Entering the Antisocial Arena: A Cognitive Analytic Kaleidoscope

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Overview

The Cognitive Analytic Therapy (CAT) evidence base for the treatment of clients with personality disorder (PD) diagnoses is growing (Calvert & Kellet, 2014). CAT has been particularly embraced in forensic tertiary services (Ministry of Justice, 2007) providing specialist support for narcissistic and antisocial presentations. These individuals are often excluded from community mental health services and psychological treatments (Crawford et al., 2007). Thus, within community outpatient services there is a gap of provision for this client group, often avoided, and clients can find themselves in a void between criminal and mental health systems.

This paper describes a CAT informed approach by a trainee clinical psychologist in a NHS outpatient psychotherapy service, where a man with criminal and aggressive behaviours would have been excluded due to his risk to others. As a novice in this therapeutic approach, CAT was a refreshing surprise, where its flexibility and accessible language provided an opportunity for treatment for a man who would have struggled to find his place within PD services, as they are often dominated by females, consisting of group components and oriented to Borderline Personality Disorder (BPD).

The Roots of CAT

Dr Anthony Ryle started his career as a General Practitioner in the 1950's, where his interest in mental health difficulties emerged. In his early psychotherapeutic stages, Dr Ryle's practice was mainly influenced by British object relations psychoanalytic principles. His interest into psychotherapy processes and devising accessible, clear and generalised language of client's difficulties drove him close to George Kelly's (1955) personal construct theory and grid repertory (Leiman, 1994). In an early paper Frames and Cages (Ryle, 1975), traditional psychoanalytic patterns such as "oedipal conflicts", "penis envy" or "identification with the aggressor" are described in simpler terms (Leiman, 1994).

Thus, the operationalisation of conscious and unconscious difficulties in terms of reciprocal roles, traps, dilemmas and snags that could be shared and constructed collaboratively with clients (Ryle 1979) was the cradle of CAT. In this process, a short term and intensive therapy that could be available in the NHS emerged (Fozooni, 2010).

Phase 1: Mark and Developing Reformulation

Mark was referred by his community mental health team (CMHT) for psychological therapy. He was diagnosed with depression, post traumatic stress disorder (PTSD), borderline personality disorder (BPD) and possibly met criteria for antisocial personality disorder (ASPD).

Mark had a longstanding history of violence, being physically assaultive, self-harm and serious suicide attempts. Mark was an only child; his mother abandoned him when he was three. He grew up with his father, a stepmother and two stepsisters. From the age of six, he suffered extreme physical violence and deprivation at the hands of his stepmother. The abuse continued until puberty, when he was able to defend himself and end the abuse. Mark's adolescence was marked by excessive substance misuse and extreme violence towards himself, others and properties. During his adulthood, Mark found himself in dysfunctional relationships, where women would often beat him up, in what resembled a painful frozen memory from the past.

Despite being severely neglected, Mark developed different talents and worked as a dance instructor, practised martial arts and worked on building-sites. However, his unmanageable levels of aggression eventually led to him losing his job which triggered major depression, leading Mark to make serious attempts to take his own life as well as being involved in a number of violent assaults. After two years of unsuccessful involvement with his local CMHT, Mark was referred to our service. The therapist and Mark worked together for six months and 22 sessions – his target problems were:

1. Antisocial Behaviours & Substance Use

ASPD is defined in the DSM-5 (American Psychiatric association, 2013) as a consistent disregard and violation for the rights of others. At the time of our assessment, Mark

described a significant number of past aggressive and criminal behaviours and fluctuated between a disregard and lack of remorse to some sense of guilt and acknowledgement of the damage caused. He showed some concern for his anger, a fear that he might hurt the people that he loved which resulted in him living separately from his partner and children. This state of mind was represented by his reciprocal role of blaming-guilty, which was accompanied by feelings of numbness and depression (see Appendix 2). Mark was also a heavy cannabis user.

2. Anxiety and Depression

Mark's body was flooded with anxiety. He seemed suspicious and terrified, in a relentless fight or flight mode. Mark had learned to treat himself similarly to how he was treated as a child. He developed critical and punitive thoughts towards himself and a disregard for his needs or his longings, which had led to a core pain of feeling unworthy and rotten to the core. Mark was thus feeling profoundly depressed and hopeless. His reciprocal role of attacking-attacked was evident through him internalising his aggressor, becoming the aggressor towards himself and others in order to avoid feeling vulnerable and scared like he did when he was a child.

3. Self-Harm and Suicidality

Mark engaged in different self-injurious behaviours such as punching walls, cutting his legs and stabbing his arms he had also attempted to kill himself by a variety of methods.

Phase 2: Recognition and Revision

The therapist and Mark co-created a collaboratively developed risk assessment and management plan and a contract which included Mark agreeing and committing to appointments. The first few sessions were devoted to a careful appraisal of anxiety regulation and anger management techniques. The purpose of this was to access his mind through his body, by helping him be curious about his body experiences, to identify and regulate his hyper arousal before it became too overwhelming and unmanageable. Consistent with CAT and other relational therapies, the focus of the sessions was in the room, and the therapist purposely avoided "following his narratives outside of the room". The aim was to help Mark understand that he could learn to manage those impulses before it was too late, rather than feeling that he was "acted upon" by the phantoms of the past. This was in itself the construction of a new reciprocal role acknowledging-acknowledged in which he could relate to his body as a good object, rather than as a persecutory one that needed to be punished.

The sessions were video-recorded and an excerpt of one of the sessions is transcribed in appendix 1, depicting how the therapeutic relationship can be used as a psychoeducation tool in the "here and now". In this example, the therapist tries to help Mark recognise what is happening between them, how Mark's body is responding and how he is ignoring the signals that are indicating that his body is being inundated with difficult experiences. Mark was neglecting these signals not because he wanted to, but because he did not know how to pay attention to them. As a child, he did not have the experience of an attentive and attuned caregiver, who helped him acknowledge his body reactions, his inner reality and who provided him with comforting responses. In the therapy room, one could see the body enactments of his fear, in a constant state of hypervigilance that he could not manage, as he had never learnt how to. Moreover, the therapist was also aware of his body enactments as he was listening to Mark's painful story. As Tim Sheard (2017) points out, working in the embodiments of both clients and therapists help us clarify the kind of therapeutic space that is constructed.

Mark's sequential diagrammatic reformulation (SDR, Appendix 2) identified three reciprocal roles together: attacking-attacked, abandoning-abandoned and blaming-guilty. Mark was constantly hypervigilant, and described extremely violent states of mind, resembling a horror film. In the countertransference, the therapist would catch himself in touch with a paternal instinct, a wish to protect Mark and to acknowledge his grief and sadness. This gave the therapist hope that a part of Mark could attach to others, love and develop intimacy, a part not saturated by violence and torture.

Throughout the sessions, Mark was able to recognise some of his dilemmas ("I must not trust anyone, then I will be safe) and snags ("I would like to be less attacking of myself, but this way of being is what made me survive") and the huge impact that they were having on his mental health. He was able to progressively start questioning them, and he managed to develop some intimacy with me and with his partner, throughout the course of therapy.

Phase Three: Ending

Ferenczi (1921) once said that therapy lays its fingers on the wounds that patients had brought to heal and therefore as therapists we can be both the cause and the solution. Given Marks' history of neglect, abandonment and sense of betrayal, the ending was highlighted throughout and focused upon. Trying to understand the emotional states, traps and procedures associated with this experience came to the forefront of the therapeutic experience. The goodbye letter was a key element of this process. Mark could receive a goodbye letter, which represented a transitional

object (Winnicott, 1945). This was the representation of a narrative that was constructed between Mark and the therapist, something that was not the self neither the other, but a space in between, where an alternative story could emerge. This was fundamental for Mark, whose early experiences of trauma had flooded the ability to differentiate between self and other, between inner reality and outer reality.

Conclusions

During the six months of involvement Mark showed significant improvements. He reduced his cannabis intake significantly and had made no attempts on his life or physically assaulted anyone. He was able to start doing activities that he enjoyed.

Mark was still experiencing anger outbursts, flashbacks and depressive symptoms but was more able to identify difficult impulses and manage them. Mark had developed more trust in services and was more able and keen to engage further.

Mark's case highlights the contributions of CAT in understanding complex mental health and personality difficulties. By understanding procedures and reciprocal roles, clinicians are able to respond to the "anxiety and not the defence". This was clear in the case of Mark, where services had often neglected him as his aggression (defence) was too unmanageable. What had been missed though was the sheer sense of fear and abandonment that he has experienced in the past, and how this had been re-enacted in services. By paying careful consideration not only to his verbal communications ("I want to hurt others") but also to the underlying motives ("I am scared and I don´t want to be hurt") we were able to open the door for different possibilities to emerge. Now Mark could at least question the deep seated state of mind that made him feel that his mind, body, the people and the world were scary, persecutory and torturing. Mark's case also awakened the gap in service for clients with such needs and the development of more evidence based for CAT groups is leading the service to consider and develop this intervention further for clients such as Mark.

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Appendix 1

Phase One Transcript

T: When I look at you...you seem tense...you seem to be anxious

*M: Yeah. This morning I wanted to punch someone´s head. I was walking down street and I saw two fellas sitting in a van, and I see them looking at me... there might have not been looking at me but then one of them smiled and I went down and I said "what the f*** are you looking at?" And they just put their head down you know what I mean but I was wanting a fight...*

T: So let´s go back to here, because I think this is what happens outside, that it escalates very quickly...

M: Yeah, I can´t control

T: So let´s get back here, I think you are feeling quite anxious now, do you notice that?

M: Yeah, I did not want to come out

T: How do you know that you are anxious?

Phase Two Transcript

M: Is not a nice thing....Like last week I went out with my mate to play snooker, and it was good, I have not been out in a while. But then is like, this voice in my head tells me "no, no, no, no".

T: I was just thinking that you were tortured as a kid, and this voice almost seems like that of the person who tortured you, who told you that you were not worth...

M: (cries) I think, yeah I think probably that would be something she made.

T: Because it sounds horrific, that you can´t enjoy things, that it puts you down

M: I can only enjoy it if I earnt it... like I may get money and I don´t even spend it because I don´t feel like I deserve to go out and buy stuff... I think society is going to think look at that waste there and he is in "trackies"... and he is going out with taxpayers 'money

T: I feel that this is just very painful and is there with you... it dominates you

M: Yeah, I have scars in my body that I have grown... but the ones in here (points out to his mind)

T: Yeah they are there all the time... but do you want to listen to this voice? Or would you like to change it?

M: I would like to change it but is hard...