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Psychotherapy with Violent Patients

Psychotherapy with violent patients can best be regarded as psychotherapy with patients having a variety of diagnoses who present with the symptom of violence. One definition of a violent patient is an individual who is physically assaultive toward other people or things (1). Except for the fact that the symptom can be so frightening and potentially dangerous, it is not really that different in kind from other symptoms, such as suicidal behavior. A suicide attempt, violence directed against the self, can also occur in a variety of different conditions. However, since violent patients present special problems, institutions often set themselves up in ways in which they are unable to deal with such patients. They are passed from institution to institution until often they end up in a punitively oriented criminal justice system, which can exacerbate the person's problem. Alternatively, the patient can find himself in an open community hospital setting which has no locked facility or capacity to deal with violent patients. Staff become frightened and can try to extrude the patient and put him into the criminal justice system.

I believe that the only constructive solution is to approach the problem as a multifaceted one. First, a unit capable of dealing with the violent patient in a manner such that both staff and patient can feel secure that no harm will come to anyone is needed. Second, one must evaluate what the immediate cause of the violent behavior is with a particular patient. Third, the underlying psychiatric problem must be diagnosed and treated according to standard techniques. Fourth, the reactions of the staff towards the patient must be handled in a way which will enable the patient to be treated in a rational manner. Last, a follow-up plan must be instituted which will help prevent future instances of the problem.

Because of the potential severity of the danger in dealing with such patients

and because of the complex reactions of staff and society towards them, it is impossible to discuss treatment without also examining some of the ethical issues involved. Violent patients are seen both in mental health and criminal justice systems. They probably produce stronger feelings, usually of a negative kind, than any other patient group. Where a particular patient is seen may depend on the seriousness of his violence, his socioeconomic status, the prevailing views of the community and social era, facilities available and many purely fortuitous factors. The violence can range from throwing something against a wall, to assaulting someone, to murder. It can be a result of many different causes, such as paranoid schizophrenia, homosexual panic, temporal lobe epilepsy, alcoholism, explosive and impulsive personalities, depression, pseudopsychopathic schizophrenia, narcissistic injury, a reflection of staff conflict, and organized criminal behavior. Each of these causes needs to be treated differently.

We also have to cope with our own tendencies to stereotype and scapegoat. Undue therapeutic pessimism can result from fears of such patients and disappointments or failure of previous unrealistic optimism. In recent years we have seen a paradoxical incarceration of violent patients in correctional facilities because mental health districts have often not even had one locked facility. Instead, a unit where one can safely examine and evaluate such patients, with adequate well-trained support staff, is required to come up with rational nonpunitive therapeutic plans on an individual basis. One should have a secure facility and a nonvindictive staff. Unfortunately, such a combination is all too rat e in our current mental health-criminal justice system.

Special Factors in Treatment of Violent Patients

Halleck (2) has discussed some of the ethical problems in treating violent patients. When the patient is seen in an institution, the psychiatrist must decide to what degree he should follow the goals of the treated subject or those of the treating agency. Treatment goals can range all the way from controlling behavior, with total disregard for the psychological state of the offender, such as prolonged restraint, seclusion, or incarceration, to the more desirable development of internalized controls accompanied by greater personal comfort and awareness. Alternatively, one could aim towards development of internalized controls, without external restraint, with no regard whether the person became more withdrawn, nonproductive, passive or even mentally ill. Hopefully, treating personnel will show respect for individual rights and values and not be hypocritical and call anything, even punishment, treatment. It is important to be honest to patients and realize that when an institutional psychiatrist acts for the good of the institution he is not necessarily acting in the patient's interest. Often, preventing a patient from doing harm is in the patient's long-term interest also, but there are times when an institutional psychiatrist's loyalties conflict and he must be honest to the patient about the conflict and to what use a potential report will be made. Reasonable risk-taking, which will allow the patient whatever responsibility he can handle, is necessary. An appropriate balance between security and ego-strengthening activities must be found.

Violent patients additionally present problems because of society's needs to have a scapegoat for its problems. Ryan (3) has stated the important symbolic role of prisoners is that they symbolize crime that has been contained and this makes the citizens feel safe. Menninger (4) has described the cops-catch-robbers ritual as a morality play which is not totally without redeeming social value, but with scapegoats necessary for the spectacle. According to Menninger (5), as long as the spirit of vengeance and a punitive attitude persists, and as long as we seek to inflict retaliatory pain, we will neither be able to assess appropriate and

effective penalties nor make headway in the attempt to control crime.

Most murders are committed as isolated acts by people closely acquainted with the victim. Mass murderers, the ones who stir up the most hatred and fear, and the least sympathy, are, according to Lunde (6) almost always insane. Contrary to the view that the United States goes too easy on murderers with insanity pleas, Lunde reports that the United States has insanity verdicts in only 2% of the cases, compared with 25% in England.

Unfortunately, scapegoating is an issue from which even mental health professionals are not immune, particularly when people are overburdened. A sort of projective identification with the violent patient can occur. The therapist can project his own violent impulses into the patient, and see the patient as much more dangerous than he really is. Kernberg (7) describes some of the problems a therapist struggling with his own aggressive impulses can have, where he can project the impulse into the patient whom he then sees as the bad dangerous side of himself. Violent patients can bring up extreme reactions in the therapist. One must guard against either being excessively punitive or alternatively masochistically submissive to the patient's control efforts, while excessively denying the real dangerousness of a patient. Moreover, the openness of aggressivity, sexuality, and dependency in such patients can lead to countertransference problems for the therapist (2, p. 330).

Involuntary commitment of such patients raises questions of dangerousness. Stone (8) has criticized the criteria of dangerousness for civil commitment because of the impossibility of accurately predicting it. Even Kozol's study (9), which succeeded to some degree in predicting dangerousness, had 61.3% false positives. The Baxstrom decision (10), which released a large number of so-called dangerous people from maximum security prison hospital in New York into the community, showed that there had been a severe overprediction of violence. The overwhelming majority of the released prisoners were, in reality, not dangerous. This natural experiment shows that psychiatrists

can be overconservative in their judgments. There can be problems with so-called indeterminate sentences where a psychiatrist must guarantee that a patient will not be dangerous in order to discharge him. I believe a better model is one in which there are yearly reviews of any long-term commitments and where a judge makes a final decision rather than putting the full burden for retention or release on the psychiatrist. The public seems better able to accept a court making a mistake than a psychiatrist making a mistake. Recidivism is acceptable from prison, but psychiatrists are often under pressure to be infallible.

Monahan (11) makes the point, though, that the difficulty with most predictions of dangerousness is that the context of prediction is a locked facility, while the context of validation is the community. In an emergency room setting, the context of prediction and validation is almost the same; the patient has been living in the community, and will likely be returning there. The time interval between prediction and validation is short, so one should be able to do a much better job at this sort of prediction. Skodol and Karasu (12) found in a study of emergency room patients, however, that most acts of violence are spontaneously occurring and unpredictable. They did find, though, that a statement of intent to do harm and a family member being the target both indicate serious situations. I believe that there can be some meaningful assessment of imminent dangerousness (2) and that, Szasz notwithstanding (13), such patients should be hospitalized even involuntarily.

The problem is not, in my opinion, so different from the suicidal patient (14), where one can monitor and assess his suicide potential even if one does overpredict it. More serious ethical problems arise because, while almost no one would seriously argue for hospitalizing or incarcerating a suicidal patient for years or even life because he might regress and become suicidal again, one does hear such proposals for potentially violent patients. It is very difficult to disentangle feelings about a patient and values of a particular psychiatrist from any long-term assessment of a patient's dangerousness. However, it is unrealistic

to think that the criminal justice system always handles these situations reasonably, or that psychiatrists could even agree about the treatability of such patients, should treatability become the prime criterion as some have proposed. I believe reasonable assessments of imminent danger to others can be made, as well as danger to oneself. Longer-term assessments of potential danger are possible but much more questionable.

It is also important to be aware of the social factors that contribute to law-breaking. Law-breaking (2, p. 322) can have many different meanings. Undoubtedly, not every law is correct and moral. Certainly, there are differences between the professional criminal, civil rights demonstrators, American Revolutionary leaders and a poverty-stricken adolescent who steals. Some of the abuses of Soviet psychiatry stem from psychiatrists' being willing to see all law-breakers as mentally ill. Obviously, the treatment of violent patients can be fraught with many political implications. Psychiatrists must watch not to become an agent for political and social repression.

Kernberg (7, p. 115), in assessing the meaning of antisocial behavior, suggests assessing whether the behavior is antisocial from the viewpoint of a conventional social prejudice, reflects a normal adaptation to a pathological environment, is an adjustment reaction of adolescence, is reflective of other character pathology such as a narcissistic or infantile personality, or is reflective of an antisocial personality proper. He feds factors other than pure antisocial personality improve the prognosis.

The diagnosis of antisocial personality itself can often obscure more than it enlightens. Many workers have been impressed by the similarities of so-called antisocial personalities to psychotic patients. Schizoid elements, such as poor interpersonal relationships, are a part of most diagnostic criteria for the diagnosis. Lewis and Balla (15) feel it may be a forme fruste of a psychotic disorder. Cleckley (16) believes the central disorder may not only be similar in degree to schizophrenia but more similar in quality that is generally realized.

Menninger (5, pp. 178-180) believes many individuals perform criminal acts in order not to go crazy. Violence and crime may be attempts to escape from madness, and mental illness may be a flight from violence. Murder can be used to avert suicide or can even be a form of suicide attempt.

Lewis and Balla (15, p. 39) suggest that many of the symptoms used to define sociopathy, such as poor school performance, discipline problems, cruelty to animals, fire-setting, and multiple delinquent acts, are found in children with many types of psychiatric disorders. Guze (17) diagnoses antisocial personality, if in addition to a criminal record the person has two of the following five in their history: excessive fighting, school delinquency, poor job record, a period of wanderlust, and running away from home. It is not clear that the list says much more than the lay judgment of a prior criminal record, the first of the criteria, and a long-term history of behavior problems. The danger of such diagnoses is that they may lead to premature closure attempts to find underlying psychopathology and lend themselves to hidden moral judgments disguised as medical science. As Lewis and Balla (15, pp. 41-42) indicate, DSM II uses terms like selfish, callous, irresponsible, and impulsive to describe antisocial personalities, giving an indication of the feelings of the psychiatrist towards a patient whom he gives such a diagnosis.

These issues are not academic matters; a diagnosis for a patient involved with the legal system can have profound consequences for the patient. In some states it can make the difference between six months in a psychiatric hospital and a life sentence in a maximum security prison. The American Law Institute (118) criteria for criminal responsibility exclude conditions manifested solely by repeated criminal or otherwise antisocial conduct, although this exclusion, if applied meaningfully instead of being equivalent to a personality disorder as it has been defined by case law, would apply more properly to dyssocial behavior, such as organized crime, rather than to antisocial personalities or personality disorders, to whom the exclusion is generally applied. Appropriate diagnoses of underlying psychopathology can lead to proper treatment, both

psychopharmacologically and psychotherapeutically. It is important, though, that mental illness not be used as an excuse for indefinite incarceration.

Kernberg (7, p. 13) states that all antisocial personality structures he examined present a typical borderline personality organization. Borderline patients (7, p. 24) seldom give evidence of formal thought disorder in clinical mental status examinations, but on projective testing with unstructured stimuli, primary process thinking shows itself with primitive fantasies, peculiar verbalizations and a deficient capacity to adapt to the formal givens of the test material. These indications show the patient's tendencies to become psychotic for brief intervals and implicate that he could have been psychotic at the time of a crime. It is rare, however, that projective tests are given in forensic evaluations and rarer still that the patient has either the trust or the time to reveal his psychosis to an examining psychiatrist in an unfriendly setting. The diagnosis of borderline personality at least calls attention to the potential for psychosis though this possibility must be stressed since DSM III lists borderline personality as a personality disorder potentially obscuring a patient's propensity to have brief psychotic episodes. In contrast, antisocial personality, in most people's minds, implies the absence of psychosis, certainly a matter with potentially grave implications for a patient.

Guttmacher (19) coined the term "pseudopsychopathic schizophrenia," a condition which in my experience occurs frequently. Lewis and Balla (15) have called attention to the presence of all types of psychopathology in people with antisocial behavior. My own experience in a maximum security hospital setting in the corrections system confirms these observations by showing numerous instances of frank psychosis in people whom correctional staff saw as merely antisocial. Psychosis and violent or even antisocial behavior are by no means mutually exclusive and are, not uncommonly, coexistent.

It is important to realize that antisocial behavior, as well as violence, can be found in people with all types of psychiatric disorders, and can have diverse

etiologies. The danger of antisocial personality as a diagnosis, however, is that it can foreclose all further attempts to look for underlying psychopathology which can be treated by standard procedures. Too often the diagnosis of antisocial personality leads to therapeutic nihilism and nontreatment in a prison facility, or to discharge of dangerously mentally ill people into the community. At least in some places, a diagnosis of mental illness can lead to appropriate treatment.

As I have indicated earlier, the best approach to violent patients is, first, to contain the violent behavior, then to accurately diagnose the cause of the behavior, next to determine the extent of underlying psychopathology, and finally, to institute appropriate treatment procedures. It is important to remember that violence can be a symptom of many different conditions and that lesser forms of violent behavior may even be appropriate responses to certain situations. One must also remember that the violent patient is a person and be careful not to use him as a projection of our own unwanted impulses or our own stereotypes. One must examine the patient in a setting where both start and patient can feel secure, and institute appropriate treatment procedures for whatever underlying psychopathology the patient is found to have.

The initial problem one may need to confront is how to contain the violent behavior. This containment may entail restraint and appropriate pharmacotherapy. Redl (20), writing about children, says patients can exhibit fits of rage which remind us of total abandon and constitute a real state of emergency. The situation can also occur with violent adult patients. One may have to hold the patient physically, remove him from the scene of danger and involvement, and prevent the patient from doing physical damage to others or himself. Since psychiatrists are ordinarily not skilled at handling physical violence, it is necessary to have members of the start who are able to subdue the patient sufficiently without becoming overly punitive. Redl and Wineman (20, pp. 211-212) describe the ideal approach as one in which no more counterforce is used than is necessary to achieve the goal of restraint. Ideally, the therapist should remain calm, friendly, and affectionate, neither threatening nor blaming

the patient. Patients in a fit of rage can sometimes be totally irrational, and a show of force can often be reassuring. It can be a face-saving device for a patient, allowing him to feel that it is not shameful to stop fighting in the presence of an opposing army. It is important to realize that the underlying theme in the lives of such patients is helplessness, which leads to feelings of inadequacy and terror (1, p. 14). It is crucial to approach patients in ways which are reassuring and do not increase the panic.

Lion (1, pp. 3-4) writes that the psychiatrist must be comfortable with a violent patient in order to convey a sense of security. Often, the presence of ancillary personnel can help lessen the physician's own anxieties and later allow him to work better individually with the patient. The patient's underlying fears of loss of control can be accentuated by panic like states in personnel. Most violent patients are afraid of their impulses and want controls furnished so that they will not hurt or kill. After the patient is subdued, he may be put in restraints, and may be given barbiturates such as sodium amobarbital intramuscularly or intravenously, benzodiazepines such as diazepam administered slowly intravenously, phenothiazines, or other antipsychotics (21). Haloperidol, intramuscularly, is especially useful and has less of a hypotensive effect than chlorpromazine. On a longer-term basis, one should prescribe medications, but not overmedicate with the idea that large dose will help a dangerous patient. Sometimes paranoid patients can be made worse by drowsy side effects which feel like a loss of control. Antipsychotic medications with frequent side effects of sexual inhibition, such as thioridazine, should probably be avoided in patients with conflicts about their sexual identity.

It is also crucial to accurately assess the patient diagnostically. The patient should be tested neurologically and an EEG performed to rule out temporal lobe epilepsy (22, 23). In addition, it is important to evaluate for the episodic dyscontrol syndrome (24). One must try to understand what social situation triggered the violent behavior to attempt to make certain the patient does not return into exactly the same situation which initially set off the behavior. Family

intervention may be essential in this process.

It is useful to further determine whether the violent person has been what Lion (1, pp. 29-30) describes as an obsessive compulsive and schizoid individual who doesn't ordinarily express anger, and who one day loses control in a fleeting violent psychotic episode. Alternatively, the person can be an individual with labile mood swings who is immature, explosive with low' tolerance for stress, and impulsive with poor judgment. Megargee (25) has referred to overcontrolled and undercontrolled patterns of aggression.

The underlying psychopathology must be assessed. One should ascertain whether there is an underlying situational disorder, which psychosocial interventions in the community can affect; whether the violence is due to a schizophrenic episode, which antipsychotic medications can alleviate; whether a psychotic affective disorder is the problem, which appropriate medications can help and control; whether the problem is alcoholism, and an alcoholic abstinence program like Alcoholics Anonymous is indicated; or whether drug use, such as amphetamine use, is the problem and appropriate treatment needed. Lithium has been found helpful in emotionally unstable patients who have problems with frustration and who are impulsively violent. Anticonvulsants can be helpful in people with seizure disorders. Additionally, the problem can be a long-standing characterological one which would require long-term treatment in facilities that are unfortunately rarely available to lower socioeconomic level patients. Also of use is the assessment of the person's childhood, since child abuse and the triad of enuresis, fire-setting, and cruelty to animals have been associated with violent behavior (26).

Havens (27) has described an interpersonal technique of displacement and resultant reduction of projection, which can be helpful in the acute management of such patients, especially when the patient is either building up to a violent outburst or is recovering from one. "Counterprojection" is a technique used to displace aggression towards other people and, at the same time, have the

therapist on the side of the patient. During the acute phase one should not talk of introjection and projection. So-called reality interventions may often just lead to the therapist's being included in the patient's projection and the patient's becoming violent toward the therapist. Such clarifications can be offered later on if needed. During the phase where the patient is building up his projections, the therapist must do everything he can to separate himself from the patient's projections. Moralistic statements at such times can be dangerous as well as untherapeutic. Some reality-testing about the doctor can sometimes be useful. If the doctor has reason to believe that the patient is favorably disposed toward the medical profession, he might emphasize that he is a doctor and there to help. Pinderhughes (28) has stated that violence toward another can't occur in a moment of introjective relationship, while the victim is seen as an acknowledged and valued part of the self. Violence can occur only in moments of projective relationship against a renounced part of the self, which in the moment of violence is perceived as evil. The victim is seen as deserving and needing the violent act to bring about justice. This dynamic operates both in individual violence and in group violence, where there are shared projections.

In counterprojection, one might speak negatively about the introject, thereby giving the patient permission to do likewise. Since speaking too negatively about introjects can terrify some schizophrenics, one might have to use ambiguous and double remarks like "Mother wasn't an unmitigated blessing." By expressing such feelings, the therapist helps the patient to bear what he cannot bear alone and has previously had to project because he could not take responsibility for it. As the therapist takes over the feeling, the patient can give up the feelings he really didn't want anyway—which was why he projected them in the first place. In dangerously conflictual situations, ambiguous and double statements can help. Double statements explore the other side; for example, the therapist might say, "She is a pain but she has, I suppose, a good side." By techniques of successive approximations, the truth eventually comes out. The use of the counterprojection technique can sometimes be difficult; other people can

become upset if they feel the doctor is taking the patient's side against them. This situation can be especially difficult when the other people are police or correction officials, or even other hospital officials. In my experience, one sometimes has to direct counterprojective devices toward other staff when referring to violent patients, such as exaggerating how dangerous or difficult a patient may be.

Another frequent error in dealing with violent patients is premature confrontation motivated out of the therapist’s own hostilities. The borderline patient’s narcissism may be the healthiest part of him. Buie and Adler (29) describe the fear of abandonment and aloneness of the borderline. It can feel like annihilation, and lead to destructive rage in a desperate effort to obtain the needed person permanently. The patient may not be experiencing the neurotic narcissistic entitlement described by Murray (30), but more of what Buie describes as an entitlement to survive. An overlay of megalomania may help the patient keep from facing the painful belief that he is devoid of all significance. The struggle can be perceived as a life or death matter. Confrontation may be used by the therapist to express his own fury and resentment (31). It can be disastrous to ask a patient to prematurely give up narcissistic demands when that patient is struggling with an entitlement to survive.

Countertransference problems (used in the total sense defined by Kernberg (7) as conscious and unconscious reactions to the patient’s reality as well as his transference) can be difficult when treating such patients. The therapist, according to Adler (31, p. 157), may have to deal with a sense of helplessness and hopelessness in a patient who seems to remain unresponsive for long periods. Glover (32) writes that the therapist must handle repeated disappointments and assaults on his most cherished possession, his capacity to heal. The psychopathic patient begins treatment in a state of negative transference and tests the therapist with a series of relapses or crises, repeating his lifelong tendency to exploit, hurt, and disappoint people. Unfortunately, too often therapists give up on patients at such junctures, confirming the patient’s view of the world. In order

to withstand, in any long-term work with such patients, the pain and suffering psychopathic patients can cause the therapist, he must basically like the patient, and accept the patient as he is, much as Day and Semrad (33) have described with schizophrenics. He should also be hopeful, but realistic, and aware of the patient's tendencies to appear much more healthy and motivated than is real in an "as-if" manner. Both therapist and patient can sometimes avoid facing the real problems and can engage in a shared denial. The patient can put on a charming facade to appease the therapist, and can then suddenly regress and disappoint him in order to keep what he believes will be an inevitable rejection under his control. Sometimes interpretations of such maneuvers, particularly when they have been previously predicted by the therapist to the patient, can be helpful.

Lion (1, p. 62) warns of the importance of monitoring the transference since negative feelings about the therapist can be converted into destructive behavior outside of sessions. With potentially violent patients, neglect of negative transference feelings can be disastrous. If the patient is allowed to get too close too soon and then the therapist becomes frightened of the patient, this can lead to an accentuation of the patient's panic and potential violence towards the therapist. Usually, however, in an inpatient setting the transference will be diffused, and in an outpatient setting the patient's avoidance defenses will lead to the patient's taking off rather than seriously hurting the therapist. It can be helpful for a therapist to tell a patient when the patient's behavior frightens him, so that the patient doesn't misinterpret and, by means of projective identification, see the therapist as frightening and attack him. Therapists can at times also experience what Kernberg (7, p. 59) describes as complementary identification, where the therapist is identified with the transference objects of the patient. The therapist experiences the feeling the patient is putting into his transference object, and the patient experiences the feeling he had in the past with that particular parental image. Commonly, the therapist can feel angry at the patient and the patient wary and suspicious of the therapist.

On occasion, work with such patients can lead to an additional potential

problem described by Kernberg (7, p. 62), whereby the therapist has unrealistic ideas of being able to help a patient in spite of all reality factors and approaches the patient with total dedication. Unfortunately, the unrealistic views of the therapist can break down in a sudden way and lead to an abrupt termination of treatment. MacVicar (34) writes about a not uncommon problem of masochistic submission by a staff member, with attempts to gratify every whim of a patient to avoid an explosion. It can be a problem to overly submit to a patient, and it can deprive a patient of an opportunity to learn how to handle small amounts of unpleasant affect, with resulting strengthening of the patient's ego. Interpretations to the patient can be helpful at such junctures. Either overpunitiveness or oversubmission can be counterproductive. Timing is also important, since underlying character pathology should not be confronted too soon.

Helplessness (1, p. 15) is an important underlying dynamic with violent patients, and should be kept in mind in determining how to approach them. They have reaction formations against helplessness and dependency. They pretend to be tough and independent to cope with helplessness, and are threatened by any insults to their masculinity or potency. Menninger (5, p. 183) describes bravado crimes done with brutality and ruthlessness which seek to prove to the doer that he is no weakling but a tough man who fears nothing. Nazi storm troopers were often mere boys trained to stifle all tender emotions and behave heartlessly brutal and ruthless. Halleck (2, p. 317) says that men who have serious doubts about their masculinity and a need to constantly reassure themselves and others are more prone to violent behavior. People driven to prove their masculinity can ignore the consequences of their actions.

Homosexual panic can lead to violence. Ovesey (35) has referred to pseudohomosexual concerns, motivated by strivings for dependency and power, which can develop in men not meeting societal standards for masculine performance. The man tries to dissipate his weakness in compensatory fashion through competition about anything and everything and a show of strength (35,

pp. 56-58). He exaggerates so-called masculine traits with care to look manly, be overaggressive (with a hypersensitivity to any slight that connotes feminine behavior), the power motivation being predominant (35, p. 111). He tries to have men submit to him, sometimes sexually, and denies his own dependency at the expense of the weaker man whom he makes into a woman. It is a fragile adaptation; the homosexual act is ego-alien and is often felt to be a confession of masculine failure.

Sometimes, a male patient who becomes afraid of dependency feelings on a male therapist will become afraid that he is a homosexual, and can become violent in a homosexual panic. It can help to discuss the patient's fears of and wishes for dependency and define the issue as fear of closeness and fusion, with feared annihilation of the self. It often can relieve the patient to see the conflict as a pseudohomosexual one, rather than a homosexual one which can imply to a patient loss of his identity as a man, with resulting destruction as an individual. Other times, desires for dependency in and of themselves can make a patient believe he is not a man and lead to his becoming aggressively violent in a panic-like attempt to prove to himself that he is a man and that he is not afraid. He can project his feelings onto a therapist and can become violent if the therapist does, in fact, become afraid and not explain to the patient that it is the patient's threatening behavior that is making the therapist uneasy. Woods (36) has described instances of pseudohomosexual panic leading to violence. Sometimes a patient needs to be able to discuss homosexual feelings with a therapist in order to feel comfortable enough with them not to project them onto the therapist. It can be an error for the therapist to avoid discussing the issue with a patient at such times. When hypermasculine behavior is exhibited in relation to women, the patient becomes a Don Juan. He has a need to "score" with women to prove his masculinity, often in a compulsive and, on occasion, desperate manner. Sometimes sex and aggression can become fused or, in instances of rape, sex can be used in the service of aggression (37).

Patients with an underlying dynamic of helplessness and a need for

hypermasculine behavior often seem to be the male counterparts of the female hysteric, and might appropriately be called male hysterics as described by Blacker and Tupin (50). They exhibit masculine sexual behavior in contrast to the feminine sexual behavior of women hysterics. In addition, the aim is often not really sexual, in spite of the overt behavior; their behavior is an exaggeration of the culturally defined male stereotype, often accompanied by sexual anxieties and inhibitions. The patient can function at a relatively high narcissistic level or at a low borderline level. Similar to the so-called good hysteric of Zetzel (38), such a patient can use masculine behavior as part of proving his entitlement to survive, proving his adequacy as an individual, or even satisfying dependency needs at the hands of nurturant women or men. Alternatively, he can struggle in a reaction formation way against all feelings of dependency or passivity.

Guze (17, p. 97) finds an interesting association between sociopathy and hysteria, giving added credence to the suggestion that some sociopaths may be the male equivalent of the primitive borderline hysteric, each using exaggerations of the culturally defined sexual stereotypes. Guze, in studying female felons, found sociopathy or hysteria in 80 percent of them, suggesting a possible relationship between the two disorders. Hysteria and sociopathy are the two psychiatric disorders he found to be most often associated with classical conversion symptoms. It is possible that the two disorders are related, but hysteria tends to manifest itself most often in women and sociopathy manifests itself most often in men. Women's liberation, perhaps, may lead to more sociopathic behavior previously reserved for males. Women with behavior problems frequently show signs of sexual promiscuity and running away from home (2, p. 138). However, it is possible that they will now turn to more violent behavior. Women hysterics, according to Chodoff and Lyons (39), can use exaggerated femininity and passivity in a controlling way; men tend to be more directly aggressive. It is important to realize that the hypermasculine behavior of what has been labeled male hysterics, or what Oversey calls pseudohomosexual anxiety, covers over feelings of helplessness. A challenge to the patient by a staff

member who also needs to prove his masculinity can precipitate violent behavior.

Yochelson and Samenow (40) use a reality-moralistic approach which can, I believe, be helpful for those patients who need a male authority figure for identification. However, I believe the approach only can work with significant numbers of patients in an atmosphere of warmth, and that Yochelson and Samenow (41) are too pessimistic about more standard approaches. I believe their approach is not immune from being vulnerable to the possibility they fear of patients' giving the therapist merely what he wants to hear. Yochelson, in my opinion, is too ready to confirm the patient's own already low opinion of himself, which society also already has confirmed.

The patient may initially feel understood if the therapist believes he is bad. However, I believe it is more effective not to confirm the patient's notion but merely to convey to the patient that the therapist understands that the patient himself believes he is bad but that the opinion is not necessarily correct. I believe Yochelson's approach leads to overly rigid bad-good dichotomies and, even when successful, can lead to patients' becoming narrow, conventional people who lead lives almost the opposite of the chaotic ones they led before. Too often people feel that an overly hard, tough, authoritarian approach is needed for such patients, who at least on the surface present a tough, hard exterior. It can be important to realize the patient's underlying insecurity; often, a non-threatening, sympathetic, though aware and incorruptible, approach can be much more effective.

Secondary gain issues can be prominent in the treatment of patients with a more sociopathic picture. Some patients have advantages to be gained by feigning mental illness; however, at least an equal number will probably try to conceal mental illness, even from themselves, because it is more acceptable in their subculture to be considered criminal rather than crazy. It can be difficult, at times, to establish a real therapeutic alliance, and the therapist can often be

“taken in” and believe a more meaningful alliance has been established than is really the case. Patients may be more mistrustful than is at first evident, and participate in therapy in more of an “as-if” manner. A therapeutic alliance can often eventually be established around issues of concern to the patient himself, such as his self-defeating behavior or his loneliness. The alliance is fragile and tested on many occasions. However, ambivalent motivation occurs with many types of patients. Some patients even need to be “forced” into therapy, such as by a probation condition, in order to “save face.” The danger with the treatment of more sociopathic patients is that a naive therapist can be led to falsely believe he has “cured” the patient, and react in an overly rejecting, punitive manner, when he discovers he has been deceived. Disappointments such as these lead, in my opinion, to many therapists’ becoming disillusioned and giving up on working with such patients incorrectly at crucial junctures. The therapist must set realistic goals for his work and expect regressions and disappointments.

Longer-term intensive treatment, in my opinion, though rarely available, can help a number of violent patients with characterological disorders. However, one needs a setting which can cope with the patient’s behavior and regressions, and the patient needs at least the potential for both a locked setting and more independence when he can handle it. The setting can be a locked hospital setting, or a therapeutically oriented correctional setting with a nonpunitive atmosphere (a rarity). Motivation is important, and therapy is most necessary and useful when the patient is aware of how unreasonable his behavior is and wishes to do something about it (2). Many patients also need things like vocational rehabilitation, and group therapy can be of value.

The psychotherapy study of the Menninger Foundation (42) indicated intensive psychotherapy, combined with hospitalization, to be useful for borderline patients. Therapists who worked on undoing the manifest and latent negative transferences were the most successful. This study contrasts with many prevailing views regarding treatment of borderlines, and notions about their untreatability. Kernberg (7) sees a continuum between the narcissistic

personality and antisocial personality, which he sees as an extreme form of pathological narcissism with absence of an integrated superego.

Treatment of such patients requires consideration of other dynamics which are sometimes present and can require intervention. Johnson and Szurek (43) have described superego lacunae in antisocial patients, who act out their parents' unconscious conflicts. Family intervention may be required in such cases. Also, as stated earlier, it is important to interpret projective identification when it occurs, whereby the bad part of the self is projected into another person with lack of self-object differentiation. The patient continues to experience the impulse as well as the fear of it and this dynamic can sometimes lead to violence (7).

Treatment of narcissistic personalities requires consideration of the idealizing and mirror transferences, described by Kohut (44), which narcissistic patients develop about their therapists. Therapists can find such transferences difficult to accept and reject them by prematurely given, though correct, genetic or dynamic interpretations. The therapist may experience embarrassment, self-consciousness, and shame at the narcissistic tensions generated by his own repressed fantasies of his grandiose self being stimulated by the patient's idealization. Accepting the admiration would be a more correct response when an idealizing transference starts to germinate. In the mirror transference, the patient wants the therapist to reflect, echo, approve, and admire his exhibitionism and greatness. For a long time, the therapist should encourage the patient to reveal his grandiosity; it would be a mistake to prematurely emphasise the irrationality of the grandiose fantasies or stress that it is realistically necessary to curb his exhibitionistic demands. The therapist must accept a limited role. In settings which allow for long-term treatment of patients with characterological disorders, or even in brief, limited insight therapy, issues of narcissism and techniques for treating borderline personalities become especially relevant.

It is useful to realize the importance of narcissism and its connection with

aggression. Rochlin (45) says that aggression always issues as a reaction to threatened or actually damaged narcissism. Narcissism, moreover, is in double jeopardy; when threatened it becomes intensified and more brittle. We deal with aggressiveness easiest (45, p. 164) when we are, or believe we are, the victim of another's hostility. Aggression, and identification with the aggressor (45, p. 213), can enhance self-esteem and fend off fears and uncertainty. Social and other factors influence the development of narcissistic personalities. Upper-class narcissistic personalities can become businessmen and political leaders; lower-class narcissistic people may feel that their only resort is antisocial behavior.

Rochlin (45, p. 157) suggests that the value we accord another person acts as the most effective deterrent to violence. I have seen (46) several examples of Capgras' syndrome, where patients insist that an important figure has been replaced by an impostor, as a delusional way of coping with unacceptable hostility and as an excuse for violent action. The patient seems to need to deny that the individual is a valued other person in order to cope with his hostility; however, this denial unfortunately can enable the person to become violent towards an individual he would otherwise not harm.

I believe, like Halleck (2, pp. 324-327), that one should not be moralistic but should approach the patient in a manner that suggests that the patient's behavior is not bringing the patient what he is looking for and can lead to even more discomfort. Since this behavior can result in loss of liberty, one should suggest that there are better ways for the patient to achieve his own goals. Insight can lead to the discovery of alternative adaptations which can be chosen by a patient. It is also relevant to look for instances of what Alexander (47) called the neurotic character, describing a person who commits crimes in order to be punished for things about which he feels unconsciously guilty. Halleck (2) describes a close linkage of masochism and paranoia, with the criminal denying that he brought his difficulties on himself and projecting all his problems to the outside. The sociopath has conflicts with dependency and searches for a painless freedom from object relations—an ideal which is never achieved. He says he doesn't need

people, in a way to ensure a return to dependency. Moreover, it is important to work with whatever elements of a positive transference exist, as Aichhorn (48) did in his work with delinquent youth.

Conclusions

I have suggested that violent behavior is a symptom. It is important to keep one's countertransference feelings under control; violent patients, probably more than any others, lead to all types of countertransference difficulties usually related to the therapist's difficulties with his own hostility towards the patient. Mental health people should try not to engage in scapegoating but realize that violent patients are people who have problems with violent behavior. They are not inherently different from other patients or members of a different species.

It is important to contain the violence on an emergency basis and then try to assess its causes. Certain types of problems, such as situational difficulties, acute psychosis, or unresolved hospital staff conflicts, such as described by Stanton and Schwartz (49), lend themselves to emergency, crisis-oriented interventions. Antipsychotic medications can have dramatic results, if the violence is a result of a psychosis. Assessment and treatment must be done in settings where both patient and therapist can feel realistically safe and dangerous acting-out by the patient can be prevented. Attempts should be made not to become confused with the patient's projections. Structure and limit-setting are necessary.

A further assessment of the patient's characterological difficulties should be made and treatment instituted if suitable facilities exist. Otherwise, one is often forced to settle for incarceration or release of the patient to the streets. Issues regarding commitment of dangerous patients can produce problems and must be considered. Motivation of patients is an important factor for successful psychotherapeutic endeavors. Many patients with characterological difficulties will probably be found on careful examination to have borderline personality organizations and/or narcissistic personalities and should be treated appropriately. Issues relating to object splitting and trouble integrating good and bad introjects are encountered.

Depending on the nature of the patient’s problem and the severity of the pathology, the patients can be difficult or relatively routine to treat. I believe it is important, however, that mental health personnel not shun their responsibilities and neglect treating such patients. Such neglect leads to violent behavior in the streets and paradoxical incarceration of such patients in prisons. The majority of violent patients are treatable by one of the approaches I have described and it is important that neglect of the problem not be rationalized by the myth of their untreatabiliiy. While it is true that some patients have been so badly scarred and are so suspicious, mistrustful and unmotivated that they may be untreatable, the majority are, in my opinion, treatable by appropriate personnel in appropriate settings. It is essential that facilities be available where therapists and patients can feel secure. Therapists, moreover, must be aware of and constantly examine the complex ethical problems which the treatment of such patients represents and try to not let their own moral values or their own political beliefs overly influence treatment decisions made for patients. Patients should not be forced to adopt the therapist’s life style in the name of treatment. We can also be overconcerned with a patient’s rights instead of treating him, and the result can sometimes lead to his being incarcerated in an antitherapeutic prison paradoxically.

It is also crucial to remember that emergency crisis intervention approaches may be all that is needed for many violent patients, but such patients should not be prematurely discharged, without any psycho-social intervention, right back into the problematical or crisis situation which originally led to the violent behavior. It is ironic that large amounts of money are often spent to keep someone incarcerated in prison, but sufficient funds and personnel are often not available to treat someone less expensively for shorter periods of time in mental health facilities. Some judges are reluctant to send clearly mentally ill violent patients to treatment facilities because they do not have confidence that mental health personnel will keep the patient hospitalized for adequate periods of time or follow him persistently in the community. Instead, such patients can be sent to

expensive, often antitherapeutic, penal facilities which encourage regression, dependency, and stifle any constructive, ego-developing efforts by their inmates. Prisons generally have inadequate follow-up resources with poor recidivism rates. Hopefully, psychiatrists will continue to be actively involved in the treatment of violent patients and will keep in mind specialized techniques such as the ones I have described. Moreover, serious attempts should be made to organize treatment programs in an individualized manner and not require that patients have the right psychopathology to fit in with someone's idea of what a program should be. Careful attention to some of the techniques I have discussed will help in treating patients who have already become violent or who have a great potential for becoming violent.

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