Dinamički orijentirana grupna psihoterapija u forenzičkoj psihijatriji

/G Dynamic group psychotherapy in forensic psychiatry

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Sažetak/Summary

Forenzička psihijatrija bavi se među ostalim liječenjem neubrojivih počinitelja protupravnih djela. Te osobe sud upućuje na prisilno liječenje. Liječnik koji ih liječi redovito izvješćuje sud o napretku u liječenju. Iz toga proizlaze problemi dinamički orijentirane grupne psihoterapije forenzičkih pacijenata.

Rad se bavi specifičnim pitanjima provođenja dinamički orijentirane grupne psihoterapije u forenzičkim uvjetima: kako voditi grupnu analizu u uvjetima prisilnoga liječenja, koje su specifične kontratransferne reakcije s obzirom na činjenicu da su članovi grupe počinili protupravna djela, uvođenje treće (suda) u terapijski proces, homogenost grupe s obzirom na dijagnostičke kategorije, velik broj osoba s antisocijalnim poremećajem ličnosti, osjećaj (ne)sigurnosti u grupi počinilaca.

Iskustvo je autora da, unatoč mnogobrojnim specifičnostima grupne psihoterapije forenzičkih pacijenata, osnovna terapijska tehnika ostaje ista, uz potrebu pomnijeg praćenja vlastitih (kontratransfernih) emocionalnih reakcija.

/ Forensic psychiatry deals with a treatment of offenders of unlawful deeds that were assessed as not guilty by reason of insanity. These people are sent for an involuntary treatment by the court. Therapists who treat these people are obliged to inform the court about the process of treatment. These two characteristics are basic problems in the dynamic group psychotherapy of forensic patients.

This manuscript deals with specific issues of dynamic group psychotherapy in forensic settings: how to do dynamic group psychotherapy in involuntary treatment setting, what are specific countertransferential reactions due to the fact that group members all committed an unlawful deed, the introduction of the third party (the court) in the therapeutic process, homogenous group in regard of diagnostic categories, large number of group members with antisocial personality disorder, feelings of (in)security in a group of perpetrators.

The author’s experience is that, although there are many specificities of group psychotherapy with forensic patients, the basic therapeutic techniques are the same, with the important task of continuous and thorough analysis of own (countertransferential) emotional reactions.
OPĆE INFORMACIJE O FORENZIČKOJ PSIHIJATRIJI

Forenzička psihijatrija u Hrvatskoj bavi se među ostalim liječenjem neubrojivih počinitelja protupravnih djela, dakle duševnih bolesnika koji su (najčešće) u psihotičnom stanju počinili neko protupravno djelo, a u vrijeme izvršenja djela nisu mogli shvatiti značenje svojega postupanja ili nisu mogli vladati svojom voljom, a sve zbog duševne bolesti (psihotičnog stanja) od kojeg boluju. Osoba za koju se utvrdi da je djelo počinila u neubrojivom stanju i u koje je prisutan rizik da bi u budućnosti zbog tog duševnog stanja mogla počiniti novo djelo upućuje se na smještaj i liječenje u forenzičku psihijatrijsku ustanovu. Prvo liječenje traje šest mjeseci, a nakon toga ponovo se procje-

FORENZIČKA PSIHIJATRIJA / FORENSIC PSYCHIATRY

Forensic psychiatry in Croatia is defined as treatment of people not guilty by reason of insanity, i.e. people with mental disorders who committed a crime in (most often) a psychotic state and were not able to understand the meaning of their act or were not able to control their will at the time of the criminal act due to their mental disorder (psychotic state). The person who is assessed as not guilty by reason of insanity and who is assessed as having a risk to commit a new crime in future, due to his/her mental disorder, is referred to treatment and placement in a forensic psychiatric institution. The duration of the treatment is six months, and after this period, the person is assessed again for the need for the continuation of the treatment (1). This assessment is repeated every six or twelve months.
njuje potreba za daljnjim liječenjem (1). Ta se procjena ponavlja svakih šest ili dvanaest mjeseci. To liječenje je prisilno, u bolničkim uvjetima, na forenzičkom odjelu. Moguće je procijeniti i je li za smanjenje budućeg rizika dovoljno ambulantno liječenje, u tom slučaju bolesniku se određuje liječenje na slobodi.

Forenzička psihihijatrija u nekim drugim zemljama (npr. Sloveniji, Velikoj Britaniji) uključuje širi krug bolesnika, pa se tako bavi i osobama koje se nalaze na izdržavanju kazne zatvora i tijekom tog izdržavanja psihički se dekompenziraju do razine da im je potrebno bolničko liječenje. U Hrvatskoj se te osobe nalaze na liječenju u Zatvorskoj bolnici (koja je dio pravosudnog sustava, za razliku od forenzičke psihijatrije koja je dio zdravstvenog sustava).

Bez obzira na te razlike forenzička psihijatrija u jedним i u drugim zemljama bavi se prisilnim liječenjem osoba koje su počinile neko protupravno djelo (u forenzičkoj psihihijatriji rabi se pojam protupravnog djela, a ne kaznenog djela, jer je za kazneno djelo potreban psihički odnos prema djelu, što neubrojivi počinitelj nemaju – stoga neubrojivi počinitelji nisu kazneno odgovorni i nisu počinili kazneno djelo) (2). Karakteristike forenzičke psihijatrije jesu da je osoba na liječenje upućena od suda i da se to liječenje mora provoditi neovisno o tome želi li to osoba ili ne želi. Daljnja

This treatment is involuntary, inpatient, at a forensic ward. It can be also assessed that, to reduce the future risk, only outpatient treatment is sufficient, and in that case the person is sent for an outpatient treatment.

Forensic psychiatry in some other countries (e.g. Slovenia, United Kingdom) includes a wider range of patients, e.g. people who are in a prison and during their imprisonment become psychologically unwell and need psychiatric treatment. In Croatia, these people are treated in a prison hospital (which is a part of the judicial system, whereas forensic psychiatry is a part of the health system).

Despite these differences, in both cases, forensic psychiatry is concerned with involuntary treatment of people who committed an unlawful act (in forensic psychiatry we use the term unlawful act, and not a criminal act, because for a criminal act there is a need of a psychological relation to the act itself, which is absent in those not guilty by reason of insanity – for that reason these offenders are not considered criminally responsible, and they did not commit a criminal act) (2). The characteristics of forensic psychiatry are that the person is referred to treatment by the court and this treatment has to be carried out irrespective of whether the person agrees or not. The next characteristic of a forensic psychiatrist is that, in addition to treating mentally ill offenders, after a certain time (six months in Croatia)
je karakteristika forenzičkih psihijatara da osim da liječe oboljele počinitelje nakon određenog vremena (u našim uvjetima nakon šest mjeseci) pišu sudu izvješće o dotadašnjem liječenju i potrebi daljnjeg prisilnog liječenja osobe.

Prethodno navedene značajke (prisilno liječenje i dvojna uloga psihoterapeuta i vještaka) u potpunoj su suprotnosti s osnovnim načelima psihoterapije, pa tako i dinamički orijentirane grupne psihoterapije. Cilj ovog rada jest metodologijom preglednog članka prikazati mogućnosti i teškoće u primjeni dinamički orijentirane grupne psihoterapije kod forenzičkih bolesnika.

FORENZIČKI PSIHIJATAR / PSIHOTERAPEUT

Osvrnut ćemo se na neke temeljne zakonitosti u psihoterapiji kao što su povjerljivost, svojevoljno prihvaćanje psihoterapije kao metode liječenja, pridržavanje granica koje zahtijeva grupno psihoterapijsko liječenje, raznovrsnost kliničkih slika psihopatologije. Dinamički orijentirana grupna psihoterapija temelji se na dobrovoljnom liječenju osobe (koja želi izliječiti svoje simptome, ali i promijeniti strukturu svoje osobnosti), a sadržaj grupne psihoterapije (kao i dinamičke individualne psihoterapije) ostaje „tajna“ grupe, tj. ne iznosi se nigdje drugdje. Jedno od osnovnih pravila s/he has to write a report to the court about the treatment and the need to continue the involuntary treatment of the person.

These two characteristics mentioned earlier (the involuntary aspect of the treatment and the dual role of a therapists and an assessor) are contrary to the basic notions of psychotherapy in general, and group psychotherapist in particular. The aim of this manuscript is, using the methodology of a scientific review, to pinpoint the possibilities and difficulties in dynamic group psychotherapy of forensic patients.

FORENSIC PSYCHIATRIST/ PSYCHOTHERAPIST

Some basic rules of psychotherapy, such as confidentiality, acceptance of psychotherapy as a therapeutic method, acceptance of borders in dynamic group psychotherapy, and heterogeneity of clinical presentations of psychopathology, will be described further in this text. Dynamic group psychotherapy is based on a voluntary treatment of people (who want to treat their symptoms, but also want to change the structure of their personality), and the content of the group meeting (which is also the case in dynamic individual psychotherapy) is a group "secret" and should not be talked about outside the group. One of the basic rules of group psychotherapy is the secrecy of the contents said during the
grupne psihoterapije jest tajnost sa-
držaja koji se u grupi iznosi i zabrana razgovora o tim sadržajima izvan gru-
pnog okruženja (3). S druge strane, sve što forenzički psihijatar sazna tijekom rada s pacijentom obvezan je iznijeti u svojem izvješću ako smatra da se iz tog sadržaja može zaključiti o budućoj opasnosti pacijenta. Dakle, dok grupni psihoterapeut ima obvezu presa pacijentu, forenzički psihijatar ima obvezu i prema pacijentu (za liječenje duševne bolesti i očuvanje njegova duševnog zdravlja) i prema društvu (tj. obvezan je procjenjivati društvenu opasnost pacijenta). Druga je bitna razlika da je „idealni” pacijent za dinamičku grupnu psihoterapiju pacijent s neurotskim po-
remećajima (premda se danas sve češće vode i primijenjene grupe sa psihotič-
nim pacijentima, grupe ovisnika i slično (4)), dok je većina forenzičkih pacijenata psihotične razine funkcioniranja (ili su barem bili takvi u vrijeme djela).

DINAMIČKI ORIJENTIRANA GRUPNA PSIHOTERAPIJA NA FORENZIČKOM ODJELU

Je li onda uopće moguće, uz takve ra-
zlike, provoditi dinamički orijentiranu grupnu psihoterapiju na forenzičkom odjelu? Čak i ako se bolesniku na fo-
renzičkom odjelu omogući da odabere hoće li dolaziti na ponuđenu grupu ili ne, uvijek postoji izravan ili neizravan session and the ban on talking about these topics outside the group (3). On the other hand, a forensic psychiatrist has to report everything that s/he gets to know during sessions with a patient, if s/he considers that this content could give a clue to the future risk for a new crime. Thus, while a group psychotherapist is primarily obliged to keep secrets for a patient, a forensic psychiatrists is obliged to a patient (to treat his mental disorder and promote his/her mental health), but also to the society at large (i.e. s/he has to assess the social danger posed by the patient). The other big difference is that an “ideal” patient for a dy-
amic group psychotherapy is a patient with a neurotic disorder (although today, we more often have applied groups with psychotic patients, patients with addic-
tions etc. (4)), while the majority of fo-
rensic patients are at a psychotic level of functioning (or at least, they were at that level at the time of committing the crime).

DYNAMIC GROUP PSYCHOTHERAPY IN A FORENSIC WARD

Taking into account all that has been said so far, is it possible to have dynam-
ic group psychotherapy on a forensic ward? Even if we give an option to the patient on a forensic ward to choose whether or not to attend a group, there is always a direct and indirect pressure (coercion) to participate in the group. In-
pritisak (prisila) da se to liječenje pro-
vodí. Naime, neke terapijske zajednice
forenzičkih odjela funkcioniraju na
principu da će se poželjno ponašanje
(a to može biti i pohađanje grupe) na-
građivati, a nepoželjno kažnjavati. U
situaciji kad i ne postoji takav direktan
pritisak za dolazak na grupu postoji ne-
izravan pritisak jer bolesnik zna da se
njegovo cjelokupno ponašanje, njegov
odon prema djelu i prema terapiji pro-
cjenjuju i da će biti osnova za nastavak
prisilnog smještaja ili odluke o liječe-
nju na slobodi. Može li onda bolesnik u
toj situaciji zaista donijeti dobrovoljnu,
samostalnu odluku o sudjelovanju u
grupi? Tome treba nadodati da i tera-
peut može imati svoje kontratransferne
reakcije koje mogu proizlaziti iz bole-
snikove odluke o sudjelovanju ili nepo-
hađanju grupe. Hoće li terapeut imati
„bolje” mišljenje o pacijentu koji dolazi
na grupu, neće li njegov dolazak na gru-
pu procijeniti kao veći stupanj uvida u
svoju bolest i uvida u potrebu liječenja
i promjene, pa time i dati bolju progno-
stitičku ocjenu kod sljedeće procjene po-
trebe daljnjeg bolničkog liječenja?

Druga spomenuta okolnost, da bi sa-
držaj grupe trebao ostati tajna za one
izvan grupe, ponovo ima svoja ograni-
čenja u forenzičkim uvjetima. Uzmimo
za primjer terapeuta koji se dosljedno
drži tog pravila. Što ako bolesnik izne-
se neke sadržaje o samom djelu ili o
svojim planovima za budućnost (npr.
deed, some therapeutic communities in
forensic wards function on a principle
that desirable behavior (and attending
groups can be seen as a desirable behav-
ior) will be rewarded, while undesirable
behavior will be punished. In a situation
with no direct pressures on attending
groups such as just described, there is
always an indirect pressure because
the patient knows that his/her whole
behavior, his/her relations towards the
unlawful act and towards therapy, is
assessed and can influence whether s/
he will need to stay in a hospital or be
released for an outpatient treatment.
Therefore, is it really possible for the pa-
tient to reach a voluntary, free decision
whether to participate in a group therapy
or not? It should be added that a thera-
pist can have his/her countertransfer-
iental reactions toward patients if they
decide to participate or not to participate
in the group therapy. Maybe the thera-
pist will have a “better” opinion about a
patient who attends group therapy, and
will conclude that attending group ses-
sions seems to show better insight into
the patient’s illness and need for treat-
ment and change, so will have a better
prognostic assessment when the court
asks for the decision about future invol-
untary treatment.

The other basic notion that the content
of the group should be secret for people
outside the group has its own constric-
tions in forensic settings. For example,
what should a therapist who is strict in
following this rule do in case that a pa-
da počini novo djelo u budućnosti, kad izide iz bolnice), hoće li terapeut moći (i smjeti) zadržati taj podatak samo u grupi ili će ga unijeti u izvješće sudu (treba napomenuti da se sličan problem može pojaviti i u dinamički orijentiranoj grupnoj psihoterapiji neforenzičkih pacijenata – npr. što ako u grupi pacijent iznese sadržaj iz kojeg je vidljivo da će počiniti neko djelo prema drugoj osobi – i u tom slučaju grupni psihoterapeut ima obvezu spriječiti takvo djelo, no u forenzičkim uvjetima takva će se situacija događati gotovo svakodnevno, a kod dinamičke grupne psihoterapije neurotskih pacijenata to će biti uglavnom teoretsko, samo iznimno rijetko stvarno i praktično)? Forenzički psihoterapeut, za razliku od neforenzičkog psihoterapeuta, osim što liječi bolest zbog koje je bolesnik upućen na liječenje, ima zadatak smanjiti rizik od novog protupravnog ponašanja. Forenzički bolesnici već su počinili djelo i nisu u istoj poziciji kao “civilni” pacijenti koji su možda maštili o nekom djelu ili su ga čak i izvršili, ali zbog njega nisu procesuirani ili su odslužili svoju kaznu te terapeut više nije dobio jasan zadatak da procjenjuje njihovu buduću opasnost. Može li se forenzički psihoterapeut u svojim kontratransfernim reakcijama, ali i u svojim svjesnim razmišljanjima oduprijeti toj svojoj dvojnoj ulozi dok vodi grupu? (5) Kao što grupni analitičar, koji je educiran tient says something about the offence s/he committed earlier or about the future plans (e.g. to commit a new crime in future, after leaving the hospital)? Will the therapist be able to keep this information secret or will s/he write it down in a report to the court (it should be mentioned that such a case can happen in a dynamic group psychotherapy of non-forensic patients – e.g. when a patient in a group says that s/he will commit a crime against another person – in this case, a group psychotherapist should, in line with the law, inform the judicial system; but, in forensic settings, such a situation happens almost daily, while in a dynamic group psychotherapy of neurotic patients, this question is mainly theoretical and only rarely real and practical. As opposed to non-forensic psychotherapist, a forensic psychiatrist should not only treat the mental disorder that was the cause of criminal irresponsibility, but is also obligated to lower the risk of committing new unlawful acts. Forensic patients have already committed offences and are not equal to “civil” patients who might have fantasized about some criminal acts or even committed them, but were not sentenced for these deeds or had served their sentence. In any case, the psychotherapist was not appointed by the court to assess their future risk. Is it possible for a forensic therapist not to have countertransference reactions and conscious ruminations about this double role during group sessions? (5) Similarly to the situation of a dynamic group psychotherapist who is also educated and
i radi i kao individualni psihoterapeut, nerijetko mora u grupi svjesno razmišljati da ne radi individualne interpretacije, nego da se usmjeruje na grupna zbivanja, i forenzički psihoterapeut koji je ujedno grupni psihoterapeut mora stalno preispitivati svoju ulogu i zadatak u grupi – vodi li tog časa dinamičku grupnu psihoterapiju ili iskorištava te podatke za procjenu bolesnikova budućeg društvenog rizika (6).

Autor ovog rada vodi grupe u forenzičkim i neforenzičkim uvjetima. Tako je u jednoj grupi neforenzičkih pacijenata jedna od članica ispričala da je muž zlostavlja. Postavilo se pitanje što učiniti s tom informacijom budući da zakon nalaže da se svaka spoznaja o obiteljskom nasilju treba prijaviti. No takvom prijavom narušit će se odnos povjerenja s članovima grupe. U drugoj, forenzičkoj grupi, pacijent je ispričao da će se nakon izlaska s liječenja osvetiti osobi koja ga je dovela u te uvjete (riječ je o žrtvi prema kojoj pacijent pokazuje ideje proganjanja). Treba li i u toj situaciji imati isto stajalište prema povjerenju u grupi kao i u prvom primjeru neforenzičkih pacijenata?

Također, što će (svjesno i nesvjesno) učiniti bolesnik kojemu psihoterapeut u dinamičkoj grupnoj psihoterapiji ponudi da iznese sve svoje asocijacije na grupni razgovor, bez cenzure. Neće li taj bolesnik znati da to što kaže u grupi works as an individual psychotherapist and has to consciously refrain from individual interpretations in group sessions and continue to think about group processes, the forensic psychotherapist who is also a group psychotherapist should constantly ask himself/herself about his/her role and task in a group – is s/he doing dynamic group psychotherapy or is s/he using the data to assess future risk for the society from this particular patient (6).

The author of the manuscript works in both forensic and non-forensic group settings. In one of the non-forensic groups, one of the female members said that her husband was abusing her. The group psychotherapist asked himself what to do with this information, because the Croatian law says that any piece of information about domestic violence should be reported. On the other hand, reporting the case would endanger confidentiality in the group. In other, forensic group, a patient said that, after he leaves the hospital, he would take revenge against the person responsible for him being in the hospital (the victim about whom the patient has persecutory delusions). Should we have the same attitude towards the confidentiality in this situation as in the first case of non-forensic patients?

Also, when a psychotherapist proposes to the patients in dynamic group psychotherapy to talk about all their associations without censoring, what is a patient going to do (consciously and unconsciously)? The patient knows that
pi čuje psihoterapeut koji je ne samo psihoterapeut nego i onaj koji će sudu dati procjenu treba li on i dalje ostati u bolnici. Premda svaki bolesnik (i onaj neforenzički) u svoj odnos sa psihoterapeutom unosi nesvjesne, transferne želje i očekivanja i premda će upravo zbog tih razloga pacijent iznosi ili neće iznosi određene asocijacije u terapijskoj situaciji, u forenzičkog pacijenta to će biti narušeno i svjesnom spoznajom da u taj „siguran“ odnos ulazi i netko treći, tj. sudac i sud. Uloga psihoterapeuta kao autoriteta, kao svemogućeg roditelja koji upravlja cjelokupnim životom pacijenta u tom pogledu nije samo transferna, „kao da“, nego stvarna i jasno vidljiva. Psihoterapeut zaista upravlja životom pacijenta, tj. određuje hoće li pacijent ostati u bolnici ili će biti otpušten na liječenje na slobodi.

Drugim riječima, u grupnoj psihoterapiji u forenzičkoj psihijatriji prisutan je stalan paralelni odnos kulture zatvora i terapijske kulture grupne analize, stalno preispitanje pripadnosti psihoterapeuta/psihijatra forenzičkom (pavosudnom, kaznenom) ili grupnoterapijskom (prihvaćajućem) sustavu (6).

Preporuka je kod uvođenja pacijenata u dinamički orijentiranu grupnu psihoterapiju da pacijenti budu heterogeni te da bude samo jedan pacijent psihočne razine funkcioniranja, jedan what is being said will be heard by the psychotherapist, who is at the same time not just the therapist, but also the person who will give report to the court if the patient needs to stay in the hospital. And, although each and every patient (also non-forensic patients) incorporates into his/her relationship with the psychotherapist his/her unconscious, transferential wishes and expectations and although, due to these reasons, a patient sometimes reports having certain thoughts in the therapeutic situation, in forensic patients this is made more difficult by the conscious notion that the third party (i.e. the judge and the court) penetrates into this "secure" relationship. The role of the psychotherapist as an authority, as an allmighty parent who dictates the life of the patient, in the case of a forensic patient is not only a transferential, "as if", but also real and clearly visible. The psychotherapist does dictate the life of the patient, i.e. suggests if the patient will stay in the hospital or will be released to be treated as an outpatient.

We can also say that in dynamic group psychotherapy in forensic psychiatry there is always a parallel interference between the prison and the group psychotherapy culture, the constant questioning of the psychotherapist if s/he is the member of the forensic (legal, punishing) or the group-therapeutic (accepting) system (6).

When forming a dynamic group and when inviting new patients, the guidelines say that patients should be hetero-
granične strukture i jedan psihopatske strukture. Više pacijenata takvih karakteristika narušit će dinamiku grupe (7). U forenzičkim grupama većina je pacijenata psihotičnog funkcioniranja i velik je broj onih s antisocijalnim poremećajem ličnosti. Jedno je od obilježja antisocijalnog poremećaja osobnosti upravo kršenje društvenih normi i činjenje kaznenih djela. Zbog toga u zatvorima (a i u forenzičkim psihijatrijskim ustanovama) ima i do 75 % pacijenata koji su antisocijalne strukture. Kako se u grupi nositi s tri četvrtine članova koji su psihopati? Kakve će biti njihove grupne asocijacije, sposobnost empatije (antisocijalne osobe nemaju osjećaj krivnje ni empatije za druge, nego druge iskorištavaju za ostvarenje svojih ciljeva). Takav sastav poseban je izazov psihoterapeutu u poticanju grupe na suočavanje i potporu. Kakvo će zrcaljenje dati psihotični antisocijalni članovi drugim članovima grupe? Hoće li terapeut poticati zrcaljenje u grupi ili ga kočiti i ako odabere kočenje, neće li to kočiti i sam razvoj grupe i grupno specifične fenomene (7)? Budući da je riječ o specifičnoj grupi osoba s antisocijalnim poremećajem ličnosti koje su već počinile protupravno djelo, smatram da je potrebno kočiti one vrste zrcaljenja koje će i nadalje poticati i učvršćivati nezrele i antisocijalne obrasce reagiranja. Grupni proces koji će se u tom dijelu možda i zakočiti geneous with only one member at the psychotic level of functioning, one with borderline structure, and one psychopathic. More of such patients can endanger the dynamic of the group (7). In forensic groups, the majority of patients are at the psychotic level of functioning and the majority is with an antisocial personality disorder. One of the characteristics of the antisocial personality disorder is violation of social norms and committing criminal acts. For that reason, there is up to 75% of patients with antisocial structure in prisons (and also in forensic psychiatric units). So, how to deal with three-quarters of group members who are psychopaths? What kind of group associations will they have, what will be their empathic capacities (antisocial persons do not have feelings of guilt, do not empathize with others, but abuse others to achieve their own goals)? Such a group composition is a special challenge for the psychotherapist in encouraging group members to sympathize and support others. What kind of mirroring will a psychotic antisocial member give to other group members? Should a psychotherapist encourage mirroring in the group or should s/he stop it, and if s/he chooses to stop it, will this lead to stopping the group to develop and group specific phenomena to develop (7)? In my opinion, because this groups are specific groups of people with antisocial personality disorders who have already committed unlawful acts, it is needed to block those types of mirroring that will further encourage and fixate immature and antisocial patterns of
vjerojatno će se nastaviti u drugim aspektima, a grupno specifični fenomeni manifestirat će se u drugoj prilici.

Unatoč svim zamjerkama, otporima i problemima pojedini grupni psihoterapeuti vodili su grupe u forenzičkim i u zatvorskim uvjetima. Mnogi su radili i individualnu analitičku psihoterapiju počinjaju protupravnih djela te pisali o psihoanalitičkim aspektima i mogućnostima liječenja forenzičkih pacijenata od 1970-ih nadalje (8-10). Dok su s jedne strane prisutne mnogobrojne objektivne poteškoće u stvaranju slobodne grupne psihoterapijske situacije, činjenica da su članovi grupe zatvoreni u sustavu olakšava održavanje apsintencije od alkohola i droga, što je jedan od uvjeta za grupnoanalitički rad (6).

TRANSFER/KONTRATRANSFER
U RADU S PACIJENTIMA NA FORENZIČKOM ODJELU

Jedna od specifičnih značajki forenzičke dinamičke grupne psihoterapije jest da se u mrežu transfera između terapeuta, grupe i pojedinih članova umeće i treći partner – a to je pravosudni sustav / forenzička institucija. Slično triangulaciji djeteta, s uvodenjem trećega (oca), predstavnika stvarnosti, i u ovom slučaju treći (pravosudni sustav) znači uvodenje vanjskoga, realnoga. Na njega ne moramo nužno

behavior. The group process that might be blocked by this action on the side of a therapist will probably continue to develop in other situations, and group specific phenomena will manifest themselves in another situation.

Despite all of these objections, resistances, and problems, individual group psychotherapist have been doing dynamic group psychotherapy in forensic and prison settings. Also, many psychotherapists have been providing individual analytic psychotherapy with people who committed crimes and have been writing about psychoanalytic aspects and therapeutic possibilities for forensic patients since 1970s (8-10). While, on the one hand, there are many objective problems in forming a free group psychotherapy situation, the fact that group members are incarcerated makes abstinence from alcohol and from drugs easily achievable, and this is one of the prerequisites for a dynamic group psychotherapy (6).

TRANSFERENCE/
COUNTERTRANSFERENCE IN A FORENSIC WARD

One of the specific characteristics of forensic dynamic group psychotherapy is the penetration of the third party into the network of transferences between the therapist, the group as a whole, and the individual members – and that is the judicial system and the forensic institution. It is similar to a situation of a child
gledati kao na zapreku i problem u terapiji, nego on može biti dio procesa zdrave triangulacije (11). Kao malo dijete prije formiranja zrelog superega (savjesti, morala, kontrole, mogućnosti promišljanja prije reagiranja), tako forenzički pacijenti (neubrojivi počinitelji protupravnih djela, koji u vrijeme djela nisu bili sposobni shvatiti značenje svojega postupanja i kontrolirati ga svojom voljom) nemaju kapacitet da promisle/prorade/mentalno obrade afekt prije reagiranja (upravo su zbog toga i počinili djelo u neubrojivom stanju) (11). Upravo tijekom terapijskog rada potrebno je stvoriti okolinu (uvjeti) u kojima će biti moguće stvoriti mentalnu obradu prije reagiranja. I u tome taj treći (otac u individualnom razvoju, sud u forenzičkoj psihiatijiji) može biti taj koji će predstavljati vanjski (realni) superego, koji se tijekom terapije može "pounutriti". Ako bolesnik nauči umetnuti misli između impulsa i akcije (tj. ako se stvori mogućnost za stvaranje pojmova, za prepoznavanje emocija, za opisivanje iskustva, tj. za stvaranje sekundarnog procesa, dakle ako nema potrebe za acting out), tada ima mogućnost ne reagirati fizički, nego misaono, umom. A upravo je to i cilj forenzičkog liječenja (12).

Još je jedna specifičnost forenzičke dinamičke grupne psihoterapije činjena da u dinamičkoj grupnoj psihoterapiji neubrojivih počinitelja upravo in a triangulation, where the third party (the father), who is the representative of the reality: here, this third party (the judicial system) introduces the external, real world. Therefore, we should not look at this phenomenon exclusively as an obstacle and a problem in therapy, but as a healthy process of triangulation (11). Similarly to a young child before forming a developed superego (conscience, moral, control, the possibility of thinking before acting), a forensic patient (the person not guilty by reason of insanity, who was notable to understand the meaning of his/her deed or control his/her will) does not have a capacity to mentally process the affects prior to acting out (and due to this incapacity, in particular, they were not guilty by reason of insanity) (11). During the therapeutic process, it is important to establish the environment (conditions) that will facilitate mental processing before acting. The third party (father in the individual development, the court in forensic psychiatry) can be the one who will represent the external (real) superego, which can be incorporated during the therapy. If the patient learns how to insert thoughts between the impulse and the action (i.e. if there is the possibility of concept formation, emotion recognition, description of experiences, i.e. forming the secondary process and, therefore, no need for acting out), then the patient has the possibility not to react physically, but mentally, intellectually. And this is the goal of the forensic treatment (12).
that in dynamic group psychotherapy with people not guilty by reason of insanity, it is the presence of other members, all of whom have committed some antisocial, socially unacceptable and unlawful types of behavior, that softens the relationship of each of the members towards (healthy, not-sentenced, socially acceptable) group leader. In individual psychotherapy, the patient (in case of forensic patients) is confronted with a psychotherapist who is a representative of the “healthy” society that punished the patient for what he committed. In a therapeutic group, the forensic patient is not confronted with a single representative of a society, but has by his/her side other members who are placed in the same position, and this alleviates his/her position of a disgraced, punished, the one who needs to change (11). In such a homogenous (in terms of unlawful behavior, i.e. unlawful deed) group of forensic patients, emotions of fear, rejection, and humiliation will be less pronounced than in groups with other, non-forensic patients or in individual psychotherapy, with no similar members.

Feedback and mirroring will be more acceptable when they come from other group members who are similar to the patient and the patient will be more willing to accept views of other group members even outside the psychotherapeutic setting. Taking the view of the group can help patients to use the group as an auxiliary ego in conflict situations. For example, in a situation where a patient is
thinking about a new crime, s/he can ask him/herself what the reactions of other group members (who are very much like her/him, and who do not represent the healthy society, as they are neither the psychotherapist nor the judge) would be and s/he can react in a new way (12).

We should keep in mind that the group psychotherapist is not the only representative of the external world and the system in the forensic institution; there are other staff members, such as nurses, social workers, social pedagogues, and psychologists. Therefore, transferential emotions of the patient will be diluted, divided. There is also an institutional transference toward the forensic institution (hospital) (6). While in dynamic group psychotherapy of non-forensic outpatients we are dealing with transferences towards individual group members, the psychotherapist, and the group as a whole, in dynamic group psychotherapy of involuntary hospitalized forensic inpatients, there is a parallel system of transferences (apart from transferences towards other group members, the therapist and the group) towards the institution’s staff members and the institution (hospital) itself, as well as towards the legal institutions outside the forensic hospital (13).

We should not forget dynamic specificities of forensic psychiatry as compared with outpatient treatment of neurotic psychiatric patients. Forensic psychiatry is the area where fantasies (the world of inner objects) penetrated the reality (into
and the world of real people), the area where transference is not only the feeling, emotion, expectation, but also a real attack (sometimes even lethal) (14).

Because some members of a forensic group are dangerous (usually they committed murder, attempted murder, threat or physical harm), the psychotherapist can fear some individual group member, the majority of members, or the group as a whole. We should ask ourselves if in a specific situation this is a psychotherapist’s countertransfer resulting from the specific therapeutic situation, or if it is the result of the psychotherapist’s individual development, or if it is a real fear that should not be neglected, as danger can be real. A mistake to assess real danger as our own neurotic countertransference feeling in such a group can even have fatal consequences. The truth is that all these members have already done something similar (14). On the other hand, the author of this manuscript has never felt fear and has never had any uncomfortable experience in a forensic setting, but on the contrary, felt more fear and felt more uncomfortable (and even had realistic uncomfortable experiences) while working at a general psychiatric ward and in an emergency psychiatric unit. Is this denial (defense mechanism) or the real situation? Was this denial the consequence of the need to negate realistic fears in order to be able to work more comfortably and to be able to have empathy with patients and develop a psychotherapeutic relationship or is it really safer to work at a
rad na akutnom psihijatrijskom odjelu? Forenzički pacijenti najčešće su hospitalizirani više godina te redovito uzimaju terapiju, zbog čega je moguće da su i zaista manje opasni od kratkotrajno hospitaliziranih pacijenata na civilnim odjelima.

Talking about countertransference, the psychotherapist should take into account the fact that each and every forensic patient committed a crime, some of which can produce different emotional reactions. Some of these reactions will be similar in many psychotherapists, and some will be specific to individual psychotherapists (e.g. infanticide, rape, murder). Some of the defensive possibilities for the psychotherapist are to withdraw from the psychotherapeutic situation either emotionally or even physically, i.e. to conclude that is not possible to work with forensic patients due to all of the earlier reasons or even to decide to leave the forensic unit and find another job. The reality in Croatia is that, in the entire prison system at this moment, there is only one psychiatrist working. The reasons may be exclusively realistic or financial status-related or there may be influence of unconscious, defensive causes. Another defensive possibility is to develop deeper relationship with a patient or even to develop a grandiose defenses, believing that s/he is the only one who can help these patients (14). No matter what defense mechanisms we use, it is important to understand them because the level of the patient’s regression, the type of crime committed (mur-
regresije, vrsta djela koja čine (ubojstva, teške tjelesne ozljede, prijetnje), kao i činjenica da su djela usmjereni na najbliže članove obitelji (roditelje, bračnog druga, djecu) neće pobuditi snažne kontratransferne reakcije u psihoterapeuta.

Ta kontrantransferna pitanja bit će od još većeg značenja kod specifičnih djela – npr. incesta ili čedomorstva, u kojima će psihoterapeut stalno morati preispitivati svoje emocionalne reakcije na osobu koja je počinila djela koja su većini ljudi (i psihoterapeuta, kao i autoru) strana i odbojna. Postavlja se pitanje što da učini psihoterapeut kad ne može pronaći empatiju za svojeg bolesnika jer mu djelo koje je bolesnik počinio izaziva snažne negativne emocije. No smatram da radom s tim bolesnicima svaki psihoterapeut vrlo brzo nauči koliko smo slični i koliko i u sebi možemo prepoznati i takve agresivne, destruktivne impulse koji su katkad usmjereni i prema nama najbližim osobama. Ili, kad u pacijentu naidemo na tople, pozitivne, općeljudske kvalitete. I u jednom i u drugom slučaju to iskustvo pomaže nam u razvoju empatije.

**Umjesto zaključka**

S obzirom na specifičnosti forenzičkih pacijenata treba se zapitati koliko se grupni psihoterapeut treba držati der, physical injuries, threats), and the fact that these crimes were often committed against the closest family members (parents, spouses, children) necessarily elicit strong countertransference reactions on the part of the psychotherapist.

These countertransferential issues will be even more pronounced in case of specific crimes, such as incest or infanticide, where the psychotherapist will need to continually think about his/her emotional reactions towards the person who committed such a deed that is strange and repulsive to the majority of people (including psychotherapists, and the author as well). The important question is what a psychotherapist should do when s/he cannot develop empathy for his/her patient, because the deed committed by the patient produces such a strong negative emotion. My personal experience was that, through working with these patients, every psychotherapist quickly learns how similar all of us are and that we can find and recognize inside ourselves even such aggressive, destructive impulses that are sometimes directed even towards people who are close to us. On the other hand, we can also find in these patients warm, positive, human qualities. In both cases, these experiences can help us develop empathy.

**Ininstead of conclusion**

Due to specific characteristics of forensic patients, there is a question whether
pravila o poticanju slobodne grupne rasprave i slobodnih asocijacija pojedinih članova. Treba li dopustiti/poticati pričanje o samom djelu. Je li razgovor o djelu koje je pojedini član počinio potpuno jednak svim drugim sadržajima koji se u grupi pojavljuju. Kao i kod drugih sadržaja, razgovor o konkretnom djelu može imati različite dinamičke razloge (npr. to može biti znak da postoji intimnost, sigurnost i povjerenje u grupu, pa je osoba spremna podijeliti i svoje najintimnije sadržaje kojih se zapravo srami; no moguće je i da član grupe govori o djelu kako bi impresionirao, kako bi zadovoljio svoje ekshibicionističke i narcistične potrebe). Kao i u svakoj drugoj grupi, i tu možemo otvoriti pitanje pozadine otkrivanja detalja djela. No ne smijemo zaboraviti i na moguće psihoterapeutove kontratransferne reakcije da na te razgovore reagira poticanjem (zbog vlastitih voajerističkih potreba) ili sprječavanjem daljnjeg razgovora o toj temi (zbog straha od agresivnih sadržaja).

Na kraju se čini da je dinamička grupna psihoterapija forenzičkih pacijenata tehnički potpuno istovjetna dinamičkoj grupnoj psihoterapiji bilo kojih drugih pacijenata. No emocionalne reakcije psihoterapeuta bit će intenzivnije, pobuđene snažnijim podražajima i na njih treba paziti vjerljatno i više nego u neforenzičkom okruženju.

a group psychotherapist should follow the rule of encouraging free floating discussion and free associations of certain individual patients. Is the talk about the crime a person committed the same as talking about all the other group contents? The same as with any other topic, talking about the specific crime can have different dynamic reasons (e.g. it can be the sign of intimacy, safety, and confidence in a group, so the person is ready to share even the most intimate topics that s/he is ashamed of; but it is also possible that the group member talks about the crime to impress, to satisfy his/her exhibitionistic or narcissistic needs). As in any other group psychotherapy setting, in this case we can open the reasons behind the content. But we should not forget that there are also some countertransferential reactions on the side of the psychotherapist that can lead the therapist to a certain type of behavior – e.g. to encourage such topics (due to his/her voyeuristic needs) or to stop any further discussion (due to his/her own fears from aggressive contents).

In the end, it seems that the dynamic group psychotherapy with forensic patients is technically exactly the same as dynamic group psychotherapy with any other type of patients. However, the emotional reactions of the psychotherapist will be more intense, aroused by stronger stimuli and the therapist should be more aware of them compared to non-forensic settings.
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