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Forensic psychotherapy: a new discipline in italian psychotherapy and psychiatric tradition

La psicoterapia forense: una nuova disciplina nella tradizione psicoterapica e psichiatrica italiana

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Abstract
Forensic Psychotherapy consists of the psychodynamic treatment of those who have perpetrated a crime or also have suffered from a crime. By extension, it also concerns other things that are related to this field: supervisions of forensic therapists, therapeutic groups with workers at various levels in the field (guards, social workers, nurses, etc) are within the spectrum and competence of Forensic Psychotherapy. Currently, it also considers the application of cognitive, behavioural or systems/family therapy interventions. The aim of this psychotherapy is not to condone the crime or excuse the criminal. On the contrary, treatment should achieve an assumption of responsibility of what has been done by the perpetrator, along with the clarification of the individual causes that gave origin to the crime, linked to the real – conscious and unconscious – emotions of the individual and their personal history. Benefits for society are mentioned, and they consist in a decrease in criminal behaviour, harmful behaviour, risky expositions, with a concomitant saving of public money. The essential aspects of the treatment (assessment, the setting, the therapeutic relationship, the evaluation protocols) are illustrated. Future perspectives are shown.

Key words: psychotherapy • crime • psychoanalysis • treatment • society

Riassunto
La Psicoterapia Forense è una psicoterapia psicodinamica rivolta a coloro che hanno perpetrato o subito un crimine. Nell'attualità clinica, nell'ambito della Psicoterapia Forense, vengono considerati anche altri indirizzi quali cognitivo, comportamentale, sistemico - familiare. Per estensione, riguarda tutto ciò che è correlato a questo settore: le supervisioni di terapeuti forensi, l'attività di counseling o di gruppi terapeutici con operatori impegnati a diverso livello nella area giuridica e dell'esecuzione penale (guardie carcerarie, operatori di comunità assistenti sociali, dipartimenti di salute mentale, ecc.), sono nello spettro e nella competenza della Psicoterapia Forense. Lo scopo della Psicoterapia Forense non è quello di condonare o giustificare il crimine commesso bensì la terapia mira ad ottenere un'assunzione di responsabilità da parte del paziente, via via che vengono alla luce le cause che hanno portato al reato e le emozioni ad esso correlate, consce ed inconsce, nonché la sua storia personale. In questa sede si affrontano i benefici sociali conseguenza di questa pratica clinica, quali la diminuzione della prevalenza e della reiterazione del comportamento criminale e dei comportamenti a rischio violenza ed il risparmio di denaro pubblico. Vengono illustrati gli aspetti essenziali del trattamento psicoterapico: l'assessment, il setting, la relazione terapeutica forense, il protocollo di valutazione, nonché le prospettive future.

Parole chiave: psicoterapia • crimine • psicoanalisi • trattamento • società

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1. Foreword

Forensic psychotherapy is a discipline that was born and has developed approximately in the last 30 years. The aim of forensic therapy is the treatment of people who have dealt with and deal in violence. It means that, above all, it regards offenders and victims, that is people, men, women, minors who have acted with violence towards other human beings, objects, or society, or it regards those who have suffered themselves from violence. In a wider perspective, an aspect of forensic psychotherapy is also studying and working psychotherapeutically with people involved at different levels in the various fields and institutions that are crime-related: prisons, mental health organizations, community care, etc.).

Understanding what is behind an act of violence it is a quite recent interest in the history of mankind. In the far past, criminal acts were discussed and resolved without too many psychological considerations. Victims received even less consideration. Among the ancient Romans, the founders of the Law in the western world, criminal law occupied a very small space compared to the very detailed and wide-ranging civil law. Generally, people who had committed a crime were put on trial quite quickly and punished with cruel retaliatory punishments such as beatings and the stocks or were put to death through sadistic tortures, such as beheadings, eviscerations, lynchings, etc. (Kahr, 2011). We would say that there was either a form of unconscious identification with the aggressor (Kahr, ibidem) or a cathartic and symmetric expression of the aggressiveness and violence of the punisher.

Only in the last two centuries an interest in crime and violence has arisen, being observed from perspectives different from that of the strict trial and criminal procedure. The evolution of philosophy in Existentialism and Phenomenology, the birth of new disciplines like Sociology, Anthropology and mostly Criminology, founded by the Italian psychiatrist Cesare Lombroso, together with the systematization of psychological studies, and the birth of psychoanalysis are the reasons for such a rich proliferation of new studies in this field.

Therefore, people who have committed a crime have begun to be studied and classified. Their existences have been collected and phenomenologically described. In some cases, a personal rational meaning was investigated and found. A social etiology begun to be hypothesized. Philosophical reasons were proposed (Foucalt, Arendt). And of course psychiatrists who have been working in criminal mental hospitals of various levels of security, since their foundation, have studied and classified and treated their patients.

The birth and the development of psychoanalysis opened the area of treatment to what has been called "the talking cure", laying the foundation for all the psychotherapies. And its principal contribution remains the discovery of the unconscious, which means that all the acts of men and women have not only a conscious origin and explanation, but also an unconscious one.

Indeed, it has to be said that the founder of psychoanalysis, Sigmund Freud, after having recognized the role of the death drive as equal to the sexual drive in being the basic driving forces that direct the human behaviour, was quite reluctant in investigating the role of the death drive (in its psychological expressions: hate, destructiveness, aggressiveness) in manifestations other than mental disorders. On the other hand, many brilliant psychoanalysts and their pupils began to investigate this field, opening it to the attempt of a more profound comprehension of the human violence, and, after all, of the entire human behaviour: among the first generation, Ferenczi, Mrs Klein herself (who was also interested mainly in the role of hate in the inner world and there is no doubt that her contribution to this field is determinant), Alexander, Staub; and later, in the UK Winnicott, Fairbairn, Glover, Limentani, Friedlander, Pailthorpe, Welldon; while in the United States Menninger and more recently, Kohut, Kernberg, Gabbard among others; in Italy, already at the beginning of the nineteenth century Edoardo Weiss, (see Migliorino, 2016). Understanding the individual, conscious and unconscious, reason behind a crime has become therefore an area of increasing and increasingly enthusiastic research.

The passage from understanding the reasons – integrating classic psychopathology with psychoanalytic knowledge – to the treatment has been consequential and forensic psychotherapy has thus been born from the coupling of forensic psychiatry and psychoanalytic and psychodynamic psychotherapy (Cox, 1993; Welldon, 2011).

Here, I would also underline the fact that in medical sciences, clinical research and clinical therapy are two faces of the same coin. This means that the more forensic psychotherapy is applied, the more it reveals its potentialities in understanding the origin of violence in individuals with the ambitious aim of finding ways to prevent its acting out.

2. Forensic Psychotherapy

Forensic Psychotherapy consists of the psychodynamic treatment of those who have perpetrated a crime or also have suffered from a crime. By extension, it also concerns all things that are related to this field. Therefore, supervisions of forensic therapists, therapeutic groups with workers at various levels in the field (guards, social workers, nurses, etc) are within the spectrum and competence of Forensic Psychotherapy. In current clinical practice Forensic Psychotherapy also considers the application of cognitive, behavioural or systems/family therapy interventions (Riordan, 2017).

It has to be immediately clear that the aim of this psychotherapy is not to condone the crime or excuse the cri-

minal (Cox 1993; Welldon, 2011). On the contrary, treatment should achieve an assumption of responsibility by the perpetrator of what she/he has done. This assumption of responsibility comes out of the psychotherapeutic process along with the clarification of the individual causes that gave origin to the crime, linked to the real – conscious and unconscious – emotions of the individual and their personal history.

A further peculiarity of this discipline is that while psychotherapy is generally a dual situation (therapist/patient, therapist/group) and any other presence has to be avoided, otherwise the relationship can be put at risk, Forensic Psychotherapy is always a triangular situation: therapist/ patient (or group) and reality. Where reality is represented from time to time by the Court, the Prison, the family, the probation rules, the social workers that have a duty to monitor, the surveillance system, and so on. The most evident consequence of this is that the inner world and the outer world are always forced into a symmetric position. This means that the inner world fantasies aim to have a role in the outer world, the real one, (as happened in the crime). And, vice versa, the real world in some cases, as it may happen in psychotic individuals, or individuals with psychotic personality features, may be considered as a phantasmatic world.

It has been widely accepted that one of the characteristics of psychoanalytic and psychodynamic therapies is self-reference. Especially in the past, the more orthodox therapists would not accept any other parallel treatment for their patients. It is not important if things have changed in technical psychoanalytical guidelines, but it must be clear that Forensic Psychotherapy is only one of the treatments and rehabilitation investments, or projects, that the patient, it does not matter if it is an offender or a victim, has undertaken. This is an important point and it is linked to what has just been expressed above on the triadic (therapy, patient and society) experience of Forensic Psychotherapy. The therapist has always to discriminate what belongs to the inner world and what belongs to the real world. And he has to do this first with himself, then with the patient and also with society, represented by other psy-workers, workers in the field of law (judges, policemen, lawyers), social workers and so on. The more the forensic psychotherapist is integrated and collaborative with the other people and agencies involved in the world of the patient, of course without abandoning his deontology, the more he is orientated in the therapy. Feeling him- or herself to be omnipotent, being the only one that knows the truth about the patient, can be fatal in this field (Cordess & Cox, 1993).

Being part of a complex treatment and rehabilitation system and not being alone also allows the therapist to avoid being overwhelmed by responsibility and thus allows them to be able to read through the primitive unconscious defence mechanisms that forensic patients prefer and are accustomed to use (Bateman, 1996), and therefore avoiding the inclination towards acting, avoiding also the trap of collusion.

It has also been stressed that forensic psychotherapeutic treatment can evoke reactions in the other operators, or in the staff of agencies and institutions involved. These reactions may come from the unconscious mobilization of the patient's projections or from the internal mechanisms of defense of the operators themselves and of the agencies. They are elicited in order to reduce increasing anxiety (Mc Gauley & Humphrey, 2003) or simply to avoid the change, which is, even if expected, always disturbing.

This has to be always considered with the highest attention by the therapist in order to immediately take action to prevent or treat destabilizations in the other operators and agencies that eventually may attack and jeopardize the forensic psychotherapy.

3. The Aim of Treatment

The aim of Forensic Psychotherapy in its specificity is to develop a better awareness of the patient's mind and of the other's mind, to experience a better awareness of who they are, what they have done, and how the crime inflicted (offenders) or suffered (victims) has impacted on their mind and life and what damage it has created, to be able to experience powerful emotions and to be able to contain them. Things that eventually can involve a better sense of identity and a way to avoid psychotic and paranoid solutions (Mc Gauley & Humphrey, 2003).

A more ambitious aim could be to try to relate what life was before and after the crime. And try to compare the patient's inner world to the outer world in relationship with the crime, particularly with regard to the passage of time and relating the emotions to the time they actually belong (Spadaro, 2016).

Benefits for society must be mentioned, and they consist in a decrease in criminal behaviour, harmful behaviour, risky expositions, with a concomitant saving of public money.

In the treatment, we recognize many aspects. I describe the ones that in my opinion must be analyzed: the assessment, the settings, the therapeutic relationship, the evaluation protocols.

A) *The Assessment*

The assessment of a patient is a necessary procedure. It can be required by the Court, lawyers or other agencies, or it can be included in the multi-team working program. However, it is a fundamental step that precedes the eventual treatment (Carabellese, 2017). Indeed, we must have a perception of his/her psychopathology that is as clear as we can manage to have, to know his/her capacity to work and evolve, and to be able to sincerely participate to the therapeutic project. Very helpful are the Welldon's (2011) suggestions regarding the behaviour that the therapist has to maintain: clarity for the patient regarding the purpose of the meetings that must be three (in her model); to keep with the exact time frame of the meetings; "keep a straightforward approach, no too cold not too friendly", providing clear information so as to then have a correct evaluation, listening to the patient but being able to ask direct questions.

There is a general agreement on the efficacy of a clinical interview (Mc Gauley & Humphrey, 2003; Yakeley, 2010, Welldon, 2011). In this case, the capacity of a patient to undertake an introspective work will be investigated and the assessment does not differ from the clinical interviews performed in other settings different from the forensic ones. It is important

though that in forensic settings some precautions must be taken. For example, giving more space to the life history of the patient. A detailed report of the offending behaviour, with an attempt of classification of the type of violence acted out by the patient, relating all of it to the associated conscious and unconscious fantasies, has been suggested (Yakeley, 2010).

We must always remember that in most cases the forensic psychotherapist is working along with other figures and he/she is involved in a multi-team program. Thus, the interview report has to be legible also for people who are not psychologically and psychodynamically orientated.

The assessment should give us the idea of what *type of forensic patient* we have in front of us and whether he/she can begin forensic psychotherapy, individual or group therapy, or not.

The *type of forensic patient* is a very generic expression. However, it proves appropriate because this generality gives us the possibility of classically categorizing our patients following the current or preferred psychopathology of forensic psychiatry, or classifying the patient in accordance with psychodynamic theories (and the one to which we are closest), and also eventually adding a more practical classification such as the one proposed by Welldon (2011), evaluating the offence perpetrated: the offence as an equivalent of a neurotic symptom in which there is no financial gain, the "careerist" offence in which there is a financial gain and there are the patient's efforts not to be detected, the offence as a manic defence against a deep and underlying depression, a crime perpetrated to cover a sexual perversion, or, vice versa, sexual behaviour that stands for hidden violence.

In the assessment, it is also important to validate our clinical interview with all the elements coming from reality: such as the work of forensic psychiatrists, the court and the police reports, the reports of the family's interviews, prison reports, hospital clinical diaries.

The function of the assessment is to decide: whether work can be performed with the forensic patient (and what type of work); to contribute to the multidisciplinary management of the case (Mc Gauley & Humphrey, 2003); to investigate and identify the defence mechanisms of the patient's ego and have a vision, if possible of his/her main inner-world fantasies and how they are related to the violence perpetrated or suffered.

B) *The Settings*

The settings in which the forensic psychotherapy is performed varies widely, depending on many factors. First of all if it is important establish whether he/she is an in-patient or an out-patient. In the first case, he/she can be hosted in a high-, a medium-, or a low-security hospital. They can be patients of non-secure in-patient units. Or they can be out-patients of non-secure units, residential therapeutic communities or patients managed by forensic units and teams.

The Italian situation is very peculiar since there are no longer any long-term psychiatric hospitals and all the secure hospitals have been recently closed (Carabellese & Felthous, 2016). Forensic patients are either out-patients followed by day hospitals and national mental health units (Sacco, Losito, Carabellese, Buzzerio, 1991).

Or in-patients of residential therapeutic communities or for the more severe cases of offenders they are in-patients of special therapeutic communities called REMS (Residenze per la Esecuzione di Misure di Sicurezza). These last ones are under the control of the Department of Health and not the Department of Justice. It has to be underlined also that there is a very long tradition in the Italian Prisons of the presence of psychiatrists and psychologists working at different levels, also psychotherapeutically, with prisoners. This is due to a rehabilitation-orientated value of the sentencing in line with Italian Law (Catanesi, Carabellese & Rinaldi, 1998). Obviously the setting can be very different in these different types of units in which restraint is the most important element of reality and it is very different when the patients are out-patients.

In the first in-patient cases, violence is evidently considered an evident feature. The attention here not only regards the significance of violence for the patient, and what it stands for, but also what is left in the personality of the patient that can be useful for him/her in entering a less primitive level of mental functioning. It is always important to stress that the therapist, in order to be able to work, must have a feeling of being secure in his or her setting (Kernberg, 1992). For those in-inpatients who suffer from severe disorders and who belong to high- and medium-security units, speaking of a classical psychodynamic psychotherapeutic setting has no sense (Minne, 2008). Instead, what is important is creating a relationship that may provide the conditions necessary to get along, to work basically together, and eventually to feel together, and finally (who knows when it may happen) to think together.

Very different is the situation with out-patients, in which violence is not evident but has been acted out in the past and can be replicated. Generally speaking, the patients present less severe disorders or less severe symptoms. The forensic psychotherapy here has better potentialities and a better prognosis. However, the therapist may feel herself/himself to be in an uncomfortable situation if she/he is alone in dealing with the patient. He/she may feel that his/her main role is the control of violence, feeling responsible for this, more than understanding the inner and outer world of the patient. Another factor to be aware of is that with out-patients, the therapists often risk underevaluating the disorder of their patients. With patients that are subject to probation, trust and confidentiality, both in the therapist and in the patient, may not be totally sincere, challenging the effectiveness of the psychotherapy. Again, it is necessary that forensic psychotherapy must be considered separately from the evaluation of the patient in terms of his or her route in coming back to (or beginning, or finding) a fruitful role in his or her life and in society. This allows the pair, or the group in cases of group therapy, to be more open in feelings and emotions. It allows the therapists to attune with the unconscious and conscious psychic manifestations of the patient, pushing themselves to negotiate with him/her on how to approach their inner world. During this negotiation in this context it is important to avoid the therapists and/or their patients both being overwhelmed with paranoid, depressive, unbearable and destructive emotions (Minne, 2003).

C) *The Relationship*

Establishing a positive treatment alliance is a necessary condition, even if not sufficient in itself, in performing a good psychotherapy also in the forensic setting. It is evident that this not an easy task. Indeed, a positive treatment alliance means that the therapist and the patient work together to let the patient improve in his/her relationships, in his/her external world, in his/her relationship with the internal objects. A forensic patient has experienced violence and destructiveness in his/her history of relationships. If the transference is authentic (meaning that it is not perverted or collusive) the therapist will be object of quite the same types of feelings and emotions, in the range of violence, rage, destructiveness, despair. The therapist's countertranference can be similarly full of dread, rage, violence, despair, anguish, paranoid sensations.

Faced with these overwhelming emotions, unconscious defences such as idealization or denial can be elicited by both the parts. The devotion to containment by the therapist can lead to a depletion of his/her energies. An eventual abandoning of the therapy by the exhausted therapist may lead to catastrophic reactions by the patient, and may jeopardise the trust of the multi-disciplinary team regarding the effectiveness of the therapy.

Some authors differ among themselves in suggestions to avoid the above described disturbing and potentially psychic lethal elements. Perelberg (1999) considers the importance in the capacity of the analyst to perform maternal and paternal functions. In her theory, being the violence of the patient a defence towards a maternal fusion with a terrifying object, she considers the importance of the interpretations, as an activation of a healthy paternal function, which introduces separation and differentiation. Cartright (2002) considers as essential the therapist's empathic mirroring of the patient to establish and reinforce the therapeutic alliance, warning of precocious interpretations and interventions that can challenge the idealized self of the patient, thus leading to negative consequences in the treatment. Some authors (Bateman, 1999; Davies, 1999; Cartright, 2002) recommend the use of analyst-centred interpretations with violent patients, a technique through which the analyst attempts to clarify with the patient what he or she feels is going on in the mind of the analyst.

It is essential to be aware of the feelings or the emotions in the relationship, and in the transference-countertransference relationship. I personally consider useful and less dangerous to explicit to the patient those particular feelings or emotions, related to the unconscious fantasy in the *here and now* situation, and simultaneously timing it to the personal history of the patient's existence.

Yakeley (2010) highlights a very interesting point: while the forensic therapist is accustomed to experience negative feelings and thoughts, positive feelings and thoughts are often neglected or ignored. She considers the positive emotions (warmth, hope, enthusiasm) not only as a reflection of a good therapeutic alliance and progress, but in her view they can also be the fruit of a dangerous idealization. This observation is important and brilliant. However, I think that positive feelings and thoughts are not always necessarily something to beware of. Without hope and warmth there is no improving route. Also, the relationship with a forensic patient has some important landmarks that we have to bear in mind and that condition specifically this type of therapy.

The first one is the psychopathology of the patient (it is not really important whether the patient is an offender or a victim). Much more than in neurotic patients, or patients whose violence has been contained in fantasy or transformed into neurotic symptoms, or even sublimized, the crime, and the type of violent feature manifested or suffered by the forensic patient, is the tone that conditions for many years the therapy. Thus, paranoid patients will use paranoid mental function mechanisms. Sadistic patients will try to transform the therapy in a sadomasochistic relationship. The perverted patients will try always to pervert the therapeutic relationship and the meaning of the therapy. The masochistic patient will always demonstrate a masochistic solution. Psychotic patients will try to make the therapist mad. A patient in depressive despair will flood the setting with his or her anguish. And so on. This is a trend, a monotone trend, that the forensic patient can maintain for a long, long time, before the psychotherapist will be able to enlighten other tones in his/her soul. Another landmark in the forensic therapy is the crime itself, which, in the offender and in the victim, has functioned as T0. We can divide, with a benchmark similar to that of the birth of Christ, the life of our forensic patient as Before the Crime (bc) and After the Crime (ac). It is important to compare in the therapy, and with the patient, the two external lives – bc and ac – and his or her phantasmatic atemporal life in his or her internal world. The timing of the events and the emotions is a fundamental tool that it is necessary for the containment of violence (Spadaro, 2016) and of its trend to expand infinitely (Matte Blanco,1975).

6. Evaluation protocols

Here, there is not too much to report and and very much to do. Many reasons for this. First of all Forensic Psychotherapy is a fairly new discipline, and above all, it has been developed and performed in clinical settings and by clinicians more than academics. There is also a traditional reluctance of the psychotherapists in accepting any type of evaluation protocol. It is something that is considered to be against one of the foundations of the value and efficacy of psychotherapy: it being a unique and intimate experience. Nevertheless, Forensic Psychotherapy needs to develop evaluation protocols. It needs this because dealing with the forensic field and reality, in terms of society, Forensic Psychotherapy has to give proof of the efficacy of its methods. Let us also clearly say that public opinion, while it is apparently caring of victims, does not accept, or accepts with quite strong resistance, the treatment of the offenders.

Another obvious reason is that the evidenced based effectiveness of psychotherapeutic treatments for such difficult disorders has to be plainly indicated in such a difficult field, which engages so many professionals and social and economic resources, in order to avoid pseudo-scientific beliefs and therapeutic practices validated by habit. One example above all is the difficult psychotherapeutic treatment of personality disorders, which is one of the most controversial despite the fact that, in the end, its effectiveness has never been really evaluated (Bateman & Fonagy, 2000).

4. Conclusions

In the last 30 years a great deal has been written about the treatment of people who have experienced violence as offenders and/or as victims. Forensic Psychotherapy was born and has grown as a discipline. Many scientific associations that gathered clinicians working in this very special field have been created around the world: among these, the Italian Society of Forensic Psychotherapy (SIPFo; www.sipfo.it), as well as an International Society (the International Society for Forensic Psychotherapy). However, there is still a lot to do. The clinical field of Forensic Psychotherapy has enlarged its area of intervention: not only strongly suggesting the importance of clinical supervisions of forensic psychotherapists, but also promoting clinical work with social workers, police people and other workers in this field, implementing supervisions and counselling work for agencies and institutions. All this work has to be structured, evaluated and promoted. Moreover, the shortage of evaluation protocols has to be filled to make this discipline more widely recognized and essential as it clinically appears to be. Also, interdisciplinary relations with other areas, Criminology, Forensic Psychiatry, Law, have to be improved. Finally, a reorganization of all these 30 years of specific knowledge has to be performed.

However, it must be proudly stated that already Forensic Psychotherapists are giving humankind the possibility to bring light into the *Heart of Darkness* of men and women.

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