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Can We Treat Violence? Transcript

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Can We Treat Violence?

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In these lectures, I have tried to emphasise the complexity of violence as a human behaviour and suggested that it can be considered a form of communication; albeit a harmful and dangerous one. I have suggested that while numerically far too common, violence is still an unusual way for humans to break the law or express distress. I have also emphasised that different types of relationship underpin different types of violence: that there is violence against people one knows well, and there is violence against strangers, and these are not the same.

I want now to consider the 'treatment' of violence. An immediate objection may be that the word treatment is inappropriate; that violence is not an illness, and that the language of treatment minimises the harm done by, and the cruel intentions of the perpetrator. Space does not permit me to explore this issue in any depth here; suffice to say that I accept that warning and agree with it to some extent. (I discuss this argument in detail in a chapter in a forthcoming book: Crisp & Harrosh, in press). However, in the context in which I work as a doctor, treatment is the word we use for those interventions that are offered to mentally disordered offenders who are detained in secure hospitals. It is relevant that prisoners are offered 'interventions' by psychologists working in prison, not 'treatment'; although sex offenders are offered a 'treatment' programme (about which I say more later).

The tension is both linguistic and philosophical. It arises because 'treatment' is usually reserved for people called 'patients', who are facing a problem not of their choosing. Treatment is usually reserved for conditions or problems that will help someone feel 'better' in themselves; less discomfort, less pain. But in the case of violent crime, there is often a demand that the offender should *not* feel good about himself; and should *not* suffer *less* discomfort or pain, but should suffer more because they have chosen their situation when they offended. Although it is a mantra of the criminal justice system that it is the loss of liberty that is the punishment, not the spending of the time in prison, nevertheless there is a strong voice in most communities that argues that violent offenders should suffer as part of their punishment.

We also sometimes say that the treatment will restore someone to their 'normal' self. Another objection to the use of the word 'treatment' is that we (the non-offending citizenry) may not want prisoners to be returned to their 'normal' selves; in fact, we may want prisoners to undergo a significant change of mind, feelings and behaviour. Bluntly, we want offenders not to feel better, but to behave better: to 'become' better people. Health care interventions are usually seen as being morally neutral, and doctors have traditionally felt uneasy about operations and treatments with moral aspects (abortion being the most obvious example). Interventions of any kind that might change people permanently are usually seen as being rather serious and special; and requiring consent of the person who undergoes them.

This theme could take up a whole lecture in its own right. At this point, I want to look at what is offered to offenders (in both prison and secure psychiatric care) and its purpose. There is a clear expectation in prisons that interventions which are offered to prisoners will help reduce their risk of re-offending; and the interventions are offered on the basis that they might help prisoners change their behavior. In secure hospitals, there is a similar purpose, although the aim of risk reduction is also combined with an objective to help the offender recover their mental health (Glorney et al 2010). A key concept here is that of *desistance* (Maruna, 2001): the choice to give up the antisocial choices and identity of the past and develop a new way of engagement with the self and others. I will discuss this also further below.

I will continue to refer to the offenders as male; only because they are the majority of violent offenders, and violent women are a rarity. I would also take the view (as discussed in my last lecture) that violent women are remarkably similar to violent men.

The 'index' offence

The 'index' offence is the offence that led to a man being convicted and sent to either prison or hospital). It is the offence that defines a perpetrator, and it is this offence that will be explored in depth: usually in terms of antecedents, beliefs and consequences. The most widely used model of offending assumes that an offender 'chose' to offend; and that the beliefs and feelings that underpin that choice need to be explored and the meaning understood. Prison psychologists use models of intervention that draw on a wide variety of theories of why people choose to commit crimes of violence: including concepts like Rational Choice Theory (e.g. Becker, 1993), the Risk-Needs-Responsivity model (Andrews & Bonta 2010; Bonta & Andrews 2007); the Good Lives Model (Ward & Brown, 2004; Ward & Gannon 2006), Life minus Violence (Ireland, 2007); violence as cultural identity and violence as a masculine construct. These models emphasize the possibility of interventions as 'turning points' for offenders who wish to desist from offending (Sampson & Laub, 2005). Few of these models address the potential difference between violence that arises in the context of relationships, and violence between strangers: and they tend not to distinguish between habitually violent men, and men who are rarely (but seriously) violent.

Prisoners serving a sentence for violence will be expected to participate in programmes that explore their risk factors for violence, their antisocial attitudes and the strengths that they might use to stay away from violence. Substance misuse is a major area for intervention in violence risk and most prisons offer some form of support, advice or programme in this area. Some prisons offer programs for Intimate partner Violence, general violence reduction and programs for reducing sex offending (e.g. the sex offender treatment programme (SOTP):

Grubin & Thornton 1994 : note the use of the word treatment). The greater the harm done, and the level of intent shown, the more expectation there will be that the offender will have done programmes like this before he can be released on parole. There are considerable problems about the provision of resources for these course and interventions; and prisoners have mounted legal actions against the government, claiming that they should not be penalized in terms of continued detention when the state that detained them does not provide enough interventions to help them reduce their risk.

Do the programmes work?

There has been considerable research into the outcomes for violent offender interventions in prisons; commonly known as the 'What works' literature (McGuire, 2004, 2008). Historically, there was some gloom about the value of offender programmes, but this has changed with the advent of more structured programmes, and better quantitative methods for measuring offender engagement. There are a huge range of interventions offered to offenders of all types; only a minority address violence *per se*.

The main outcome variable here is the risk of recidivism i.e. the chance that a man will be reconvicted for a similar offence. The overwhelming conclusion is that most violence reduction programmes can reduce the risk of violent offending to some degree; and may also reduce the risk of non-violent offending i.e. there is a general effect on criminal rule breaking (Dowden & Andrews, 2000; Joy Tong & Farrington 2006). Results are better if programmes are delivered in a human way that addresses strengths, motivation and the potential for human growth; as opposed to programmes that emphasise bad character, guilt and shame. (Ward et al 2012; Marshall & Marshall, 2014). Two key findings from meta-analyses should make political policy makers stop and think: there is no evidence that punishment reduces re-offending, and some evidence that sanctions and deterrence *increase* the risk of offending.

The exception to this is sex offending; which seem less responsive to the variety of psychological programmes developed to address them. Two studies, ten years apart (Marques et al, 2005; Grady et al 2015) find remarkably similar outcomes: that interventions make little difference to rates of recidivism in sex offenders. There are a number of reasons why this might be: the most obvious is that the kinds of men who are jailed for sex offending are also likely to be violent men who are more antisocial than most. They may not 'see' sexual offending as violent, or even wrong; and they may have highly misogynistic attitudes as part of their antisocial mind set.

It may be that the most effective interventions are those which address multiple risk factors for violence, such as substance misuse, poor education and unemployment. The Delaware Crest project is one that combines substance misuse reduction programmes with a therapeutic community approaches, to good effect (Nielsen et al 1996; Martin et al 1999). The interventions could be still more general: as I discussed in my first lecture, there is evidence that rates of violence tend to go up as unemployment goes up, especially in cultures where there is an honour based culture of masculinity (Gilligan, 2013). Reducing economic inequality and improving literacy may be more effective in reducing overall rates of violence than programme that look at offender beliefs about themselves and others; not least because the men who go to prison have already developed a life time habit of offending. In an earlier work (2001) Gilligan tells a story about a literacy programme that was offered in a prison, and which was proven to reduce re-offending rates; this programme was stopped by the Governor of the state because it was giving prisoners a benefit that other non-offending citizens outside the prison were not getting.

Narratives and agency

Most criminological interventions focus on improving thinking skills and reasoning in offenders. Although valuable, a key feature of desistance from crime is the offender being able to develop a sense of agency (Sampson & Laub, 2005). It seems important not only to treat offenders as people who have made bad choices, but as people who would like to be a different version of themselves. Desistance approaches to offender rehabilitation have drawn on the work of Shad Maruna (2001) and Tony Ward (*supra*), which show that people who offend are people who have stories to tell; and who need to have an opportunity to tell those stories as part of a process of changing identity. This approach complements the more purely cognitive approaches that emphasise thoughts and thinking, by trying to help the offender think about his experience of himself, and especially how his dysfunctional beliefs and antisocial motivations grew up as a way of engaging with the world.

It is rare for violent offenders *not* to have suffered early childhood adversity (Fox et al 2015, in press) and their antisocial stance and pro-violence motivations develop in response to that adversity. Interventions that address this adversity are not a form of 'abuse-excuse', but a strategy for helping people accept and take responsibility for their values and beliefs. This involves a process of understanding how early adversity encourages the development of beliefs that (a) vulnerability is pitiful and pathetic; (b) defensive hostility may be life-saving and (c) others have agency and power so they have all the blame.

The key concept in offender therapy is that minds are dynamic and can change: it is possible to develop a new

relationship towards oneself and others. However, this does involve a giving up of some beliefs and attitudes, and this giving-up-process is sometimes hard and painful: as the internet joke has it, 'I used to have super-powers but my psychiatrist took them away'. Not everyone can do the psychological work entailed in desisting from antisocial and violent behaviours. But it may be that those who can desist do so because they are learning to think about themselves as people who make choices; not people who are helpless to act in their own behalf. No therapy can take place without consent; but psychological therapies sometimes are taken up by people who have mixed feelings about them. Although there are novels, films and dramas have been about people who *wanted* to become morally 'better' people. There are many more about people who were forced by circumstance to become better, and for whom the transformation was not an easy one.

Miserable offenders: violent offenders with mental illness

I now want to turn to consider the people I know best; those whose violence is thought to be linked in some way with mental illness, or who become mentally ill in prison and have to come to a secure psychiatric hospital for treatment. Treatment is offered in settings which offer a range of security measures that are low, medium or high, depending on the risk posed.

Broadmoor hospital is a high secure service, which recently celebrated its 150th birthday. An early service user was Edward Oxford, who at the age of 19 waved an unloaded pistol at Queen Victoria. The reason for this behaviour was never established, but Mr Oxford was sent to Broadmoor where he was a model patient, and it was generally agreed that there seemed to be nothing wrong with him. After 10 years had passed, it was agreed he could be released as long as he went to Australia. He did this, changed his name to Freeman (thus indicating a sense of humour worthy of his adopted country), and lived a life of utter ordinariness for the rest of his life.

Mr Oxford's story is a kind of success story, and there are many successes in Broadmoor, in terms of people leaving the hospital for less secure settings: although perhaps not so many make it to live in the community. Improved research methodology and more longitudinal studies that follow up people over time have improved our understanding of the risk of violence posed by people with mental illness. The good news is that most severe mental illness does not generally lead to any increased risk of violence; the bad news is that if a person with a mental illness is going to be violent, then the violence is likely to be unpredictable, and therefore very difficult to prevent. We do know that family members are more likely to be at risk of violence by the mentally ill; and that the other risk factors for violence combine with some symptoms of mental illness (mainly delusions about other people) to make a high risk mixture. The best evidence to date is that mental illness is a far less important risk factor for violence than alcohol and drug misuse (Fazel et al 2009)

Treatments for mentally disordered offenders focus on the recovery of mental health and reduction of risk factors more generally (Glorney et al 2010). Most secure psychiatric services offer psychological and occupational therapy as well as medication to reduce symptoms. It is not enough that patients behave well in hospital; we want to know that they have thought about their offence, and want to understand what happened and why. The Ministry of Justice no longer asks explicitly about whether mentally disordered offenders show remorse for their offences, but lack of any sign of remorse or concern is taken to be a bad prognostic indicator.

Psychological therapy for offenders (whether individual or group) starts by engaging the patient; and exploring his wish to be curious about his offence and his life after wards. The therapists seek to understand the meaning of the offence for the perpetrator, and what was being communicated to the victim. We seek to establish whether the 'message' got through; or whether the offender believes there is 'unfinished business'. We want to know how the offender feels about his offence now; how it fits with his identity, both past and current; and whether he can think about the impact on families and communities.

This process often begins with the offender telling his story; or rather what might be thought of as the 'cover story' of what happened (Adshead 2011). This 'cover story' is not necessarily a deception; it may reflect what the offender wishes had happened or what was legally established, or even what the mental health team has told him. This 'cover story' then needs to be gradually dismantled and explored in depth; and then a new version of the story is 'discovered': a version which is richer, more nuanced and usually reflects more agency and responsibility. This move along 'a continuum of agency' (O'Connor, 2000) reflects a slow process of self-examination and acceptance of the reality of the offender identity.

One of the very first tasks is to help the offender name their offence: to articulate their action. Without naming a problem, there can be no possibility of thinking about the problem; and no chance of change. For example, in a therapy group for men who had killed someone close to them, this sometimes meant that the therapist would ask a question which began 'When you killed So-and-So..', as part of a process, the next step of which is to help the offender say 'When I killed so-and-so' (Adshead, 2011) These are strange and powerful moments in group therapy: to hear the unspeakable named. My much-missed colleague Murray Cox (1976) referred to this as a 'scala integrata', but I have always thought of the process of therapy for offenders, especially those who have killed, as a *Via Dolorosa*: a long and painful journey, where the therapist keeps the offender company but cannot do the work for him.

Here are some further examples from a therapy group for men who have killed:

Jim has a severe mental illness. He often mutters inaudibly in the group. On one occasion, one of the therapists

comments that they can't hear him very well when he mutters. Jim's reply is very clear:

"I was thinking about the person I killed and how I would like to say sorry... when I killed my [relative] I was mentally ill, but... there was no reason for me to kill the second person".

From a philosophical point of view, Jim is exploring a complex question of agency, choice and responsibility. He clearly sees that his mental illness provides some form of explanatory framework for the first homicide that also reduced his blameworthiness, and need to feel sorry. He distinguishes this first homicide from a second one where he had 'no reason' to kill, and therefore needs to express an apology and sense of remorse. This fragment is all the more remarkable because Jim was clearly mentally ill still; but this did not remove his understanding all together.

The following quote comes from Tim:

I feel I'm stuck in my previous age... the age I was when I did my offence.. Time's passing here and there are things I'm not doing.. I want to capture time with magazines and pictures to show what I was doing when I was here... What will it be like in 10 years time? Where will we be? What will I think on my deathbed about this time?

This speaker is actively reflecting on the experience of being in the therapy group and discussing his offence; and the possibility of thinking differently in the future about himself and his experience. He cannot yet articulate his offence completely (*'did my offence'*) and he has an awareness of his identity being stuck and unable to change. He wants to take a picture that might indicate the process of change, as if he does not yet appreciate the importance of invisible change. The reference to a *'deathbed'* is poignant for someone who has killed; but also is alluding to a time of huge experiential significance, the end of his time.

Finally, a quote from Harry:

If I can make something of myself after leaving here, then two lives will not have been lost.. And she will not have died in vain.

This speaker is articulating a need for redemption: the wish to make something good come out this terrible event that he caused. Some readers may feel that it is easy for Harry to say this; that his victim paid a terrible price for Harry to be able to feel sorry now. No matter how true and valid that response may be, it is surely better for society that Harry is pursuing some vision of change. What cannot come across in a quote like this is the affective tone of the communication: the intense regret and sadness that accompanied Harry's expressed wish.

Does therapy for mentally abnormal offenders work?

The best evidence to date suggests that recidivism rates for men and women released from secure psychiatric care are low (Blackburn 2004; Howells et al 2004) ; and these rate are comparable or better than those achieved by detention in prison. One caveat is that although the risk reduces after treatment, it is not completely abolished, and there remains an unpredictable risk of violence for many years after release. Suicide is also a real risk for violence perpetrators with mental illness, especially those who inflicted violence on family members.

A cynical response to the data on recidivism risk reduction might be ' well, the risk should be reduced, given the costs'. The costs of secure psychiatric care account for a disproportionate amount of the NHS mental health budget, and it is sometimes argued that it is unjust to provide such intensive and expensive psychiatric care to the tiny sub-sample of mental health service users who are violent to others when ill. In response, it might be argued that enlightened self-interest supports the provision of care for very disabled people who have been risky in the past; and that secure services act as a standard for how good mental health care should look. It is painful to remind ourselves that many of the people who end up in secure psychiatric settings have done so because of a lack of good enough care in the community; that cuts to services mean that when they needed help, there were no therapists, no psychiatrists and no beds where people could gain asylum. What is really unjust is the lack of good quality services for mental health, compared to physical health; and the disproportionate cuts to mental health.

There remains however some powerful ethical questions about how the funding of interventions to reduce violence risk. Criminologists in the USA (e.g. Aos et al 2001; Drake et al 2009) have assessed the economics of crime reduction to identify those interventions that reduce crime in an economic way: that produce cost benefit to tax payer and victims. One of the most economically efficient intervention for crime reduction is a package called Multi-systemic therapy (MST) a package of care that supports young people at risk of violence and their families. MST workers go into families and support them for 12 months or more; the young people are helped to go and stay in school and away from drug misuse and antisocial groups; and the parents are helped to get work, and provide more supportive parenting to their children. The data internationally is absolutely clear: MST is expensive in the short term but in the long term provides the most economical intervention for serious crime reduction.

The problem is that this sort of intervention is unattractive to the sub-group of the community who want revenge on, and punishment for, offenders; a wish that gets more attention in the media than offender

rehabilitation. The ethical question is this: should we fund interventions that help a small number of people do much less harm? or should we concentrate our funds on helping many more less serious offenders, with a less intensive intervention? Who should get to decide this question? and which would you choose for your delinquent son?

Finally, the most effective intervention of all would be to reduce the level of childhood adversity: especially interventions that reduce the rates of physical abuse and neglect of children and those that reduce the level of substance abuse and intimate partner violence in the home. One comparatively straight forward intervention would be the provision of therapeutic interventions for parents who physically abuse their children. There is (bizarrely) no provision for parents who physically abuse their children: those men and women who offend sexually against children can access therapy, but those parents who break bones and hurl abuse do not. But every child who is hurt and abused in this way is at double the risk of a non abused child of growing up to commit an act of violence. Common sense therefore, as well as common humanity, would suggest that prevention is better than detention.

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