

Commentary: On Walking and Talking

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I welcome Dr. Kapoor's reflections on psychotherapy with offender patients. In this commentary, I will discuss the value of psychodynamic psychotherapy in the treatment of forensic patients and some of the technical competencies required. I hope that these thoughts, and Dr. Kapoor's fine writing, will inspire other forensic practitioners to practice psychodynamic forensic psychiatry and to utilize psychodynamic ideas in both their formulations and their conversations with patients.

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Any psychological therapy has a two-fold purpose: first, to help an unhappy person develop a narrative of his current problems, and then, by considering that narrative, to see if the problems can be understood in a different way. Since most psychological distress arises from fixed persistent beliefs and attitudes, change becomes possible only when one is able to think differently about it—when the person can see something new in his own appraisal of the situation. Kierkegaard described hope as a passion for the possible, and hope is both a curative factor and a mature defense in times of distress.^{1,2}

Forensic patients need hope. Many, if not most, general psychiatric patients can now expect to make reasonable recoveries from their disorders; and in many ways, the larger communities in which we live are more psychologically minded than they used to be, and so less stigmatizing than in the past. But forensic patients are people who have been damaged by life. The phrase “ruined pieces of nature” (Ref. 3, p 337) has never seemed more apt. They have severe degrees of developmental psychopathology (of which more later), and multiple, usually treatment-resistant mental disorders, all of which combine to render these patients severely disabled. The care of such patients resembles palliative care, or the care of disturbed and handicapped children. It is long-term care, in which treatment goals must be set appropriately and which includes damage limitation.

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In addition, forensic patients, like J.M.,⁴ are survivors of a disaster, in which they were the disaster. One aspect of disastrous experience is that it suddenly and fundamentally changes one's identity. In narrative terms, the story takes an unexpected and shocking turn. Stories in forensic psychiatry are not only crime stories but horror stories, that you have to be prepared to hear—really prepared:

So shall you hear of carnal, bloody and unnatural acts [Ref. 5, p 417].

Like anyone who has survived a disaster, forensic patients need a space to make sense of their actions and their consequences. Making sense of experience is also part of moral discourse. There is a close connection between the capacity for moral reasoning and the capacity to develop narratives of experience.^{6,7} Clinically, this process is of enormous importance: it goes to the matter of risk assessment and key psychological constructs such as regret, remorse, and responsibility. The data on violent recidivism seem to confirm our human intuition that those who take no responsibility and are contemptuous of distress in others are more likely to offend again.⁸ In terms of risk, therefore, it becomes crucial to know what sense patients like J.M. make of their offenses. In addition, practically all offenders have a need for a story to tell to the various interested strangers they will meet in the future, a story that makes sense to them as well as to others.

The stories that ordinary people tell (and hear) about disasters and journeys and meetings with monsters nearly always involve a transformation of the hero's identity.⁹ By their offending history, forensic patients also have acquired a new identity, one that may seem very alien to them. It is sometimes easy for

forensic professionals to assume that the patients are somehow accustomed to their existence or experience, that being under the scrutiny of the law or in custody is normal for them. It may be normal (in the sense of the most frequent experience they have had in life); but that does not mean that it is not as distressing and disturbing for them as it would be for anyone. Not many of our patients expected to end up in a maximum-security hospital.

This is particularly true of patients who have killed. To be someone who has killed another is to have a permanent marker on your life. As one of my patients said to me, "You can be an ex-bus driver, but you can never be an ex-murderer." I was struck by the moments in Reena Kapoor's narrative⁴ when she became acutely aware of J.M.'s identity as a murderer, of the social absurdity of choosing to sit with a man who has killed. I suspect that her fluctuating awareness of this identity was a mirror of J.M.'s daily existence:

Is there a murderer here?

Yes. No. I am.

Then fly!

What from myself? [Ref. 10, p 318].

Or, as one of the patients in my homicide group pithily described, he looked into the mirror and said to himself, "Who the f*** are you looking at?"

Another important purpose of therapy for patients is to assist in social reconnection. Those who commit violence are often socially isolated at the time of the offense, and their offenses are experienced as attacks on the wider social group, which then excludes them. So, most forensic patients, like J.M., need social skills, by which I mean that they need to rediscover the pro-social self inside them. They need to be able to be alongside others, and not be frightened or overwhelmed. I would see this as being a basic requirement of forensic rehabilitation; and all types of psychological therapy will be useful. Psychodynamic psychotherapy has a particular role to play, which I will now attempt to explicate.

What is Forensic Psychotherapy?

Freud was interested in the possible implications of psychoanalysis for understanding crime, as he was interested in implications of psychoanalysis more generally. Later practitioners, such as Edward Glover, applied psychoanalytic ideas to work with delinquents; and in 1944, John Bowlby published

data suggesting that there might be a link between the unconscious sense of deprivation and repetitive theft.¹¹ Since then, various clinics and prisons have offered psychodynamic therapies to offender patients, mainly in Holland, Germany, and the U.K.

Vastly increased knowledge of developmental psychopathology has led to an understanding that forensic psychotherapy is not the practice of psychoanalysis with forensic patients. It is the application of a particular technique that seeks to improve patients' capacity to mentalize, in a group of patients who find mentalizing hard and painful. Forensic psychotherapy requires modifications of traditional technique to meet the different psychological needs of forensic patients; but at the same time, the forensic psychotherapist is mindful of the potential for boundary violations and the unconscious compulsion to repeat dangerous attachment patterns in the therapeutic space. Context is also important. Some forensic psychotherapists take traditional therapist roles with patients, whereas others are integrated into forensic institutions and clinical teams.

Let me say a little more about mentalizing, by which I mean the capacity to keep mind in mind.¹² The capacity to think about your own mind, and by extension, the minds of others, is a function of early attachment relationships.¹³ I do not have space to review the evidentiary base for this; key theorists and researchers in this field are Allan Schore and Peter Fonagy,^{12,13} who have shown how being raised in frightening childhood environments has a disastrous impact on the capacity for self-reflection. It is the impact of these hostile and neglectful environments that interacts with genetic vulnerability to produce an increased risk of chronic rule-breaking, as well as increased risks of developing Cluster B personality disorders.

As more than one analyst colleague has said to me: "How do you even start?" Lack of self-esteem means that our patients are often not interested in themselves, and their lack of empathy for others is evidenced in their offending. Unlike most patients referred for psychotherapy, they do not have access to a range of mature and neurotic defenses when they are distressed. Instead, they have psychotic and immature defenses, such as splitting, acting out, and denial. As a result of chronic trauma in childhood, they are likely to have chronic hypothalamic hypocortisolemia, which in turn produces hypervigilance and increased sensitivity to threat (a state that I think of as

being at psychological DefCon 5); so that threatening stimuli can lead to deployment of pathological defenses at any time. Both conscious and unconscious distress are disavowed, which results in chronic impairment of reality testing that in turn, makes the learning aspects of therapy problematic.

There are two technical solutions, both based on the theory that our patients need to learn how to manage horrible feelings without being overwhelmed, that they did not learn this in childhood, and they are therefore either hyper- or hypoaroused to feeling. Those who are hyperaroused present with borderline personality pathology and need increased cognitive capacities to distinguish between reality and fantasy. They need a therapy with a cognitive stance. Those who are hypoaroused need techniques that allow for the carefully controlled exploration of feeling and emotion, usually via the use of imagery and metaphor.¹⁴ Psychodynamic and creative therapies are examples of these techniques (*nota bene* to Dr. Kapoor: psychodynamic psychotherapy is always highly structured in terms of time and place; the content is unstructured in that it is left to the patient). In both cases, a reflective empathic stance on the part of the therapist allows an attachment to form to the therapeutic work (of which the therapist is naturally a part). Severe personality pathology in particular calls for both techniques.¹⁵

Perhaps most of all, forensic psychotherapists should pay attention to the feelings engendered in them by the work: countertransference in its widest sense. Many of our patients deal with horrible feelings by projecting them into others, and if we identify with them, it can lead to abusive boundary violations. These violations may take the form of a rejecting or punitive attitude toward the patients. It may also take the form of colluding with the patients or refusing to see their dangerousness or madness. Such violations don't just happen in dedicated therapy settings. It is likely that these dynamics are played out all over forensic institutions and with all professions involved in forensic patient care.^{16,17} So, what I wanted to know is exactly what Dr. Kapoor felt when the patient said, "I wish we could walk outside"; and more about the panic she felt when he asked her about "feelings of desperation" (Ref. 4, p 566).

The Best Words in the Best Order

This is Coleridge's definition of poetry, but I think it is not a bad definition of what psychotherapists try to offer patients. We are trying to help the patient to

say a little more about the problem in mind at the time. We are also trying to find ways to speak to the patient that will help in the process. Whatever we say is an attempt to make it easier to both think the unthinkable and speak the unspeakable: as therapists, we are always trying to open up a reflective conversation. We may not always succeed, but it is the goal of every therapeutic utterance, and we monitor our own discourse continually to see if what we say opens something up or closes something down. So much of being a therapist is acquiring the skills to communicate with those who are speechless with grief, rage, or horror. It is remarkable to me that one can still become a psychiatrist without demonstrating that one has these skills.

We are helped in talking to patients like J.M. by the use of attention, not only to the countertransference, but our own nonverbal, preconscious associations.¹⁸ If the patient's left brain is not articulate, the right brain is still communicating, so that for the therapist, both physical countertransference phenomena and right-brain associations (such as metaphoric language or music) may be responses to unconscious communications from the patient's nonverbal mind.

So, for example, when J.M. says, "Doctor, do you know what it's like to be filled with desperation?" we know several things. We know that we will have to answer the question. We know that there are ways that we could answer that would shut down the conversation, so we want to answer in a way that helps J.M. to say a little more about his feelings of desperation. We also know that we try and keep self-disclosure to a minimum, because at best it may be distracting, and at worst, it can be exploitative. It is also hard not to feel a sense of anxiety when such a personal question is asked, because in the forensic realm, we are rightly cautious about patients' motives for asking personal questions.

Therefore, I might take a moment to reflect on what has been asked, and tell J.M. that I am doing so. (Point of technique here: prolonged silences are usually experienced by most forensic patients as aggressive, especially in the early stages, and so it is helpful to keep up a limited running commentary on the process.) "I'm going to think about that for a moment," has the benefit of being both true and performative; it buys time to think.

I would think about the anxiety I felt in answering, and I would think (like Dr. Kapoor) that I really have

no idea what it is to be desperate; at least, I have no idea whether my experience of desperation will help to understand J.M.'s. Although my empathic response is warm (nonrejecting and therefore a good thing technically), its expression may not actually help J.M. to say more about what he means by desperation. I am inclined to think that when J.M. heard, "I think so," he stopped himself from saying more because he heard the therapist talking about herself and not him. This is not a criticism or a correction. It was one small moment of process that went one way when it could have gone another. If J.M. has something to say, he will probably say it again, and therapists usually get another chance.

My immediate association to what J.M. said was that famous quote of Thoreau's: "Most men lead lives of quiet desperation." So I might say something like, "I have heard it said that most men lead lives of quiet desperation"; putting the emphasis on most. Then I would wait to see what happened next. Again, the advantage of sharing an association like this with J.M. is that it lets him know that I have heard the word desperation. It is also not a why question. Although a common technique used in all therapies, people can find "why do you say that?" a bit persecutory after a while. If a question begs another question, then I would formulate it as a statement: "Your question makes me wonder what prompted that thought about desperation." A statement of what I am thinking not only has the advantage of being true (crucial in any therapy, but especially in forensic work), but it also models the process of active monitoring and sharing of thoughts. What one wants to avoid is any sense of one-upmanship. The psychotic patient will just shut down even further, and the psychopathic patient is much better at it than you.

The use of metaphorical associations in forensic psychotherapy was pioneered by my much-missed predecessor, Murray Cox, who worked for over 20 years as a therapist in a maximum-security hospital with patients like J.M. In highly paranoid worlds (like the patient's mind, and the institution that secures him), an image or metaphor can help to mentalize and manage awful feelings in ways that non-metaphoric language does not. It can make it possible to put into words what would otherwise be literally unspeakable; so that we can "speak what we feel, not what we ought to say" (Ref. 19, p 392). Such honesty in communication has particular clinical implica-

tions when it comes to risk assessment, quite apart from helping people process traumatic events.

Walking and Talking

In the end, J.M. wishes that his therapist could walk outside with him. Like Dr. Kapoor, I thought this suggested something much more complex than erotic transference as basically taught. For a start, "erotic" doesn't begin to cover the range of relationships that might be in the patient's mind. Many forensic patients have no concept of the erotic at all. Long-term psychiatric patients are deprived of intimacy and may very naturally become attached to the first person who has shown any interest in them for years. Such attachments often have a childlike quality and need to be handled with great care if the patient is not to be left feeling ashamed. The trick is to be able to hold in mind the heuristic possibilities that may all have some validity. It may be an erotic transference (which may or may not be sinister), or it may be that J.M. was actually doing what was asked of him. He had been invited to develop more social awareness, and he expressed a wish to be more sociable.

But I thought there was something more profound there. I thought that J.M. was saying that his therapist was now walking with him in his mind—that he had internalized her as a good object. As the end of the session approached (and, I wondered, was the end of the therapy also in sight?), I thought that J.M. was saying something about how much he would like to have his therapist to keep him company in the external world, which might be very lonely for him. It also reminded me that for many patients who have killed, life after death involves walking along a Via Dolorosa,²⁰ and who would not like company along a hard way?

There is so much more to say about Dr. Kapoor's fine work with J.M. and her fine writing. I hope that other forensic psychiatrists reading this work will feel stimulated to move away from an interrogative style of discourse with patients and into a more narrative mode, so that there can be a conversation. Interrogation undoubtedly has its place, but if you really want to get to know someone, you have to talk to him, and even more important, listen. If we want to make really good assessments of risk, or motives, or criminal responsibility, we must help the person tell his story his way.

Cox once gave an example of a patient who said to him, "If you could talk to me the more human way, the night would come in slowly." I think Dr. Kapoor's reflections have demonstrated the value of talking the more human way more often in forensic psychiatric practice. I hope that there will be more such reflections in *The Journal*, and I am grateful to the editor for giving me the chance to add some reflections of my own.

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