Instilling Hope Into Forensic Treatment: The Antidote to Despair and Desperation

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The importance of hope in the treatment of physical ills is well documented. Less is known about its role in the treatment of mental illness. Hope, the expectation of achieving a goal, figures prominently among the curative influences that help forensic patients recover. The cognitive processes that fuel violence and bring patients into our care often result in the loss of hope. Successful treatment requires the restoration and fueling of hope as patients progress through the phases of recovery. We review the extant literature on hope as it relates to clinical concerns, including the genesis of violence, mood, adjustment to physical illness, spirituality, forensic assessment and treatment, staff morale, and patient-centered care.

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The scientific literature in most branches of medicine and psychology contains a balance of articles on disease processes and articles on treatments. Such a balance is true of general psychiatry and clinical psychology, but not of forensic psychiatry or forensic psychology.[1] A casual glance at recent issues of the leading journals in this field reveals that contributions about treatment are fewer, probably less than 10 percent. One way to rectify this inequality, following the path of such pioneers as Bergin and Garfield[1] and Frank and Frank,[2] is to investigate the nature of the curative influences that help forensic patients recover.

Many insanity acquittees experience the tense coexistence of powerful opposing forces. On the one hand is despair resulting from hopelessness and desperation, the recklessness that arises from despair. Together these propel individuals, first toward violence, and later toward a nihilistic stance about the possibility of healing. On the other hand, there is hope. At the time of the offense, most acquittees experience some degree of hopelessness. Residing at the hospital in itself may or may not restore hope. An essential goal of forensic treatment is to instill and foster hope while containing the anger associated with despair and desperation.

Beck[3] argues that the basis of aggression consists of cognitive distortions similar to those that account for depression and suicidality. These include attributional biases such as the egocentric bias, automatic thoughts, catastrophizing, dichotomous thinking, and personalization. He suggests that interpersonal losses, fears, and threats activate thoughts and later feelings that set the stage for aggression. Beck summarizes this process as follows:

> Loss and fear → distress → focus on the "offender" → feeling of anger → mobilization for attack [Ref. 3, p 31].

Thus, externally directed aggression involves a cognitive redirection from the self onto the perceived offender.

Hope plays a role in this process. Once an individual loses hope about the possibility of peaceful resolution for a painful situation in which he or she feels mistreated, removing it through retaliation becomes the only option. Scholars have used the term cognitive myopia to describe the single-minded and exclusive focus of angered people on what they experience as provocation.[4–6] When cognitive myopia leads individuals to commit a desperate, violent act and end up in our care, they often first profess that they were justified in their actions. As their treatment helps

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them discover the wrongness of that belief, it is not uncommon that they become overwhelmed with guilt to the point of losing hope that they could ever be forgiven, let alone forgive themselves. One focus of therapy at that point is on restoring hope.[7]

Hope plays an important role in the adjustment to physical illness.[8] Irving *et al.*[9] for instance, have shown that hope is associated with greater knowledge of and better coping with cancer. Donoghue and Siegel[10] describe what happens to individuals who suffer from what they label invisible chronic illnesses such as chronic fatigue syndrome and fibromyalgia. They come to lose hope, at which point the physical illness is compounded by despair and other negative emotions. Many physical conditions have been shown to be psychologically and physically adversely affected by hopelessness, just as they have been shown to be positively affected by hope. Individuals fare worse physically (e.g., shorter survival after cancer diagnosis) and emotionally (e.g., high depressive morbidity) if they lose hope.[8] This is because people with high hope are more likely to engage in preventive behaviors (e.g., exercise if they have heart disease) and less likely to engage in harmful behaviors (e.g., smoke if they have lung disease).

Although the medical literature gives abundant witness to the importance of hope in the treatment of physical ills, the same cannot be said of the mental health field. This may be a result of the understandably excessive attention to psychopathology. This stance is driven by clinical concern, but increasing advances in psychopathology allows us now to focus on human strengths. Just as the degree of hope affects physical illnesses, it also affects the experience of psychological suffering. As they progress in their treatment enough to give a narrative explanation of their offenses, we find that our patients, to various degrees, describe the influence of desperation in the commission of their offense.

Of interest to forensic clinicians is the following question: what clinical characteristics are associated with a greater sense of hope among forensic patients? To examine whether spirituality might be one such characteristic, we asked 33 maximum-security forensic patients to fill out anonymously three questionnaires: the Goals Scale (a measure of hope[11]), the Religious Coping Scale (R-COPE, a measure of spirituality[12]), and a demographic questionnaire. Hope, as measured with the Goals Scale, has been shown to have two distinct components, labeled agency and pathway. The agency factor measures individuals' perceived capability for initiating and maintaining the actions needed to reach a goal; the pathway factor measures the perceived capacity to generate routes to one's goals. In our sample, agency was strongly related to spirituality ($r = 0.49$, $p < .005$), but pathway was not ($r = 0.32$, NS). In other words, patients' initiative and persistence about the pursuit of a goal go hand in hand with how spiritual they are, but resourcefulness in the pursuit of a goal does not.

Hope is a main theme in a new school of psychological inquiry that has been labeled positive psychology.[13] It is the scientific study of the strengths and virtues that enable individuals and communities to thrive. Central in this field is the assumption that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play. Three main topics of inquiry in positive psychology are positive emotions, positive individual traits, and positive institutions. The study of contentment with the past, happiness in the present, and hope for the future are important themes in the study of positive emotions. Strengths and virtues, such as the capacity for love and work, courage, compassion, resilience, creativity, curiosity, integrity, self-knowledge, moderation, self-control, and wisdom are of interest to scholars investigating positive individual traits. Justice, responsibility, civility, parenting, nurturance, work ethic, leadership, teamwork, purpose, and tolerance are the strengths that identify positive institutions.

Hope has become an object of considerable scholarly interest in the field of positive psychology. Snyder *et al.*,[11] for instance, have shown that hope is best understood as a group of connected ideas (a cognitive set) with the two main components of agency, the belief in one's capacity to initiate and sustain actions, and pathway, the belief in one's capacity to generate routes to reach goals. A rich body of literature has emerged that examines how these components of hope relate to clinical phenomena such as anxiety and depression.[14]

Hope is also a central theme in patient-centered care. This term is used to describe a collaborative model of service delivery that emphasizes active collaboration between clinicians and empowered service consumers.[15–17] The main values of this model are autonomy, dignity, respect, self-direction, and hope. Patient-centered care is becoming the leading model

of mental health service delivery in the United States,[18] though it has only begun to enter the forensic arena.[19]

Hope sometimes emerges from unpredicted places. For instance, Siegel and Meyer[20] showed that individuals who react with despair and suicidal ideation after notification of HIV seropositivity emerge from treatment of that initial phase of illness with a greater sense of hope and better coping than do individuals who react to the news of their HIV status with apparent equanimity. They suggest that the best way to facilitate this process is for therapists to be tolerant of patients' despair and suicidality. By listening compassionately and without feeling compelled to eliminate these mood states, therapists can facilitate this transition from despair to hope. Forensic psychotherapists certainly have to be willing to listen to patients' despair without identifying with it and despairing themselves. This separation is particularly difficult to attain, as forensic patients may actively engage in therapy-interfering behaviors intended to cause despair in therapists, such as avoidance, devaluing, oppositionality, and overt hostility.

How does psychotherapy engender hope? The structure of therapy intrinsically promotes hope. Weekly sessions that reliably take place at the same designated time and place engender in the most despairing individual the expectation of, and the hope for, future sessions. As painful affect states are contained in the therapeutic process, the patient envisions the possibility of containment of other such states and becomes able to envisage a state of greater psychic well-being. Later on in treatment, the weekly psychotherapy session becomes the primary place where painful memories and motives are explored, allowing greater peace of mind the rest of the week. As patients learn during therapy to attend to and tolerate emotions, they can envision doing the same outside of the sessions. As this ability takes hold and becomes habitual, the patient can look forward to having similar control, even outside the hospital.

We have experienced the importance of hope in the Genesis group, a psychotherapy group for parricidal offenders that we have conducted for many years.[21] It was created to address the treatment needs of patients who have killed a parent. Prior to its inception, we had observed that many parricidal offenders appeared to have given up. They appeared profoundly dysphoric, socially isolated, and minimally involved in treatment. On our long-term treatment unit, one man sat in a chair for most of a decade, seldom saying much of anything, unreachable. We speculated that a group restricted to parricides might create a therapeutic environment in which engagement would be possible. Very quickly, our hypothesis was supported by the positive response of its members. The group remains in existence a decade later. Most of the original members have been able to leave the maximum-security hospital and have moved on to lead more autonomous lives.

Several group alumni have told us that they had totally lost hope after their offenses. They had resigned themselves to living the rest of their lives in a hospital. They described the kindling of hope as resulting from the compassionate care they received in the group. Once they had begun to trust the empathy they consistently experienced within the group, they began slowly to find themselves able to carry this trust from the group and apply it to the rest of the care being offered to them. One profoundly depressed young man later stated that his sense of hope returned while experiencing the daily ministration of attendants who insisted that he get up every morning and be active and periodically reassured him that "things would eventually get better." He sat silently in the Genesis group for several years. He then emerged from his depression. As he seemingly came back to life, he thanked the group and the unit staff for "not giving up on me." He sustained this treatment response and made further progress during the next four years. We encountered him as he was about to return to the community. He had recently completed an advocacy training program for individuals with psychiatric disabilities. He was free of the incapacitating symptoms of psychosis, was optimistic, and was grateful for the inpatient care he had received.

Hope must be better understood in the context of forensic risk assessments. Individuals with the feeling that they have nothing to lose are prone to full-blown desperation. Thus, they are particularly dangerous. Clinicians recognize this phenomenon in death row inmates, in secure hospital patients, and in restraint situations. Patients have revealed after being restrained in a violent episode that during the incident they thought that, since their violent behavior had resulted in restraints, they might as well hurt a few people in the process. Such desperate individuals had reached the end of the line. They felt as though they had little or nothing to lose. Yet clinicians routinely

assessing violence risk in other settings may not be sensitive to the importance of hope as a protective factor. An individual who possesses risk factors such as impulsivity, vulnerability to drug abuse, and paranoid thinking presents a lower risk if he or she has a meaningful connection to a treater and has hope that he can be helped, that he can heal, that there is a possibility of a life in the community for him.

Many forensic patients struggle with suicidality at various points in their lives, including prodromally, immediately postoffense, and soon after incarceration. Suicidal despair contributes to many offenses.[22,23] Suicide attempts follow some offenses, particularly intrafamilial offenses.[24,25] Many forensic inpatients pose a suicide risk throughout their hospital stay. This suicidal intent typically grows out of hopelessness and despair.[26] Like the opioid agonist naloxone for opiate overdoses,[27] hope is the antidote to suicidal wishes. But unlike naloxone, hope requires a collaborative effort on the part of the patient and the caregivers.

Hope defies easy restoration. When hope is lost, the most likely first source of restoration of it is a relationship with a caring individual who has not lost hope.[26] This relationship may be with a therapist in the context of psychotherapy, but may also be with any compassionate individual who has rapport with the despairing person. Constant observation is the usual inpatient intervention that targets acute suicidality. One of its essential components, besides watchful control, is the promotion of a caring relationship between the suicidal person and his or her "sitters."[28]

How can forensic treatment planning incorporate the promotion of hope? One means to accomplish this is within the framework of positive behavior support planning. This conceptual model switches the treatment focus away from problem behaviors and toward adaptive behaviors.[29] The treatment is focused on teaching new coping skills rather than on the containment of maladaptive behaviors. These include healthy use of leisure time, effective self-soothing, proper illness management, strengthening self-esteem and self-efficacy, and promoting reciprocity in interpersonal relationships. Central to this conceptual model is emphasis on hope as a force that propels individuals on a trajectory toward greater autonomy and freedom from heretofore incapacitating psychopathological symptoms.

It is not only patients who need hope to heal in forensic environments, it is the staff as well. Forensic psychotherapists experience the same tension between despair and hope felt by their patients. Hope in the possibility that a patient may get better helps us contain the negative reactions we sometimes experience toward our patients. Sadly, some of our colleagues have lost the hope. They despair of ever being able to help some of their patients, let alone all of them. Eventually, they risk becoming resentful, losing their ability to contain their patients' hateful projections. Worse, they add their own hateful projections and countertransferences. All too often these may be overheard in casual conversations as well as during the handling of crisis situations. When this tendency is expressed as it should be, namely in staff meetings, then it is available to be addressed in ways helpful to all parties. Sometimes staff hopelessness results in a patient's being held for life: everybody has lost hope in him, as he has in himself. Only those paraprofessionals who are hopeful about the process of improvement can be effective in promoting their charges' recovery. Paraprofessional staff can be hopeful and positive only if clinicians and administrators consistently model how to be positive and adopt a positive, hopeful stance toward them. Ironically, a few patients resist leaving the hospital. The cause is often that they believe they need the structure of the inpatient forensic environment to contain their anger. In other cases, they have simply lost hope, and they see that some of us have as well.

Hope can be promoted in a systematic manner amenable to scholarly study. An investigation at the Rangipapa Maximum Security Hospital in New Zealand suggests so.[30] Nurses at this facility decided to modify the institutional culture by promoting a few simple concepts: "leveling," "working together," and "putting a human face" on treatment. Leveling was defined as deliberately altering the balance of power to promote a healthier sense of self in staff and residents alike and a greater sense of connectedness. Working together was the term used to denote the collaborative character of the work between staff and residents. Putting a human face reflected active efforts to humanize the treatment setting to counteract the objectifying that typically occurs in forensic surroundings. The results of the intervention, labeled the Tidal Model, were that nurses stated that the changes had "engendered hope," that they were able to "make a difference," and that they were able to "communicate in their own words" to their patients their "feelings of hope and optimism."

A recent evolution in the field of risk assessment is the emergence of dual focus on risk factors and protective factors and their interaction. One such protective factor is the capacity for hope. Unlike many static risk factors, it constitutes a dynamic factor. It is amenable to modification through treatment such as group therapy, in which it is a core therapeutic factor.[31,32] We hope and expect that a focus on human strengths such as hope will enrich our forensic work and improve the quality of the lives of the men and women in our care.

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