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ABSTRACT - In psychotherapy, the term 'forensic psychotherapy' is generally applied to the treatment of crime suspects and/or detainees. What makes it 'forensic', of course, is the focus on the criminal aspects involved and, in somewhat broader terms, on the application of civil and/or administrative law in each case. Examples of this are : court order psychiatric examination/treatment, Disablement Insurance issues, and employer/employee procedures brought for arbitration before the administrative courts. In this paper, the term 'forensic psychoanalytical psychotherapy' will focus specifically on the clinical or ambulatory psychiatric treatment of court order patients and other detainees. A largely pragmatical psychotherapy method will be discussed in terms of the borderline personality disorder, based on basic psychoanalytical techniques such as free association, transference/counter-transference, and the acknowledgement of the problem as the principal aid-instrument for entering into discussions on defence-mechanisms.

Introduction

In another paper is described how a psychosis department was set up for court order patients at the Dr. S. van Mesdag Clinic, and the subsequent changes this brought about in the treatment of psychotic behaviour in such an institution (Oei & Van de Mark 1990). These changes concerned sociotherapy for psychotic delinquents (Oei 1992a), of which case management was an essential part, and whereby psychopharmacotherapy proved to have a positive influence on patient behaviour.

Individual clinical psychotherapy treatment of court order patients with a person-

ality problem, had been a tried and trusted method for many years within the Dr. S. van Mesdag Clinic (van Marle 1988). The specific atmosphere, ie communication channels between all levels of personnel were kept as open as possible and were essential to the ultimate success of the total treatment (security, approach and psychiatric involvement).

The confines of this paper do not allow a detailed analysis of the psychoanalytical method used in the clinic, although there is fairly broad coverage of the treatment as applied to an individual patient and a group of psychiatric delinquent detainees.

I have become increasingly aware in my contacts with such detainee borderline personality disorder patients, that psychotherapy needs to be adapted to the particular circumstances. It became apparent, for instance, that firm agreements should be reached with such patients on specific aspects of their life-styles, in response to their need for feedback on their daily activities and about the most effective and logical way of fulfilling them. We regularly evaluated how best to link their needs to my potential as a psychotherapist, and vice versa. They were pleased that there was daily discussion and evaluation of our joint agreements, and we also talked about such things as the activities they would participate it, who they would be speaking to, and the extent to which their feelings of uncertainty in terms of the court order extension, or the interpretation of their dreams and/or aggressive fantasies, were reflected in the daily events within the department. The interactions between the patient and treating-specialist were often extremely animated, sometimes in a relaxed and, occasionally, very tense atmosphere, dependent on what was happening in the clinic generally.

My viewpoint, therefore, has developed from my practical experience gathered in the Mesdag clinic in the period between 1990 and the early part of 1993, both in terms of the clinical psychoanalytical treatment of detainees with a borderline personality disorder and the ambulatory forensic psychoanalytical practice with individual patients and a group of psychiatric delinquent parolees. This included fruitful consultations with sociotherapists supervising court order patients during their periods of parole, or for other reasons.

Boeykens' premise is that everyone, including detainees, should have access to psychotherapy (Boeykens 1993). One might conclude from this that, in principle, every detainee or exdetainee with psychic problems actually receives ambulatory psychotherapy. This, however, is not the case. The reason for this, I feel, lies primarily in the fact that many psychotherapists are unfamiliar with, and inexperienced in, the field of the mentally disturbed detainee, which also explains why this category of patient usually ends up in a kind of 'no man's land'. Viewed from this angle, therefore, there is an undoubted need for psychotherapy expertise in the interests of crime suspects and detainees.

Hopefully this paper will contribute to the on-going discussion within the field of forensic psychiatry. The discussion rotates around the question of whether psychotherapy is appropriate for delinquent patients, and if so in which form? A largely pragmatical psychotherapy method will be discussed in terms of the borderline personality disorder, based on basic psychoanalytical techniques such as free association, transference/counter-transference, and the 'acknowledgement of the problem' as the principal aid-instrument for entering into discussions on defence-mechanisms. The

method is also functional in that it repeatedly refers back to the patient's own situation and needs at any given moment. In this sense, the method is not purely psychoanalytical; it also comprises identification-points in common with general counselling principles, in which the degree of empathy, and the genuine ness of the relationship play particularly significant roles. As we will see later, further research into the psychotherapeutic requirements of forensic psychiatric patients is necessary, both for the patients themselves and the various institutions responsible for policy-making and finance in this field.

Defining the concept

In broad terms, the problems of people suffering from 'borderline personality organisation disorder' (Kernberg 1984), further referred to as 'borderline', are twofold in nature. From the psychological point of view, these patients have difficulty both in placing themselves in relation to others, and in putting things into perspective.

The borderline is usually well able to analyse what is happening inside himself, and this is why we have used the personality organisation (disorder) as an instrument for gaining greater insight into the workings of the functional-oriented model as applied in forensic psychotherpy.

Approaching the borderline Patient : aim and structure

In my work with court order patients with borderline problems I have been struck by the lack of structure and the often chaotic way they perform their daily tasks. I have, therefore, come to regard borderline as a badly organised organism, rather like an organisation teetering on the brink of bank ruptcy. In every organisation, employees do their work according to a defined pattern, and it is the task of the managers to ensure that the work-agreements (or company aims) are followed (or achieved), and amended when and where necessary - but not so the borderline.

What is at stake in any organized community, is that common goals have to be pursued by and on behalf of all its members. In the course of time, these goals will be adapted in response to changing needs, changing times and changing policies. Changing the aims means that the most practical structures can also be changed.

If we take Kernberg's theory of the 'borderline' structure (Kernberg 1984) as our starting point, then we know in advance what our aim must be : ie developing sufficiently well the capacity to control impulses, to accept frustrations, and to tolerate anxiety (rooted in a sense of helplessness) to enable the patient, if necessary, to sublimate his own needs. This means reinforcing the ego so that stable, satisfying and intimate relationships can be established.

The scope of Kernberg's aim provokes the question of whether the borderline personality (structure) needs some kind of practical support, the kind which will enable him to understand himself better. If such an aim proves to be unfeasible in practical terms, then its value is only theoretical. For the time being, however, we will assume that the goal can be achieved, on condition that our borderline is actually given the specific practical support we are talking about. What matters is understanding the role played by the borderline's individual 'self' in his inner experience and in

his social contacts. We will, therefore, now look at how he relates both to himself and to others.

Personality profile as an organisation

We can each regard ourselves as an organism, with its own needs and potentials, and the requirements of the various psychic 'agencies' (ego, id and super ego), should be linked to the individual's own potentials in relation to his surroundings. Problems inevitably rear their ugly heads in this type of model, as indeed is usually the case in any working-relationship.

Problems tend to result in the person turning in on himself - he broods; this brooding, however, is not unproductive in itself and should not be discouraged. It may lead to a deeper understanding of certain basic principles in his daily existence, although it may also create an impasse, a fruitless preoccupation with an internal maelstrom of recurring, and often negative, thoughts. What we have then is a downward spiral, requiring help from outside (recurring compulsion of the id!).

The external needs and potentials call for coordination; the therapeutic relationship between psychotherapist/psychoanalyst (pp) is an example of this and it raises two main questions:

1. From the patient's point of view: am I satisfied that together we (the therapist and I), are working well towards the set goals, in this particular situation and in this particular way? (Individual-situational approach).

2. From the therapist's point of view: are we (the patient and I) together achieving the goals, here and now, in this particular way and in this particular situation? (Content-structural approach).

In the quest to change both the patient's potentials and needs, what matters primarily is the integration of these two approaches, and it entails putting events and situations in his life into perspective. In particular, it means identifying areas of further development, both in terms of the individual and his problems. It challenges him and requires him to create a link between these apparently opposing approaches, starting from within himself.

The Personality organisation profile

The organizing capacities within an 'organism' touch on a number of basic principles (van Veen & Oei 1993), and they concern:

– goal-orientation (as a producer, what kind of product do I want to make?);

– solution-orientation (as a specialist, am I responsible for my own contribution?);

– situation-orientation (can I put my own views next to those of the other person (colleagues) and work jointly towards finding our way out of this situation?);

– problem-orientation (do I feel responsibility towards my organisation?);

– development-orientation (do I feel responsibility towards myself?).

The working-method described above, focuses on the structure of the patient's own sense of responsibility within the therapeutic relationship, and if we take this situation as our guideline, the following questions inevitably arise

– goal-orientation: "am I now able to work towards my goal?";

– solution-orientation: "am I clear about what has to be solved?";

– situation-orientation: "is the basis strong enough (in myself and in the other(s)?)";

– problem-orientation: "have I got stuck somewhere in this situation?";

– development-orientation: "when, and why, am I likely to get into difficulties here?".

Brooding and its consequences

Brooding can sometimes create such problems for the patient, that he will feel himself driven to asking himself a number of questions, such as: what am I actually doing?, or am I really working in the proper way towards my goals? Weighing up his own situation in this way, can also be very fruitful. What are the feelings of dependence I foster in the way I function and towards whom? Do I lay the emotional and programmatical essence (what I want) largely (or often) at my own feet, or precisely at the feet of the other(s)?

Brooding on difficult matters like this can sometimes result in his revising his own personal opinions and convictions, desires and yearnings, needs and ideals, and indeed this re-look may be a response to the question: when do I not assert myself? or when do I lay my problems at my own feet? and when do I lay them somewhere else, possibly at the feet of another?

Personal development analysis can be the next logical step for the borderline, when problem-analysis has failed to give him a greater awareness of, and insight into, his own (non)potential, and when the brooding has obviously been a non- productive exercise. This stage presents its own question marks: where do I stand?, what have I achieved so far in the treatment? (evaluation). The treatment might thus comprise both a concrete goal- orientation (I want to improve my collegial functioning), and a personal aim (I want to be able to react more flexibly to unexpected situations).

The therapeutic process

The initial phase of the therapeutic process consists, on the one hand, of constantly probing and of reacting, if necessary, to each other's wishes, hopes and needs, and on the other hand, of defining and inventorizing the specific problem areas (what is going on?, which points must, or can, be dealt with?). These considerations determine the way the patient and the pp express themselves, and it means that a common communication method has to be established acceptable to them both, as well as creating equal rapport. Once this atmosphere of security and trust is achieved, the 'working alliance' (the bond which forges effective and improved mutual cooperation) can be implemented. Note, however, that this common bond (confidence and trust) and common aim (what do we want to achieve?) can only be achieved within the treatment programme if both parties (pp and patient) have the courage to 'look each other straight in the eye'. Transference and counter-transference problems may also arise.

Problem-solving

The patient can present problems stemming from all the function-levels (goal-, structure, situation-, problem- or development-orientation), including such areas as familiarity, rules, norms, values, insights, perceptions, objections, counter-arguments, convictions and ideals. And they are usually linked to his own past.

Important here is that the problems should preferably be discussed at the function-level slightly above the presenting one. If, for instance, it is a question of which treatment is required (structure- orientation), it will be necessary for pp and patient to reach a joint agreement in order to test their common ground (what goals are we striving for?);

In the case of the patient's personal problems (problem-orientation, ie: I am so afraid I will oversleep tomorrow morning and not be able to see you), the matter can be approached in terms of the pp's role in the transference situation (situation- orientation), and in terms of how their joint interaction is proceeding.

Only in cases of development-oriented problems (eg I feel so empty, which suggests that the feeling is so real to the patient that it must stem from a deep-seated psychic development problem), is specification and interpretation on the part of the pp the most likely path towards a solution (ie problem-orientation) (Oei 1992b).

A casuistic example

A male patient tells his pp: a few days ago, I heard the telephone ring five times in succession, but I didn't ask my girl friend, Anne, who it was. She was busy in the kitchen and I was working upstairs in my study. I thought for a moment that it might have been my colleague Peter, or Eric my tennis instructor. But later I also thought that it might have been you, but I dared not pursue the matter any further, because I wanted to hold on to the illusion that it really was you. I kidded myself that it was you, and with that fantasy secure in my mind I felt at ease, as if you were standing next to me: "that's fine, carry on with your work", I said to myself. I continued to work on my books but realised after an hour or so, that it was not you who had rung, because you have never telephoned me in all the time that I have been receiving therapy. I was looking forward to our next appointment but I was also afraid that I would not see you because perhaps you would have no time for me. And at that moment I became extremely angry and began to swear very loudly. My girl friend rushed upstairs and asked me, caring as always, what was the matter. I suddenly realised at that moment that I had 'left' the room for a moment, and I told her quite calmly, almost coolly, that I was angry because I had not been able to concentrate on my studies. Anne must have felt intuitively that I was making a very feeble excuse, but I didn't care - she wouldn't understand anyway what happening inside me -and I was ashamed at what had happened.

The above example illustrates in a nutshell the mood-swings, the anxiety and the uncertainty, with which a borderline has to contend. Feelings of attraction and abandonment, coupled with illusions and/or disillusions, determine the frequent swings in his behaviour pattern. The instability of his self (organisation) means that he often oversteps the confines of his own and other's reality and fantasy.

We might use the following approaches in analyzing what our borderline patient is actually saying; on the basis of the goal-oriented approach, the psychotherapist might ask himself whether the patient has made himself sufficiently accessible, or whether the patient's story is sufficiently clear to 'grasp'. The story, as such, may seem plausible enough, but can it be reconciled with the patient's non-verbal attitude? Does he tell his story with bursts of laughter, or is he clearly disappointed? His story is perhaps rather more an expression of his feelings, or is he trying somehow to convince the therapist about something? If the therapist is not really sure about the situation, it would then be possible to work from the structure-orientation approach, thereby enabling the pp to ask questions using the psychoanalytical structure and deliberate on both the patient's position and his own. Is the patient telling his story so that he can project himself more clearly, or is he using it simply as a defence mechanism?

If the positions of the patient and the pp, in the here and now, have been sufficiently well established, the time has come to move on to the situation-orientation in which the pp assesses the extent to which the patient's story can have a bearing on their relationship.

Working in a situation-oriented way, is actually a daily occurrence in that it usually takes place in a psychoanalytical situation, ie the 'experiencing space' is shared by the patient and pp - an analytical space in which an affective basic unity develops. The psychoanalytical situation is created by consciousness, and contains everything that is conscious (both for the patient and the pp). The patient's personal problems usually constitute the greater number of theme-discussions in the situation-orientation approach. In certain cases - and certainly in psychoanalysis - it will be the patient's development-orientation problems which will be stressed during the (problem and situation-oriented) interactions between patient and pp.

Discussion

We have discussed the approach to the 'borderline personality organisation' in order to illustrate the functional view in forensic psychotherapy. Emphasis has been laid on the most typical features of the borderline, features so important for the intereactions which take place during psychoanalytical psychotherapy. The purpose of this article has been to describe the functional method within psychoanalytical psychotherapy, and it was the confrontation with the borderline's 'organisational self-mismanagement', his personal problems, that led me to apply this method of treatment in forensic psychotherapy. I have also applied the same method to other personality disorders (in cases of obsessive compulsive behaviour, hysteria, and psychopathic and psychotic patients). Experience has shown that my decision was a fortunate one. Further study is required, however, if we are to discover whether this pragmatic method really is worthwhile in treating delinquents with disturbed conscience functions. The bases of the approach method described are:

1. The pp works as a specialist, with the help of both the analytical structure and the analytical situation, towards a common goal (shared with the patient), ie towards a situation in which the patient will be able, as much as possible, to accept and test his own freedoms and limitations. The pp is well aware of the patient's problems,

and through his learning-analysis has gained insight into the patient's (un)conscious desires and longings.

2. The patient's personal problems can be handled within the pp/patient context, and this situation has conscious and unconscious affective elements which need to run parallel until they meet somewhere between what the patient needs and what the pp can offer.

3. Clarify (explain clearly), confront (pp explains to the patient whether or not he has been fully understood; is the patient really saying what he means?), (guide) pinpoint (deliberate probing when the message is unclear), interpret (add to what the patient says by linking it, in development psychological terms , with earlier behaviour patterns or situations), stipulate (put patient's statements into perspective), and evaluate (regularly assess patient/therapist contact) - these are all current psychotherapeutic techniques. They can, however, only be really effective, if applied and related to the primary aim of the pp's intervention.

4. They are also only truly productive if the pp's intervention is realistically linked to the patient's own experience- modality. The pp's empathic powers will enable him to 'feel' this level of 'experience'.

5. Aids to sharpen the pp's capacity to empathise, are the five personality organisation function-levels, already discussed.

6. The borderline, in his turn, expects to gain greater insight, from this approach, whereby he will be better able to 'feel', and react to, what is happening within himself.

7. The court order patient, in particular, needs greater self-sufficiency in terms, for instance, of successfully completing his parole period, as a necessary supplement to his social behaviour repertoire. I have seen such patients who, armed with the insights achieved from the application of the function model, have been able to keep good control on themselves, and thus able to make better use of the parole opportunities, in addition to judging for themselves which questions they had, or had not, answered correctly. In other words, I saw how they were able, faster and better, to solve the problems they met during their stay outside the clinic.

8. Improving the ambulatory forensic patient's problem-solving capacities - such as the ability to say 'no' more often (both to himself and/or others) - can lead just as much to his developing more socially acceptable behaviour alternatives. I noticed that with the function-model as their guide, detainees on parole and confronted daily with the, for them, threatening world 'outside', were able to orientate themselves better in the ever-changing circumstances. In other words, strategies giving them greater control over themselves (coping mechanisms) became easy reference points, thanks to the methodology described above. The patients were also able to differentiate more effectively (more choices) and even became more efficient (finding the best solution to the most difficult problem) - on the basis, perhaps of 'it can't do any harm and it might even do some good'. What is activated here is the specific learning-process, geared to the patient's own specific problems, resulting ultimately in improved coping capacity - and that surely, in more senses than one, is well worth the effort.

The question of whether or not, as Kernberg suggests, the aim of the treatment is too extensive for the (limited) potential of the borderline patient, cannot as yet be answered. We will need, first of all, to examine whether with the help of technical skills, the borderline detainee can be

helped to conduct himself more effectively. More (experimental diagnostic and clinical forensic psychiatric) research is called for (Oei et al 1990).

It would also be interesting to elaborate on the function model described here, in order to address the question of whether or not the increased level of selfficiency in the court order borderline patient's (and other detainees), is linked to the seriousness of the disorder, the chances of recidivism, and so on.

The aim ultimately must be to determine to what extent detention orders, from the point of the available psychotherapeutic facilities, represent added advantages for this category of patient. My own experience with these patients has convinced me that there is an urgent need for further research in this field, so that we can examine the question of whether or not there are increased risks of serious recidivism in cases of long-term detention compared with detainees allowed out on parole.

It has already been stated that detainee-patients should also be entitled to psychotherapeutic treatment. Regardless of whether the detainee-patient is, or is not, always sufficiently motivated towards psychotherapy, it is the task of governments to ensure the provision of adequate forensic psychotherapeutic services. Current facilities, as I have experienced them, also suggest that the linking of this care to the actual (limited) capacity of forensic psychotherapy, leaves much to be desired.

It is to be expected, therefore, that when the various parties concerned (universities, governments, private institutions, professionals) devote more effort to the training of forensic psychotherapists and to the technical possibilities of forensic psychotherapy research, there will in consequence be more interest in forensic psychotherapy as a science in its own right, and as a profession. We hear often that 'what we do not know, we do not want', and it would be wrong to assume that the same is not true of forensic psychotherapy. The right of suspects/detainees to psychotherapy goes hand in hand with the forensic psychotherapist's own right to official recognition. I cannot help feeling that the clear reactions to the International Association for Forensic Psychotherapy Congress held in The Hague (The Netherlands) in April 1994, and organised under the auspices of the Dutch Ministry of Justice in cooperation with representatives of private detention centres, are evidence of the fact that large numbers of workers in the field are extremely sensitive to the urgency of providing an adequate response to the needs of the mentally disturbed detainee in our care.

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