The Portman Clinic

Perversion and how to handle it

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Seventy-five years ago, a middle-aged woman walked into a London clinic to receive help with her violent temper. She'd attacked her employer and was judged to be worthy of psychological examination. There are a few more things known about her case, but the details are less significant than the fact that she was the first recorded appointment at the new clinical wing of the Institute for the Study and Treatment of Delinquency.

The Institute had been formed to examine the fringes of society. Founded during the political and social upheaval of the interwar years, it dealt with those thrown up and then tossed aside by a turbulent world, and its mainstay was troubled youth. The clinic attracted the psychoanalytical superstars of the day, along with some literary ones: its vice-presidents included Sigmund Freud, Carl Jung, Havelock Ellis and HG Wells. The Institute saw cases of habitual criminality, desperate addiction, extreme violence and sexual perversion. Today, 75 years later, under its less revealing but more aesthetically pleasing name of the Portman Clinic, two things have changed. The caseload has increased and there's a lot more sex.

Many people who visit the Portman Clinic today come out of Swiss Cottage underground station and walk a little way up Fitzjohn's Avenue. On their right they will pass the Tavistock Clinic, a much larger and better known therapeutic institution that tends to deal with a broader range of patients, patients who may never have been in serious trouble with the law. The Tavistock is based in a bland Sixties utility building, but the Portman can be found at a grander address, an attractive red-brick Edwardian house that in another age would almost certainly have employed waiting staff.

These days there is only a waiting room, and when you are ushered into it for the first time as a patient you may have no idea that you will visit this high-ceilinged place for several years before you show signs of improvement, or that to make progress at all you may uncover a past so fraught and painful that your strongest impulse may be to flee.

The Portman practises what it calls 'forensic psychotherapy', a detailed, long-form treatment designed to help those who have nowhere else to go but back to jail. A few weeks ago, Stanley Ruszczynski, the clinic's clinical director, sat at his desk and explained that he had always been interested in the more disturbed type of patient. 'They're much more challenging and oblige you to keep thinking about the nature of what you understand, and often make you realise that you don't.'

Ruszczynski is 57, and in appearance he reminded me of the actor-director Albert Finney. He first trained as a social worker and then as a psychotherapist. He has always been an active communicator, and writes books and articles that are accessible to the general reader (recently he wrote an article about Gary Glitter for The Observer, in which he argued that we should not just rage against the man but try to comprehend his unsettling actions: 'It is essential to hold in mind both the victim and perpetrator aspects of the patient - to neither collude with the first nor to demonise and condemn the latter.')

Ruszczynski joined the Portman 12 years ago and has been director for the last four. 'Not all psychotherapists can work with these sorts of patients,' he says. 'You bear quite a lot of emotional responses to them - sometimes you get angry, sometimes you get disturbed, sometimes you get scared. Any patient is going to arouse feelings in a therapist, but these ones can push you to extremes, which is why society tends to have a very belligerent attitude towards them. They have an impact - they hurt people, they do horrible things, and society understandably tends to be punitive towards them.'

Ruszczynski argues for a more sophisticated attitude, an approach that may be more beneficial to us in the long term. 'It is helpful to believe that there can be control and also care, a belief that some of these people can make use of good intervention. That's our job - the best way of helping society is to make sure these people don't do these things again. This is at the edge of mental health, and I feel that if we can't at least help some of these patients then I'd feel rather sad for my profession.'

What sort of people are we talking about? One of Ruszczynski's patients is a serial rapist, another has been involved in violent 'enforcement'. 'These days we get very few straightforward arsonists or fraudsters,' he says. 'The biggest shift is towards violence and perversion.'

Accordingly, the clinic has well-defined structures in place. Ruszczynski is the only full-time worker ('nobody can work with these patients all day - it would give you a very skewed view of the world') and all the psychotherapists have undergone years of analysis themselves, 'which hopefully strengthens us'. There is an obligatory meeting of colleagues every Friday to discuss their patients and a guarantee that there is always someone else on duty while a patient is being seen. 'And people are not allowed to see patients on the top floor after six at night - the attic is a long way up, so if someone gets a bit anxious or frightened, you're trapped.'

I had first met Ruszczynski and a colleague a few days before, when I asked whether it would be possible to speak to a patient, or hear a specific case study. I said I would conceal any identifying details, but I was told this would be out of the question. Patient confidentiality is the bedrock of effective treatment, and if a patient believed that their case was being discussed with a stranger, or if they even suspected that a disguised description might be depicting them, then years of intricate work and hard-won trust could be jeopardised. Beyond this, a patient may leave treatment and harm again.

But Ruszczynski did give me a copy of an audit showing the reason that patients were referred to the Portman. Most were there because of 'compulsive sexual behaviours' - fetishism, transvestism, transsexualism - and some for sexual and criminal offences, including exhibitionism. The most severe cases made up about 17 per cent of the total: rape, paedophilia, sexual assault. The mean age of referred patients was 39, 15 per cent were over 51, and 87 per cent were men.

In an average year, the Portman receives about 250 referrals, of which it accepts about 50 for treatment (the most common reasons for refusal are psychotic behaviour and addiction to alcohol or drugs). Patients are seen both individually and in groups - there is evidence that some are better dealt with in the presence of others, including paedophiles (according to Ruszczynski, 'there is some self-regulation that goes on').

'It helps if the patient is "psychologically minded",' Ruszczynski told me, 'that he or she is interested in the idea that what they're doing has some sort of psychological basis. But the fact that they have not just thought about a crime but committed one means their capacity to think psychologically is limited - they don't just feel and dream, but they act. When I get angry I might say that "you piss me off" - but I'm processing the anger. The patients we see don't usually have that capacity.'

The audit Ruszczynski gave me was compiled four years ago and is already out of date. The Portman's casebook has shifted significantly in recent years, for one principal reason: internet pornography. Ruszczynski told me that the number of patients who are either addicted or otherwise adversely affected by it is 'phenomenal'. Referral letters mention it regularly, and if they don't the patient will often mention it during his assessment. 'I don't just mean bonking sites,' Ruszczynski says, 'but heavy-duty material.' Frequently patients mention searching for paedophilic material. 'There's something about the internet... I imagine that 20 years ago some chap somewhere was sitting there with a very strange

perversion that he probably thought he had all to himself. But then he gets on the internet and finds there are 33 sites where other people are doing something similar. So suddenly something that was quite contained is automatically normalised. I think this is a real issue. On the internet you can get anything you want, so that people who were once constrained by societal moralities and values, they now find there's a doorway... I don't want to sound like a dinosaur, but it definitely opens up people's possibilities for actively pursuing some of these compulsions. And if you find that a lot of other people are interested in the same things you are, you will tend to believe, "Well, what's the problem?"'

Not long ago Ruszczynski received a self-referral from a middle-aged doctor who knew he was addicted, 'not to paedophilic material, but hard-core pornography. Just more and more of his time and his energy was spent online. He said in the letter it was destroying his relationships and potentially could destroy his career. What lies behind all of this we're yet to assess.'

But work is ongoing. In another consulting room I met Heather Wood, a psychotherapist and chief of research at the Portman, who has made a special study of the use of internet pornography and other related technological developments, including chat rooms and phone sex. As one of the researchers of the clinic's 2004 audit, she came across the problems of virtual sex almost by accident. There were categories for all of the usual reasons for assessments at the clinic, and a catch-all box for any other, rarer, scenarios. When Wood analysed this category she discovered it was much larger than expected, accounting for 11 per cent of cases. All these concerned internet pornography. She then looked back to see when this had started and found there had been no cases in 1997, but it had predictably increased with the boom in home computers. She is currently conducting a new audit, and believes the figure may have jumped to between 25 and 50 per cent.

Wood says there are three ways of thinking about the internet. The

first is that it is just a different way of accessing pornography. The second is that it makes access easier, so people are looking at more than they had done previously. And the third is that there is something in the nature of the internet that serves as a catalyst for the viewer and changes his relationship with pornography. 'It doesn't just facilitate access but accentuates it,' she observed, 'and changes what they look at and how they look at it. I think there's growing evidence that this is what's happening.'

In an essay published last year, Wood considered the literature relating to virtual sex, observing that men and women tend to play different roles. Men would be more likely to engage in solitary activities (viewing and distributing material), while women were inclined to be more participatory, taking part in chat rooms and live web sites. She tried to summarise the psychological appeal of watching or participating in online sex: 'The access to powerful and exciting technology, the possibility of a fit between a sexual fantasy and external reality, the degree of control afforded to the individual and the absence of any other with vitality and a will of their own, the promised gratification of sexual curiosity sealed by the excitement of sexual orgasm - all these can fuel omnipotence and can seem very intoxicating.' But she concluded that it was wrong to treat obsessive use of internet pornography merely as an addiction, as this may mask its significance as a perversion. It represented more of a psychological imbalance than the chemical dependency created by alcohol or drugs, and thus was perfect for the Portman treatment. If the connections between the fantasy world and a patient's anxieties could be unravelled, then the compulsion could be reduced.

When I met her, Wood said a comprehensive understanding was still some way off, and she responded to questions with questions of her own. But she was edging towards some interesting possibilities. In the United States, addiction to internet pornography is defined in hours - more than 11 hours a week - and in terms of the way it disrupts lives. Wood says such a definition is less popular here, as it takes little account of the different types of

users. She mentions the person who collects thousands of images, the person searching for one particular kind of image, and she compares it to alcohol consumption, to regular drinkers and binge drinkers who turn to their vice under stress. Like rape, excessive use (rather than 'recreational use') may counteract feelings of impotence, creating the illusion of control over their lives and desires. Users may be trying to solve something within themselves, or compulsive viewing may just serve as an antidepressant. Wood feels that it may also fulfil a destructive need: 'There's a part of them that feels bad about themselves, and they may feel a need to do something that makes them feel worse.' She finds another addictive analogy, with gambling. 'You might think that a gambler is trying to win, but sometimes what emerges in the course of therapy is that the gambler is hooked on losing. There's some sort of masochistic gratification in leaving themselves impoverished and empty-handed. Something similar can happen with pornography; sometimes it's about compounding a feeling of self-disgust.'

There may be an obvious solution to all of this - just shut down your machine. But the human machine is more intricate, more impulsive, and Wood must divine what function internet pornography serves within her patients' psyche and try to dull or replace it. After a prolonged period of treatment she will hope to see an outcome that is even more profound - not just self-control in a patient, but a state of mind where they are no longer attracted by the impulse that brought them to the clinic some years before.

Increasingly, perversion is not just a problem for adults. In a basement room I met John Woods, a specialist in young people's perversions. When he was a school teacher he dealt frequently with 'maladjusted children', the former, more judgmental description of those with 'special needs'. When he trained as a psychotherapist he began working with boys who had committed sexual offences, and when he joined the Portman in 2000 he found that this category had far surpassed those adolescents being assessed for 'delinquency', the nostalgic and faintly humorous

term once used for the Asbo crowd. His patients range in age from nine to 21, and the majority are male. On average, two young people are referred to the Portman each week. 'There's been such an increase in social paranoia around sexual abuse,' Woods said, 'that young boys have learnt, consciously or not, that there's one thing they can do that will raise the alarm - that will make adults pay attention to them. Even the threat may be enough. If a teenager is feeling really powerless and wants to rage at the world, if he begins to take an interest in a younger child, people will notice. The balloon really goes up, and social workers will march in.'

One of Woods's colleagues is seeing a 10-year-old girl displaying aggressive sexual behaviour towards younger children. It's an unusual case, as girls tend to respond to sexual abuse by self-harm and neurotic symptoms, whereas boys tend to externalise it. Both sexes pose similar problems of treatment.

'Youngsters are more inclined to denial and blanking the therapist out,' Woods said, and they are usually less self-aware. Most will attend with a parent or guardian, but will often act up. 'If one can get the youngster to sit in a chair long enough, one tries to form some sort of alliance. They would already have suffered some pain or humiliation from having gone to court and been seen as an offender, so often they may be quite motivated to help themselves. A more cynical boy who has been doing it for some time will be harder, but the younger they are the more hopeful it is.'

The clinic's most recent survey of adolescent referrals showed that 'sexually inappropriate behaviour' dominated the caseload, with more than 50 per cent of patients committing some form of sexual assault. Threats of violence to others and cruelty to animals were also frequent reasons for attendance. But increasingly Woods has found that internet pornography is almost as serious a problem for adolescents as for adults. 'I do think it has a profoundly corrupting effect on youngsters, and leads them into all sorts of wrong thinking: sex is instantly available, all these glamorous people. An

adult finds it easier to make a distinction between reality and the fantasy. A boy without sexual experience may get confused about whether he's more excited by the male or female, and so sexual aggression targeted against a younger person may be a way of him proving his masculinity, showing that he's not the submissive one. The boy will often talk to us about this - he fears he may be homosexual, so he assaults a girl.'

With his background in teaching, Woods has struggled to find a solution to the trend. 'Schools can go a long way to foster a culture of fairness and being listened to and setting the right values,' he said. 'But I feel a bit in despair of it - it's a bit like global warming and the destruction of the environment, a terrible thing. But it may be worse than that, because the technological advances may be irreversible. We have such a strong belief in the freedom of the individual and the lack of censorship, and the more you forbid someone to look at something, the more fascinating it becomes. The best that can be hoped for is a maturity in social care - that people will not be so fascinated by porn because they will have proper relationships and come to the same conclusion most of us do, that pornography is fundamentally boring and frustrating because it's not real. But kids who are emotionally deprived will find it harder to make that distinction and put it into context. The Dutch have always had this attitude that you can have pornography because it's not ultimately that interesting, but that assumes a mature society, not desperate people who have little in their lives.'

Patients are referred to the Portman from GPs or GP counsellors, from psychiatrists at other practices, and from professionals in NHS mental services. Others may come from probation officers and the social services, and about 5 per cent refer themselves. The clinic, which is part of the Tavistock and Portman NHS Foundation Trust, is funded by the Department of Health through contributions from all the primary care trusts within the M25. The funders have one key requirement of all patients at the Portman: they must be perpetrators - that is, they must have acted out their

criminal, violent or perverse impulses.

Richard Davies has been at the Portman for 26 years, four of these as clinical director before Stan Ruszczynski. 'It's good that some things have become more normalised,' he said. 'There are still a lot of young people who feel it is abnormal to masturbate, so it's helpful that that's become more open. The clinic used to treat homosexuals for years. They were grateful to come somewhere, because many homosexuals found they didn't have an easy life and they had a lot of conflicts. But the social situation changed in the Eighties with gay pride and more equality, and so those homosexuals who wanted to come here may have felt, "I'll be letting down my friends." We got a lot of criticism from gay pressure groups who used to hate us - we were treated as a clinic that treated homosexuality as a perversion, but we didn't: we just treated homosexuals who came to this clinic.'

These days, the clinic is often visited by transvestites and transsexuals, and people who practise bondage and other sexual fetishes. 'They come here because the desired effect of those things, what they were intended to do, has started to break down, usually when they're in their thirties,' Davies says. 'The papering over the cracks that those practices fulfilled is no longer working. Some patients who are just post-operative can be despairing.'

Whenever psychotherapists from the Portman turn up at a dinner party and people ask them what they do, they rarely escape the question of success. Just how do you measure the effectiveness of their theorising? There are obvious factors - the patient does not reoffend, the patient begins to understand their impulses and suppresses them - but these may take a prolonged period to achieve and may not satisfy a health and political system hungry for the quick fix. Ruszczynski told me that his rapist has taken many years to understand why he committed the rape, and only now does Ruszczynski consider him safe. The self-audits conducted by the clinics in 2004 do not attempt to measure successful outcomes, but there is a familiar pattern of response to

treatment.

'Usually they'll be initially grateful because you've taken them on,' Davies said. 'You're not judging them, not telling them what to do, not calling the police or laughing at them.' But this 'positive transference' is generally followed by a more aggressive stage. 'The therapist will have projected on to them figures from a patient's life who have abused and damaged them, or tricked them or abandoned them. So you may get an enraged patient, and they don't usually have a way of processing this negative transference - you can't just say to them, "Do you see what's happening? I'm your friendly psychotherapist, I'm not your axe-murdering father..." It's not like the Hampstead man, the walking well who usually reads a bit and goes to see a therapist and lies on the couch.'

Ruszczynski told me that one poignant sign of progress in a patient may be temporary absence. 'One problem is, if you have a good session and do some good work, a patient may feel that you're getting too close and get anxious. And they may not turn up for their next appointment, because they're worried about what you may uncover.' A patient once told him that having her mind interfered with was far worse than being interfered with sexually.

Ultimately, the success of the Portman Clinic may be found in a more definable measurement - the fact that it exists at all. It is a unique institution and its reflection of the dark corners of our lives may gradually illuminate them. Before I left his consulting room, Davies handed me an essay he had written eight years ago. He had called it Turning a Blind Eye, and it encapsulated the work of the Portman and the forensic psychotherapist in a clear but slightly despairing message. The essay was written in response to the lynch mob fury that inevitably follows a newly exposed case of paedophilia, something he equates with a toddler's wild tantrum.

'The rage and violence recently directed toward paedophiles had more to do with the wish to remove what was evoked in people's own minds rather than the removal of paedophiles from a community,' Davies writes. 'That there seems to be no community

for paedophiles to be removed to suggests that it is their complete removal which is demanded. This notion is of course a fantasy, since paedophilia is part of society and cannot simply be removed like amputating a limb.' He argues that our most primitive fears produce primitive responses, and that if we cannot tolerate what we have created we look for others to hold responsible.

'It is easy to condemn paedophiles,' Davies continued, lighting the most incendiary material. 'Their abhorrent behaviour makes them a natural object for people's rage. It is easy to condemn the authorities for releasing paedophiles from prison and locating them somewhere. It is easy to think of a paedophile as purely an evil force intent on injuring children. Less easy to remember is that he is a human being, and I contend that to forget this is to turn a blind eye to something of crucial importance. By ignoring the human being and regarding and treating him as an evil animal, we ignore the potential for understanding something about him. In so doing we relinquish any hope whatsoever of devising an informed strategy to manage paedophiles and control their behaviour. More significantly, we also relinquish any real possibility of protecting children in the future from both being abused and becoming abusers.'

Davies and his colleagues believe that a sense of futility only arises from the belief that there is no solution to the unpalatable extremes in our lives. A scientific understanding does not imply sympathy or forgiving, but it may have advantages beyond mere punishment and retribution. It is a biblical conclusion, and a civilised one, and it may be the only way we can salve a troubled soul, both the patient's and our own.