Split-Egg Fantasies: Incorporating Fantasy into a Developmental Model of CAT

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Introduction

In a specialist youth service, it is important that a developmental model is incorporated in all clinical work. CAT speaks to the development of the self in relational terms, but this is not always incorporated explicitly into clinical work. This paper looks at the incorporation of development and fantasy into CAT and outlines a simple model that can be easily explained to adolescents and young adults. The model also works well in adult populations as the case example illustrates.

CAT's Concept of the Development of the Self

CAT has a 'radically social' concept of the self in which the self is seen as emergent from the internalisation of the dyadic interactions of early life. Infants, with a set of inherited characteristics and evolutionary dispositions are theorised to interact reciprocally with care-givers in a given culture and time so that these interactions are internalised. In this way, the infant develops a mature personality and a sense of self. The model draws upon a broad range of ideas including those of Bahktin, Vygotsky, evolutionary psychology, and genetics (Ryle & Kerr, 2002).

Jenaway (2007) takes this theoretical basis and brings it together in the form of a Sequential Diagrammatic Reformulation (SDR) outlining the way in which this process occurs during the course of infancy. She starts with the needs of very young babies and the way in which they strive to get these needs met.

At the bottom of the SDR Jenaway places the baby's distress, the cause of which, in Jenaway's model, might be hunger, being too cold, or being wet. The baby, however, has no understanding of the cause of the distress. As a result, the distress experienced by the baby can be seen to be existential; the baby fears it might die, it fears for its existence. Indeed, if the baby does not receive care from an adult, this will be the case. The baby cries or screams in an attempt to bring rescue to this perceived life-threatening situation. The expectation or the hope of the baby, from this position, is that a carer (usually a parent) will fix the problem and rescue them from this perceived life-threatening situation. In this way, the baby holds the expectation that even though they themselves have no concept of what might be wrong, the caregiver will know and will fix it on their behalf.

In Jenaway's model, the caregiver needs to provide good enough care. This will enable the baby to learn, over time, that the caregiver might take some time, might get things wrong for a while, but that usually, they manage to resolve the issue. As the baby grows, they also learn that they can support the caregiver to get things right quicker, for example, by indicating what they think the issue is. In this way, the baby, over time, gains confidence that there will be somebody there who can support them and provide care and that they will be OK.

Jenaway draws this cycle out with two poles of reciprocal role, the feared place at the bottom and the ideal place at the top. The two other roles are the striving place on the left, and the failure of the ideal place on the right.

Fantasy and Development

The important consideration for this paper is the way in which fantasy fits with the developmental model of CAT outlined above. The developmental model incorporates a clear fantasy that is often referred to in CAT; that of perfect or ideal care. This fantasy is that another will detect the distress, find its cause, and resolve it, all without any input from the individual experiencing the distress. This fantasy might be outlined reciprocally as "perfectly caring forever, without limits to perfectly cared for, blissful". This concept is included in a variety of models, particularly those relating to work with people with borderline personality disorder (Ryle & Kerr, 2002; Nehmad, 2010). A great deal of work in CAT often involves helping clients to understand that the care for which they are striving is fantastical; that it is unrealistic and cannot be achieved.

What is important, from a developmental point of view, is that there are not one, but two fantasies. The first is the fantasy of perfect / ideal care, placed at the top of Jenaway's diagram. The second fantasy is the fantasy of utter abandonment and complete failure of care, resulting in death. This fantasy might be outlined reciprocally as "utterly and completely abandoning to completely abandoned, helpless, and alone". Many CAT diagrams include concepts of abandonment and rejection, but usually these are spoken about as if they are representations of reality, of actual events in people's pasts. For many

individuals, they have experienced emotional abandonment, or have been left by their caregivers temporarily. The fantasy that derives from childhood, however, is that the abandonment will be total and complete; that they will never receive any level of care again and will die as a result.

With these ideas, we can develop the model suggested by Jenaway such that babies can be assumed to be born with two extreme models of the world. They expect either that they will be completely cared for and blissful or that they will be utterly abandoned and die. During the course of a trajectory of good enough development, babies and children learn that these two positions are too extreme to represent reality; that, in reality, they will receive a level of care that is good enough, in which the majority of their needs will be met within a reasonable time frame, and in which they have the ability to assist the process of care by taking some responsibility for it. This moves them away from the two extreme positions and towards the reciprocal roles in the centre of Jenaway's diagram of caring with limits to cared-for with limits. In this way, over time and across development, individuals eventually internalise these reciprocal roles and reach a point at which they are able to appropriately care for themselves and are able to provide and receive appropriate care from others.

Developmental Difficulty

Of course, the majority of clients presenting for therapy have experienced care that has fallen short of this good enough care and experience difficulties as a result. Indeed, for those presenting for CAT the primary issue often results from an insufficient experience of care.

In the context of this model, what we would expect to see is that the individual, for whatever reason, has not had their needs understood regularly enough for them to learn that the caregiver usually manages to get the care right. This means the individual has not had sufficient experience of caring with limits to be able to learn or to internalise this reciprocal role pair. As a result, they are left with the two fantasies of childhood; perfect care and complete and utter abandonment.

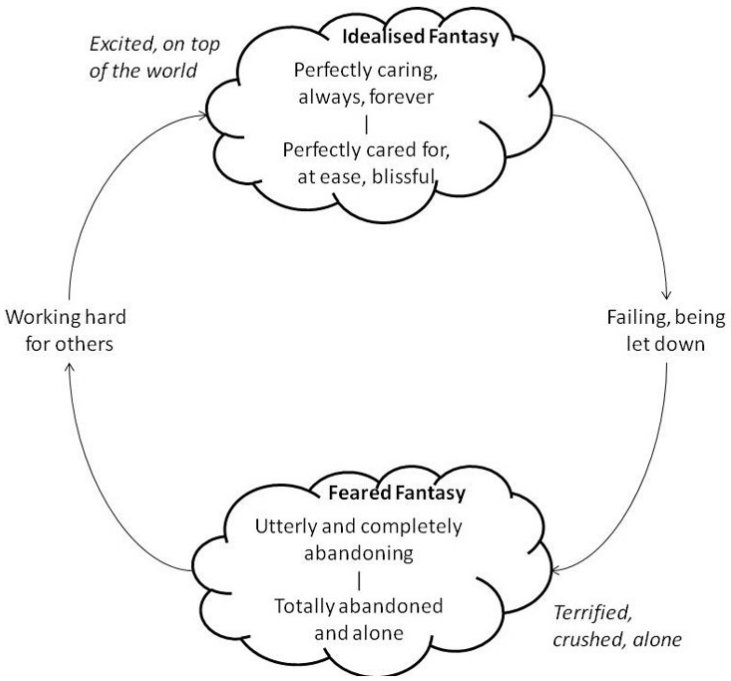
That perfect care is a fantasy is illustrated in many papers (e.g. Nehmad, 2010; Melton, 1995). That the reverse is also a fantasy rather than reality is illustrated by the fact that none of our clients have been abandoned to the point of death; there has been sufficient care to keep them alive and functioning in some form, even though they may have experienced extreme neglect or abuse.

Resulting Model

The model that results from this understanding of the development of reciprocal roles around caring relationships is outlined in Figure 1. It is a fairly simple CAT SDR in which the two fantasies of care are placed at the top and the bottom of the diagram. The top fantasy is an idealised perfect care fantasy, containing reciprocals such as perfectly caring to perfectly cared for, or completely valuing to completely valued. The bottom fantasy is the fantasy of complete failure of care, containing reciprocals such as utterly abandoning to utterly abandoned, or completely rejecting to completely rejected.

It is important, in this model, that the fantastical nature of the two extremes of the SDR is captured; that it is clear that they are fantasy. In relation to the idealised fantasy, for example, it is important to make it clear that the level of care that an individual is seeking is unrealistic. A useful example of this is a client who has no idea what they want for their birthday, but is hoping and expecting that their partner will buy them something which will be a surprise, that they will adore. This desire illustrates the hope that another will know them better than they know themselves; a level of care that is ideal and unattainable.

Figure 1



Many CAT practitioners will be familiar with the process of helping clients to see that the care they desire is fantastical. However, this is less true of the feared fantasy. A common example of this is the case of a child who has been left by the side of the road whilst their parent drove angrily away, to return five minutes later to pick up the child. The fantasy in this case is that the parent has utterly abandoned the child and they are entirely alone, fearing for their lives. However, in reality, whilst the child experienced emotional neglect and abuse, the parent returned to collect their child and so they did receive sufficient care in order to survive. In this case, they were abandoned by their parent, but only temporarily; they were not utterly abandoned by everybody, forever, which is the fantasy.

In this model, the two fantasies at each extreme are the most important parts of the diagram and the most important concepts to grasp. Following on from this, the procedures that link the two fantasies and hold them both together can be linked. These are usually some level of work and effort on the left-hand side, which represents the attempt to create the idealised fantasy and some level of disappointment or rejection or even abuse that maintains the feared existence of the feared fantasy.

As with any psychological formulation, emotions are always driving force, so it is important to include these on the SDR. CAT practitioners will be familiar with the idea that procedures are often ways of escaping from feelings that are perceived to be negative or uncomfortable. These emotions should be included on the SDR. However, in this model, there are also intense feelings (e.g. excitement or elation) that are associated with brief periods of getting close to the idealised fantasy. It is important to include these on the SDR as well. Thus, the resulting SDR can be seen to contain both positively and negatively reinforcing feedback loops.

In true CAT form, this helps clients to understand that the procedures in which they engage have developed for a reason, which is associated with their past experience, but they also continue to work in some ways, which is why individuals continue to use them. It also helps them to understand the apparently rapid way in which they cycle between different emotional states depending on apparently small events in their environment, which invite them into one or other of their fantasies.

In elucidating the fantasy that is most accessible, the rest of the model flows relatively easily. The two fantasies are usually polar opposite: for example, mattering completely to one person versus not mattering at all to anybody, or feeling completely loved by everybody versus feeling entirely and completely unlovable by all. The procedures that flow between the two poles then illustrate how the fantasies are also inextricably linked and that one cannot exist without the other. This can then help clients to consider the option of allowing themselves to move away from the fantasy towards a reality that is less extreme.

Indeed, exits, in this model, are all based on a less extreme reality in which there exists potentially a great deal of sadness and aloneness, but not the complete abandonment that is feared. There is also the presence of some care, not least from the therapist, which falls short of the ideal but which can be nourishing and contain goodness none-the-less. This, in CAT terms is often termed the middle ground.

What does the Model Add?

The model outlined here is, in many ways similar to other models of extremes, for example Jenaway and Rattigan's model (2011), the split egg (Ryle & Kerr, 2002) or Nehmad's model of narcissism (2010). However, there are two important factors that this model addresses in addition to these models:

1. Fantasy

This model, as opposed to other models, is explicit about the two fantasies integrated in individuals' relational patterns. The explicit nature of the fantasies in the model enable a more open and in-depth exploration of many of the experiences relating to care. Most individuals report experiencing some level of fantasy in their lives (Bivona & Critelli, 2009; Rosenfeld et. al. 1982; for individuals who have not experienced good enough care, these fantasies are likely to be more prominent and have a greater impact on their lives and their functioning.

Beginning with a model premised on fantasy allows space for people to be open about their fantasies and to feel that they are a normal and expected part of their experience. This allows the avoidance of the shame or embarrassment that can arise as a result of ideas that individuals clearly know to be over-valued or fantastical, but which nevertheless have a powerful influence on emotions and behaviour.

Naming the fantasy also allows for the hope of an alternative, namely reality, which is that experienced in the therapy room and in other places besides, but which often gets missed or not thought about as a result of the focus on the more emotionally salient fantasy worlds. The naming of this as reality can be more powerful than the more common 'middle ground' which can invite a sense of giving up on something exciting and interesting for something mundane and boring.

2. Letting go of BOTH Fantasies

Many similar models, for example the split egg or the model of narcissism, have an explicit fantasy at the top pole of the diagram, but an implicit fantasy at the bottom. This can lead to treatment endeavours that apparently aim to help individuals to give up on the fantasy of perfect or ideal care and to

accept a reality of abandonment and rejection. In the present model, it is clear that both of these poles represent fantasy; that reality lies somewhere in between, in which there is some aloneness, some pain, some hurt, but also some care and some possibility of happiness and connection.

Allowing individuals to see that by giving up on the idealised fantasy they can also give up on the feared fantasy often enables them to consider what might exist in between, in reality. The separation in the model of fantasy and reality also encourages individuals out of the extreme fantasy worlds by explicitly labelling these extreme places as fantasy rather than an achievable reality.

Summary

The dual fantasy model builds on CAT's understanding of psychological development to produce a model that embraces the fantasies that people hold about themselves and the care they provide and receive from others. It is powerful in that it is embedded in a developmental model that helps people to understand its origins. It also explicitly incorporates fantasy, providing space for individuals to express their fantasy worlds and to understand the way that these fit with their earlier experiences and their experience of life in the present. By naming these extreme positions as fantasy it also allows individuals an exit into a less extreme reality.

Case Example: Wallie

Wallie has provided consent for his case material to be presented in the anonymised manner outlined next. He was a man in his 40s, married with children. He presented talking of a long history of depression; all of his life. He described periods in his life in which he withdrew into himself and stopped communicating with those around him. He said that other people experienced him as angry and that he had been blamed for family conflict. He initially requested Cognitive Behavioural Therapy but an early discussion about his tendency to avoid feelings and to function in 'robot mode' led to a joint decision to do a 16 session CAT instead.

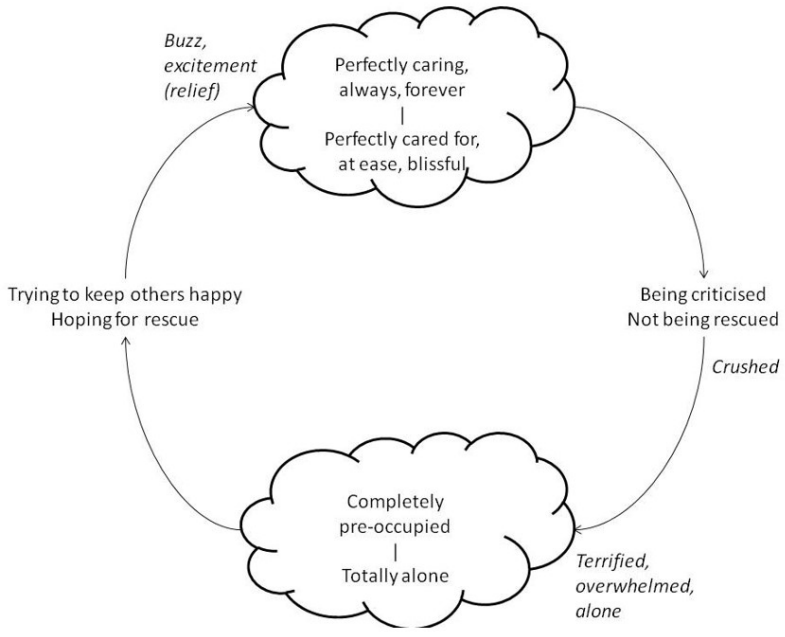
Wallie's early life was characterised by a lack of time and space. He repeatedly used the phrase 'on the straight and narrow' to describe his experience. It was as if he had no choices, only to go forward and hope for a better future. We talked about how he was so scared of doing anything outside of this narrow path that it hardly even crossed his mind to try it.

Wallie talked about experiences in his marriage in which his wife had threatened to leave, or in which they had lived apart for a period. He became extremely upset when talking about these times and said that he had no idea how he would cope if his wife were ever to leave him. It was this fear that she would leave and her sense that he should stop being so depressed that had led him to seek help. When we talked in early sessions about what it might be like to change, or to be more open with others, Wallie talked about being terrified of making any change for fear that his wife would leave.

Wallie had become a successful professional and worked in a self-employed capacity. He worked extremely hard and talked of a 'buzz' when he got a new piece of work; a feeling that was almost addictive. It made him feel valued and wanted. This was one of the reasons for his hard work. However, he also worked hard for fear of letting others down and their rejection of him as a result.

Wallie functioned almost all of the time in 'robot mode' and rarely asked anything of anybody. At home, he felt best when everybody in his family was happy; when they were happy he felt he could relax. In his family life, he was also scared of letting others down, a fear that was associated with a terror that they would leave or abandon him. His depressed periods were characterised by an anger that he dare not express that nobody ever did anything to help or even

Figure 2



commented on his depression, except to blame and criticise him for it.

In drawing out Wallie's SDR (Figure 2) we used the dual fantasy model as a structure. The most salient fantasy in Wallie's case was the fantasy of utter abandonment and isolation; this was the fear he held in relation to his wife and in his earlier childhood. This was drawn reciprocally as preoccupied to completely abandoned and alone.

The opposite fantasy – the idealised fantasy – was the fantasy of perfect care: perfectly caring to perfectly cared for. In relation to Wallie's position at the top pole, he was striving to keep others happy all of the time; i.e. he was striving to provide perfect care. On occasion he did feel some positivity as a result of this endeavour, for example the 'buzz' that he felt when he was offered work, which was interpreted personally as a sense that others valued him. He also acknowledged that he was hoping that others would be able to rescue him from his depression and make it all better, even though he remained silent about his feelings and what he wanted. This was the hope that others would provide perfect care for him.

When he did not get care from others, he felt he was moving towards the feared fantasy or the worst nightmare, which was that of utter abandonment; Wallie feared he would lose the little care he felt he received and be left entirely alone.

Wallie was able to understand this SDR, aided by the developmental explanation outlined above. He could see that, as a child he had not felt cared for, not felt that he mattered and not felt that people were thinking of him. This understanding helped him to try to make some changes, which he did in a somewhat dramatic fashion one weekend. He had spent the weekend feeling depressed and on Sunday night, made the decision that nobody was ever going to help him and that he would have to do everything on his own. In taking this decision he gave up on the fantasy of perfect care and embraced the feared fantasy that he was entirely alone and utterly abandoned. He forced himself to do things, he planned a day in which he took all of the responsibility on his own shoulders and pushed himself forwards. He found that in giving up on the fantasy of perfect care he did not, in fact, find himself utterly alone. Instead, he found a reality in which he was able to receive some care from himself; he thought about what he needed and made plans accordingly. He also found that those around him noticed him, noticed his efforts, praised him for his efforts, and demonstrated their care for him. Wallie was able to see that in giving up on the fantasy of perfect care he could also give up on the fantasy of utter abandonment and an entire absence of care. In doing so, he could reach a reality, in which he could care a little for himself and receive a little care from those around him.

As a result of this process of spending less time involved with his two fantasy worlds, Wallie began to connect more with the reality of his life. In some ways this gave Wallie a feeling of immense relief that he did not have to struggle so hard to achieve these unattainable goals. However, he also began to connect more with the struggles of his life and the feelings of sadness and fear about the situation in which he found himself. He talked of a need to find solace and comfort in ordinary life, rather than looking to the fantasy to resolve his feelings.

Over time Wallie gradually built a better reality for himself in which there was more time and space for him, so that he was more connected with himself, more connected with his family, and more able to make decisions in his own interests. He worked a little less hard and whilst he didn't get the same intense buzz from work, he felt much less alone and much less depressed in his life.

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