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Therapeutic Assessment of a Violent Criminal Offender: Managing the Cultural Narrative of Evil

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ABSTRACT

Therapeutic Assessment (TA) emphasizes the importance of the clinical relationship and the core values of collaboration, respect, humility, compassion, and curiosity, which guide all aspects of the endeavor (Finn, 2007). Those values are not easy to apply with violent offenders. However, this article explains how TA can significantly contribute to the treatment of those clients by helping the therapist avoid common cultural narratives about evil. We see that these culturally based myths permit us to explain violent behaviors, but also prevent us from treating them because they lead us to a circular countertransference–transference process. Through a clinical case, I show how the TA process can help us to work empathically with violent people while addressing the dangerousness effectively.

Ed was referred for a psychological assessment by a psychiatric unit within a correctional facility to better understand the dynamics of his dangerousness toward others. The client had been isolated from the other patients for 3 months at the time of our first meeting, and immediately prior, he had spent 6 months in a special unit for dangerous (i.e., potentially violent) patients. The unit staff seemed compelled to try every option available to them. As such, they wondered if they should return Ed to the special unit. Most of all, the psychiatrist wanted to know whether there was an efficient way to treat his violent behaviors. The referring psychiatrist informed me that Ed had been deemed incompetent for trial due to mental illness. In the French justice system, this means that the offender will be hospitalized in a community-based psychiatric hospital, with noncriminal patients, instead of going to prison, and be regarded as a patient rather than a prisoner. The patient, therefore, would be allowed to leave the hospital if granted permission by a forensic expert.

Ed was diagnosed with schizophrenia and convicted of holding people hostage. In the past, the psychiatrist added, he had also been convicted for an armed bank robbery and assault with a deadly weapon (a knife). She noted that he was addicted to multiple illicit substances as well as alcohol. Mainly, she was concerned about the way he looked at people, especially the female nurses who worked on his unit. "He looks like he could explode at any time," the psychiatrist stated. The psychiatrist and the nurses' descriptions of him were obviously influenced by fear. Despite my experience with violent offenders, I was quite impressed by this narrative of a man who scared all the staff members of a unit such as this.

Right before I was scheduled to meet with Ed, I was afraid of him, too. I was concerned about his potential unpredictability and impulsiveness, but most important, his violent potential. I began to have the urge to decline this first meeting to avoid Ed. I was ruminating about him exploding during the meeting, reacting violently to one of my interventions, or running away and slamming the door. I was worried about my own safety. In my mind, I had already pronounced him to be a dangerous madman. Interestingly, I realized that all these worst case scenarios had never happened before in my 15-year career (at that time) working with violent offenders. Exploring where those scenarios came from, I came to think that they were a by-product of the fear expressed by the treatment team. I therefore sought support from colleagues outside the hospital. The feedback they gave me reversed the messages I was giving myself (e.g., that the case was a waste of time, that Ed was a lost cause, that I was crazy to try to work with him). Paradoxically, the intensity and the unanimity of this feedback helped me distance myself from my fear so that I was able to start thinking about what was happening around Ed. I came to think that my fears were instilled by something more and not simply a reflection of the fear the treatment team had expressed. This article is the result of my processing these experiences.

Violent offenders, such as people who abuse, rape, kill, or commit any number of other heinous crimes against other adults or children, are usually considered a difficult population to work with by mental health professionals (Hollin, 2004). This is especially true in settings where treatment is mandated by the system, such as in the criminal justice system when a judge prescribes psychotherapy, a psychological assessment, or both. In the correctional system, violent offenders are often

described by clinicians as passive, disengaged, lacking personal motivation, and even oppositional and unable to get deeply involved in psychotherapy. This stereotypic, experience-derived description of violent offenders is very common and generally agreed on by clinicians, despite the fact that research has repeatedly shown significant heterogeneity among this population in terms of engagement, motivation, and willingness to partake in psychological services (e.g., Megargee, 2006).

Chudzik and Aschieri (2013) conceptualized professionals' reactions as a product of the justice system. Chudzik and Aschieri proposed a tridimensional model to explain that the therapist, in mandatory treatment, is asked to intervene in a system created, in a sense, by three elements: the victim, the offender, and society and the justice system. In this system, the clinician runs the risk of identifying with one of these elements and in turn losing sight of his or her own role. Mental health professionals are challenged to consider their reactions and judgments by remembering that what they observe in those clients is embedded within, and likely in large part, a product of the criminal justice setting where they are mandated to treatment, rather than attributing reluctance, passivity, and so on, to the client's personality. In this article, I consider the way Therapeutic Assessment (TA; Finn, 2007) can help mental health professionals, particularly assessors, navigate this complex population and setting.

Core values of TA and the cultural view of evil

TA is a brief semistructured therapy grounded in the process of psychological assessment that aims to help clients change their core narratives about themselves and their environment (Finn, 2007). TA emphasizes the importance of the clinical relationship, and the core values of collaboration, respect, humility, compassion, and curiosity guide all aspects of the endeavor (Finn, 2015). Tests are used in this model both as sources of nomothetic data and as "empathy magnifiers" (Finn & Tonsager, 2002). The core values of TA are not easily applied with clients like child sex offenders, attempted murderers, rapists, and sociopaths (Chudzik, 2015). Being "in our client's shoes" with this population requires assessors to acknowledge some part in ourselves against which we are very defended, both as a person and as a member of a larger culture.

The reluctance of professionals in treating and assessing mandatory clients aligns well with what Baumeister (1999) called the myth of pure evil. The myth describes perpetrators as "wicked, malicious, sadistic perpetrators inflicting senseless harm on innocent, well-meaning victims" (Baumeister, 1999, p. 17). He added, "people are strongly attached to these particular ways of thinking about evil, and news stories or victim accounts about violence are often chosen, distorted, and adapted to correspond more closely to this myth" (Baumeister, 1999, p. 18).

In fact, there is a long tradition of social scientists attempting to explain the origins of this powerful myth. Philosophers like Foucault (1975/2012, 1972/2013), Girard (1982/1989), and Mattéi (1999); sociologists like Elias (1939/2000) and Goffman (1961, 1963); and many others describe how civilization needs to believe that it does not have an inhumane or barbaric side, leading members of the mainstream to constantly project unacceptable feelings onto those they deem "barbarian," who are always "other" people who need to be rejected and fought. This can lead to a process of dehumanization and invalidation of criminal offenders by a process that Bandura (1999) called moral disengagement.

Clinical implications and the utility of TA

Our first reflex as human beings when we hear about a sex crime against a child, a violent murder, or marital violence, is typically disgust. Offenders know this by their experiences of humiliation, rejection, and misunderstanding, and they are constantly testing societies' ability to consider them as human. When a mental health professional first meets an offender, a complicated dance of nonverbal steps intended to test the possibility of an interpersonal relationship involving the offender ensues. The culture in which we live predisposes us to fail these tests. We have an overwhelming and instinctive difficulty coping with people who have committed these kinds of acts against others. This is not necessarily a bad thing. As psychologists, we are embedded in a society with beliefs and constructions that are not easily evaded. However, our culturally determined, instinctive reaction can prevent us from helping and understanding people by rendering a therapeutic alliance nearly impossible.

Consider, too, that humans experience affect before being consciously aware of the accompanying feeling(s). Schore (1994) described this as the right-brain-to-right-brain connection, meaning that although we primarily interact through language, above all we do so through our inner affective states. For example, clients sense the inner state of the psychologist and adapt themselves accordingly. This is the intersubjective aspect of psychotherapy. Intellectually, we might consider that offenders are as human as we, but it is something else entirely to believe this deeply and wholly and to act accordingly. What do we experience when, as part of our job duties, we meet a man who has tortured another man all night with various "techniques" and has left him alive in a cave to die alone some hours later? What if tomorrow we meet one of the leading organizers of a terrorist attack, such as the London subway or World Trade Center bombings? What if we have to meet with a priest who abused six boys? Could we say to ourselves, "We are all much more simply human than otherwise," as Sullivan (1954) suggested? Could we imagine that we have something in common with him, and probably even more than we expected?

This internal, culturally determined reaction leads to a specific type of countertransference even before actually meeting the client. This is the first step of a pathogenic, circular countertransference–transference process. The second step occurs when the client experiences the first right-brain-to-right-brain connection. This connection becomes dangerous for the client and the psychologist because the client is either going to (a) fight (e.g., be noncompliant, or oppositional), (b) have a flight reaction (e.g., avoid you or the topic), or (c) freeze (e.g., experience memory problems, become superficially and exaggeratedly compliant). The third step is the psychologist's reaction to the client's course of action. Many of the client's actions will confirm our culturally determined beliefs that dictate how we react: "He is so aggressive"; "he is avoiding the topic"; "he is trying to manipulate me"; "he is in denial"; and so on. In other words, he

is trying to hide his true nature and his real personality. When this happens, we usually become more structured and assertive. This reaction in the psychological sequence triggers further second-step processes, which lead to more third-step processes, and so on. In this way, we maintain our client in an incomprehensible place of pure cultural evil, whereas we, the professionals, feel safe because we are not like "that."

This is precisely the interpersonal dynamic that the TA model can counteract. Aschieri (2012) recently explained that TA works as an epistemological triangle; that is, a triangle of narratives. Aschieri suggested that, during a psychological assessment, three narratives are created: a narrative with personal meaning (from the client), a narrative written by four hands, (in other words, created by the interaction between the clinician and the client), and a narrative written with numbers (from test results). The stories we are used to hearing are those shared by the client (e.g., about his or her past life, life events) and those written by the clinician (e.g., from his or her countertransference, theoretical perspective, scientific literature). TA allows us to give a voice also to the important narrative written by our test results. In other words, psychological test results can lead to a perspective we have not accepted before and can provide us a way out of the countertransference–transference process. We have a tendency to build culturally based narratives before our interpersonal relationship with the client has time to blossom. Test results are not free of cultural influences, but by this comparison to the norms, test results place our clients into the group of human beings from their own culture and underline what they have in common and in what they differ. The TA process facilitates the development of a new story that affords the opportunity to view our clients differently. As Finn (2007) stated, we can view our clients in a more compassionate and accurate way.

Case example: Approaching evil

During my first meeting with Ed, we talked about his past and his diagnosis. He told me that 3 months prior to the hostage situation for which he was currently incarcerated, he began to isolate himself in his apartment. Once a day, his mother would come to put food on his table. She would leave without saying anything, sometimes without even seeing him. He used to wander the streets alone at night, hiding his face in a hoodie. Sometimes, he visited the cemetery at night. We talked about these behaviors extensively and right before we ended our conversation, he told me, looking at the floor, that the reason he went to the cemetery was because his grandmother was buried there. He explained that this grandmother was the only person who took care of him during his childhood, adding that she was the most important person in the world to him. By the end of this meeting, we agreed to do a TA. He developed these assessment questions to guide us:

1. How can I understand my sadistic part? Why do I think about hurting people like that?
2. Why am I so fascinated by death?
3. Why have I taken so many drugs and drunk so much alcohol in my life?

To answer these questions, I selected the Psychopathy Checklist–Revised (PCL–R; Hare, 2003), the Minnesota Multiphasic Personality Inventory–2 (MMPI–2; Butcher et al., 2001), and the Rorschach Inkblot Test (Exner, 2002).

As the assessment progressed, it became clear to me that Ed was more complex and less unpredictable than my fear initially led me to believe. His PCL–R total score was 16, with 10 points on Factor 2. Although the PCL–R is a dimensional test, a total score of 30 is commonly considered an indicator of psychopathy. Ed's high score on Factor 2 was consistent with the antisocial aspects of his past behaviors.

The MMPI–2 was an unguarded protocol (L = 41, F = 80, K = 40) and clinical scales confirmed the primary opinion others held about him. According to Graham (2011), Ed's scores displayed a well-defined 6–9/9–6 code type. Graham described clients with this code type as dependent with strong needs for affection. They are also easily vulnerable to real or imagined threats, they withdraw into fantasy, and have difficulties expressing emotions in an adaptive way. Patients with a 6–9/9–6 code type experience intense vulnerability and possess a good deal of anger and hostility. They look for approval and affection, but find it intensely difficult to accept or experience intimacy. Other scales indicated intense, but inefficient thought process (OBS = 77), and sometimes bizarre cognitive activities (BIZ = 68). Ed reported that his relationships were not problematic (Si = 40, SOD = 41) but at the same time they were very insecure and marked by projections (Pa = 75, with Pa1 = 70; ANG = 73).

The Rorschach, however, told a different story. Ed provided 20 responses and had a Lambda of 1.0, suggesting a concrete view of the world with little contact with his inner world. He lacked interpersonal skills (CDI = 4), was socially isolated and lonely (H = 1), experienced many painful feelings, and had a poor self-representation (SumC' = 4, MOR = 3). Interestingly, his accuracy of thinking shows some flaws (X–% = 45, XA% = 50, WDA% = 59), especially in the area of relationships and emotions (M– = 1, S– = 2), but his protocol contained no severe cognitive distortions (Sum6 = 0, WSum6 = 0).

After the Rorschach, we did an extended inquiry concerning a response from Card X: *a demonic face, with bloodshot eyes*. I asked him what this face could say if it could talk. He said that the demonic face will say to take care of him. During our discussion about this, he said that he always felt profoundly alone his whole life. His father was absent and cold, and his mother was easily overwhelmed and perpetually misattuned. He would stay in his bedroom, which his father called his "burrow." He liked alone time outside, which he used to shoot cats around the nearby farms. In adolescence, he said he started to feel like a sheep following the flock, empty and lonely. He used drugs and started to isolate himself more and more. Several suicide attempts led him to the hospital. He saw the devil during periods of delusion, and one time he gave the devil his soul. After that, each time he isolated himself, he was scared of the hallucinations of the devil.

After standardized testing was completed, I designed an assessment intervention session (Finn, 2007) to help both Ed and I understand the links between loneliness and violence, and between violence and despair, by helping Ed become particularly aware of his loneliness and painful feelings. For that I used some cards from the Thematic Apperception Test (Murray, 1943) that pulled for themes of loneliness (e.g., Card 13B,

the little boy sitting in the doorway). His stories each contained these themes but each story he told had a manic happy ending or a dramatic suicide. After the last one, we talked about his loneliness directly. Through our discussion, we figured out how loneliness can trigger and increase even greater and deeper loneliness. For example, before he held the hostages, he began giving up his normal activities and stayed at his apartment all day long. He started to get anxious about his hallucinations and about the outside world, so he closed the blinds during the day. He isolated himself more and more, being scared all the time. We figured out how extreme loneliness could lead to hallucinations and delusions. He said that it became unbearable, and that there is a peak in loneliness when something has to happen. For Ed, he wanted to escape his loneliness when he took the hostage. His first plan was to steal a car, but he realized that he had no license to drive it. He then entered the first house he found and took a hostage who could drive him around. They drove across the country, to the middle of France, and they talked. When the driver finally abandoned the car, Ed found another house and another person to talk with. When the police arrived, he was arrested without resisting.

The most remarkable part of Ed's story was the bank robbery. It also happened after a long period of loneliness when, at the peak of it, he decided to commit suicide. After stealing his uncle's rifle, he put the rifle in his mouth and sat there for a long time, he said, without having the courage to pull the trigger. He then drove his car a long distance until he reached a small village. When he arrived, a man was opening a bank. He thought this was an easy way to commit "suicide by cop," as he had seen on a television show. He robbed the bank and waited in front of it for several minutes, but the police never came.

During the summary discussion session, we came back to the question of his sadism. We agreed that he has the potential to be dangerous and can enjoy it, but that this state was relatively rare and occurred after long periods of extreme loneliness. We talked about his second question, concerning his fascination with death. He did not remember this question, and I made the suggestion that, as he had reported during the Rorschach, he is fascinated by the devil theme and, independently, he has attempted to kill himself several times in the past. He said this was his "dark part" that was fed by loneliness. We then agreed that alcohol and drugs were used as an antidepressant and that getting high was an attempt to regulate his cognitive and emotional disorganization and potentially escape the extreme loneliness. At the end of the session, we agreed that when these moments come, he and the staff of his psychiatric unit will have to consider finding a solution in which he will not remain alone and isolated.

Several parts of the TA model helped me connect to Ed and allowed him to explore himself as he did. The core values of TA, specifically collaboration and curiosity, allowed me to abandon the collective representation of him as a dangerous madman. For example, the process of gathering assessment questions pushed me to be curious about him. This curiosity led us to explore his loneliness and his connection to his deceased grandmother he visited at the cemetery. To conduct this session, and the TA process as a whole, building a secure attachment with the client was a necessity. It also helped me to stay out of the pathogenic circular countertransference–

transference process mentioned previously. Moreover, first gathering information around his questions allowed me to have a different image of this man as he shared his experiences and emotional life in a way that exposed his vulnerability to loneliness—a very humanizing experience. The assessment itself, and the extended inquiries and the assessment intervention session in particular, were very important in understanding the depth of the test results. Those sessions were a genuine collaborative exploration of his personality that allowed us to explore his dangerousness, and avoid generalization and minimization. At the end of this process, we were able to address his violence in a more realistic and effective way. This topic, linked to the loneliness and to his first question, became the core of our work. Since the completion of the TA (in 2012) Ed has not acted violently while in the psychiatric unit and has never been caught under the influence of drugs or alcohol.

Concluding thoughts

In working with Ed, the TA process helped me to integrate the three narratives of Aschieri's (2012) epistemological triangle: (a) his story, which was incomplete, influenced by the justice system, and the preceding 9 months of isolation; (b) the story written with numbers from the formal test results; and (c) my story that, at least initially, was heavily influenced by beliefs and reactions embedded in Western culture about the nature of evil and the people that perpetrate evil deeds. As I consulted with other professionals on the case, I realized that this third narrative was not unique to me—everyone shared the myth of pure evil. Once again, I do not believe we can say that it is an inherently bad or inherently good thing to have this view. It just is. It is embedded in the fabric of our society and culture. Despite its seeming omnipresence, we as psychologists need to be aware of how our view is shaped by the myth of pure evil, and many other myths, as they can interfere with connecting with our clients on a level that will lead to understanding and potential change.

The TA process helped me realize the biases I held before I first met with Ed. It did not mean that he was not dangerous. To the contrary, his history showed that he could be very dangerous under certain circumstances. My work with him using the TA model and therapeutic processes, though, helped me to understand how his dangerousness was inextricably linked to loneliness. Sullivan (1954) said that loneliness is one of the most painful experiences humans can have. Loneliness means a lack of intimacy, a lack of feeling understood, or the failure to achieve an intimate relationship (Evans, 1996). Considering this, alongside the test results indicating concerns about personality disorganization and antisocial tendencies, perhaps we could imagine how painful it would be to be Ed and how it could lead him to these extreme attempts to relieve his sense of dire aloneness in the world. With this understanding, Ed might be able to leave the incomprehensible place in which our culture has isolated him. At the end of the TA, Ed's narrative had changed. He agreed that he had been dangerous, that he enjoyed it, and that he could be dangerous again in the future given the right (or wrong) circumstances. He also came to understand that most of the time he was not violent; the violence happened at very specific times in his life; that is, always after a long period of loneliness, which

led to delusions and acting out behaviors that he had hoped would alleviate his aloneness.

After the TA, I conducted a feedback session with the unit team to discuss the findings of the assessment and the next steps in Ed's care while he was incarcerated. This was certainly the most powerful aspect of the case, as it contributed to systemic change in the way Ed was viewed. The findings of the assessment and my therapeutic work with Ed helped the psychiatric team to shift their view of him. They gained more compassion for him as they came to appreciate the underlying feelings that triggered his violent behavior. They began to view him as someone who could perhaps learn to cope in prosocial ways, rather than as an unreachable, unpredictable perpetrator of evil, who should be feared and isolated from others for their safety.

Most of all, though, they realized how the isolation strategy they adopted with him was counterproductive. We talked about the vicious cycle that was in place: They isolated Ed to protect others, then Ed felt intensely alone (like in his apartment before the hostage taking), which made him feel intensely lonely, which led to further violence. This was a particularly important understanding for the unit team, as isolation, which led to loneliness, was Ed's primary trigger for the violent and seemingly erratic behavior that everyone previously feared so much. The unit team developed a management plan for Ed that reduced, but could not completely eliminate, the time he was isolated from other prisoners and staff so as not to trigger his feelings of loneliness.

With this change on the unit, Ed's delusions, antisocial behavior, and disorganization slowly improved over the following year. Following those improvements, the team allowed him to spend time alone in the hospital park. Later he was allowed to walk unsupervised within the hospital for different activities and to meet me at my office. He was not incomprehensible anymore, and this has opened space for relationships that staved off his feelings of aloneness. At the time of this writing, 2 years after the assessment, Ed was no longer hospitalized, but was living independently in an assisted living apartment for people with mental illness in the community. He was under the supervision of nurses, had regular meetings with a psychiatrist, and was in once-a-month psychotherapy. In the 2 years since I conducted the TA with Ed, he has had no reported aggressive or violent incidents and no drug or alcohol abuse.

Acknowledgments

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