is ... in all cases the result of his own judgment, and that also holds for the question whether he has adequate data.' (*Parliamentary Papers II*, 22909, 6, p 3 (Memorandum of Response))

This license to the judge sharply contrasts with the claim that:

' ... the purpose of the bill is ... an improvement of the quality of the decision-making with respect to the imposition of the tbs ...' *(Parliamentary Papers II*, 22909, 6, p 1 (Memorandum of Response))

The question, however, is how the judge can have adequate data and how he can know that he has adequate data when he has no advices of behavioural experts at his disposal. Although article 37a paragraph 4 CCRL states that the judge should take into account the content of remaining (e.g. earlier) advices and reports about the personality of the defendant, these articles do not state that experts must have established that the defendant suffers from a defective development or mental disorder.

It is remarkable that not all behavioural experts consider this to be a serious problem. The psychiatrist Mooij for example argues that the concept 'disorder' need not be explicated in strictly medical terms because the term has a 'conventional' (i.e. common sense) background (16). Conventional or not, the question remains how can a judge can be capable of determining the presence of a disorder if experts claim that they are unable to make claims about that. What extra or superior knowledge or competence does the judge have? Moreover, even if we go along with Mooij's claim that 'disorder' is a conventional and normative concept and that therefore the assessment of a disorder is not principally reserved to experts, the question still remains how judges can make an assessment of the risk that defendant will again commit a serious criminal fact. Obviously, the question what risk is acceptable is a normative and legal question to be answered by the judge, but the assessment of the risk itself is not a normative judgement. It is a factual statement that should be based on empirical and statistical theories. So again the question is how can a judge offer a reliable judgement without well-grounded reports of behavioural experts on both matters. This brings us to the Hoogerheide case.

4 The Hoogerheide case

In the Hoogerheide case Juliën C. stands trial on the charge of murder or manslaughter of an eight-year-old boy at a primary school in Hoogerheide. The last relevant judicial decision in this case is of the Court of Appeal Arnhem (May 18th 2011, *LJN* BQ4981).[11] Whereas the Court of Appeal 's Hertogenbosch

11 The final decision in this case has been offered by the Dutch Supreme Court (May, 22th 2012, *LJN* BJ2315). Unfortunately the Supreme Court does not deal with the plea in cassation of the defence that the Court of Appeal has wrongly imposed the order of tbs or that it has insufficiently motivated its decision to impose the order.

(February 26th 2008, *LJN* BC5105) considered murder proven and convicted Juliën C. to a lifelong sentence, the Court of Breda (September 6th 2007, *LJN* BB3032) as well as the Court of Appeal Arnhem did not consider murder proven. They convicted the defendant to 12 years of imprisonment and tbs with compulsory treatment for manslaughter.

The decision of the Court of Appeal Arnhem is important to the central question of this paper because this Court, like the Court of Breda, but unlike the Court of Appeal 's Hertogenbosch, claims that it has been able to determine that it has become sufficiently probable that the defendant suffered from a mental disorder at the time of the crime and that the risk of recidivism is unacceptably high. This conclusion is remarkable since the behavioural experts involved in this case have declared that they are unable to come to this conclusion, mainly because of the fact that the defendant refuses to co-operate with their investigations.

The Court of Appeal of Arnhem offers the following argument why it can impose tbs without the advice of behavioural experts:

'Neither the code nor the case law demands that the disorder is classified in accordance with the handbook DSM-IV and that it must be determined by a behavioural expert. This implies that ... the judge ... can establish a disorder, even if behavioural experts cannot do so on the basis of the scientific criteria and disciplinary rules that are valid for them. The judge should find sufficient support for his decision in that which behavioural experts, if possible, have been able to establish and in that which the judge has come to know about facts and circumstances with respect to the person of the suspect.'

And:

'All of this, in conjunction with the passages reproduced in the statement of the reasons for the conviction, implies that according to the Court it is to a sufficient degree probable that the suspect suffered at the time of the crime from a mental disorder or a defective development. The Court agrees with the lower court that the disorder is such that it is, from the point of view of safety, irresponsible to let the defendant return into society without a treatment.'

5 Not only the facts, also a theory ...

In principle the Court of Appeal has reason to argue that the judge is not, at least not automatically, committed to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), the most recent version of the psychiatric classification system of mental disorders, or to any other criterion

that behavioural scientific theories might offer. Mooij argues that judges do not need to use the psychiatric classification system because the focal question in criminal law does not concern the particular type of mental disorder the defendant suffers from. According to Mooij, the question rather is whether the capacity to reflect on thoughts, desires and actions has been affected (16). However, if Mooij is correct to state that the court can use other criteria than the behavioural experts, the question arises why the court is obliged to ask for the advice of experts in the first place. What use do these advices have? To what extent is the court bound by the advice of the experts? To what extent is the judge autonomous to divert from the conclusions of the advice?

Unfortunately the Court of Appeal Arnhem does not address these questions. It only states that judges should find 'sufficient support' both in the findings that experts were able to determine and in other facts and circumstances that the judge has been able to ascertain. However, the Court of Appeal does not explicate which findings or which type of findings of experts are relevant and it does not explicate any criteria that might be of help to determine which 'further facts and circumstances' are relevant to establish the presence of a disorder and, even more importantly, the presence of risk of recidivism.

From a legal perspective this might not seem to be a serious failure; from a scientific perspective, however, it is. 'Facts and circumstances' are not free-floating objective entities; they derive their relevance from a theory. When deciding on the judicial 'proof' of the presence of a disorder and risk of recidivism no evidence is a 'hard' fact that can simply speak for itself. On the contrary, all evidence derives its relevance as evidence from a theory. Stated differently, when a judge comes to the conclusion that the disorder and the risk of recidivism are proven he should not only, as the Court of Appeal does, refer to specific facts and circumstances; he should also explicate which theory other than psychiatric theories and the DSM allows him to conclude that these facts and findings are indeed evidence for the presence of a disorder and a risk of recidivism. Only on the basis of the theory we might be able to evaluate the evidential value of the facts and circumstances that the court enumerates.

A legal scholar might argue against this view and refer to the fact that, as far as the proof of the criminal fact is concerned, a judge can confine himself to refer to, or even simply assume, 'facts of general knowledge' (article 339 paragraph 2 CCRP). Analogously it would suffice for the 'proof' of the presence of a disorder and risk of recidivism that judges refer to facts of general knowledge. This is what the Court of Appeal does. Not only does it offer an extensive summary of different advices of behavioural experts that bring to the fore a life story that is unmistakably alarming, it also offers a lengthy enumeration of facts and circumstances that lay people definitely give the impression that the defendant

is a 'dangerous madman'. Among others the Court implicitly refers to 'facts of general knowledge' that people who talk a lot to themselves, who behave strangely, who have bizarre ideas about energy radiation and gravitation, who phone their family in the middle of the night, who suffer from mood swings etc., suffer from a mental disorder.

The question, however, is: what role can this conventional or *common sense* view – that it is a fact of general knowledge that people who behave themselves in the ways mentioned suffer from a mental disorder and, even more importantly, are dangerous – legitimately play in a judicial sentence? Again, neither the criminal code nor case law forbids the judge to use common sense views to arrive at the conclusion that the defendant has a disorder and that he is dangerous, so it is not *illegitimate* to do so. The question, however, is whether the grounding of such a sentence in these common sense views is *sufficiently reliable*. This question is even more pressing given the fact that experts in this particular case, who were well aware of all the specific facts and circumstances mentioned by the court, nevertheless did not consider these facts and circumstances sufficient to constitute the evidence needed to conclude that the defendant suffered from a mental disorder and has a heightened risk of recidivism. The Court of Appeal explicitly mentions the fact that the experts themselves have claimed that they were unable to 'upgrade' their 'diagnostic considerations' to 'diagnostic conclusions'.[12]

6 'In dubio pro reo' and the right to remain silent

'In dubio pro reo' is a fundamental principle of criminal law. The judge should only convict a defendant if he can determine 'beyond reasonable doubt' that the defendant did in fact commit the criminal fact as charged. The question is whether this doubt should only prevail as far as the proof of the criminal fact is concerned or also with regard to the 'proof' of the disorder and the risk of recidivism.

Why does the Court of Appeal argue that it can, without the support of behavioural advices, determine that the defendant suffers from a disorder and that his risk of recidivism is such that it is irresponsible to let the defendant return to society without a treatment? Is the choice of the Court evidence of *risk- or safety-thinking*: the shifting of thinking in terms of past norm violations to a thinking in terms of the prevention of current and future safety and risks (17)? Or does the Court rather, as Van Hattum seems to argue, make a choice for the

12 In another case of a 'refusing observandus' who was convicted to tbs, the Court of Appeal of Amsterdam (June 12th 2012, *LJN* BW8075) offers a more thorough analysis and motivation on this issue.

most *humane* treatment of the defendant (18)? Could the choice of the Court be read as a last resource to protect the refusing defendant against himself, viz in a case where otherwise a lifelong sentence (Court of Appeal 's Hertogenbosch) or at least a long imprisonment without treatment would be in the offing?

If safety and/or humanitarian considerations are the driving force behind the decision, the question arises whether the Dutch criminal law system has less questionable means to diminish the risks and/or to treat the defendant in a humane manner. As far as the humanitarian considerations are concerned it is possible to transfer a convict to a psychiatric hospital or to a forensic clinic if he turns out 'unfit for detention' (article 13 CCRL). As far as safety risks are concerned it is possible to ask for a 'judicial authorization' if the convict, after having served his prison sentence, is (still) considered dangerous to others (or to himself). Finally, if a defendant gets a lifelong sentence, a petition for a pardon is possible. Van Hattum (18), however, is correct to stress that the order of tbs has more guarantees than a lifelong imprisonment if only because a judge regularly examines the prolongation of tbs.

Criminal law is an instrument of the government to ensure *safety* for its citizens as well as a *safeguard* for citizens against that very same government. Criminal law is meant to serve both purposes. The legal system of the government distinguishes itself from most other regulatory systems in that it – after it has been created in the political arena for different and often conflicting purposes – is relatively autonomous in relation to those political purposes. The relative independence of law in relation to politics is the fundamental idea behind the rule of law. In this respect (most) legal rules, in particular those of criminal law, are fundamentally different from goal norms like recipes in a cookbook. Legal rules cannot be arbitrarily transformed and deformed at the will of the person who applies them. A person who wants to bake an airy cake, but does not have the right number of eggs at his disposal, can adapt the recipe to the number of eggs that are available. The criminal judge on the other hand should apply the law, even if the end result is not to the liking of himself or of 'goal-thinkers' (19). Only through retaining its relative autonomy law can offer legal certainty and legal equality. Accordingly, it is not up to the judge to adapt the law to make it fit certain purposes. This task is reserved to the legislator. In the case of the conviction of a defendant who refuses to cooperate the legislator has in fact changed the law via the Reparation-code that was discussed in section 3. Therefore the decision of the Court of Appeal Arnhem respects the boundaries of law. However, in this paper I have argued that this code is at odds with the demands of reliable truth finding.

The right to remain silent is another fundamental principle of criminal law that is relevant to the Hoogerheide case. The fact that someone refuses to talk about

the indictment cannot be used as evidence against him. Analogously, the refusal to cooperate with experts should, in itself, not be counted against him either. However, one might argue that the view of the EHRM and the Dutch Supreme Court that a judge can legitimately weigh the fact that a defendant maintains silence to the disadvantage of the defendant is also applicable to a defendant who refuses to cooperate with the behavioural experts who are appointed to offer advice to the judge. In the bus ticket case the Supreme Court argues:

'The circumstance that a defendant refuses to make a statement or to answer a particular question cannot in itself, taking into account the content of article 29 paragraph 1 CCRP, contribute to the evidence. This, however, does not imply that the judge, if a defendant does not offer for a circumstance, that in itself or in combination with the further content of the evidence should be considered as reason-giving for the evidence for the criminal fact as charged, a reasonable explanation that invalidates the reason-givingness, is not allowed to take this into account in his considerations about the evidence as used.'[13]

If we apply this line of argument to the Hoogerheide case it is not the refusal to cooperate in itself that is considered to be an indication of a mental disorder; that seems to be a point of view that might only have been acceptable to some psychiatrists in the former USSR. However, one might argue that a refusing defendant has himself to blame for an incorrect view about the presence of a disorder and a high risk of recidivism. In the case of Juliën C. experts state that they were unable to determine whether the strange remarks of Juliën C. are a sign of a mental disorder or merely provocative remarks of an otherwise normal person. Following the argument of the Supreme Court one might argue that Juliën C. owes an explanation for his strange statements and that if he refuses to give such an explanation the court can legitimately let his strange remarks play a role as evidence for a disorder. Although this is an interesting view that deserves further thought, I am hesitant about it. It seems to imply that, in the end, a defendant is forced to cooperate with his own conviction, be it to imprisonment or to tbs.

My conclusion therefore is that even though the Dutch legal system allows the criminal judge to decide on his own, i.e. without at least two reports from behavioural experts that a defendant suffers from a disorder and has a heightened risk of recidivism, an autonomous judge should take the stance that he is not competent to make such a decision on his own.[14]

13 See the Dutch Supreme Court June 3th 1997, *NJ* 1997, 584 (Bus ticket case) and EHRM February 8th 1996, 18731/91 (John Murray vs. UK). Also see [20, at p. 183].

14 I thank all persons present at the meeting of the Lutje Psychiatrisch Juridisch Gezelschap, September 15th 2011, especially Wiene van Hattum, for their inspiring contribution to the debate. I also thank Diederik Aben for his thorough comments on an earlier version of this paper. Their comments have resulted in an adaptation and further substantiation of my argument.

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