CJM
CRIMINAL JUSTICE MATTERS

A DARK LAMP

Special hospitals as agents of change: psychotherapy at Broadmoor

Murray Cox

The Editor's request for a 'short lively piece', on a topic so innately concerned with offender patients legally detained 'without limit of time', poses a considerable challenge. Yet it is encouraging to be told that 'too many references are actively discouraged', as this is written at that reflective distance provided by a reference-free holiday.

The timing of this invitation is also doubly significant. Firstly, within a month of the publication of this issue, I shall have broken the quarter century endurance barrier of employment as a psychotherapist at Broadmoor. Such professional longevity should validate the ensuing comments on the long perspectives of change necessary when indeterminacy is under scrutiny. Second, thanks to the good offices of synchronicity, this autumn also sees the publication of a two-volume work on Forensic Psychotherapy, of which I am a co-editor. This means that, at the time of writing, my editor's mind is loaded with detailed references which are crucial to an understanding of the field. And over-loaded with many which are not!

The duration of first-hand experience needs to be linked to the recent contact with 60 colleagues whose cumulative forensic experience touches our theme at many points. Such synergism frees me to make personal comments in an editorial mode on Special Hospitals as Agents of Change. Those seeking a systematic survey are referred to relevant pages in Cordess and Cox.

The constraints of space compel condensation, so that a staccato sequence of inadequately elaborated subjects will ensue. They are numbered in order to facilitate subsequent reference, but they are not presented in order of significance. Clinical vignettes will serve as illustration. Some of the topics justify an entire volume for adequate wrestling with their implicit complexity.

I Selective perception is at work if the title of this piece is construed as referring solely to change in the attitudes and behaviour of patients. Another crucial variable in the therapeutic equation is the capacity for change in staff - at all levels and of all disciplines - and in managers. Thirdly, the institution itself, which is more than the sum of patients, staff and managers, needs to be capable of change. Nevertheless our title specially addresses 'Special Hospitals as Agents of Change'. Psychodynamic psychology constantly draws attention to inner world and outer world phenomena, with reference to the individual and the group-as-a-whole but it also points to the inner and outer life of the hospital (institution)-as-a-whole . Is a fulcrum outside the hospital necessary to effect change within it? Is unfacilitated autogenous change possible?

But those outside the wall can never know of the cut and thrust (a deliberately chosen metaphorical phrase with concrete forensic clinical connotations) of life inside. This is why the theme of murality is so ubiquitously relevant when discussing change in patients, staff, managers and their communal life. Murality refers to the 'wallness' - the inherent nature of every kind of boundary; the intrapsychic defences (or lack of them) and the quality of the interdisciplinary boundaries between all within the custodial secure perimeter at last being the *ne plus ultra*, in every sense, of the concrete reification of all that murality stands for. The semi-permeable exchange of degrees of intimacy and mutuality, safely explored within a special hospital, is a personal exploration profoundly influencing the self-esteem regulation of patients, staff and managers.

II A recent call for 'creative clinicians' stretches the scope of possibility and endorses the theological claims that life can be 'saturated' with possibility.

III Much is written on the therapeutic process and psychological change. But there is a constant danger of therapeutic self-aggrandisement if it is presumed that changes for the better, such as improved social functioning, enhanced self-esteem and cognitive-affective integration, must solely be due to a particular '50 minute hour' of an analytic session or 1½ hours in a therapeutic group. Evidence of a patient's endopsychic change may also be due to events other than formal therapy; - the welcomed return of a hitherto absent and 'unvisiting' parent, success in passing an exam or scoring the winning goal ... and the like.

There is so much evidence of the 'both/and' quality of change-inducing agents and even of the nature of change itself - rather than a divisive, dichotomous 'either/or'.

IV It needs to be remembered that a technically 'correct', mutative psychodynamic interpretation does not drain a therapeutic exchange of other equally relevant meanings. This is because they transmit signals on different wavelengths. Psychoanalytic truth is an important veracity. But it remains one among others. Existential predicaments for both partners in a therapeutic relationship may persist.

V Heated debate is fired by the volatility of some special hospital patients and the degree to which their very uncontrollability militates against participation in 'controlled' research cohorts. Study of the small group as an *agent of change* is therefore fraught with logistic problems. But the value of the cloistral proximity experienced in a small group as an *arena of change* is indubitable i.e. change can be *seen at close quarters*.

VI Time is a sub-text running throughout this presentation. Trust and the capacity to trust is another. Those who have been repeatedly let down by 'reliable' care-takers need time-without-limit-of-time in which to risk trusting with its inbuilt threat of rejection.

> "Mum said she was going down the road for a loaf of bread and the bugger never came back"

was the experience of a 5 year old whose incrementally violent assaults culminated in homicide. His inability to trust in those who *appeared* to be caring was not difficult to understand. Such a personality disorder needs long term confrontational psychotherapy, in which self-confrontation is facilitated by a tested - 'trusted' therapist.

VII Psychotic patients, whose disturbed perceptions may have led to arson or other violent offences against the person, present us with a vast cosmos, or rather chaos, of distorted meaning. It would be patronising to dismiss this psychic universe in a sentence or two. The clinical need is usually for supportive psychotherapy and appropriate medication. In my experience their inner world is often entered with least resistance and most welcoming affirmation via the poetic pathway of *aesthetic access*. This has been explored in several publications, yet we merely seem to have stirred the surface after touching the depths to adapt Bachelard. (Cox, 1978, Cox and Theilgaard 1987)

One such patient, whose words have become a kind of aesthetic emblem, said

> "I'm blind because I see too much, so I study by a dark lamp".

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VII Twenty five years is long enough to re-invent the wheel several times and for the wheel of fortune to make more than one revolution. I have been present at several meetings where prestigious rebuilding plans have been discussed in detail with architects, management consultants and clinicians. But financial restraints, reorganisation and political climates have prompted policy re-routing.

Undoubtedly, management is currently in the ascendant, itself being firmly in the grip of a Budgetocracy. We are too close to discern who or what will prove to be management's successors. But however much the hospital's wheel of fortune turns, and turn it will, the words of a psychotic patient will provoke, encourage and, may be, even haunt those who work within the walls.

> "If you could talk to me the more human way, the night could come in properly".

I have quoted this at many times, in many places. It speaks for itself. When I am asked what 'the more human way' means, I reply that I couldn't possibly tell for anyone else. But that I have an uncomfortable feeling that I knew what it meant for me, then.

Furthermore, I suspect every reader of this article who calls to mind the last defendant, client, patient - and dare I say, colleague - would know what it would have meant to talk 'the more human way'.

Perhaps this is what 25 years at Broadmoor has taught me above all else. So that the car-park attendant who said on the first day of year 25 - "Good Morning. Just visiting are you, Sir?" was right.

I suppose 'just visiting' is a relative term when 'without limit of time' is the order of the day.

It is strange how 'the more human way' can take a long time to sink in - and that visiting, even 'just visiting', the inner world of another is a relative term. ■

References

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BROADMOOR HOSPITAL

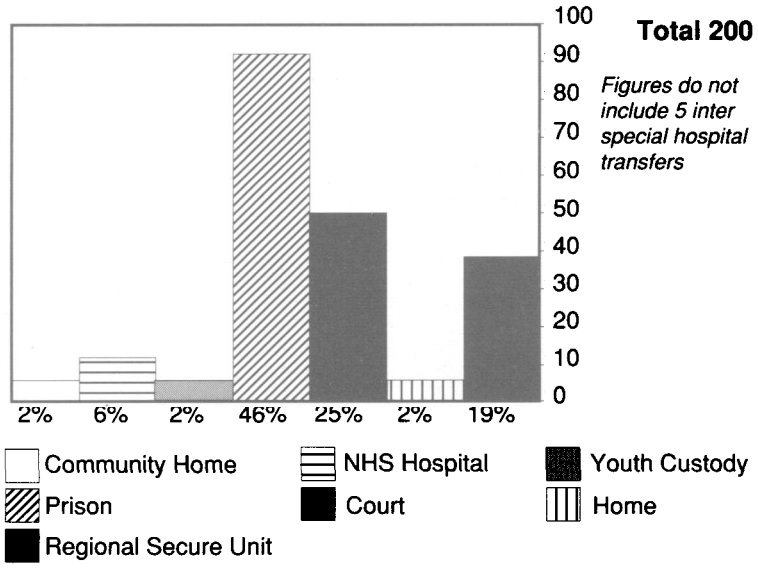
Broadmoor opened in 1863 with 500 beds. Currently it is providing care in conditions of high security for 460 patients of whom 90 are women. The average length of stay is just under 8 years.

About three-quarters of the patients at Broadmoor are there because they have committed offences. The remainder are civilly detained.

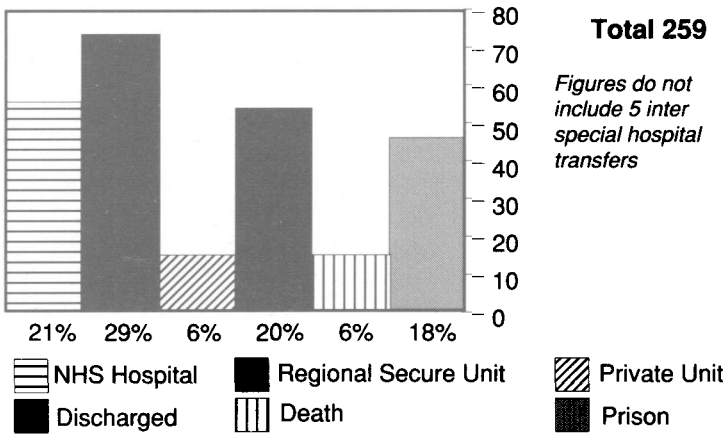
Broadmoor employs 1040 whole-time equivalent staff, from a broad range of psychiatric, nursing, social work and educational disciplines. Since 1989, Broadmoor, together with its counterparts Ashworth and Rampton, have been managed by the Special Hospitals Service Authority. In April 1996 they will each become special health authorities in their own right.

Thanks to Dr Clive Meux and Paul Robertson for their help.

Special Hospital Admissions 1993



Special Hospital Departures 1993



Source: Special Hospitals Service Authority Review 1995