

# **Their Dark Materials: Narratives and Recovery in Forensic Practice**



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## **Introduction**

In this paper, I want to describe a narrative approach to forensic psychiatry and psychological therapies that are offered to forensic patients. I will set out how close attention to the language people use is an indicator of the coherence of their narrative identity; and describe how the process of therapy may improve coherence. I will give some examples using textual quotes from therapeutic conversations. I conclude that the recovery process in forensic settings involves a transformation of narratives of cruelty and madness into narratives of regret and hope. The patients I work with have given their permission for material from therapy to be used for teaching and research, although no historical details are given and pseudonyms are used throughout.

## **Narratives and recovery**

Narrative is at the heart of the recovery and change process in mental health (Slade 2009). Our narratives are the stories we tell of ourselves, our choices and experiences that make up our identities; as opposed to the type of information that we might use in a CV or as they say in the USA, a resumé. Over the course of a person's life-span, narratives change and develop so they are *dynamic*, as opposed to fixed. Narratives are complex, layered, and integrate different perspectives of the self and social roles; they acknowledge that we may see things differently over time, and how we see ourselves may not be what others see.

The recovery movement in mental health services has emphasised the importance of narrative for a number of reasons. First, it emphasises the importance of the personal lived experience of people living with mental illness or injury, as opposed to the case history record with its emphasis on diagnostic labels and results of observations and investigations. Second, telling one's story has always been an important part of the recovery process, as exemplified by the recovery process in the Twelve Step programme of Alcoholics Anonymous (arguably the first example of the use of the language of recovery in the psychological context). Finally, the concept of recovery implies the possibility of change, as opposed to fixed or rigid categorical ways of defining people: the story of how a person lives with schizophrenia is likely to change over time, where the bald diagnosis does not.

Dan McAdams' work on narrative approaches to life change emphasises the narrative level of the personality (McAdams 1996; McAdams and Pals, 2006). He argues that narrative reconstructions of the self are mirrors of psychological change; especially in the context of the experience of negative or traumatic events. He utilises the concept of 'redemption' to describe the process whereby people describe surviving bad events, and changing the language of a troubled or tormented self into a more hopeful, generative self: a personal identity that use the language of hope and possibility (McAdams, 2006).

Narrative approaches to therapy are not new (White & Epston 1990). Indeed, one might argue that they are ancient - that stories and myths are always about psychological change. For example, most 'quest' stories involve a transformation of the main character into a 'hero'; usually after many trials and challenges (Booker 2004). At the end of a story, most people are changed in some way: they are both literally and figuratively in a different 'place'. In recovery narratives, the story is a positive one in which a new 'voice' is found, and bad experiences are transformed into the good. The following quote (from a book about alcoholism) makes the point:

*Narrative is not a cure, but it is a method, a path toward redemption. Redemption lies in a better understanding... recognising counterfeit, seeing through duplicity and resisting snares and seductions (O'Reilly, 1997)*

And this, from a theological paper:

*Language can be a means of redemption, and then in some mysterious way, language is healed and healing (Louth 1989)*

## **Narratives of offending**

A particularly ancient form of story or narrative is the story of the overcoming of a Monster that threatens a community (Booker, 2004). In traditional stories, the Monster is defeated or killed by the hero; and this process of finding and defeating the Monster is the change process by which an ordinary person is transformed into a hero. In the modern world, the Monster is usually a psychological monster; the Monster Within. The modern protagonist may also overcome an internal 'monster' of inauthenticity, to discover their 'true' self. The 'hero' is also there inside oneself, to be liberated by overcoming or transforming an internal 'darkness', usually through a process of (sometimes painful) change.

These narrative devices have increasingly been applied in non-fictional accounts of overcoming traumatic or negative events, such as trauma or illness. They can be a particularly rich way to describe the process of living with mental illnesses, such as depression (Styron, 1992; Solomon, 2002; Lewis, 2006) and, as McAdams suggests, 'redeem' something positive out of the negative, usually in terms of lessons learned, and change of attitude to self or others.

Early studies of the narrative of offenders focussed on their language and experience of prison (Parker, 1969, 1990; Presser, 2004). Tony Parker's work in particular was one of the first researchers to use taped and transcribed interviews that allowed the 'voice' of a previously excluded group to be heard. Lois Presser's work explored linguistic constructions of agency in the language of offenders, finding that they often generated narratives of their offences that diffused their responsibility; an example of what criminologists Sykes and Matsu (1975) called 'neutralisation discourse'.

What is 'neutralised' in these discourses is any negative feelings that might cause pain or distress in the offender, such as shame, guilt, anxiety or self-reproach. Like most other people, most offenders want to see themselves as 'good' people who have made mistakes, or been provoked into doing wrong. Psychological processes (both intrapersonal and interpersonal) that encourage the ownership of responsibility and agency for wrong-doing may be painful to experience, and generate negative affects that have to be endured and accommodated.

Those working with offenders in rehabilitation programmes hope that offenders who do 'own' their agency and responsibility for offending are less likely to re-offend. Although in intuitive accord with cultural and religious norms, there is surprisingly little research to support this hope. One piece of research that does support intuitions about the importance of agency and responsibility in desisting from crime is work by Maruna (2001) using narratives generated by two groups of offenders: those who had desisted from crime and those who had not. The 'desisters' generated narratives of themselves that emphasised their sense of a 'previous' offending self which was not 'real'; and also used the language that indicated that they experienced a sense of agency in taking steps to act differently. In contrast, the 'persisters' (who continued to offend) used language that suggested that they experienced themselves in a passive way, as people to whom things just 'happened'.

Maruna's work echoes research on the effectiveness of psychological therapies which found that people who had a positive experience of therapy typically described an enhanced sense of agency and effectiveness at the end of therapy (Adler et al 2008). This research also noted that 'successful' therapy was associated with the generation of narratives of experience that were more 'coherent'.

### **Coherence of narrative**

The concept of 'coherence' is crucial to discussion of narrative. A 'coherent' narrative hangs together and makes sense overall: it does not have gaps, lapses or intrusions that render it incomprehensible. Grice (1976) has argued that language and conversation follows communicative principles or conversational maxims:

- Quality: be truthful and have evidence for what you say
- Quantity: neither running on interminably nor speaking so tersely that the communicative process is lost
- Relevance: Keeping to the subject in hand ; and if changing topics, licensing them with some explanation or indication of how they connect
- Manner: completing speech acts, use of grammar and syntax, appropriate use of imagery, metaphor and tense

Work using Grice's conversational maxims has shown that psychological security is associated with coherent self-narratives (Hesse, 2008; Cassiday et al 2012); and that conversely, those who have insecure sense of self generate narratives that are incoherent in a variety of ways. Lack of coherence is most clearly seen in autobiographical narratives; and there is good quality evidence that insecure attachment status is revealed in less coherent or incoherent autobiographical narratives. Insecurely attached children talk about themselves in ways that lack detail, words for negative feelings or the personal pronoun compared to securely attached children (Beeghly & Cicchetti 1987; Cicchetti & Beeghly 1994).

'Coherence' does not mean elegant prose or flowery language: a coherent narrative is one that communicates a message with meaning in a fresh, authentic and reflective way. Here is a quote from Tim, a member of a therapy group for men who killed someone close to them:

*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?'*

The language communicates a lively thoughtful voice, asking serious questions about complex human experience. The language is not complicated or extensive, but in a few well chosen words, Tim conveys his awareness of how time changes perspective, and that time is changing and moving while he is not moving. The existential question about the end of life indicates Tim's awareness of the self-reflective process that takes place across the life-span: that he is thinking about what he will think about himself and the meaning of his total experiences across time. He communicates a complex thought in a set of speech acts that are clear, concise and indicate a willingness to cooperate conversationally in the dialogue that is taking place in the group.

Incoherence of personal narrative is manifest in language in many different ways. Common examples include denial of distress and suffering, so that speakers idealise their past or claim to know nothing of it; or use of passive forms of verbs, so that speakers are not 'actors' in their own story. Highly disorganised narratives often include the response to questions of 'I can't think'; as if the speaker is blanking out thought or lapsing into dissociation. Odd associations and metaphors may be present; often that hint at the experience of extremes of fear and distress.

We can compare the coherence of Tim's narrative with this excerpt from an interview with Kevin about his memories of early childhood experience. The interviewer is asking about childhood disruptions: in this case parental divorce:

(Did they divorce?)

*Well I don't know if he divorced [her] or not but all I know is that he left her in a sense that he told her about his companion as he called her and to cut a long story short I blamed him for her demise because the last flicker of flame in her belly had been extinguished*

(What did she do when she heard?)

*Of course, yeah, after being married to [him] since childhood days, see aunts and all the rest of it, you know from back in the army days and all the rest of it, and I thought well, he's responsible for her demise, I was just grieving so much I didn't know what to do so I thought I would kill him, probably glad that he wasn't in really, he wasn't in so I got in through the back door at the side of the house and went to go and hang myself in a tree but that didn't work so I left*

Note that an incoherent narrative is not *incomprehensible*: it is perfectly possible to read Kevin's answers to the questions and infer what he means. However, a close look at the language of the narrative shows a variety of violations of Grice's cooperative principle of conversation. We can notice how Kevin answers a very simple question with an elaborated answer that shifts very quickly from a factual reply to a discussion of a death, and Kevin's feelings about this. His first answer contains a beautiful but strange metaphor which is not licensed and doesn't help us understand why Kevin wants to communicate this at this point. His second answer again moves swiftly from discussing someone's actions (which was the question) to a continuing discussion of a death, his feelings about it and the remarkable linking of the experience of grief with instant thoughts of either homicide or suicide.

It is not that Kevin's narrative is 'wrong' or 'bad': but it is incoherent, because it does not complete the conversational 'task' agreed, and it leaves the listener confused about Kevin's choices, values and experience. It does powerfully communicate Kevin's sense of distress, confusion and impulsive riskiness; and it is perhaps of no surprise to learn that Kevin was admitted to a secure hospital because he developed a psychotic illness and killed a complete stranger.

### **Recovery and narrative approaches to therapy in forensic settings**

Speakers who generate highly incoherent narratives of their early lives are more likely to have clinical psychiatric diagnoses (Hesse, 2008), and to be actively unwell. It follows therefore that recovery from periods of illness or mental disorganization is likely to be associated with increasing coherence of narrative (as suggested by Adler et al

2008). At the level of linguistic detail, we might expect to hear more discussion about agency and perspective taking (in line with Maruna 2001); or to find increased use of the first person pronoun (Van Staden & Fulford 2004). Traumatic narratives are often characterised by verb-tense shifts into the present tense (Pillemer et al 2001), so recovery would be associated with narrative descriptions of traumatic events that locate those events clearly in the past, without such shifts.

There is no reason why these narrative aspects of the recovery process should not apply to forensic patients. In fact, there are compelling reasons why narrative therapy approaches are essential to add to offender therapy programmes. The most compelling reason is that in the course of their detention, therapy and rehabilitation, offenders will be required to 'tell their story' to a variety of professionals; and what they say about themselves and their offences will be closely scrutinized. Parole Boards, multi-agency public protection panels and probation services are interested in how offenders understand their offences, the damage done and their attitudes to risk. Offenders who have committed serious crimes will be expected to tell their story to complete strangers on a regular basis; so it is a process that they have to become accustomed to, even if it is painful.

Second, many offence-related programmes in prisons and the community already require offenders to describe their offence in detail in groups with other offenders who have committed the same offence. These exercises in 'telling your story' are usually time limited i.e. it occurs once in a programme over the course of 90 minutes, and are usually the focus of challenge by other group members. This is often a negative experience for offenders, and can be associated with shame, stress, and anxiety.

Although a single recounting may be helpful in the course of therapy, it may be less helpful if it is aversive or feels like a punishment. In addition, where the offence took place in the context of a relationship, it is likely that more time will be needed for reflection will be needed. Therefore, the third reason for offering narrative therapy spaces for offenders is the opportunity to have extended time to do the psychological 'work' needed; and space to explore and adjust to painful insights about the of their offences. This is particularly valuable for those who have attacked or killed someone they were attached to emotionally; a group that often includes young offenders, and female offenders. A more extended narrative approach to the story of the offence allows for a more gradual telling of the story, and graded exposure to shame, distress and pain.

Lastly, it is common sense that it takes time for people to come to terms with their offending and accept 'true' ownership of their past cruelty and madness. To have been (even briefly) mad and dangerous to others can be a frightening and disorienting experience for offenders even for those who have been offending for many years before the final 'Big One' that got them admitted to high secure prisons or hospitals. There is evidence that people who commit serious acts of violence can suffer post-traumatic phenomena (Thomas et al 1994; Grey et al 2003; Papanastassiou et al 2004): which would imply that these offenders will need active therapies that allow them to explore their experience of being violent, and try and resolve their distress about it. This process entails owning and articulating the story of that identity.

The recovery process then focuses on helping people articulate their offender identity, and then supports a process of reflection and discussion that allows for the possibility of transformation. The transformation is from a 'cover story' which is often mad and incoherent into a more nuanced and thoughtful story that includes an account of agency, but also expresses regret and hope (Adshead, 2011). For example, we may think the speaker below has some work to do still in respect of his offence narrative:

*I didn't kill anyone... you can dig him up and ask him if you don't believe me*

Whereas, this speaker (Tom) is actively working on his experience. He is a member of the homicide group, and is sometimes still actively psychotic, and can be heard muttering to himself:

(Therapist: Tom, I can't hear what you are saying very well when it's a mutter)

Tom: [ suddenly speaking very clearly]

*I was thinking about the lady I killed and how I would like to say sorry... when I killed my mum I was mentally ill, but... there was no reason for me to kill the second lady.*

This excerpt suggests that Tom had been thinking deeply about the offences he committed; note the very interesting distinction that he makes between the two homicides and the acknowledgment that there is a difference in culpability for offences that have mental illness as their 'reason', and those that don't. Tom had not been offered individual therapy in the past because he was thought to be too psychotic to engage; and had not been offered other group therapies prior to joining the homicide group. Tom's contribution was all the more remarkable because he was one of the quieter members generally, and the therapists did not always know what he made of the experience

It is likely that many forensic patients will have incoherent self-narratives because of the prevalence of abuse and neglect in this group; and the association with insecure attachment. Rates of childhood abuse and neglect are much higher in prison and forensic populations than the general population (Coid et al 1992; Heads et al 1997); and probably accounts for the equally high rates of insecure attachment found in these groups (see Adshead 2003 for review). Severe abuse and neglect frequently results in highly insecure or disorganised attachment states of mind, which are also associated with clinical disorders (van Ijzendoorn & Bakermans Kranenburg 2003). This evidence would seem to suggest that therapy is indicated that addresses incoherence of self-narrative and offender identity and this therapy would be part of the recovery process. In fact, it might be said that offender patients need not so much to 'recover' but 'discover' a new way of being that incorporates the tragic past, but looks to the future with realistic hope and determination ( Ferrito et al 2012).

## **Problems with narrative approaches to therapy for offenders**

Like any other treatment in medicine, psychological therapy can be associated with side-effects, including pain and short term decrease in well being. If neutralisation discourses and incoherent narratives are a way to keep psychological pain out of consciousness, then there are bound to be anxieties about engaging in therapy that explores the past; both in relation to childhood or the offence. In our experience, this anxiety is more than the resistance of giving up a particular habit of thought; as suggested by the following quotes from the early sessions of the homicide group:

*Therapy is like a car crash... it knocks you off course*

*It's like asking us to take off all our clothes*

*It's a long walk over here... like a Marathon*

*The therapists take you down roads you don't want to go*

The anxiety is not confined to patients. Professionals may also fear what the patients will say, or what might happen when they experience pain. There was considerable resistance when a therapy group was proposed for men who had killed someone close to them and who might be suffering traumatic stress: one psychiatrist said 'We have not needed such a group for 150 years and we don't need one now'. Another example of staff anxiety is revealed in an interchange between a therapist and the clinical team who were looking after a patient, Sharon, who had killed her partner in a brutal attack which took place over 3 days. Sharon started in individual therapy; but after a few weeks of therapy, the therapist received a letter from the clinical team, saying:

*'Please can you not talk to Sharon about her murderousness: she finds it upsetting'.*

It is, of course, profoundly upsetting to talk seriously about murderousness in any context; but especially when one has taken a life. Therapists who do this work must take exquisite care with their communication skills and the words they use, and it may be that Sharon did experience her therapist 'upsetting' her. However, we might also think that something important was being turned over (literally 'upset') in Sharon's mind; something about the offence which led to her admission and which (if understood) could help Sharon address her identity as an offender.

Finally, there are social anxieties about listening to offenders, and transforming their identities from monsters to protagonists in human tragedies. Knowing who and where the Monsters are helps groups feel safe; so creating monstrous identities for offenders is an important role for the media. One thinks here of Myra Hindley, whose later, (rather ordinary-looking), photographs were never used in newspapers, but only the image of her at her trial; or more recently, an article about Jon Venables (one of the two boys who killed James Bulger) which was headlined with the words, 'My Vile Life': as if his life story and experience was fixed for all time. Or, as one of my individual patients put it;

*'You can be an ex-bus driver, you can't be an ex-murderer'.*



## Conclusion

My experience of listening to the narratives of offenders is that there is a process of transformation from an incoherent 'cover story' to more coherent narrative of tragedy, regret and hope. This transformation takes time, and needs reflective, secure thinking spaces where people who have done terrible things can learn to trust enough to say what could not previously be spoken of safely. Such therapy needs therapists who are trained and ready to listen to what the offenders have to say, in their own time and in their own way. Therapists have to be acute listeners for the small shifts in narrative emphasis, tone or metaphor that indicate shifts in perspective, coherence or agency. It is a long game, but one worth playing; as one man said, 'If I can do something with my life in the future, then two lives will not have been lost... and she will not have died in vain'.

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