

## **‘Switching Therapy On and Off’**

### **Non-attendance (DNA) as a re-enactment of early trauma in psychotherapy of sexual offenders with learning disabilities**

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#### Introduction

The phenomenon of poor attendance, which usually precludes an early termination of therapy, is a well-known issue in the field of forensic psychotherapy. (Firestone et al. 1998, Hanson & Bussiere, 1998) Attempts to explain its causes focus on the characteristics of the forensic patient, on the type of the therapy and the technique as well as on the environmental factors.

The patient's lack of motivation is considered to be the major inhibitor to therapy. This could be the result of the fact that, in most cases, therapy is imposed to the patient either by the court order or by the setting. The patient's denial of the offence, and possible negative previous experiences from therapy are also seen contributing to the lack of motivation. (Willshire & Brodsky, 2001)

A number of studies have shown a correlation between the type of the patient's psychopathology and the drop-out of therapy rates, with psychopathic offenders more likely to interrupt their treatment than the non-psychopathic offenders (Mulloy et al. 1996, Ogloff et al. 1990, Alterman et al, 1998, Hare et al. 2000) Moreover, studies indicate that patients with borderline personality disorder are more likely to drop-out of therapy, and Sea et al. (1990) found different rates of drop out according to the different clusters of personality disorders (with cluster B -antisocial, borderline, histrionic and narcissistic types having the higher, 40% rate) (Christopher Cordess, 2004, p.80-81)

In addition, Jones (2004) considers factors such as the history of the patient's engagement and disengagement patterns with services as well as the lack of engagement skills, including the ability to trust, to form a relationship, to tolerate feelings of interpersonal vulnerability, shame and other affect associated with change. Whilst Cordess (2004) suggests that the use of the

Adult Attachment Interview (AAI) in the assessment would provide information about the patient's attachment style and predict the patient's capacity to form a therapeutic alliance.

The choice of type of therapy as well as the style of the intervention have also been discussed as a factor determining the rates of non-attendance. (Willshire & Brodsky, 2001, Mc Murran, 2004) For example, evidence-based treatment programmes,( usually structured cognitive - behavioural programmes) that are used in prisons and probation services are concerned about the different stages of the patient's process of change (precontemplation, contemplation, preparation, action, maintenance and termination) and the appropriate interventions in each of these stages. Non-attendance is considered to be a possible result of a mistaken assessment about the patient's current stage and consequently a mismatch between the intervention and the patient's needs. (Prochaska & Levesque, 2004)

In Psychoanalytic psychotherapy non-attendance is usually interpreted as a reaction to the therapy material, which could be understood and worked through via the transference and countertransference. Under that perspective, non -attendance also brings the question of the patient's analysability, which, in brief, is the patient's capacity for psychological insight, the capacity to maintain basic trust in the absence of immediate gratification and the capacity to maintain the discrimination between the object and the self. (Etchegoyen, 1999) Yet, as Rosanna Gagliardi Guidi (1992) points out, the criteria of analysability have changed for very many diagnostic groups throughout the years, leaving analysability a matter of the particular relationship between the patient and the therapist. Generally, there is currently a shift of focus from the ‘untreatability’ of the patient to the responsibility of the therapist to engage and provide the appropriate treatment for the individual.

Environmental factors include the family's negative response and sabotage of therapy (Cordess, 2004) as well as rigid structures and resistance in some settings (Willshire & Brodsky, 2001) There is also criticism about the shift in the forensic practice from ‘client centred’ to ‘offence centred’ with the result to focus more on risk issues rather than on the welfare of the patient and for the treatment to become more compulsory rather than the patient's right. (Garland, 2001, Cordess, 2004)

In the therapy with offenders with learning disabilities, there are further complications. To start with, the learning disabled patients have little information about the therapy options and may easily get coerced into a certain treatment by the carers. In addition, many people with

learning disabilities, who offend, rarely get arrested and even more rarely go to Court. As a consequence, they may find it difficult to understand their offence and accept the need for treatment. The choice to attend or not may not be solely theirs, as they may either need to be reminded about their session or escorted to the session by their carers. Therefore the carers' attitude towards the therapy as well as their relationship with the therapist may determine the progress of the treatment. However, the patient is usually supported by more than one carer at a time. Issues of consistency and communication between the different carers, as well as between the different support systems (family, residential home, day care, education) and the micro-politics and dynamics of the patient's network also influence the therapeutic process.

In addition, the clinical practice is influenced by controversial views about what theoretical approach works, or rather what does not work with people with learning disabilities.

Treatment programmes need to be adjusted both in content and in length of time in order to be applied to people with learning disabilities. Very little is known about the different psychotherapeutic approaches in the field of learning disabilities. The psychoanalytic approach with this group has been questioned even by the therapists in the same field due to the issue of analysability, despite clinical examples that have proven the opposite (such as Valerie Sinason's and Sheila Hollin's analytic group work with sex-offenders with learning disability at St. George's Hospital).

Based on the above, the patient's non-attendance does not constitute merely an issue between the patient and the therapist but it is rather understood in the triadic relationship between the patient the therapist and their environment. Moreover, the therapist's response varies according to her/his theoretical approach, and the particular dynamics of this triadic relationship. (A. Browne & B. Dolan, 1991)

Using a case study of psychoanalytic psychotherapy work with a patient with learning disabilities, who offends, this paper will aim to understand non-attendance as a possible re-enactment of the patient's early trauma, and to consider the impact of the re-enactment in the triadic relationship. In the case, the prevalent issue of the trauma of learning disability and how it is transmitted by the parents to the child, becomes interwoven with Oedipal conflicts as well as with external circumstances and it is acted out in therapy. Moreover, the patient's internal world gets projected into his external environment, forcing his current network (carers and other professionals -including the therapist) to re-enact his primary family

dynamics. The paper, will further try to highlight ethical and technical issues as they appear in the case study.

### Case Study

#### *Background information*

George<sup>1</sup> is a forty-year-old man with moderate learning disability and an autistic spectrum disorder. He was born and brought up in South Africa, by Greek parents and he is the first of four children (two sisters and a brother -none with disabilities). According to his description, George had a close relationship with his mother and sisters, who ‘spoiled’ him, whilst his father and brother were strict with him. He also described that his parents quarrelled a lot and that his father was aggressive towards his mother. Later in therapy, he disclosed that his father was at times physically aggressive towards both George and his mother.

George spent most of his life in South Africa in boarding schools and later in adult units. He came to the UK four years ago, together with his brother, due to the political situation in his country. He is currently living in a 24-hour care home with other two men with learning disabilities, and he attends a Day Centre five days a week and a social club once a week. Although he reports that he is friends with everybody, he had never had any close friends and his social interaction is restricted to the members of staff.

The Psychiatrist referred George to our psychology team for therapy, due to his inappropriate sexualised behaviour towards women as well as his aggressive behaviour towards both men and women. George would verbally harass female staff at the Day Centre, being very explicit about his sexual desire towards them, and getting aggressive if they tried to discourage him. He would exhibit a similar behaviour towards schoolgirls in the street. On one occasion he was found masturbating in front of his open window at home, with the expectation that he would be seen by the school girls that were passing by. Very often, if the members of staff were not able to respond to his needs immediately, he would get angry and punch them or try to strangle them. The police were involved on numerous occasions, but he was never arrested due to his disability.

George started therapy in October 2006, in the form of weekly fifty minutes sessions, which is still ongoing. Initially, he idealised therapy and expected a ‘magic cure’. During the early

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1 The name has been changed to protect confidentiality

stages of therapy, George's anxious repetitive questions about ‘changing’ predominated our interaction, allowing little space for relatedness and serving as a resistance to being understood, to understanding and to change. Our interaction was enriched with ‘moments of meeting’ (Stern et al. 1998), followed by increased anxiety, which was acted out through George's ambivalence towards therapy. For example, in one of our early sessions, there was a moment of silence, when we both looked at each other, as recognition of each other's presence and of being in the room together. The following week George arrived more anxious than usual. He said that he had lost his college identity card and he was convinced that he had left it in the room the previous week, spending most of the session looking around the room. A brief moment of connection may have triggered the fear of losing his identity in an engulfing relationship with me.

The focus of our first sessions was about his anger, which spoiled his relationship with others, especially with authority figures, such as the home manager. There was an evident rivalry between George and the home manager. At the time of the referral, George had already made allegations of physical abuse against the manager, which were investigated and proven false. George was entertaining the fantasy that I would help him ‘destroy that man’ or that I would make him ‘good for this man’, which gave rise to a very early transference of his Oedipal material and the projection of the parental roles on to the home manager and the therapist. The therapist's Greek origin may have also facilitated such an early transference.

### Remembering and Acting-out

There is a plethora of evidence in the psychotherapy practice about how breaks may trigger feelings of loss and abandonment in the patient. (Greenson, 1981, Etchegoyen, 1991). In my work with George, the Christmas break triggered a number of issues related to the fear of annihilation, loss and helplessness, and it was significant in the development of the therapeutic process. It also highlighted the multifaceted effect of the disability on George, the therapy and me as a therapist.

At a practical level, the disability interfered with George's capacity to make arrangements for his own therapy during the Christmas holidays. It also interfered with my capacity to differentiate what constituted George's resistance and what belonged to his carers' ambivalence towards his therapy. To start with, we had decided to continue our sessions during the festive period, and George was very keen on doing so, as this would have been his

first Christmas away from his family and he had already expressed his sadness and nostalgia about it. However, week after week, a member of staff would call to cancel the session, first due to George's sickness, then due to trips for Christmas shopping and lastly due to George's last minute trip to France.

I was left feeling helpless and angry, wondering whether this ‘break’ in the therapy was due to the carers' collusion with George's resistance to coming in contact with painful feelings of the loss of a ‘family Christmas’ and so activities had replaced the thinking space of therapy. I also observed my helplessness and anger as they were providing me with a glimpse of George's experience of breaks and separations.

In his paper ‘Remembering, repeating and working through’ Freud (1914), introduced the idea of the patient's attempt to reproduce-repeat- what he has repressed, not in the form of memory but as an action. In this case, George's absence from therapy was a re-enactment of how he had experienced his separation from his family. All occasions of separation (when he was to go to the boarding school, then to the boarding unit and recently when he came to the UK) were presented to him in an idealized way, as an opportunity for independence and fun- the same way as the Christmas activities were organised for his fun. Yet, George had experienced these separations as an abandonment by his parents and siblings. It was not surprising that on his return to therapy not only was George overwhelmed by anxiety about death and loss, but he was also under the impression that I was the one responsible for that long separation, the one that had sent him away. According to his experience, George had no saying in all this. Separation had always been imposed to him and I -like his mother, was responsible for letting him go. The following is an extract from the first session after the Christmas break:

*George- I remember about my past ... (called my name)... Tell me how can I forget about it? I want to forget. Tell me how to forget...*

He was almost shouting, repeating the above sentence over and over again, all through our way from the reception to the therapy room. Later, in the session, George told me that he had remembered his maternal grandmother, who had died years back in South Africa. He talked about his memories of visiting his grandmother in hospital, and how he was missing her. He also identified himself with her, leading to memories about his own life, disability and death.

*George- I need you to write down about my past. Please, write it down for me, please...*

*Therapist- What would you like to write down?*

George- *Why my mother switched off the machine but I came to life after*

Therapist- (looking puzzled)

George- *You know, the machines that they put the babies in. If they switch the machine off, the baby dies. The doctor wanted to switch the machine off because I was brain damaged, but my mum said: ‘No, switch the machine back on’. How did I come back to life, how did it happen? .... I was brain damaged....brain damaged*

(His voice sounded distorted – he was sobbing)

*I want to remember, I want to ask my mum on the phone: Why am I alive? What happened? What the doctor said, what my mum said?*

I felt paralysed by pain and guilt, for in George's experience I had switched off and switched back on the therapy. The memory of his mother's ambiguous moments between his life and his death was not there- he might have heard the story from his mother, or others- but his experience of being in limbo between life and death in the mind of others was vividly present in the room.

Greenson (1981, p.260) has pointed out that the patient's tendency to re-enact instead of remembering is linked to non-verbal material, as well as to trauma. George had no recollection of what had happened, but his experience of the interruption of therapy had triggered some past sense data, what Bion (1962) called ‘beta-elements’ that needed to be transformed into thoughts and meaning ‘alpha-elements’. For doing so, he had asked me to ‘write them down for him’. George does not know how to read or write. I think that what he was asking me to do was to help him re-write his story; not in the descriptive way that it was told to him before, but in a meaningful way, where his questions could find answers and his terror could be transmuted into bearable thoughts. The paper could contain the written words- the symbols of what was still unthinkable. Possibly, it could contain the symbolic proof that he was alive and not dead, or lost in between life and death, waiting for his parents and the society (represented by the doctor) to decide whether to keep him alive or kill him for having brain damage.

However, George's wish to remember and reconstruct what had happened in these early moments of his life, was also accompanied by the terror of knowing, which resulted to his

ambivalence towards therapy. In her paper *'Psychoanalysis and Mental Retardation: A Question of 'Not-Wanting-To Know'* Claire Morelle (1999, p.97-98) describes how the stance of 'not-knowing' or 'not wanting to know' in the learning disability is connected with the resistance to acknowledge the issue of death, which is present when a handicapped child is born or even when an anomaly is observed during pregnancy. Therefore, as Valerie Sinason (1992) wrote, the conscious attempt not to know is the child's defence against the fear of annihilation derived from the acknowledgement of the murderous feelings of his/her parents.

### Switching Therapy On and Off

The theme of being in limbo between life and death has been re-enacted a number of times in therapy, through George's attempts to end our work.

After another break, this time due to my annual leave (which was planned and discussed with George well in advance), George refused to come back to therapy. His carers described how he would get ready to come for his session but change his mind when out on the bus or in the car, insisting on returning home and becoming extremely aggressive if they tried to persuade him otherwise.

This description suggested not just ambivalence towards therapy, but also intense feelings of fear, as if in the anticipation of a catastrophe, like having to fight against an impending death; as if therapy was now killing him for it was the space in which George was encountering the issue of death.

When George eventually returned to therapy, after my letter and a phone call, he announced that he wanted to end therapy at once, as it was 'too difficult' and 'tiring' to remember. He wanted to forget. At this stage, George's environment was also acting out his impulse to end therapy. The carers' anxiety about George's uncontrollable rage lead them to search for a 'magic, quick cure' themselves. They requested that the psychiatrist would refer George to another professional for 'anger management', and they also referred him to another organisation for sex-education, despite the fact that George was already attending a sex-education group at his day placement.

In his paper on transference and countertransference, Tsiantis (1996) demonstrated how parental roles are projected on to staff working with adolescents in a unit, creating splits between staff groups. George's internal reality of his mother, who wanted to keep him alive against the powerful male figure, represented by the doctor (possibly later by his father), who

wanted him dead, was projected into and re-enacted in his external world in the present (here and now) with the female therapist trying to keep the therapy alive against the male home manager, who wanted it to end.

One may only speculate how many times this internal battle of the good and bad objects had been re-enacted in his external world in the past, for example when he was sent to the boarding school, or to the UK; only on these occasions the bad object won and every separation has been experienced as his own death. This speculation came more to light, when in one of our agreed ending sessions, responding to George's repetitive, almost sadistic comments of how he disliked therapy, I reflected back to him that it felt as if he was dumping me. George was delighted by the use of the word ‘dumping’. He smiled and repeated in a triumphant manner: *‘Yes, I'm dumping you, I'm dumping you’*. Months later, George used the same word to describe how his father sent him to the UK to *‘get rid of’* him and how he felt *‘dumped’* by not only his father, but also by his mother, his siblings and all his extended family. He also used the same word, describing that he feared that the home manager would dump him in the streets because he disliked him for his aggressive behaviour.

On another level, the word ‘dumping’ may have invited a hint of possible erotic feelings in therapy. It may have also served as a narcissistic triumph for George, who was now able to dump a woman, reversing his experience of being dumped by his mother, by the women who had refused his love, as well as by me, who had left him to go on holidays.

The erotic feelings in therapy became more apparent later on, after George had decided to continue his sessions. He had started talking more about his wish to have sex and his fantasy of picking up a school girl from the bus stop and *‘do it to her’*. He was curious about sex and he was complaining that his sex-education class was not enough, inviting me to discussions about sex. Stanley Ruscynski (2007, p.29) describes how aggression becomes sexualized as a defence *‘...against the anxiety of the loss of the self or the other by creating the fantasy that rather than engulfment or abandonment there is an interpersonal relationship’*

However, the erotic feelings had also triggered Oedipal anxieties and George stopped attending once more. When, after my phone call he came back to therapy he announced that his sister did not like him having a female therapist and she had asked him to end the therapy with me. My dilemma in dealing with this development was whether I should focus on George's resistance or take into account and deal with his external reality. Was this

development due to George's material or because his sister and his carers had thought that his sexual behaviour, which was causing a lot of concern at the time, would have been better dealt by a male therapist?

In his therapy George explored his wish to have a male therapist or any other therapist and his wish to -using George's words- ‘*start from fresh*’ as a way of avoiding being really known by somebody and being connected with the therapist. Greenson (1981) described negative transference both as a resistance and a defence against positive transference, occasionally emerging out of the patient's fear of the analyst's criticism. In this case, possibly it had to do with George's fear of whether I could bear know him and be with him or not. Moreover, the possibility that I could really bear know him, may have triggered his anxiety emanating from his aggressive feelings towards me as a reaction to his fear of engulfment.

In his concept of ‘The Core Complex’ Glasser (1964, 1979) described the constant movement between the infant's wish to unite and merge with the object (usually the mother) and the wish for distance, for having experienced this closeness as claustrophobic and as a threat of the annihilation of the self. He viewed aggression as an integral part of the core complex, arising from the fear of annihilation and aiming at self-preservation and the destruction of the object.

There was a hint of these aggressive feelings when George and I were exploring whether his sister thought that having a female therapist was risky:

*George- Yes, it is risky, it is risky*

*Therapist- Am I a risk to you or are you a risk to me?*

*George- Yes, you are a risk to me! You are a risk to me* (shouting his words)

George had projected his aggressive feelings on to me, whilst later in the same session he acknowledged that he was also a risk to me, but he ‘*would never attack*’ me. In his paper ‘*Aggression and sadism in the perversion*’ Glasser (1964, p.286) described that in order to deal with the aggressive feelings, the ego splits the affective impulses towards the mother, projecting the aggressive component on to her, so she is then experienced as the threatening one.

The discussion about the risk to attack or being attacked, had introduced an erotic element or even the risk of a sexual attack, which George was acting out, outside the therapy, via his infatuation with and sexual advances towards a pregnant female member of staff at the Day

Centre. In that way not only was he able to return to therapy as the erotic feelings were evacuated outside the sessions, but he was also entertaining the fantasy of having a fresh start either by penetrating and impregnating this woman producing a healthy non-disabled child, or by penetrating her and becoming the new child in the woman's womb; a fantasy which may also resonate with George's experience of his mother being pregnant with his younger siblings.

### The external reality

Acting out has been viewed as a resistance to remember (Freud 1914, Green son, 1891). In my work with George I followed Greenacre's (1950) and Limentani's (1966) position according to which, acting out is a form of remembering, providing information and communication about the internal world and the conflicts of the patient. A technical issue arose when George's external environment reflected his internal reality and acted out the projected roles from George's past. At times it was -and still is- difficult to differentiate what was an enactment of George's history and what constituted people's negative attitude towards firstly the learning disability and secondly the aggression.

From the beginning of the work with George a psychologist from my team was also involved, working with the members of staff, in order to support them with the management of George's aggression. Later, the Intensive Support Practitioner followed that role, as the staff team needed on-going support and training.

Besides my colleagues' involvement, there was an urgent call for my direct involvement (eg staff would call me to inform me about incidents, and I had to call a number of professionals meetings to deal with the issue of the numerous referrals to professionals). My direct involvement raised my concerns about safeguarding confidentiality and George's trust. Yet, it provided the opportunity for the members of staff and the therapist to act as a containing couple. Acting as a parental couple that think together about how to help George could offer him a different experience from his own internal couple, who fight with each other and eventually agree only to ‘dump’ him.

However, that was not proven possible, as the staff team, represented by the home manager was engaged in a constant acting out of siblings rivalry with George. As a consequence, they would either look up to the therapist, who as a ‘good mother’ would ‘sort out’ George's behaviours, otherwise, they would be angry with the therapist ‘the bad mother, who spoiled

George’ or ‘the bad mother, who was too weak to protect them from George's behaviours’ and therefore they would seek help from the other parent (the psychiatrist or the Intensive Support Practitioner).

During the course of the work, a parental couple was formed by the Intensive Support Practitioner and the therapist in an effort to contain both George and the staff team. The role of the Intensive Support Practitioner, had a male element -energy- containing and balancing ‘the whole family’- the therapy and the staff team. It dealt mostly with the environmental and systemic issues (such as behavioural guidelines, staff training, staff communication) and communicated with staff about therapy, offering information and explanations about the process.

### Discussion

The aim of the work with George is to provide a containing psychological space, where we can think about and reflect on the meaning and use of his aggressive and sexualised behaviour. This process has been challenging due to re-enactment of George's trauma in the form of therapy interruptions.

Johan De Groeff (1999, p.47) described that all parents have to go through mourning for the dying of the ideal child of their dreams. This dying is not a once-only event, but an ‘*unremitting dialectical process*’ where ‘*the child (of our dreams) not only have to die but we should keep on dreaming about the deceased and the real child too*’

The child also has to mourn for the loss of his/her own ideal self and the grief this has caused to the parents in order to achieve self-discovery. In the case of the birth of a child with a disability, the death of the child is not gradual but an imminent one, and according to parents, it is experienced as trauma. (Korff-Sausse, 1999). The trauma of the learning disability is then transmitted to the disabled child via the parents' incapacity for reverie and containment (Bion, 1962), which affects the child's ability to create representations of his/her affective states.

According to Fonagy (2004, p.26) that may interfere with the mentalization process, and the child's ability to ‘differentiate reality from fantasy and physical from psychic reality’

In George's case, there has been a painful match of his internal and external world, where the normal annihilation fantasies were confirmed and possibly compounded by the external reality. In the light of his early experience of an undifferentiated state between life and death the aggressive behaviour can be understood as a self-preservative (Glasser, 1998) response to

the threat to one's own self. George's experience of being in limbo, having no control over his life or death, is repeated every time others (parents, professionals) are to make a decision about him. Therefore, any frustration of his needs and requests, any delay to respond to him is received as an attack to his life and triggers his rage. Moreover, due to his experience of the learning disability as a trauma and the cause of his ordeal, any negative attitude from his environment may be received as a physical threat to his very existence.

George's inappropriate sexual behaviour could be explained as a result of his anger as well as of his experience of an undifferentiated reality, where his oedipal fantasies and conflicts are reflected in the external world. In his undifferentiated reality there is a denial about boundaries, such as the boundaries of age, sex, social roles (Britton, 1989, Ross, 2003, Ruszczynski, 2007)

George is operating from the Kleinian paranoid-schizoid position, communicating with others via splitting and projective identifications. His interaction is characterised by polarized positions of love and hate, idealisation and devaluation and repetitive enactments of his past. Therapy aims to provide an intersubjective space, in order to assist George to move to the ‘depressive position’, where the opposites can be integrated and love and hate may contain each other, with the hope that -paraphrasing Mann (2002, p.34)- love will exceed hate, ensuring George's survival.

My ability to contain George's anxiety and aggression as well as the painful impact of the disability has been vital in this process. However, this ability was at times diminished, when I felt clumsy in my interpretations as a countertransference response to George's painful material. George has been constantly acting out his experience of being in limbo between life and death, projecting on to me both all the good nurturing mother, who wanted him alive, and the bad, murderous mother, who wanted him dead and ‘dumped’ him. These projections found a fertile ground in my own field of existential death anxieties in general and my fear of my death as a therapist in particular. It was very important that my own personal and professional environment were able to keep me alive, providing a container for me and my work. Supervision and my colleagues provided me with a ‘holding’ space to consider some prominent ethical issues.

The balance between the safeguard of confidentiality and the need to communicate about George's process and needs had proven to be extremely delicate. The environment's



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