Commentary: Psychotherapy in a Forensic Hospital

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Very little is written in American forensic journals about psychodynamic psychotherapy for patients committed to forensic hospitals. Relatively little is known of the process of helping these patients cope with their mental illnesses, to gain insight into their crimes and their unconscious dynamics, or simply to cope with the dreary landscape of the forensic maximum-security institution. In this commentary, the author hopes to shed light on some of those processes.

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I fully appreciated Reena Kapoor's article, " 'Filled with Desperation': Psychotherapy With an Insanity Acquittee,"[1] about her psychotherapy experience with a forensic patient. Although there is no shortage of journals in which one can read about the process of psychotherapy, there are few forensic journals (outside of the United Kingdom) in which the psychotherapy that goes on within forensic institutions is the primary topic. So little is written in American forensic journals about individual psychotherapy treatment for these persons, many of whom have committed terrible crimes, that one could reasonably assume that forensic psychiatry and psychology in the United States are involved only in the legal disposition of cases and the commitment of those unfortunate forensic patients to vast and forbidding institutions. Relatively little is known of the treatment process that helps patients contend with their mental illnesses, gain insight into their crimes and personal dynamics, and cope with the dreary landscape of the forensic maximum-security institution.

For those of us working deep within these institutions, patient progress is mostly the result of a slow accretion of small changes in thinking, small changes in behaviors, and small insights about their crimes and their mental illnesses, often acquired over very long periods of time (sometimes decades). As Kapoor learned to sit with her patient despite knowing full well his crime, she helped to develop a relationship that over time provided him with a sense of trust and safety. And for some patients, progress may simply be their ability to tolerate the weekly relationship with the psychotherapist.

This therapeutic relationship, or treatment alliance, is perhaps the most important aspect of therapy. And almost all psychotherapy research concludes (if it can conclude anything) that a patient-psychotherapist relationship is the most important requirement (measured by effect size) for successful psychotherapy. Development of the therapeutic relationship requires of the psychotherapist some way to be interested in, to be curious about, and to care about the patient. To do that, the psychotherapist must first find within the patient some aspect (or residue) of the patient's humanity to which the therapist can relate. Once the relationship is established, the work begins. Kapoor captures how developing such a relationship may take months of effort and then, suddenly, one day the patient piercingly demands of her, "Doctor, do you know what it's like to be filled with desperation?"[1] And the real work of psychotherapy begins.

We all struggle when confronted by such questions, and there is no one right way to answer that question except to reach deep into one's life (soul?) and look for some personal experience that might be, at best, an analog of the patient's experience. We do this not to convince our patients that we truly understand them, but of necessity to show ourselves that we do not know more about our patients than they know about themselves. Since none of us is likely to

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have been in such a situation (committed to a forensic hospital for murder), it is unlikely that we have ever suffered that kind of desperation, although we all may have, at some time in some place in our lives, suffered in some way. But that suffering is not analogous to what our forensic patients may bear in dealing with mental illness, or in coming to terms with the horrific awareness of the crimes they committed. They may suffer simply from being isolated from society, living in the dreary surroundings of the institution where windows are small and extra thick, covered with wire mesh, distorting what little view there is of the real world outside.

Dr. Kapoor's patient was really asking, "Doctor, are you able to try to understand me? Do you care enough to try to understand my desperation?" Kapoor's life may not have prepared her to understand her patient's desperation, but she proved herself worthy of that challenge when she looked within herself for a personal understanding of desperation. Very often this introspection, this curiosity about what the patient makes us think or feel (countertransference or projective identification), is the essence of this type of psychotherapy. (Countertransference toward these patients is to be expected, but it must be worked through in supervision or during one's own psychotherapy, so as not to interfere with the need actually to know and care about the patient.) We try to understand our patients and their unconscious communications through our emotional reactions to them. As we explore and examine these experiences, we begin to know and understand the subtle, but quite dynamic, unconscious lives of patients.

Many of us reading Kapoor's description of her psychotherapy work with this patient will no doubt have our own thoughts about what should or could have been said when her patient demanded if she knew desperation. Do we reassure him that, indeed, we do know? Do we acknowledge the limits of experiences? There is no one right answer. For how can we ever personally fathom the desperation of our patients, who live with the memories of what they did, who remember the multiple losses in their lives, and who every day engage in a Sisyphean struggle to just get through the day? For many, the guilt, shame, and angst over what they did leaves them hopeless that anyone will ever understand them or care about them again. The world certainly doesn't understand them, and so they fear rejection from the world and emotionally withdraw from the world, but at the same time they are desperate for contact with a humane individual who will listen and get to know them without judging them.

These patients often need a relationship with someone with sufficient ego strength that they can mirror and that allows them to talk about their pain, confusion, and psychosis. The psychotherapist needs only to listen, contain, and care about the patient until such time that the patient can do so for himself. For those patients still psychotic, having someone really listen and try to understand them, despite their circumstantial speech, odd beliefs, or unusual interpersonal styles, provides them a connection to a world outside the institution and their idiosyncratic references. It provides, however briefly, an anchoring experience in reality. Such patients, struggling against conscious and unconscious dread, seek connections with another real person through "interactional processes, with subjective and intersubjective experiences of being alive and real" (Ref. 2, p 320). If they sit with someone real, they begin to feel more real. These patients seek contact (and run from it), and desire (and fear) connection with another person. For patients in forensic settings, we, the expert psychotherapists, become their necessary vitalizing objects, allowing them eventually to give up their denial of need for others. The psychotherapist as a vitalizing object reminds them that they too are alive. For many of these patients have withdrawn into psychotic isolation so as not to feel any of their misery. As Winnicott noted:

> . . .[W]e are successful [in therapy if] we enable the patient to *abandon invulnerability and to become a sufferer.* If we succeed, life becomes precarious to one who was beginning to know a kind of stability and a freedom from pain, even if this meant nonparticipation in life (emphasis in original) [Ref. 3, p 199].

Kapoor wrote eloquently about the process of sitting with her forensic patient week after week, as he began to experience and express his desperate suffering. We get a look into a process where change and progress, when it occurred, did so at the speed of a glacier's movement. We know that the weight of psychological distress, of commitment, of hospital life, all bear down on the individual like a glacier's accumulated weight of ice and snow from countless eons and erode his underlying humanity. But, as is often the case in good-enough psychotherapy, there is opportunity for an emotional thaw. The warmth of the treatment relationship melts the vast, frozen emo-

tional glacier that is the patient and his illness. As the accumulated weight melts, the emotional glacier recedes, leaving behind the landscape of his unique psychological depth long hidden from sight. As the patient becomes more connected, via the therapist, to the real world, he begins to experience the real world emotionally with real feelings. He begins to suffer and to become a patient in the truest etymology of that word.

We know that for psychotherapy to progress there must be sufficient time for the patient and therapist to sit together, often for months and years, and that little may happen except for listening to whatever the patient chooses to say. This process of listening to our patients requires patience, tolerance, supervision, and support, knowing that it could take a lifetime to understand and explore their lives. For some, long-term psychotherapy leads to insights that motivate continued progress, but for others, it may simply provide the calming, peaceful experience of having something consistent (normalizing?) to look forward to, someone to help contain the suffering.

This work of sitting with patients and listening to them, helping them understand the significance of their feelings, is the work of psychotherapy. Despite what might work for more so-called normal patients outside of such institutions, psychotherapy in a forensic setting is not something we do to the patient (such as giving homework assignments or correcting erroneous assumptions), nor is it merely acting as a passive witness to their pain. "Rather, therapy, at its best, becomes a collaborative process involving the construction of potential space so that the patient—by virtue of insight, integration, symptom removal, and self-reflection—is able to experience himself as alive and real in the social and intersubjective realms of life" (Ref. 2, p 321). And working from within this psychodynamic approach, the goal is to create "good-enough therapy [in which] the therapist, as a vitalizing object, represents a process that *partially transforms tragic misery to a sense of being alive and real in the midst of the exigencies and vagaries of life*" (emphasis added; Ref. 4, p 120). And nowhere is that more necessary than within the walls of the forensic institution.

By and large, however, most people are likely to think of these patients in forensic institutions as serving out their time until they are declared sane, or at least less insane, and ready for transfer to some lesser level of care and restriction. And for most people, the extent of their understanding of what happens within forensic institutions consists of the knowledge that these patients' lives are managed day to day, based on legal rights, medication, and risk concerns. But in Connecticut we are now (finally) moving to a place where patients are treated from a recovery point of view,[5] rather than from a correctional model of containment and management. The Recovery model, though not a perfect fit for a forensic setting, nevertheless promulgates the necessary belief that psychiatric patients—even forensic patients—can get better and be returned to a reasonably productive life outside the hospital, and that treatment and discharge should be the goals for the forensic patient throughout the individual's entire hospital commitment.

In her article, Kapoor did not have time to wonder what it is about the process of psychotherapy that brings an individual insight and understanding and sometimes peace of mind that can allow him to move forward and eventually out of the forensic hospital. What are the therapeutic actions that move individuals forward?[6] There is neither the intent nor the space in this article to explore the empirical evidence for the claim that psychodynamic psychotherapy has great potential to help these patients improve clinically and socially. I believe, and Kapoor was certainly thinking in this direction, that for patients such as these, insight-oriented psychodynamic psychotherapy helps them develop the capacity for relationships and for emotions. It helps them process the reality of their crimes and helps them understand what the crimes might have meant intra-psychically. When necessary, psychodynamic psychotherapy can enhance our understanding of any potential future risk through a more sophisticated understanding of the patient's unconscious problems and conflicts as they are repeated in the psychotherapy process[7] and can provide information that can be invaluable in assessing the patient's readiness for greater privileges and eventual discharge from the forensic hospital. In this regard, psychodynamic psychotherapy is often superior to any other treatment in exploring the individual and complex risks for certain patients that are often not easily accessible with actuarial measures. A psychodynamic:

> . . .assessment can shed light on the nature of the unconscious impulses and beliefs that were, and are currently, expressed in the patients' behavior and interactions and on the configuration of the patients' defense mechanisms. It can also provide information about the patients' ability to

> tolerate uncomfortable affective states and on the extent to which these are projected into the external environment, resulting in unthinking and aggressive actions [Ref. 8, p 119].

Risk concerns aside, even if the individual were never to be released from the forensic hospital, he would still need help and support to live with the limits imposed on him by his illness, the courts, and even his conscience. To judge from what is typically written of forensic patients, once all the legal machinations have more or less ground to a halt, pharmacology is effective, and the patients remain clinically stable. Very little is known of the patients, the persons who are the containers of the symptoms and the vessels for the dynamics that led up to their crimes. Those of us doing this work, by sitting with the individuals in psychotherapy one or more times a week and getting to know them is a very unique and human (and humane) way. And it becomes clear that they often come to appreciate the opportunity to sit with a professional, privately, to talk about their lives, their families, their regrets, their crimes and all the attendant guilt, shame, and confusion. Many look for an understanding of themselves that runs deeper than "you have a mental illness." Very often, and very simply, they want to feel validated; they want to be known as who they are now; they want to be known as the persons they were before they committed their crimes; they want to be known as individuals who some day may reclaim their humanity outside of a mental hospital. They are desperate to be known to another and not to be invisible, to be understood, even if unintelligible, and to have their personhood known and accepted by another. As the French philosopher Paul Ricoeur noted in his work on ethics, to be human is to suffer and suffering can only find a place for expression in the presence of another.[9] There is no better place than psychodynamic psychotherapy for the patient to become human again.

Kapoor was only in the beginning phase of her therapy with this patient when her rotation ended and forced termination. She was just beginning to connect and form a therapeutic relationship with him in which his suffering could be acknowledged. When the patient was able to say to her, "I wish you didn't have to go. I wish you could stay here always, and we could take walks outside together," Kapoor hoped to get to the patient's unconscious or denied emotions when she returned to him the following week. However, it seemed to her that he "simply would not budge" and she was left feeling disappointed, even a little angry that he was unwilling to "get at the emotion behind the statement," and that he would only talk about the concrete thought of walking on campus (Ref. 1, p 565). I suggest that he feared he might have gone too far in expressing his feelings. Perhaps he realized he distressed his therapist with his emotions and worried that he had somehow hurt her, as he had his victim many years before, and fittingly like a turtle in its shell, he withdrew the following week, as much for his emotional protection as hers.

This is a powerful reminder that those individuals struggling with schizophrenia are not removed from the same emotional needs that most of us possess. However, the thought disorder of the more impaired individuals may confuse their wants, needs, and wishes, and thoughts and feelings and reality and fantasy become mixed up in the cognitive disorganization that is the hallmark of the illness. Sometimes, the best they can do is to express their emotions in what seem to us simplistic, concrete statements, or at other times in abstract metaphors often beyond our immediate comprehension.

Given enough time in individual psychotherapy, the patient teaches the psychotherapist his language, and the psychotherapist translates the patient's statements into a more commonly shared terminology. They then begin a conversation about what Winnicott called the "primitive agonies," which for these patients comprise the most primitive (i.e., infantile) "annihilation and engulfment anxiety" (Ref. 4, p 101). In other words, interpersonal relationship (closeness with an "other") creates a fear of losing oneself, of being engulfed by the other, so the patient withdraws to avoid that frightening possibility. The patient is then confronted with being alone, and his belief and fear that aloneness equals nothingness, an annihilation of the self. It can be argued that psychosis itself is an annihilation of the self. The psychotherapist must therefore create the relationship in such a way as to allow the patient to experience and tolerate—and survive—both situations.

What Kapoor didn't notice, however, was that her work with this patient was successful in that he was already expressing his emotions. The normal desire for companionship was his expression of the underlying emotions that spoke to the significance that their relationship had taken on for him personally. Such a sweet, sad thought that she might never leave

him; it spoke to his awareness that psychotherapy would be ending and she would soon be leaving, in its own way reenacting one of the primitive agonies, but this time perhaps leaving the patient a little better prepared to manage it. I think also, and maybe most important, that his wish for her to stay with him represented his wish to make restitution, to undo and repair what he had done so many years earlier when, psychotically, he committed his crime and he killed off, literally and figuratively, an unbearable unconscious, emotional conflict in his relationship with his victim. In ongoing psychodynamic psychotherapy with no time limit, such an interpretation would eventually be offered to the patient, perhaps allowing him to talk more in depth about his crime, his grief, and his remorse, and perhaps even allow for some greater understanding of why the crime occurred, beyond the simple fact of his mental illness.[10]

What Kapoor missed, and perhaps what many would have missed, is that his statement was, in fact, his progress. Perhaps all one had to do was simply interpret to him his fear of loneliness and he would probably have continued to talk about his feelings. But all was not lost; such things do not surface only once in psychotherapy. Feelings, transferences, and unconscious material continue to surface as long as the individual feels safe, and will keep surfacing until the psychotherapist notices and correctly interprets what it is the patient is trying to communicate. In agreeing to take on this type of work with these patients, we are also making a commitment to be there, within reason, as long as possible. As a colleague of mine expressed it, "That's the power of our work. It's what makes us so important to others. Sometimes we are all they have. You never know the day that you shake a new client's hand and introduce yourself that you may be beginning a lifelong relationship" (McElfresh P, personal communication, October 2008).

Sadly, many of our patients rarely have the opportunity for long-term psychodynamic psychotherapy in which such problems manifest themselves, asking to get interpreted and resolved, only to return in some new permutation (e.g., a symptom) requiring more interpretation. Over time, psychodynamic psychotherapy allows the patient to gain ever greater ability to understand himself, to understand his longings, and to express them in a relationship (via unconscious transferences) in which they can be accepted, contained, and discussed.

Kapoor's thought that the experience for her patient of "holding a warm hand" might have gone a long way to alleviate his desperation and would have been better than a psychodynamic interpretation, however, misses the point. Through the powerful dynamic of psychotherapy, we come to know what the patient wishes for, but we give interpretations rather than grant wishes, like teaching someone to fish rather than giving him a fish. Although no psychotherapist should accede to a literal granting of the patient's desire to walk the campus hand-in-hand, the nature of the psychotherapy relationship itself provides for the patient the psychic experience of holding a warm hand, as patient and psychotherapist meet each week and go for a walk together in the patient's life.

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