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Forensic psychotherapy in forensic mental health

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Abstract
Forensic psychotherapy is a talking cure that aims to work with meaning making processes and defensive manoeuvres in offenders, in order to make them progress in their search for the meaning of the offence. An offence can be understood and contextualized once it is considered from the perspective of the life history of the offender. At the same time, the question of where the violent or sexual motives come from, are much more difficult to grasp. This paradox is problematic to society, that wants an answer from the criminal, but it is also problematic to the criminal him- or herself.
The development of the embeddedness of forensic psychotherapy in English and Dutch forensic mental health institutions and the relevance of training are described and explained.
For Belgium, two small scale projects are discussed that cater for mentally ill offenders who have difficulties to cope with more intensive psychiatric care. Within these projects, patients are offered the possibility to take part in therapeutic activities on a voluntary basis. The aim is to motivate people, who have difficulties to socialize, participate in group and reconnect with other.

1 Introduction

In this chapter we pay attention to the implications of speech and language in the forensic psychotherapeutic talking cure (§ 2). Especially in forensic mental health the role of the committed crime is of central importance (§ 3). The institutional embeddedness of treatment in forensic mental health is discussed in § 4 based on the experiences in The Netherlands. The rich historical development of this professional super specialism in the United Kingdom is outlined in § 5. Its contribution to research is reflected in § 6 and to teaching and training in § 7. We conclude this chapter with attention for the international forum of forensic psychotherapy in § 8.

2 The role of speech in forensic psychotherapy

Forensic psychotherapy is a talking cure. We ask our patients to talk about their offence, about their lives and about very intimate aspects of those lives, such as their romantic relations and sexuality. Moreover, we ask them to talk truthfully and frankly about these topics, frequently in the presence of other patients. This is a not an easy ask. In addition it is often assumed that offenders are not particularly good at this task because they have the tendency to minimalize their offence, to misrepresent the facts and to exaggerate the role of the victim (Abel, Becker, & Cunningham-Rathner, 1984; Wallinius, Johansson, Larden, & Dernevik, 2011). Such minimalizing and legitimizing is known as cognitive distortion and is used by offenders to waive their responsibility. The idea that 'Criminals do not think like law-abiding prosocial people' (Sharpe, 2000, p. 2) is taken as a fundamental idea in some types of treatment programmes for offenders. But how can we provide psychotherapy if we assume that the patient is not up for the task? How can we listen to the patient who we assume is distorting the truth? This will require us to question the role of speech in forensic psychotherapy. Let us start with an anecdote.

A man goes to a forensic psychiatric institution for an admission interview with the psychiatrist. He has prepared for this interview very well by reading through the information leaflet and checking the website in order to know as much as possible about how the institution functions. He is really motivated to start treatment. What scares him though is the fact that he will have to talk about his sexual offence to a group of patients. In order to make a good impression, he talks very honestly during the assessment interview; he talks about the offence and about his sexual attraction to children. The psychiatrist takes notes. When the man stops talking, the psychiatrist raises his head and says: 'So you deny your problem.' The man is astonished and asks the psychiatrist how he reaches that conclusion. 'You do not use the word paedophile to describe yourself, so you deny your problem.' The man responds that he is not a paedophile because that word literally means friend of children, and his deeds have nothing to do with friendship for children. The man is refused for the treatment programme.

In our interpretation of this anecdote, the man and the psychiatrist reached an impasse because of a misunderstanding arising from their very different way of using words. The psychiatrist seems to have a set perspective and pattern of expectations about what he wants to hear from the patient. He seems to assume that 'paedophile' is the only correct way of describing the man and his crime. The sexual offender, on the other hand, seems to be investigating the meaning of words, deliberating which are best to describe himself and his deeds. The latter way of handling language is known in psychotherapeutic practice: an aspect of psychotherapy is about finding the words to describe yourself, your problems, and others, and constantly deliberating whether these words are both correct and specific.

The psychologist Jerome Bruner referred to this use of language as the narrative modus (1986, 2008). The narrative modus refers to our use of language as a means of formulating the connections between events over time and trying to establish a sense of temporal continuity and coherence in the subjective experience; it relates to giving meaning to experiences through story telling. Those stories are about

'human or humanlike intention and action and the vicissitudes and consequences that mark their course' (Bruner, 1986, p. 13). Stories represent what people want and how they want to reach this. Through narratives, we try to organise the complex and often ambiguous world of human intentions and actions in a meaningful structure.

In forensic psychotherapy, patients use a similar narrative modus. They talk about their experience in the present and past, and try to give meaning to the events. A narrative is an act of interpretation because it provides an explanation of what happened and why it happened. In the process, individual experiences and circumstances are compared with broader social, cultural, and moral frameworks of meaning. In the case of a person talking about something he or she did wrong – an offence – the story emerges as a result of the ability to engage in a moral negotiation about what happened (Mooij, 2010, p. 291), why it happened and what that means.

From this perspective, it is delicate to say that the tendency in offenders to minimalize and legitimize their crime reflects their personality; such 'cognitive distortions' need to be conceptualized as something people do rather than something people have as a psychological feature (Auburn & Lea, 2003). The use of cognitive distortions is no evidence for the fact that offenders think differently in comparison to prosocial people, but it illustrates that the person is trying to give meaning to what he did and who he is. The psychological literature on cognitive distortions establishes that taking full responsibility for every personal failure is not synonymous with healthy functioning – indeed such behaviour would be rather unusual and possibly a sign of mental illness (Maruna & Mann, 2006). Social psychology has demonstrated that people have the tendency to explain problematic behaviour in terms of external, uncontrollable, and non-intentional causes (Maruna & Mann, 2006). To a certain degree, such explanations are adaptive because they give more resilience and self-confidence to people.

However this does not mean that the speech of offenders should be taken at face value and that minimizing and legitimizing should be accepted. We would argue that the aim of forensic psychotherapy is to stimulate the narrative search for the meaning of the criminal offence, the meaning of the motives, the meaning of the aggression or sexuality implied in that act, the meaning of events from the past (traumatic and other) as precursors for the act, and the meaning of the juridical label that is bestowed upon them. A particular challenge in this process is the fact that many of the topics that are subject of meaning making in forensic psychotherapy are so difficult to formulate. As the crime often contains unconscious as well as conscious elements the offender often has difficulty understanding the reasons that lie behind his or her crime, let alone the capacity to explain these to others. Consequently many offenders reach a point where their motivation to commit the offence is obscure to themselves. This is the moment when they will resort to psychological defensive manoeuvres such as rationalisation, denial, minimization and blaming. The forensic psychotherapist, who is aware of the role of speech in therapy, will strive to provide the patient with a safe context to think and speak, will keep his own mind open to hear the patient, and will help the patient to be curious about his own mind, motives and actions to a degree that the patient can tolerate (Willemsen, Seys, Gunst, & Desmet, 2016).

3 Crime; both a meaningful and meaningless act

Within forensic psychotherapy, we assume that it is effective to talk to our patients about the crime they committed. This is because offences are not purely an expression of certain personality traits and situational determinants. Crimes and patterns of criminal behaviour have psychic determinants that are rooted within the unconscious mind. Crimes can be considered symptoms of unconscious conflicts, and their meaning can be unravelled and understood within treatment. These ideas stem from psychoanalytic theory and also apply to the treatment of non-forensic patients. Freud (1914) pointed out that patients often find it painful to talk about the origin of their symptom; rather they will act the symptom out. For example, a patient might not remember that he was defiant towards his parents' authority, instead he acts defiantly to authority in his workplace. Freud viewed symptoms or actions as mnemic symbols which reproduced, in a repetitive way, and in a more or less disguised form, elements of past conflicts in the present (Blumenthal, 2010). In Freud's words "A thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and the spell broken" (Freud, 1909). So rather than thinking that a patient's attitude is the expression of his personality, Freud saw it as the repetition of earlier elements in the patient's life. However Blumenthal (ibid) notes that it is a characteristic of forensic work that what is forgotten appears, not in ghostly form, but in action. The following anonymised vignette is provided as illustration.

A young man came to treatment for the possession of child pornography. After a number of misfortunes in his life, he had become depressed, and had become heavily engaged in a clandestine online community of people who share pornographic imagery. What stood out of this period of illegal activities, is one message he had send to all members in this community: 'Which daddy wants to hand over his child to me, I'll treat her very well?' Shortly after, he was arrested. During treatment, he talked about his childhood and how his parents hadn't been able to take care of him. He had resided in foster care for a number of years. It became evident that questions about why his parents had failed to take care of him and why they had handed him over to a foster family still troubled him unconsciously. Considering his life in retrospect, he came to see that his period of depression had brought these issues back into his mind. His crime could then be understood as a repetition, through acting out, of conflicts around this painful childhood experience. The question 'Which daddy wants to hand over his child…?' could be reformulated as 'What kind of daddy hands over his child to foster care?'

So the crime had an unconscious meaning if we consider it from the perspective of his earlier life experiences and their legacy in the patient's internal world. In this case, it enabled us to orient the treatment to helping the patient work through the questions and conflicts in relation to his parents and parenthood that were troubling him. The unconscious meaning of the crime is highly specific to the individual and can only be understood within the broader context of the patient's life.

Although a crime has an unconscious meaning, there is always a meaningless aspect to it as well; meaning and lack of meaning are the two sides of a coin. The meaningless side of a crime relates to the sexual or aggressive drive behind the act. The primary forces of sex and aggression are buried so deep in our psyche, that they are (partially) alien to ourselves. We might gain some understanding of these primary forces through psychoanalysis; in particular through the analysis of our dreams but, for the most part, they are repressed from conscious awareness. These ideas originate in Freud's work described in his paper on 'Instincts and their vicissitudes' (1915). Freud posits that the sexual and aggressive drives are at the frontier between the somatic and the mental. In other words, as the drives are rooted within the body, they cannot be fully grasped psychically. The individual can develop a partial understanding of his sexual and aggressive drives, but there will always be a part that he cannot put into words.

Studies on the antecedents of crime have shown that committing an offence is preceded by certain negative life events (Ward & Hudson, 1998; Webster, 2005). On the offence trajectory there is a period where the sexual and aggressive drives start to manifest themselves in sexualized or aggressive feelings, thoughts, rumination, phantasies and behaviours. This period varies in length but it is at the moment of the crime that these drives manifest themselves most clearly. This means that the offender is confronted with a part of himself that he neither knew nor probably wants to know. Since sexual and aggressive forces are related to the motives of the crime, it is particularly difficult for offenders to fully understand and disclose the motives underlying their offence (Willemsen & Verhaeghe, 2010). That's the reason why very often, offenders produce unsatisfactory or even contradictory explanations about their offence: everything they say is in some respect beside the point. They lack the words to express what it's really about.

4 Forensic psychotherapy embedded in forensic mental health institutions

In the Netherlands, influenced by pioneers such as the criminal lawyer Willem Pompe, the criminologist Ger Kempe and especially the psychiatrist and lawyer Pieter Baan, in the second half of the last century as a reaction to and an alternative to strong custodial based TBS hospitals (hospitals for treatment of mentally ill offenders under a special criminal law sanction) an emphasis on a more psychotherapeutic oriented method came in vogue in Dutch forensic psychiatry (Koenraadt, 2015). The Utrecht Dr. H. van der Hoeven hospital was designed as a secure and controlled therapeutic environment. A few key elements were crucial in the therapeutic approach. Pieter Baan was strongly influenced by the ideas of Maxwell Jones who pioneered the use of small therapeutic group in his treatment model. The therapeutic community approach grew from dissatisfaction with both the strict medical approach to mental health problems and with the hierarchy of the organization. Maxwell Jones prescribed a number of conditions that the community must meet in order to work as a therapeutic community; a reciprocal communication at all levels of the organization; shared leadership and decision-making at all levels; and consensus in decision-making and social learning through social interaction in the here and now. In addition to the Dr. H. van der Hoeven

Hospital most other forensic hospitals embraced the therapeutic community model adopting key elements of this approach. The group is a central part of treatment; on a daily basis the patient shares many of the experiences with the staff and fellow patients. The challenge for therapists in this treatment setting is to confront the detainees with external reality and the demands of everyday life. The hospital is considered as a protected and protective environment where residents can practice and experiment with new behaviour (Blankstein, 1979); a special and safe environment for re-education.

Contact between patients and their families is an important tool in the therapeutic approach, along with opportunities for work, education, sport, education, leisure activities. In recent decades, the original model of the therapeutic community has given way to a grafted environmental therapy, which has incorporated some principles of cognitive and behavioural therapy (Jansen, 1997; Janzing & Kerstens, 2009). The Dr. H. van der Hoeven Hospital is now recognised as the forensic psychiatric centre where the most far-reaching group therapeutic approach has been implemented. In his contribution "The forensic psychiatric hospital as a therapeutic tool" Blankstein (1979, p. 15) concisely describes the position of the hospital. "But a hospital is more than the sum of a number of treatment moments. There is a specific emotional climate, which is reflected in the attitude of all practitioners and other hospital staff. This climate is also fuelled by formal and informal rules and codes of conduct, which both have impact on the staff contacts with the residents as well as to the handling and methods of collaboration between staff members. This climate pervades all treatment contacts and often transcends the power and influence of a particular treatment sector or practitioner. This emotional climate, with its translation into rules and codes is supportive for certain approaches, but can neutralise or even fundamentally disempower other approaches."

Van Marle (1995) in his dissertation entitled *Een gesloten system* ('A closed system'), describing a psychoanalytical frame of reference for the care and treatment of TBS-patients, emphasises the importance of the therapeutic milieu as a holding and containing environment. In this perspective the psychiatric ward is perceived as a substitute for the family. Due to the many restrictions and constraints necessary in a forensic institution, patients' transference feelings come to the fore strongly and are often directed at therapists or socio-therapeutic workers. Also the concept of the hospital as a substitute mother has a meaning that goes far beyond the mere idea of a building where patients are being treated. Van Marle's description is based on the Dr. S. van Mesdag Hospital in Groningen, a forensic psychiatric hospital for treatment of TBS patients. Although its psychodynamic roots can still be traced in daily practice in the hospital, nowadays cognitive and behavioural approaches are dominant.

The TBS measure for treatment of mentally ill offenders requires that, within the secure environment of the hospital, the detainee should be able to 'experiment' with other behaviour. Changing one's own behaviour is difficult for the offender and is often met with both conscious and unconscious resistance; however effecting change is even more of a challenge when it is required by the criminal court. Treatment as part of the TBS measure starts in the closed protected and protecting

environment of the hospital. Inherent to the treatment process in the TBS system is that the treatment team gradually facilitate increasing amounts of freedom and leave for the offender under strict security safeguards and risk management protocols. Within the TBS system security and treatment are closely interlinked so that successfully increasing the patient's freedom of movement is seen as marker of treatment progress but only occurs if clinically justified and requires robust and vigilant risk management (Koenraadt & Mooij, 2007, p. 179).

There is often a tension between restricting a patient's movement and the patient's wish for freedom. In recent years, partly because of public discussions following several serious incidents, an emphasis on security as oppose to treatment has permeated the patient management within the TBS hospital. This shift has been reinforced by the development of more risk-adverse societal attitudes. Some have argued that this pendulum swing towards security has compromised the detainee's rights. The incorporation of a mentalization-based approach into the therapeutic programme of the Forensic Psychiatric Hospital at Assen (Pfäfflin & Adshead, 2004; Koenraadt *et al*., 2015) has helped enhance acceptance of the regime, the rules, and increases motivation for treatment as shown in recent research. Within a mentalization approach a mentalizing stance requires the clinician to prioritise and be curious about the patient's state of mind, as oppose to his behaviour, and explore and make explicit differences in perspectives (Bateman and Fonagy, 2016a). This approach is entirely in accordance with the theory of *procedural justice*. The concept of procedural justice deals with the conditions in which people experience authority, regardless of the outcome of specific decisions. Important conditions are that people feel heard, trust the authorities, feel that they are treated with respect, and have the feeling that decisions are made impartially. In the context of the forensic system it will mainly depend on the quality of the relationship whether the requirements of procedural justice can be met. Good contact between the staff and detainees, where one can communicate with openness and trust to some degree (however tricky this can be in a closed institution), has a positive effect on the experienced *safety* (Boone, Althoff & Koenraadt, 2016).

5 The historical and conceptual roots of forensic psychotherapy in the UK

In the United Kingdom (UK) the discipline of forensic psychotherapy has developed mainly within the National Health Service (NHS), as opposed to the Criminal Justice System, and was pioneered by psychiatrists and forensic psychiatrists, many of whom were also psychoanalysts and group analysts. Although there were several pioneers who worked independently in prisons and secure forensic units the institutional cradle for the development of the discipline was the Portman Clinic; part of the Tavistock and Portman NHS Foundation Trust, London. The Clinic grew from the idea of a small group of psychoanalysts who wanted to establish that there was a better way of dealing with offenders rather than incarcerating them in prison. Thus, forensic psychotherapy developed from psychoanalysis, psychodynamic psychotherapy and forensic psychiatry and psychology and refers to the application of psychoanalytic principles and treatment in the service of understanding and managing mentally disordered offenders; irrespective of whether these individuals

are in secure NHS units, prisons or the community. In other words, forensic psychotherapists, not only provide treatment, but also apply psychodynamic thinking to the complexities and dynamics within staff teams and institutions treating these individuals (Welldon, 1994). One of the unique selling points of forensic psychotherapy is that central to its work is a psychoanalytic consideration of the unconscious mind and the internal world of the patient. This contributes an additional dimension to understanding the mind, criminal acts and ongoing risk of the offender (Blumenthal, 2010; Cordess & Williams, 1996; Doctor, 2003; McGauley, 1997; Sohn, 1995).

Forensic patients have highly disordered and fragmented internal worlds. They rely on primitive unconscious defence mechanisms in an attempt to stabilize their inner world. Aspects of the patients' internal world can be projected into staff and evoke reactions in both the staff and the institution that arise either from the unconscious response of staff to the projected aspects of their patients' internal world or from mobilisation of the unconscious defence mechanisms of the staff and the institution to reduce internal anxiety. If left unattended, these processes result in staff teams becoming 'split' and re-enacting aspects of the patients' intra-psychic and interpersonal situation within the professional network. The therapeutic potential of the environment is decreased along with the effectiveness of the particular therapeutic task, irrespective of whether this is one of containment, assessment or treatment (McGauley & Humphrey, 2003). The understanding that forensic psychotherapists can bring to the intra-psychic function and the interpersonal consequences of such splitting for both their patients and the systems in which they work can significantly contribute to assessment, treatment and risk management (Norton & McGauley, 2000). However to achieve this it is crucial that forensic psychotherapy is a team effort (Welldon, 1997) and, as such, embraces inter-professional, inter-disciplinary and inter-agency working. The impetus for the further development of forensic psychotherapy came from two drivers; one creative, the other tragic.

To further multi-professional expertise in forensic psychotherapy and to encourage the growth of the discipline beyond psychoanalytic departments and clinics in the UK Dr Estela Welldon established the first training course in Forensic Psychotherapy in 1989 which was accredited by The University of London and run at the Portman Clinic. This was an innovative and highly successful course however, it could be argued that health service policy makers and the bastions of forensic psychiatry did not fully appreciate its worth.

Tragically it took several public enquiries before policy makers and the secure institutions, which sit at the heart of forensic psychiatry, realized what forensic psychotherapy could offer. In the 1990's, Ashworth Hospital (at Maghull, Merseyside, UK), one of the four high secure hospitals in the UK, was the subject of two public inquiries because of concerns about staff behaviour towards patients. The first Ashworth Inquiry found evidence that some staff had been physically abusive to some patients **(**Department of Health, 1992). The second found evidence of serious boundary violations by staff who had either colluded with patients on the hospital's personality disorder unit or turned a blind eye their behaviours such as "the misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the availability of pornographic material on the Unit" (Fallon *et al*., 1999). As a result of

the 1992 enquiry the first Consultant Forensic Psychotherapy post, recognised by the Royal College of Psychiatrists in the UK, was established at Broadmoor High Secure Hospital and resulted in the development of a forensic psychotherapy service. The second enquiry recognised that clinical decision making lacked the capacity to formulate and understand the patients' internal world and acted as an impetus for the Department of Health to fund a small number of training posts in forensic psychotherapy so psychiatric trainees could be trained in both psychoanalytic psychotherapy and forensic psychiatry. The rationale was that these dually trained doctors would be better "equipped to enhance multidisciplinary teams awareness of the often unconscious dynamics arising from patients' early experiences and to consider the reverberating emotional impacts which determined relationships between patients and professionals on the wards and in other mental health settings" (Kirtchuk, 2016).

In the UK forensic psychotherapy has developed mainly within the shelter of the NHS, its growth in prisons has been slower. Early models for the application of forensic psychotherapy in the male prison estate included the "visiting psychotherapist", where the psychotherapist is added on to a traditional system (Hinshelwood, 1993), or the "whole institution approach" used in prison-based Therapeutic Communities (Hobson, Shine, & Roberts, 2000) with male prisoners at HMP Grendon. This model is geared towards providing a specific and therefore narrower treatment approach for offenders with a diagnosis of personality-disorder. In the Corston Report (Home Office, 2007) Baroness Corston argued that equal outcomes for women required different approaches; arguably this policy initiative allowed forensic psychotherapy thinking and practice to cross over into women's prisons. The Report paved the way for community mental health teams (CMHTs) to be based in prisons, where the prison is the community, and some of these teams now include forensic psychotherapists.

A recent policy initiative, the Offender Personality Disorder Pathway (OPD) is a joint National Offender Management Service (NOMS) and NHS strategy for violent male and female offenders with personality disorder and has driven the development of more joined-up services for this offender group across the Criminal Justice System, the NHS and into the community (Joseph & Benefield, 2012). The OPD supports a variety of treatment interventions including cognitively-based Offending Behaviour Programmes, however, the initiative has also drawn heavily on forensic psychotherapy principles, psychodynamic theory, attachment theory and its developmental legacy, the capacity to mentalize (Bateman & Fonagy, 2016b), to shape its treatment interventions. As part of this initiative Psychologically Informed Planned Environments (PIPEs) have been set up in prisons and in the community to provide personality-disordered offenders with progression support prior to or post treatment. PIPEs provide mentalizing environments where the affective and cognitive meanings behind actions are thought about in relation to the self and others and where offenders can think about their antisocial identities and choices. Although forensic psychotherapy is in its infancy within the prison system it is encouraging that in the UK prisons see the provision of psychological therapies as a legitimate part of their remit.

As a super specialism forensic psychotherapy always faces a particular problem; namely how to achieve an impact on and develop clinical practice across a wide and

varied forensic mental health system with a relatively small number of practitioners – this challenge has been addressed in the UK by a variety of approaches outlined below.

6 Therapy at the edge: Two initiatives for mentally ill offenders in Belgium

In the Netherlands, UK, and Belgium, community care policies have been implemented in order to move mental health care from institutions to local treatment services within the patients' social environment. Existing places in residential facilities are reduced, and patients are stimulated to progress more quickly towards return in the community. A number of people with complex and chronic mental health issues, who traditionally would be in long term residential care, are struggling to find their place in this changing world. Especially in cases where the psychiatric difficulties go together with issues of aggression or drug abuse, patient might be considered 'therapy-resistant.' In Belgium, several local initiatives are established for these patients, of which we will mention two. Within the psychiatric ward of the Prison of Antwerp, mentally ill detainees are invited to participate in a number therapeutic activities on a voluntary basis (Van Damme, 2012). Many of these detainees have complex and long-standing psychiatric histories, including psychotic symptoms, personality disorders, and substance abuse. The therapeutic activities consist in a range of creative activities, sport, psychotherapy, and open group activities (listening to music, discussing the news,…), that are offered on a voluntary basis. There is also a project involving prison radio (radio made by and for prisoners). The high amount of routine and structure, and the low amount of pressure on the detainees, helps to create a safe environment in which people who would otherwise withdraw from social activities, start to engage with the group and the therapists. In Ghent, the project 'Villa Voortman' provides a meeting place for people with a dual diagnosis of substance abuse and psychosis (Vandevelde *et al*., 2015). This meeting place is situated in an ordinary house in the city, which is open during the day. Creative activities are organised during the day, and people are free to come in and spend their day in the house.

Although very different in setup, both initiatives share some basic therapeutic principles. On the basis of the Lacanian theory on psychosis, it is assumed that psychotic subjects tend to engage in fusional and aggression-laden relations. As a consequence, the therapeutic professional may come to be perceived by the psychotic subject as someone who takes over or threatens their personality. The risk is especially high when the professional addresses the psychotic directly, for instance with a therapeutic demand. In order to avoid the development of a psychotic transference, the abovementioned initiatives put no pressure on the patients to engage in the treatment. A range of activities is offered and patients are invited to participate. Those who don't participate are not excluded or forgotten, but 'kept in mind' during the staff discussions. The therapists are available for the patients, either within the setting of a consultation room, or just for a chat in the corridor. The idea is that these little, casual interactions are as therapeutic as the interactions within a scheduled therapy session. Patients are also able to work out their own treatment programme. In accordance with the therapeutic community approach,

much value is given to the group. The group of patients are given a degree of autonomy to take decisions in relation to practical issues that arise within the institution. The aim is to organise authority horizontally as much as possible, rather than vertically.

7 Impact on practice; through research and scholarship

As clinicians and academics forensic psychotherapists have greatly extended psychoanalytic thinking and scholarship in a wide range of areas; too wide to do them all justice here. However, there are certain domains where forensic psychotherapy has made particular contributions extending psychoanalytic theory and thinking and applying these ideas to treating patients in the contemporary complex systems where our patients are contained and managed. Forensic psychotherapy is intimately concerned with triangulated and oscillating dynamics between the patient, the psychotherapist and society; often represented by the Criminal Justice System as well as triangulations commonly found when working with forensic patients when they adopt roles such as the victim; the perpetrator and the bystander (Welldon, 2015).

Ubiquitous to our clinical work are the acts of violence that our patients perpetrate and a fundamental principle of forensic psychotherapy, as noted earlier, is that the offence has a meaning to the offender; a meaning that often contains unconscious elements (Cordess & Williams, 1996) and the actuality of the individual's offence needs to be kept in mind within the therapeutic work (Adshead, 2015; Blumenthal, 2010). The forensic psychotherapist is well placed to anticipate and articulate links between the internal and external worlds of the individual and can therefore make a critical contribution to the understanding of violence, including seemingly random violence, the containment of violence and the management of risk (Aylward & Wooster, 2008; Cox 1976; Doctor 2003; Minne, 2008; Sohn, 1995; Yakeley, 2010).

Clinicians and authors have also greatly extended psychoanalytic thinking providing a model of female perversion (Welldon, 1988; 1994) and the psychoanalytic mechanisms underlying women's crimes of violence towards their partners or their children (Welldon, 1996; Motz, 2001; 2015).
Forensic psychotherapy can provide a way of thinking that helps staff understand the less conscious communications of their patients; supports staff in their work with highly disturbed individuals and helps us manage the anxieties and internal disturbance such work engenders (Rubitel & Reiss, 2011; Gordon & Kirtchuk 2008; Ruszczynski, 2008). Supervision and the provision of reflective space can shed light on how patients' psychopathologies unconsciously influence the system that contains them, whether this is at the interpersonal level or within the institution as a whole.

Two of the challenges facing forensic psychotherapy are, firstly, to develop reliable clinical tools that help teams have a systematic approach to examining and formulating the patient's difficulties from a psychodynamic perspective and secondly, how to evidence what we do through qualitative and quantitative research

methodologies. With respect to the first challenge a group of UK forensic psychotherapists have developed the Interpersonal Dynamics (ID) Consultation model (Reiss & Kirtchuk, 2009). Based on the work of the Operationalized Psychodynamic Diagnostics (OPD) Task Force (2001, 2008), which has been widely used in Germany, the ID Consultation provides clinicians with a systematic way of mapping and formulating the patient's core relationship patterns and helps the multidisciplinary team develop a shared understanding of patterns of dysfunctional relating. The ID draws on psychoanalytic concepts of transference-counter transference which become enacted between patients and staff members involved in their treatment. Such a shared understanding offers the possibility of improving unit dynamics, treatment concordance, offering protection against boundary violations and managing risk (Gordon & Kirtchuk, 2016).

Core to the work of forensic psychotherapists, and indeed to forensic mental health professionals, is the examination of the index offence however there has been no systematic way of examining and formulating the patient's offence narrative or investigating whether the way in which a patient represented his offence was predictive of progress. Using methodologies arising from the field of attachment research, and examining the patients' capacity to mentalize especially around their offence the Index Offence Representation Scales were developed (McGauley *et al*., 2013) which were shown to be predictive of both subsequent violent behaviour and treatment engagement.

One of the major treatment advances of the last two decades has been the advent of new theoretically driven psychological treatments for individuals with a diagnosis of personality disorder especially Borderline Personality Disorder. However, a sense of therapeutic pessimism has remained in the hearts and minds of clinicians in relation to treating those patients with a diagnosis of antisocial personality disorder (ASPD). Of these treatments Mentalization Based Treatment (MBT) has been of particular interest to forensic psychotherapists as there is a growing evidence base for its use in the treatment of some individuals with ASPD (Fonagy & Bateman, 2016c; McGauley *et al*., 2011). A large-scale, national multi-site RCT comparing MBT with other services offered by community based probation is now underway in the UK to evaluate MBT's effectiveness in reducing aggression, and offending behaviour and improving health and well-being in comparison to 'probation as usual'.

8 Impact on practice; through training

The legacy of the Ashworth and other enquiries led to a small number of national training posts being established for medical trainees in forensic psychotherapy however two problems remained. First, with funding pressures on NHS Trusts and commissioners it was clear that this small number of trainees would never increase to reach a critical mass of skilled clinicians who could have a wide impact within forensic services. Second, there was no established career pathway or mechanism of training for 'would-be' forensic psychotherapists who were not medically qualified. Pathways have now been developed which lead to both academic and professional registration through the British Psychoanalytic Council. Completion of the Forensic

Psychodynamic Psychotherapy course at The Portman Clinic, the iteration of the original Portman Course established by Estela Welldon, is accredited by the British Psychoanalytic Council (BPC) and equips its graduands to work as independent practitioners.

The two year MSc in "Psychotherapeutic Approaches in Mental Health" is a collaboration between the Forensic Psychotherapy Department at West London Mental Health NHS Trust, the Department of Psychotherapy in the Belfast Health and Social Care Trust in Northern Ireland and New Buckinghamshire University in the UK. Establishing this training in Belfast provides a model of how to develop a multi-professional forensic psychotherapy training in a periphery of the United Kingdom in which there is a relatively modest provision of psychoanalytically trained clinicians (Kirtchuk & Ingram, 2016). MSc graduates are eligible to apply for British Psychoanalytic Council (BPC) registration as Psychodynamic Practitioners in Mental Health (General or Forensic). A further clinical training of two years leads to BPC registration, as a Forensic Psychodynamic Therapist, with full membership of the Forensic Psychotherapy Society. All of these courses offer training for multidisciplinary professionals working across a range of forensic settings and community settings and a range of different organisations such as the NHS, the as well as for individuals working in the NHS, the Criminal Justice System and the third sector organisations such as charities and voluntary organisations.

9 Impact on practice; through communities of practice

As a relatively small group of professionals The International Association of Forensic Psychotherapy (IAFP) acts as an umbrella to link and bring together practitioners across the world. The IAFP has strong European and UK roots. It was formed in 1991 in Leuven, Belgium by Estela Welldon and colleagues who in the field of law and mental health wanted a forum to think about the difficulties they encountered in psychotherapeutically working with forensic mental patients. Today the IAFP encourages and supports the sharing of practice, research and new developments in forensic psychotherapy and through annual international conferences and national meetings enables professionals in the field to present their clinical work and extend their skills.

Take home messages

1. Crime is both an unconsciously meaningful and meaningless act for the criminal: its meaning can be deciphered by considering the act in the context of a life story; its meaningless aspect can be situated in the aggressive or sexual drive that motivates the crime.
2. An offender's use of rationalization, denial, minimization, and blaming does not reflect an antisocial personality; they are an offender's attempt to engage in a moral negotiation about what happened and provide valuable input to work with in forensic psychotherapy.

3. The institution where forensic psychotherapy takes place presents an important environment that has a crucial impact on the therapeutic and work climate for all those involved.

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