Are we afraid to break tradition? Cognitive Analytic Therapy's (CAT's) contribution to the treatment of sexual risk

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Introduction

Treatment for sexual offences has typically changed from confrontational methods used in the 1970s to more therapeutically driven 'curiosity' type approaches; that is, trying to understand why the perpetrator has committed the behaviours they have. Sex offender treatment programmes are again changing and have been under review (Mews et al 2017; and Gannon et al 2018).

Psychodynamic and Cognitive Behavioural Therapy (CBT) have been the longstanding treatment methods of choice and are often used alongside the 'Good Lives Model' (GLM: Ward 2002a). Another widely used model is the Risk-Need-Responsivity Model (RNR: Andrews and Bonta 2010), in short, treatment is matched using clinical interview, reviewing clinical histories and undertaking psychometrics to consider a risk profile which can determine the dosage of treatment and type for an individual. The ideal is that the individual learns to better cope with their thoughts and feelings and in turn adapts and changes their behaviour in more healthy ways, hence addressing their risk.

It is fair to say that sex offender treatment is moving towards a more relational stance with the introduction of 'Horizon' and 'Kaizen' in the Criminal Justice System, however I still think CAT has a lot to contribute. I have seen patients move through their care pathways and out of costly inpatient settings into the community when using it and usually in a shorter time span than with more traditional treatments.

Traditional treatment can be lengthy, before the patient is able to demonstrate a real readiness and desire to manage their behaviours differently. Some of the components of treatment, e.g. psycho-educational 'life-skills' work: addressing the deficits in someone's coping, (which is basically telling the individual how to do it differently), fails to address the emotionally laden aspect of a behaviour. Anthony Ryle (2001) talked about the importance of the contributions of work from Vygotsky, Bakhtin and Leiman in understanding how we socially construct ourselves from our relationships with others and that 'meanings' and 'signs' which derive from these interactions are heavily laden with emotion, which needs to be understood.

Traditional treatments give no real meaning as to why someone behaves in a particular way and they suggest that there is only one correct way to manage the issue; nor do they take into account individual difference, fully consider individual learning styles, or give consideration to someone's Zone of Proximal Development (ZPD) and the idea that higher mental functions develop in social interaction (Ryle 2001). Little emphasis is placed on the therapeutic relationship, (Ward, Collie and Bourke, 2009), and treatments tend to be un-relational. In contrast, I found CAT's collaborative nature enables a different experience for patients who are already disadvantaged in terms of a power dynamic, often hated by society and detained against their wishes.

I've been interested in how CAT could help bring understanding to the behaviour, as well as a more person-centred, compassionate, collaborative approach, which is more helpful to the individual and has personal meaning. A relational approach has become more prevalent in wider forensic treatment too, as working more inclusively with service users is a current commissioning interest in the NHS, and CAT's co-produced work alongside the patient contributes to that. CAT considers working with the individual's ZPD, engaging the individual in their agency from the start and throughout the therapy.

Psychodynamic and CBT therapies also make little reference to the context in which the treatment is delivered: patients are often incarcerated, which probably impacts greatly on their relational and attachment issues (Stowell-Smith, O'Kane and Fairbanks, 2006).

A Relational Approach to Treatment

Childhood adversity is a key factor in sexual offending (Levenson and Willis 2014). CAT considers how early Reciprocal Roles (RRs) and then the

Reciprocal Role Procedures (RRPs) develop and shape how the 'adult self' relates and behaves. Levenson and Willis (2014, page 251-252) describe how sex can offer ways "to feel accepted, attractive, desirable, powerful or close to someone", so paying attention to early relational patterns – as CAT does – is crucial to understanding behaviour.

Kerr and Kellett (2015) discuss how CAT is good at working with the 'hard-to-help' patient, in part by establishing and maintaining a strong therapeutic alliance. We also know that therapist style: warmth, empathy, therapists that are supportive, respectful, non-judgemental, flexible and somewhat directive are helpful in eliciting change, (Rogers 1957, and Norcross 2002). Marshall and Marshall (2014) describe how the therapeutic alliance and relationship are key factors through which change is induced in patients. This is at the heart of CAT.

The collaborative therapeutic relationship facilitates an intimate connection to another and this can provide a 'corrective emotional experience' by itself (Prescott and Wilson 2013). Watson (2011) describes how a positive therapeutic relationship allows the individual to feel accepted so they can self-disclose and explore hidden parts of themselves of which they might feel shame and despair; typically true of people who commit sexual crime. Watson describes how shame is a barrier to treatment, leading to expectations that others will be rejecting and critical.

Ryle and Kerr (2002) identified the pattern of the hard-to-help patient as wanting, but then rejecting or attacking the help. Similarly, Shannon, Willis and Potter (2006) describe how aggressive men oscillate between seeking a dominant position (as in Narcissistic Personality Disorder: NPD) and by seeking ideal care (as in Borderline Personality Disorder: BPD). Working with these anxious defences, such as levels of denial, and individuals who are resistant or fearful of change can be challenging work, making for powerful counter-transference reactions, which need reflective consideration and transparency in the relationship.

Three Anonymised Cases

Background	Past and Present	Change	CAT Results
Mike: • 36yrs old • 10yrs incarcerated in a secure hospital • Convicted of contact sexual offences • Diagnosed with Paranoid Schizophrenia • Completed 2 years standardised CBT and RNR model of treatment • Offered a 16 session CAT as he was still getting into difficult patterns of relating • Whilst his sexual risk was managed, his aggression, which was seen as a precursor to his sexual risk, was still present	• Mike had a disturbed and disrupted childhood; including experiencing both physical and sexual abuse • He struggled to form meaningful relationships – a contributing factor within his offending history, which became more alive in his CAT treatment • Behaved either passively with his peers (as the victim) or aggressively (dominant)	• Mike strived to be dominant, as the pain of being in the victim role was intolerable, linked to his past childhood trauma • Mike did not know how to find 'middle ground' in his interactions • Using CAT Mike was able to establish and rehearse a different way of understanding himself and trying out other ways of relating	• Mike was transferred to a step-down unit and is establishing a path towards a community placement • The CAT tools enabled a way to consider the context and social setting for him in a way traditional treatments did not, he was frightened • His pattern of relating (victim-aggressor) was more than just his offending. It was deeply rooted in his way of understanding himself in relation to others – linked to his childhood trauma

Background	Past and Present	Change	CAT Results
Sam: • Black African 41yrs old male • Diagnosed with Paranoid Schizophrenia • Completed 3yrs of treatment from his 7yrs in detention • Convicted of contact sexual offence • Completed a standardised CBT, RNR and GLM model of treatment • Sam too displayed ongoing risky sexualised behaviours (being over familiar, and touching others) on the unit • I thought a CAT SDR might help him. This took 6 sessions and a follow up.	• Sam strived for a loving relationship, but the reality was different • Sam felt inadequate and lonely • All his siblings had high functioning jobs and were married, which was important in his culture • Sam said his parents had high standards and expectations • Sam completed psychoeducational work addressing his feelings of inadequacy and loneliness, this seemed a little superficial and Sam could not seem to link this work together • The result was his unhelpful relational pattern left him further isolated, as his therapeutic trips away from the unit (which he enjoyed) had stopped	• Seeing and jointly constructing his SDR, which incorporated his cultural beliefs, enabled him to understand his problem better and to see the other aspects that made him feel good (insight , abstaining from alcohol, exercising, religion, and studying) which were ways he could establish his sense of agency and therefore, in his mind, 'status' • The new behaviours led to new relationships, in turn allowing him to build on his relational skills • He saw he could be good in other areas and his emphasis on finding a partner or being over familiar with the female staff seemed to lessen	• Sam regained his 'freedom' and is now having his much longed for unescorted leave from the unit after several years • His sense of pride in himself was observed by his clinical team • The CBT and RNR sexual work did not involve exploration of his cultural beliefs • CAT gave rise to a discussion about the 'voices' of his parents (Bakhtin 1986, Vygotsky 1978), and the high expectations he had to live up to • CAT enabled Sam to make the link that he struggled to make for himself, between the risk work and the GLM work around his goals and aspirations • CAT provided a contextual and cultural understanding • The sexual risk work paid less attention to his need for an increased sense of self agency, and helping him with his self-esteem and feelings of emotional loneliness • Sam described a sense of feeling listened to, validated and understood

Background	Past and Present	Change	CAT Results
Helen: • 24yrs old • Living in the community • Diagnosed with Anorexia and potential Borderline Personality Disorder • Helen had an 'all or nothing' style of thinking • Offered Helen a 24 session CAT, as she had undertaken the offence work in Prison • Convictions for contact and non-contact offences against a minor	• Helen hid her emotions • She put her needs last and was 'passive' within her relationships • Helen's wanting to do right and please others, perhaps left her with fewer outlets for her own feelings of anger, resentment and rage, which showed themselves during her offence • Helen's parents separated when she was 12yrs, which hurt her emotionally • Helen described her biological mother as 'preoccupied and absent' and her father as 'fun-loving', although she felt she had to continually strive for attention • Helen feared further rejection and abandonment	• Helen either felt 'special' or 'trashed' in her relationships • The fear of feeling 'trashed or a failure' led her to strive to do better but she bottled up her resentment and frustration, often feeling exhausted Helen would sometimes escape these places by indulging herself (getting drunk, spending, sex) • Helen did not have an emotional vocabulary to describe her pain • The focus of her CAT therapy, via diary keeping, no send letters, and generally through the use of the CAT tools enabled her to establish her own voice and understand the past voices that had contributed to her sense of herself • She began to see how she strived for attention from others and often was so preoccupied with the 'other' she had lost her own 'voice' • The CAT tools enabled her to see this was not realistic and that being more accepting of herself was her 'exit' from her old procedures	• The CAT tools allowed for an integration of her emotion, thoughts and behaviour and allowed her to integrate her different emotional states, in turn allowing her to understand herself better • We used our relationship and understanding of the counter- transference in the therapy to elicit this • I don't think the relational aspect would have been so personally meaningful with more traditional treatments • The collaborative nature of CAT made it hard for Helen to remain in her 'passive/ pleasing' reciprocation or 'striven' procedure • After therapy Helen became more independent • She described learning through our validating and accepting therapeutic relationship • Helen has not reoffended

Trauma Workshop - London

12th September 2019

Location: Abbey Centre, Westminster, London

Current Thinking regarding Trauma – some possible implications for CAT. Led by Annie Nehmad and members of the CAT and Embodied Mind Special Interest Group.

www.acat.me.uk/event/1035/ #ACATTrauma0919

Discussion on CAT's contribution

CAT is up-to-date and chimes with desistance theory (used in offender rehabilitation). CAT can potentially bring cost savings for services by enabling patients to move through their care pathways more quickly, by reducing risk and therefore the level of management required. It not only aids a robust and comprehensive view of risk on its own, but it also can be combined with CBT, Psychodynamic models and incorporated into RNR and GLM interventions.

Pollock and Stowell-Smith (2006) describe how CAT enables a patient to gain insight into their problems through the CAT tools. They suggest that CAT conceives the self to be a dynamic, dialogical entity of interacting selves (pages 8- 9). So, there are 'many 'I' positions in space and time', which I think supports the understanding that the offence may be one part, but not the whole identity for the individual. Often enabling an individual to see they are more than just their offence is an important part of their treatment.

CAT incorporates the whole individual: it is less interested in 'just diagnosis', which so often labels patients, bringing little understanding for the patient about themselves. CAT incorporates the dynamic nature of risk in its formulation and enhances the patient's responsibility and ownership from the start of the therapy. It also allows for the patient to develop non-collusive responses from others via shared formulations (Pollock 2006). The CAT map can incorporate 'social inclusion' by a shared understanding with others.

CAT considers the individual's relational patterns over time. Its use of RRs as occurring between people as well as within the patient is obliging and considers from the start the patient's societal, social, political and cultural context.

CAT offers a collaborative way of being alongside forensic patients. Getting alongside these individuals is in my opinion what helps to enable them to move forward in terms of their Secure Recovery (Drennan and Alread 2012; Moon 2015), and helps individuals to maintain 'hope' which is especially important in this stigmatised population. Especially as we know that people who commit sexual offences often lack socially meaningful relationships and are often emotionally isolated and vulnerable.

Sex offending treatment does not pay enough attention to societal and cultural issues (as with Sam), nor does it focus on the context of the setting in which the treatment is provided (as with Mike), which is often in incarceration or forensic settings which themselves breed fear, anger and anxiety. None of these feelings are conducive for healthy – let alone safe – learning.

CAT is an integrative therapy with a person-centred, collaborative and jointly-constructed approach. CAT has a transparency which I think is helpful when working with forensic patients who are often unwell, disempowered and lacking in trust. CAT enables a safe way to communicate with these 'paranoid-schizoid' style presentations often found in the forensic world.

The CAT formulation can aid a clear understanding of the transference and counter-transference issues that can be displayed and allow the therapist not to be drawn in to unhelpful patterns (as with Helen). The transparent sharing of these patterns, usually in the SDR (map), enables 'ruptures' in the relationship to be jointly acknowledged, negating blame and also validating progress.

CAT comes from the viewpoint that individuals are continually evolving, and considers this through their continual social interactions with others and their internalisation of this. CAT has a far less restricted view of human nature: it takes into account individual difference and focuses on the wider picture seeing the 'whole' person. CAT therapists don't look for a 'one size fits all model'. CAT places greater emphasis on understanding the individual 'meaning and motivations', it does not wish to only target the unhelpful behaviour and change it.

Due to its time-limited nature, CAT's focus on endings, allows for an ending that is thought about with the patient and processed rather than 'cut off' and ignored, (endings are less focused on in sexual risk work). This focus on the ending in CAT can allow for a better and perhaps 'emotionally corrective experience' (Ryle and Kerr 2002) in itself for the patient who more than likely has suffered insecure relational attachments and poorer endings in their past.

Future Direction

Since writing the paper, I have presented some of the work at ICATA and to NOTA (National Organisation for the Treatment of Abusers). As well as their interest, this work has attracted interest from Kent & Medway Partnership NHS Trust (KMPT), Kent University, and from other leading experts in the field of sexual offending. My next step is to develop this work further into a CAT informed treatment manual for those who commit sexual crime.

This is a set of observations from what is effectively a small case series which was carried out as a part of routine clinical work and wasn't initially set up as a piece of research. The next step is to design, deliver and evaluate a CAT treatment programme, using more controlled measures and by evaluating the process to establish the validity of my proposal, which is that CAT offers a rich contribution to sexual risk treatment.

I am happy for people to contact me on S.casado@nhs.net about this article or if your service is interested in becoming involved in the developments of this work.

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