Forensic practitioners' views on stimulating moral development and moral growth in forensic psychiatric care

Specker, J., Focquaert, F., Sterckx, S., & Schermer, M.H.N. (2018). *Neuroethics*, 10.1007/s12152-018-9363-x.

Abstract

In the context of debates on (forensic) psychiatry issues pertaining to moral dimensions of (forensic) psychiatric health care are frequently discussed. These debates invite reflection on the question whether forensic practitioners have a role in stimulating patients' moral development and moral growth in the context of forensic psychiatric and psychological treatment and care. We conducted a qualitative study to examine to what extent forensic practitioners consider moral development and moral growth to be a part of their current professional practices and to what extent they think that stimulating moral development is a legitimate objective in the context of forensic psychiatric treatment. In addition, we asked how forensic practitioners balance pubic safety and risk management concerns with the interests and wellbeing of the individual patient. We conclude that: (i) elements of moral development and moral growth in forensic psychiatric care practices are to a certain extent inevitable and not necessarily questionable or undesirable; (ii) yet, as in similar debates these elements need to be made explicit in order to discuss the accompanying ethical challenges and boundaries. An open academic, professional and public debate on aspects of stimulating moral betterment within current practices is therefore desirable.

Introduction

A number of separate debates invite reflection on the question whether forensic practitioners have a role in stimulating patients' moral development and moral growth in the context of forensic psychiatric and psychological treatment and care.

Psychiatrist Sean Spence has raised the question whether moral improvement (in the sense of being a better person, or a better *behaving* person) is an implicit, or even explicit, goal of psychiatric treatment: "Can pharmacology help us enhance human morality? (...) I argue that we are already deploying certain medications in a way not totally dissimilar to the foregoing proposal: whenever humans knowingly use drugs as a means to improving their future conduct." (Spence, 2008, p. 179). Apart from the – what Spence calls – 'Promethean project' of "specifically designing drugs that target and increase a pro-social feeling and behaviour such as 'kindness'" (Spence, 2008, p. 179), treatment can have morally relevant side-effects or consequences. Spence discusses the example of "a man prone to psychosis, who can be violent when ill, takes his medication reliably, thereby reducing his risk to others)" (Spence, 2008, p. 179). Here, Spence argues, the well-being of others has improved as a direct result of pharmacological treatment of a mental disorder. A number of commentators have discussed potentially morally relevant "side-effects" of existing drugs that may (or already) have altering effects on moral decision making or on morally significant behaviour, and urge more research to able to better distinguish between desirable and less desirable effects (Levy et al., 2014a, 2014b). One example discussed by the authors concerns selective serotonin reuptake inhibitors (SSRIs) that are prescribed to treat depression and anxiety disorders, but as a possible side-effect may increase aversion to directly causing harm in others (Crockett et al., 2010b).

Psychiatrist Steve Pearce and philosopher Hanna Pickard make a similar point when they argue that psychiatric treatment can foster moral growth in various ways: "First, they can lead to the emergence of new moral motives and intentions. Second, they can lead to the acquisition or development of cognitive skills such as empathy, which are central planks of moral action. Third, they can enhance the ability to apply moral understanding and skills in particular circumstances" (Pearce & Pickard, 2009, p. 281). They take it as a given that interventions that can foster moral growth occur routinely within psychiatric settings, most notably in the treatment of personality disorders. In this context the question is posed as to whether forensic psychiatric disorders should partly be understood as moral disorders, and forensic psychiatric treatment as moral therapy. Diagnostic criteria for personality disorders involve traits that involve failings of morality or virtue, such as lack of empathy in the case of narcissistic personality

disorder, or anger and impulsivity in the case of borderline personality disorder (Pearce & Pickard, 2009; Pickard, 2011). Pickard has discussed this in terms of the inherent 'Janus-faced nature' of personality disorders (PD): "The fact that the characteristics and traits that cause distress and impairment to the individual often involve harm to others. (…) Although harm to others, broadly conceived, is not part of the DSM-IV-TR definition of PD, it is part of how particular kinds of PD are diagnosed: via characteristics or traits that count as failures of morality or virtue and thus impair social, occupational, or other areas of interpersonal functioning." (Pickard, 2011, pp. 182-183).[18]

In sum, in the context of debates on (forensic) psychiatry issues pertaining to moral dimensions of (forensic) psychiatric care are frequently discussed. Although some experts have argued that moral betterment is or should be a goal within forensic psychiatry and psychology practices (Pearce & Pickard, 2009), it is unclear to what extent stimulating moral development and moral growth is a goal within current forensic mental health settings and much less so whether it should be.

In this article, we explicitly focus on questions related to the moral dimensions of forensic psychiatric practice. The main objective of this study is to explore the question whether forensic practitioners consider stimulating moral development and moral growth to be a part of their current professional practices, and to what extent they think that stimulating moral development is a legitimate objective in the context of forensic psychiatric treatment. In addition, we ask how forensic practitioners balance public safety and risk management concerns with the interests and wellbeing of the individual patient. In the discussion, we discuss whether, and of so in what ways, our findings relate to and can be informative for the bioethical debate on moral bioenhancement.

Methods

Sample and recruitment

We recruited 21 forensic practitioners (forensic psychiatrists, clinical psychologists and therapists) in The Netherlands and in Belgium. Subjects were recruited via professional organizations and by snowball sampling, meaning that initial research subjects

18 See also: "wrongfulness-laden disorders should be investigated to determine whether the disorder involves a moral incapacity (a disability in the moral sphere or "faculty") or is simply a matter of wrongful moral choice" (Sadler, 2014, p. 167); and "some psychopaths do, in fact, appear to have deficits that distinguish them from responsible offenders. These deficits appear to undermine psychopaths' ability to understand morality" (Shaw, 2016).

suggested potential future subjects from their network (Atkinson & Flint, 2004). Our sample consists of nine females and 13 males, ranging in age from 32 to 68 years. At the time of the interviews, 12 participants were employed in The Netherlands and nine were employed in Belgium.

We conducted 11 interviews with forensic psychiatrists (FP) (at the time of the interview, one participant worked as a general psychiatrist, but had worked in forensic settings in the past). We conducted 10 interviews with clinical psychologists (CP) or therapists (T) (at the time of the interview, two participants - a therapist and a clinical psychologist - were primarily involved in research and did not consult patients, but had done so in the past). Twelve participants (seven psychiatrists and five psychologists) are involved in scientific research, alongside their clinical or therapeutic work.

Qualitative interviews

Participants took part in an individual semi-structured interview lasting approximately one hour. During one interview, two respondents were present and interviewed together. The interviews were held in Belgium and The Netherlands, and took place between January 2014 and July 2016. The interview guide was developed by JS in consultation with MS, FF and SS. The interviews were conducted by JS, FF and MS. JS attended 17 interviews, FF attended seven interviews, and MS attended three interviews.

The interview schedule included open-ended questions about the moral dimensions of forensic psychiatric practice, about participants' views on the question whether they consider stimulating "moral improvement" or "moral development" part of their current work practise and as a legitimate part of their professional responsibilities, and about how to balance and prioritize public safety and risk management concerns with the interests and wellbeing of patients. The interview schedule also contained a separate part with questions on forensic practitioners' expectations and moral views regarding potential applications of current neurobiological and behavioural genetic research aiming to understand (and possibly help prevent, contain, or treat) violent and antisocial behaviour. We have reported on that topic elsewhere (Specker et al., 2018).

Coding

All interviews were transcribed verbatim and coded in QSR NVivo version 11, using descriptive theme analysis (Bazeley & Jackson, 2013). All transcripts were independently read by all members of the research team (JS, FF, MS, SS). All transcripts were independently read by all members of the research team (JS, FF, MS, SS). JS and FF discussed a random selection of transcripts with the purpose of drafting a preliminary

analytic framework. JS independently coded the transcripts by labelling sections and text units referring to one or multiple concepts relevant for the study purpose. An iterative approach was used in which new data that challenged the existing coding structure were used to revise the themes until no new themes emerged. Interpretative bias of data was avoided by means of investigator triangulation, which involved all researchers (JS, FF, MS, SS) checking the codes for consistency.

Results

Do stimulating moral development and moral growth play a role in treatment?

The first set of questions offered to participants raised the – deliberately broadly formulated – issue of whether forensic psychiatric treatment and care involve, in one way or another, elements of stimulating moral development and moral growth. In their responses, participants did not only differ in their opinion on whether these elements should or shouldn't be part of treatment, but also in their understanding of what morality entails. Nearly all participants started their response with discussing how to understand moral development and moral growth, and *what kind of* morally relevant aspects are, or potentially can be, targeted in treatment. Before outlining the different aspects of morality participants mentioned in the subsequent section, below we discuss the reasons participants offered why they do or do not think stimulating moral development and moral growth is part of treatment.

Whereas only a few participants indicated that stimulating moral development and moral growth were not part of treatment, most participants appeared to be more ambivalent in their answers. Participants who indicated that stimulating moral development and moral growth play no role in treatment, mentioned that their treatment plans do not involve aspects of stimulating moral development, and that their medical training did not involve a focus on the moral aspects of behaviour. Instead, they underlined their medical rather than 'moral' expertise. This can be illustrated with the following quote from a participant:

> Look, our task is not to create 'better people'. We want them to stop doing awful things, we want to lower the risk factors, and I think that, to create better people, that is a very big step. CP8

> If someone says to me; 'Generally, I'm quickly aroused, high in blood so to say (…) And then I feel rejected very soon', if I can improve that in any way, in how he relates to higher values and the world surrounding him, by intervening by giving him

> a beta blocker, for example, to make sure he is less quickly aroused – I will do that. But my goal is to increase his quality of life, my goal is not to improve someone's morality. Because, I actually think that that does not belong to my expertise, to my profession, and is actually not part of my assignment. FP1

A number of participants argued that stimulating moral development or moral growth should not be part of treatment, and emphasized the importance of maintaining a clinical stance towards their patients, if only to provide a safe place to discuss sensitive subjects. They argued that the primary task of a forensic psychiatrists or therapist should be to treat disorders and to improve the quality of life of their patients – not to *moralize* – and that moral condemnation and judgment, if applicable, should happen not in the consulting room, but elsewhere (in court for example, or perhaps in society at large).

> I do not like the idea that this would be a required task of a forensic psychiatrist. I think, I can only speak for myself, I think, well, we are not to judge about good and evil. I mean, we can only observe. And the only thing we are trained to do is to see if we can find a way to improve the quality of life of patients, preferably in a holistic way. And that is the only thing we can do, anything else, we cannot. FP1

> Is it the aim for psychologists to become priests? To become moralists? Please, no. There must be a place for someone, who of course is condemned everywhere else within society, to find shelter and to not be judged. If such a place is no longer available (…) that person will no longer dare to share her most immoral thoughts. CP6

> And by the way, who am I to lecture that person? Because presumably they would be able to mention a few things they disapprove of about me, right? PF5

However, other participants indicated that moral development is indeed part of forensic psychiatric treatment. These participants often mentioned that they considered improving patients' capacities for empathy (both cognitive and affective) and moral reasoning (in terms of correcting cognitions and logical errors) as explicit treatment goals.

> Empathy, for example, is certainly a goal for us. We focus on impulse control, relapse prevention, empathy enhancement, and responsabilization. CP4

> Very often with people who do not behave morally, I feel it is about logical errors. And then I try – but I am necessarily limited in this regard – I try to determine

> whether there are any thinking errors involved, and whether I can test their flawed ways of thinking, and possibly correct or adjust them, pharmacologically or psychotherapeutically. FP1

Interestingly, as the interviews progressed, several participants kept coming back to this subject and wondered whether, even though moral development is not an explicit treatment goal, this might be an implicit part of forensic treatment:

> However, as far as I am concerned, not to change him as a person, no. In the sense of trying to impose a certain kind of moral awareness, no.
> Interviewer: That is not one of the goals of treatment?
> Interviewee: No. Not explicitly, and perhaps also not implicitly, but I'm not entirely sure about that. FP8

In this context, several participants referred to the inherently normsetting and prescriptive nature of their profession and the challenge of not placing one's own moral convictions and moral values at center. Participants thus appeared hesitant to moralize, but at the same time discussed that to a certain extent, this might also be inevitable:

> Well, at least I think many psychiatrists, unknowingly, very much approach and also treat their patients on the basis of a certain moral idea, that is, with their own norms, values, and morality, which simply pervades everything you're trying to convey to your patients. So implicitly I would certainly agree. I think explicitly, also - many people, hm… Well, to provide a very concrete example, we offer a training that consists of three parts: social skills, emotion regulation, and moral reasoning. Moral reasoning is about casuistry: 'What does this mean for the other?; What do you do merely for your own advantage?; What if this would happen to you?'. So in training, for example, we do call it, 'to learn to reason better morally'. So apparently we have some kind of idea about what good moral reasoning is, and apparently it is also something we want to teach. FP10

> Coming from general psychiatry, it does indeed strike me that, the, hm, the moral framework is implicitly present – much more than outside of forensic psychiatry. It is not made explicit, but it does play a role. If you would put it bluntly: 'To what extent do we want the people whom we are treating here to be good citizens?' Yes, I'm afraid that it does, that it does play a role beneath the surface, but that we do not talk about it. On a superficial level, we aim to make sure that people no longer pose a risk, or as little risk as possible to themselves or others. But of course that

> has a very strong moral component. So, yes: it plays a big role. And no: it is not expressed as such. FP8

> So it is not my job to socialize people. Although somehow it is, but I will never say this out loud, because otherwise people will interpret socializing as re-educating, in the sense of 'becoming like us'. I embrace a socialization that takes place from within a subject's own coordinates. If someone regains a place within society – without necessarily actively participating in society, but also without wandering and suffering; if someone is able to make life bearable for himself/oneself, in a very discrete manner, without experiencing others as threatening and so forth – that for me is already a successful socialization. Whether others will share that perspective? The prevailing norms of others claiming that a normal individual should be like this or like that. I don't care about such norms. As long as that person no longer poses a physical threat to others or to himself, that's okay for me. Regardless of what that person is like at that time. CP6

Participants describe how particular patients and types of offences can elicit moral outrage or even abhorrence, and stress the importance of a clinical stance or attitude in order to overcome or distance themselves from these negative emotions. Some reflect on the ways their profession has forced them to reflect on their own moral framework and commitments.

> And of course, I experience these thoughts as well: "Come here, you boor, and I will beat you up". Apparently, that is part of us as human beings. But then I realize that this would satisfy my own frustration more than anything else. FP3

> That subcategory evokes repugnance in almost everyone. And the difficult thing is – and that is true for medicine generally of course – that we are trying to disconnect this from the disorder. So we see pedosexual offenders primarily as people with a problem, with a disorder that we should help them to get rid of as much as possible. And in interactions with patients, the moral dimension is not addressed, right? So you never say to someone; "What a horrible thing you have done!" FP8

What aspects of human morality do forensic practitioners deem relevant for treatment?

In their responses, participants identified and reflected on various aspects of human morality that are, or potentially can be, targeted by treatment: patients' remorse, conscience, or guilt; self-regulation and self-awareness; motivation and will to change; moral responsibility; capacities for moral reasoning; and moral emotions (such as em-

pathy). Participants differed in the way they conceptualized morality, and in what they understand morality to be. Whereas some focused more on capacities to be moral (such as having the capacity to empathize with others, or to reflect on one's own behaviour), others focused on more symbolic elements, such as restoration with society.

> With respect to expressing regret and restoration and such things: a chance of recovery, a bond with the victim, restoring the bond with his own family (because they are affected as well), restoration with society – these are things we certainly address. CP4

> Interviewer: "So morality is not addressed at all in treatment?"
> Interviewee: "Yes, it is, but not in terms of morality, but in terms of reciprocity. To the extent that one can build a reciprocal relationship with someone and is capable to handle and sustain that relationship and to anticipate the other's position, and best-case scenario even to mentalize it. And that he is able to take the position of the other." FP11

One of the aspects that participants deemed especcially relevant in the context of treatment and that was mentioned frequently concerns self-awareness and the capacity and will to control oneself.

> You teach people to analyze themselves. You offer a kind of frame to pay attention to what they think, feel, and do. Also in the case of sexual offenders. To make them aware of the kinds of things they tell themselves when they start to commit and continue to engage in an offence, what they tell themselves while they are doing it, and what they tell themselves afterwards, to be able to say that it wasn't that bad. And so on. So we actually give people such grids and tools to get to know themselves better and to pay attention to feelings and thoughts and actions that they did not pay attention to before, and without being fully aware, they would proceed to commit a crime. FP2

> Really, it is inhibition that is actually our core business. You try to teach these people to keep that under control. CP7

> To get a chance to, well, create a motivation, the will to control oneself. CP7

Many participants raised the question of whether focussing on one aspect or capacity would accomplish a genuine improvement in the sense of someone being 'a genuinely better person'. For example, several participants reflected on whether it is enough for

someone to stop a particular behaviour, for example by enhancing inhibition, without accompanying changes in beliefs or thought patterns.

> If someone says, 'I will not perform that behaviour anymore,' then you could say that, because of that, you have become a better person, right? CP7

> In the core? I don't know. It is also possible, you may also have a different motive to stop doing it. To prevent relapse, in your own interest. CP8

> I will quote Freud here: We are all rapists and thugs in the depths of our thoughts, but the bad ones are those who act on them, and the good ones are those who think about it, but don't act. FP9

Several participants discussed responsibility as an important part of forensic psychiatric treatment. Both in the sense of looking back (*I* was the one who did these things) and in the sense of looking forward (*I* need to make changes in order to prevent myself from doing the same thing again). Several practitioners stressed that, frequently, the first is needed to achieve the second:

> As long as patients say 'I could not do anything about it', I will tell them: 'Well, yes, if you really couldn't, if you really feel that it was because the sun was shining or it was raining, you could not do anything about it, that it was the weather; well, then you cannot go outside, can you? That must be terrible; it could happen to you tomorrow again, couldn't it?' Well, of course they do not think along those lines. (…) But when framed like that, that's not what they want for themselves. So we need to address what's possible. 'Well, then we do have to figure out what you can do about it. For all I care, you bring both your umbrella and your sunglasses, to make sure that you… But you must address it.' T2

> Even very seriously disordered people are, at a certain level, accountable. And that also makes it possible to achieve progress with them, do you understand? That's the space you need of course, because if you have the extreme, 'I cannot do anything about it' – yes, and then what? FP5

> That has to do with giving responsibility. Because it is you who makes that choice, despite the feelings you may have; you are the one who makes the choice to act. CP8

Nevertheless, several practitioners expressed reservations with respect to the importance of addressing responsibility in treatment. For example, because behaviour change

is far more difficult to achieve than was once thought, and this places limits on the degree to which moral development can be addressed in treatment. Many participants discussed the degree to which you can hold people accountable for past behaviour, for example because of societal and situational factors, or expressed a more general skepticism with respect to human free will.

> I have been working in this field for thirty years of course, the forensic field. And I started at a time when we were thinking very much about 'Malleable Man'. A period in which self-regulation and free will were values that we were holding dear. And of course, over the course of time, that optimism has diminished, with all the consequences that this entails. So we were thinking, when I started more than thirty years ago, that as long as people would be willing, and we would be motivating and stimulating them, they would move in the right direction. And now with developments, also neurobiological developments, you think that there is more to it than simply the idea: as long as you want to, you will succeed. CP1

> My belief in free will is limited. If you observe those boys – and I've really seen hundreds, also intensively – they are almost all friendly fools who fell victim to their own life, their own environment, their upbringing, their lack of intelligence, and so on. FP3

> I would say: I take human free will as a starting point. That is, ultimately, a hypothesis, a subjective truth, yes. (…) But also for the court it is a basic starting point: it's assumed that people are responsible for what they do, what they think, and so on, for their actions, until the opposite is proven. FP2

How do forensic practitioners' balance the wellbeing of the patient with public safety concerns?

Why would stimulating moral development and moral growth in fact be part of forensic treatment? Many participants stressed that their primary objective is to lower the risk that someone will harm others.

> That is a problem we have with sexual delinquents: that the bodily integrity of others is potentially in danger. (…) If I treat a serial rapist, I cannot say: 'He relapsed, but that is already an improvement, because nothing happened in the three months before.' FP2

> But within this profession, I always say to patients: 'You can remain as crazy as you are now, I am not saying that you have to change at all. I just need to change this one thing, that is, that you will never do it again.' T2

In contrast, several participants indicated that stimulating moral development may be part of treatment, when it can help to manage stress relief or to reduce the suffering of the patient. Several participants conceptualized this as an 'egocentric perspective', in that they try to refer to the patient's interests.

> Moral outrage about paedophiles etcera that's, that's very intense in society. Society demands that we do something about it. But the moment I… Opportunities to work with these people will not grow the moment I start talking about morality. Perhaps when I talk with them about empathizing with victims – maybe you could classify that under that heading? Which is of course part of the treatment of sexual offences. To empathize. But you empathize with the other, in order to enhance your own inhibition. It is not about feeling sorry for those people – do you understand that? The victim, that is merely, that is actually only just, actually only just instrumental for the patient himself. The more you empathize, the more the resistance grows, the resistance to act on it. FP5

> But what I can say is that if someone, because of his moral deficiencies so to say, gets in to a lot of trouble with his environment, and if he is rejected a lot, and because of that is acting very hostile, and so on – I will point out that mechanism to him. And I would say to him, 'I would advise you to do some tests, to take a look at what we can do, maybe that will help.' Yes, that I will do. FP1

Some participants characterized stimulating specific morally relevant aspects as a means rather than a goal; moral development may help achieve some other goal of forensic psychiatric treatment (such as lowering recidivism), but it is not an end in itself.

> "I would say, it is a collateral advantage" CP1

These different potential objectives of stimulating moral development and moral growth – a focus on safety and harm reduction to protect others versus a focus on the patients' wellbeing and treatment goals - are mirrored in two different sets of professional roles and responsibilities of forensic practitioners: on the one hand their medical background as doctors, and on the other hand their responsibilities regarding

public safety. We asked participants in our study to reflect on these roles and potential tensions between them, and to indicate which of the two, if any, they consider primary.

In general, most participants acknowledged both responsibilities. They differed however, in their views on which of these professional roles they considered primary. Whereas some participants explicitly positioned themselves as a medical doctor first, most participants also stressed their responsibilities in preventing harmful crimes from being performed again.

> If I would have to choose, I would be inclined to favor the protection of society, because the civil commitment of one disturbed forensic patient can prevent the victimization of several victims. FP9

> If we would make a list of the ten things we are doing here, that would be number one: No new victims. And this is also clearly defined in terms of professional secrecy. We have professional secrecy pertaining to all, everything that is discussed here, until we estimate that there is a real danger with an identifiable future victim. CP4

> I think the task of forensic psychiatry is, primarily, to minimize recidivism. That's really primary, because that makes the profession what it is. That doesn't mean I am blind to people's suffering of course, but that is primary, that is absolutely paramount. And then, hm, I would say, secondly, can I, can we maybe, make people suffer less, have fewer problems, improve their quality of life. Also for their environment, I think that is often forgotten; for the children and for family members, that is very important. (…) That is the system within which we operate, and that also allows the patient a certain degree of autonomy. FP5

Several participants discussed various tensions between, on the one hand, their medical responsibilities, and, on the other hand, public safety concerns.

> Sometimes these people experience profound suffering. Sometimes there is no suffering. Those are fundamentally different situations. (…) To put it bluntly, someone who does want help in preventing making the same mistakes again, and someone who refuses that help – you do have different options available. FP6

> You must adhere to the rules of medicine. And that is a danger, I think, for forensic psychiatrists. Actually, that is a danger in many disciplines in which you specialize, that you have to think carefully where you came from, where your foundations lie, to not stray from one's subject field. (…) Because a forensic psychiatrist is first and

> foremost a doctor. And must also work from those foundations, and according to the oath and principles of proportionality and subsidiarity. FP6

Some participants offered pragmatic rather than principled arguments for not focusing too much on future risk in treatment:

> Yes, both of course. But when it comes to initiating and achieving successful forensic treatment, I don't think that the focus should be on that risk. Because if you want to motivate people for their own treatment, because that is necessary for treatment success, you have to start from their own suffering. And sometimes, that is a different suffering than how society sees it, but that needs to be the starting point for treatment. Because otherwise, you will not have any commitment of your clients. CP2

Several participants drew parallels with regular psychiatry, where their medical expertise and authority solely function within a therapeutic care setting, and forensic psychiatry, where their medical expertise and prognosis become embedded within a legal framework, and non-medical or non-therapeutic considerations come into play. Participants also discussed different settings forensic practitioners can work in, ranging from outpatient care, to providing mental health care in prison, to specialized long term residental secure care, and how these different settings influence the degree to which they are able to assert their medical authority.

> Perhaps that is specific to forensic psychiatry, that this power [to extend imprisonment] does not come to lie with you, but that you are able to function within a kind of triangular relationship. But that also entails that you must be able to tolerate that someone else is watching along. And that is different compared to a dialogue in regular psychiatry. Perhaps therein lays the uniqueness of forensic psychiatry. Interviewer: In this third factor? Interviewee: Yes. FP11

> I have also worked in prison, there you have nothing to say. That is a prison, it is the warden who calls the shots. It is not a medically protected domain, with a healthcare logic. So we, as healthcare professionals, can build in safety – but it has to be on my own territory. FP2

Discussion

Forensic practitioners' views on potential moral dimensions of forensic psychiatric treatment and care are highly diverse, as these interviews show. Whereas several practitioners rejected the idea that stimulating moral development or moral growth is or should be part of forensic psychiatric treatment, other practitioners appeared to be more open to reflecting on potential elements of stimulating moral development in their work practice. And although current forensic practices do not (explicitly) seek the moral development and moral growth of forensic patients, elements of stimulating moral development and moral growth might be part of forensic psychiatric care implicitly, as this study suggests. Yet, forensic psychiatric treatment is hardly ever discussed in those terms. As discussed in the discussion, forensic experts Pearce and Pickard argue that psychiatry is both a moral and a medical science, and that a convenient blindness to the moral content of psychiatry opens the door to potential abuse (Pearce & Pickard, 2009). They conclude that our best defence against abuse in forensic psychiatry is honesty and ever-vigilant self-reflection.

In general, the forensic practitioners we interviewed appear to be cautious about moralizing and imposing particular moral views and values, and often stress the importance of a professional, clinical stance to counter this. In line with this, Marga Reimer mentions that it is widely agreed that moral judgment should play no role in the practice of medicine due to its capacity to impair clinical judgements and especially so in the case of psychiatric conditions (Reimer, 2010).

Participants identified and discussed a range of morally relevant aspects that are or potentially can be addressed in the context of forensic psychiatric treatment, ranging from stimulating empathetic concern, improving cognitive skills and correcting cognitions, strengthening protective factors to prevent recidivism, to lowering risk factors for future problem behaviour. Future research might study in a more systematic manner whether there is a relation between what respondents understand morality to be with their views on the appropriateness of stimulating moral growth in treatment.

Participants mentioned different potential objectives for stimulating moral development and moral growth in treatment: to treat mental disorders and alleviate suffering of their patient, and/ or to reduce the risk of reoffending and prevent future harm to others. Our study suggests that forensic practitioners are both security-oriented (in terms of risk reduction and recidivism prevention) *and* concerned about patient care, with some individuals focusing more strongly on the care aspect and others more strongly on the security aspect. Several participants discussed the importance of maintaining

a clinical stance and relying primarily on their medical expertise and patient-centred responsibilities, although most practitioners also discussed their role in promoting public safety, as well as potential tensions between these two responsibilities.

Professionals working in forensic psychiatric mental health care are said to indeed have diverse, and potentially conflicting, roles and duties, as they need to balance responsibilities towards patients (individual offenders), towards the legal system, and towards broader society (Day & Casey, 2009). Yet, this study also indicates that a clear code of ethics on how to manage potential tensions between promoting public safety on the one hand and the wellbeing of individual offenders on the other hand is largely lacking.[19]

Professionals may encounter a range of ethical conflicts between these two roles or sets of tasks, often discussed in terms of a 'dual role', 'dual relationship', or 'dual loyalty' dilemma (Robertson & Walter, 2008; Jörg et al., 2012; Ward, 2013). This dilemma is discussed, first and foremost, in the context of debates about potential conflicts between a psychiatrist's duties as 'healer/caretaker' and as 'evaluator', for example in the USA when forensic psychiatrists are involved in evaluations that may lead to administration of the death penalty (Robertson & Walter, 2008). In other legislations, for example in the UK, a similar conflict may occur when a forensic psychiatrist's evaluation of dangerousness may lead to a person's pre-emptive detention. Also in treatment contexts, individual forensic practitioners may face the ethical demands of two roles, one prioritizing the needs and interests of the community, the other the (medical and therapeutic) needs and interests of the offender (Ward, 2013).

Choice and consent, for example to consent to or refuse treatment, is particularly complex in a secure psychiatric care context, as Gwen Adhead and Teresa Davies discuss: "There is a sense in which the medication is fulfilling a penal role in reducing the risk of re-offending, in addition to the therapeutic role. Patients may not be allowed to refuse to take medication if professionals think that taking medication will reduce their risk" (Adshead & Davies, 2016, p. 78). Sex offender therapy might serve as an example here. According to forensic psychiatrist Bill Glaser, sex offender therapy should be characterized as *treatment-as-punishment* rather than *treatment of the punished*, for the reason that "this type of therapy does not have the interests of the offender

19 "If there are different ethical codes or systems of norms available to guide offender assessment and treatment, it could be hard to agree on a subsequent course of action. One forensic expert might justify his or her actions by appealing to obligations to the court while another could refer to the needs of patients or offenders, and an obligation to ease suffering whenever possible. The problem of ethical *incommensurability* raises its head here." (Ward, 2013, p. 94)

as its primary focus" (Glaser, 2009, p. 251; 2010). Glaser advocates that in a treatment context, it should be made clear to offenders that "the goals of treatment not always coincide with their own interests: (Glaser, 2009) as this satisfies the requirements of both minimizing distress (caused by otherwise deceitful disguising of the true purpose of treatment) and promoting equality (by providing offenders with the same amount of knowledge regarding treatment goals as that possessed by therapists)" (Glaser, 2010, p. 267). Although evidence about the effectiveness of pharmacological agents in treating sex offenders is inconclusive (Långström et al., 2013; Khan et al., 2015), Daniel Turner and colleagues nevertheless discuss that "clinical experience suggests that, for some paraphilic patients, medication is a useful addition to psychotherapeutic interventions and, as such, its use is being recommended by both clinicians and the WFSBP [World Federation of Societies of Biological Psychiatry] guidelines" (Thibaut et al., 2010; Turner et al., 2017).

Adshead and Davies also argue that forensic patients should be included in the medical decision-making as much as possible to avoid feelings of humiliation, despair, emotional isolation and stigmatization and to stimulate the long-term recovery of patients (Adshead & Davies, 2016). Forensic practitioners and forensic patients need to be able to rely on each other for support and safety. This may include that forensic psychiatrists at times where patients are unable to make fully competent decision support patients in the decision-making process to reinstate full autonomous decision-making on behalf of the patient and achieve maximal long-term rehabilitation. Liégois and Eneman similarly argue that shared decision-making should always be the desired goal within a psychiatric context (Liégeois & Eneman, 2008). Coercion should never be self-evident and should always be normatively defended.

The diversity of ideological and theoretical justifications of penal strategies and criminal justice institutional frameworks worldwide (more focused on rehabilitation versus more focused on retribution) arguably reflect these same tensions.[20] Significant differences exist between forensic mental health systems globally (Dressing et al., 2007), yet literature on international comparisons of forensic psychiatric care is scarce (Ogloff et al., 2000). In terms of legal demands, admission criteria, the concept of criminal responsibility, service provision and treatment philosophy, large differences exist, even between Western European countries (Dressing et al., 2007; Salize et al., 2007;

20 A recent comparison of forensic psychiatric care in England, Germany and The Netherlands confirms the presence of the dual role or dual relationship dilemma in Western European contexts: "Clearly, all three countries are in the process of significant challenges and changes in care provision reflecting the tensions between the two key values of forensic psychiatry: Care for the individual and protection of the public" (Edworthy et al., 2016, pp. 24-25).

Edworthy et al., 2016; Sampson et al., 2016). These differences between national legislations shape the particular ways in which forensic practitioners may experience dual role or dual relationship dilemmas. We urge for more awareness of the historical, ideological and political rationales behind particular institutional settings. If only because studies have shown that the context in which health care takes place, influences and potentially compromises the provision and ethics of health care (White et al., 2014).

Forensic psychiatrists need to be able to fulfill their therapeutic role without feeling pressured to give precedence to public safety in ways that harm or are likely to harm their patients. We agree that although forensic psychiatry "can contribute significantly to the protection of the public in individual cases, crime prevention cannot be its primary purpose. In a social climate that places increasing emphasis on the management of risk, the pressure to do so is substantial" (Buchanan & Grounds, 2011, p. 422). Forensic psychiatry as a medical discipline needs to be wary of attempts to use psychiatry as a means to impose the state's interests on the lives of offenders.

Several authors have linked the treatment of offenders, especially with neuro-biological interventions, to the debate on moral enhancement. In this debate, the main question is whether biomedical interventions that enhance prosocial tendencies and emotions and/or inhibit anti-social tendencies and emotions may – or should – be used to improve morality and moral conduct, in order to solve pressing societal problems such as crime and violence, or even terrorism and climate change. Commentators have discussed the use of neuro-interventions for offenders or forensic patients who are suffering from various cognitive, motivational and emotional impairments as examples of moral enhancement. As such impairments may involve risk factors for various kinds of immoral behaviour (e.g., sexual crimes, violence, racism), proponents argue that moral bioenhancement could provide new ways to achieve successful recidivism reduction and rehabilitation (Douglas, 2008; S. Carter, 2016).

Several commentators in this debate, including the present authors, have discussed whether psychiatric treatments that address neurobiological risk factors for deviant behaviour should indeed be understood as proper instances of moral enhancement (Specker et al., 2014; Reichlin, 2017; Specker & Schermer, 2017). Discussing the treatment of forensic mental health disorders in terms of the overall practice of moral enhancement might have undesirable consequences. One potential negative consequence of doing so might be that framing forensic mental health treatment as 'mere' moral enhancement could bring the public to disregard the seriousness of the mental health problems forensic patients may face (Focquaert & Raine, 2012). Even more problematic is the possibility that conceptualizing certain risky, invasive and non-voluntary forensic

interventions under the umbrella of moral enhancement could inadvertedly promote the acceptance of criminal justice practices that are ethically troubling. Examples of which would be coerced drug and/or hormonal treatments that may involve very serious side effects and/or affect an individual's mental liberty (Bublitz & Merkel, 2014).

Nevertheless, outspoken proponents such as Ingmar Persson and Julian Savulescu have argued that a number of psychiatric disorders can be characterized as "moral defects", and therefore, that treating these disorders should indeed be understood as moral enhancement:

> The opposite of promoting another's interests is damaging another's interests. Traits which increase harm to others cause immoral behaviour. The paradigm is psychopathic personality disorder, but other personality disorders such as antisocial personality disorders, borderline personality disorder and narcissistic personality disorder can cause great harm to those who come into contact with these individuals. The reduction in these tendencies are thus moral enhancements. (Savulescu & Persson, 2012, p. 410)

Likewise, David DeGrazia has characterized the treatment (or prevention) of antisocial personality disorder as a uncontroversial example of moral enhancement (DeGrazia, 2014), and Thomas Douglas has discussed "institutions of criminal justice'" as institutions that are arguably "already engaged in a kind of moral enhancement" (Douglas, 2014c, p. 1245).

A reason in favour of discussing certain aspects of forensic psychiatric care practices in the context of the debate on moral enhancement is therefore that it enables explicit debate on moral dimensions of forensic psychiatric care practices, and fosters professional dialogue and transparency. As Wiseman notes:

> if we are already getting moral enhancement by proxy, and this is to some extent inevitable, the best solution may be to drag the whole thing out into the open and critically inspect the process in the full light of day. If some forms of medical and mental health treatments will always have morally related aspects or societal judgments embedded within them, let us make these judgments explicit and attempt to find some way of integrating them within an acceptable code of practice – something which ensures that the therapeutic context is appropriately person-centered in nature and nonreductive, and that the healthcare professionals involved are appropriately directed and sufficiently well-armed against the dangers raised above (Wiseman, 2016, p. 219).

Moreover, the moral enhancement debate has proceeded without much attention for the specific institutional contexts in which potential moral enhancement interventions will be implemented. By exploring views of forensic practitioners on elements of moral development and moral growth in current practices, we hope to open up space for discussion about where and how 'moral enhancement' may – or may not – be brought into practice. Without adhering to the view that treatment of psychiatric disorders should be understood as moral enhancement, this exploration of views on potential moral dimensions of forensic psychiatric care can, in our view, inform the debate on moral enhancement.

In conclusion, we would submit that: (i) Elements of stimulating moral development and moral growth in forensic psychiatric care practices are to a certain extent inevitable and not necessarily questionable or undesirable; (ii) yet, as in similar debates, these elements need to be made explicit in order to discuss the accompanying ethical challenges and boundaries. The history of concepts like deviance and mental disorder has led to a wide array of "muddled concepts, systems, values, and priorities" within current psychiatry (Sadler, 2013). There is a need for philosophical reflection on the aims of criminal justice and how these relate to forensic psychiatric practices. How far should the authority of the legal system extend within forensic psychiatric practices and how should psychiatrists approach and deal with the ethical difficulties that are specific to their field? Without such reflections, forensic practitioners risk having to navigate a "moral minefield" (Sadler, 2013). Especially in view of the growing interest in neurobiological interventions, an open academic, professional and public debate on the (un)desirability of stimulating moral development and moral growth within current practices is therefore needed.