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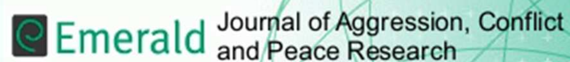

Using an integrative, Cognitive Analytical Therapy (CAT) approach to treat intimate partner violence risk

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Reviewer 1: no recommended changes

Reviewer 2:

Comments:

Abstract: move the explanation of the acronym CAT to the first sentence when you mention it for the first time. Done

Introduction: first line about the pro-fem theories, it'd be better to use an alternative reference as you go on to discuss pence and paymar in the next sentence. Edit made, reference added.

I'd recommend you move your discussion of alternative theories to before you start to discuss CBT. I think these theories need integrating a little more critically into the narrative I'm terms of why these approaches fit better with the work you have done here with this case study. I have moved CBT part to after the other theories but before CAT.

Client info - remove the psychosocial background header as I don't think it's needed. Done

P9 - I would just use the word weapon rather than specifying the weapon (so the veg peeler) as I think it's the presence of something that could be used as a weapon that's important rather than the actual object. Done

Discussion: line one, do you mean CBT rather than DBT in that sentence? Error changed

P24 - I'd remove the reference to the Duluth Model, the work you have done here doesn't fit at all with that model (in a very positive way!!). Perhaps include reference to the other models from your introduction? Edited.

Conclusion: I still feel this could be slightly stronger and firmer in the originality and contribution but I might be being picky. Slight edits made.

Tables: could be reserved better without the horizontal lines. I will leave table format to the journal proofing process – happy for these to be reformatted to fit the journal.

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Using an integrative, Cognitive Analytical Therapy (CAT) approach to treat intimate partner violence risk

Abstract

Aims: There is limited research on Cognitive Analytic Therapy (CAT) in forensic contexts; this case study therefore significantly contributes to the knowledge base. This case study presents the assessment and treatment of an adult male offender with a diagnosis of schizophrenia. The client's offence involved intimate partner violence and was committed at a time of acute psychiatric relapse.

Method: Twelve sessions of Cognitive Behavioural Therapy (CBT) and CAT informed treatment were individually designed to meet the needs of the client, delivered in an in-patient setting in the UK. The client's progress was assessed using psychometric, observational, and narrative/descriptive methods.

Results: Psychometric evidence was limited by distorted responding. However, narrative/descriptive assessment indicated that progress had been made in some areas. Recommendations for further treatment were made.

Conclusions: Twelve sessions did not meet all of the client's needs. The use of CAT as a model that his team could use in understanding his violence was conducive to risk management. Overall, insight gained through CAT based psychological intervention contributed to risk reduction.

Originality: This case study demonstrates the applicability of CAT to forensic settings.

Keywords:

Cognitive Analytic Therapy, Violence, Risk, Treatment, Intimate Partner Violence, Offender

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Introduction

Intimate Partner Violence (IPV)

Pro-feminist theories view IPV as a reflection of the patriarchal organisation of society as a whole, where men use violence when they feel their dominance is threatened (see Gondolf, 1998). Pence and Paymar (1993) discuss this in the context of Duluth 'power and control wheel' where power dynamics linked to socialisation are proposed to link to IPV. However, pro-feminist theory has been criticised for over-emphasising socio-cultural factors, resulting in exclusion of individual factors. For example, Dutton (1994) critically enquires how men can be held individually accountable for their IPV if it is a result of patriarchal society and Lawson (2003) questions how pro-feminist theory accounts for IPV within a same-sex relationship.

Family systems theory views the family as a dynamic organisation, with interdependent components, where the recurrence of behaviour of a family member is affected by other family members' responses. This theory promotes a family-level approach to IPV intervention (Gelles & Maynard, 1987) this approach may promote the view that the victim is to blame. Attachment theory, which places an emphasis on the reciprocity between individuals in a relationship, provides the perspective that IPV can be seen as an exaggerated response of a disorganised attachment system linked to disorganised attachment in infancy (Fonagy, 1999).

Cognitive behavioural theory puts forward that behaviour modification requires change in perception and interpretation (Beck & Weishaar, 2008) and can be used to frame IPV. Deeper held beliefs relating to male dominance remain relevant here as factors that may impact on perception and interpretation. Cognitive Behavioural Therapy (CBT) has become a favoured approach to offender treatment (McGuire, 2003; Gilbert & Daffern, 2010) as it lends well to identifying IPV

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intervention approaches. Despite this, group based CBT interventions have been criticised for lacking individuality (Howells & Day, 2002) and for not being sufficient to overcome automatic thoughts or learned behaviour (Walker & Bright, 2009), suggesting that more is needed to address the psychological processes involved in IPV.

These differing approaches, and their criticisms, demonstrate the need to go beyond one model in the treatment of IPV.

Cognitive Analytic Therapy (CAT), an integrative approach underpinned by psychoanalytic, cognitive and personal construct theory suggests that through early care relationships, individuals develop a range of reciprocal role procedures (RRPs) that determine how they relate to others and themselves, and some of these can be problematic (Ryle, 1997). It is suggested that offending behaviour can be a result of problematic RRPs, and RRP focussed interventions can be useful for offenders (Pollock, 2006).

Schizophrenia and psychosis have been found to be associated with general violence, with increased risk found with substance abuse comorbidity (Fazel et al., 2009). It has been suggested that the paranoia experienced by those with schizophrenia is similar to the hostile attribution involved when people experience anger or aggression (Chadwick, Birchwood & Trower, 1996). In relation to IPV, '*recent psychotic symptoms'* is an item recognised within the Spousal Assault Risk Assessment (SARA; Kropp, Hart, Webster & Eaves, 2008) as being associated with poor coping skills and increased interpersonal stress, and therefore IPV. It has also been highlighted that establishing whether violence precipitates schizophrenic symptoms is useful in treatment planning (Howells, 1998), as treatment providers can target psychological/psychiatric approaches accordingly. A range of factors can

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contribute to the development and maintenance of criminal behaviour, therefore it can be argued that an integrative approach is needed to explore and address these factors (Krampen, 2009). This case study draws upon both CAT and CBT in the psychological treatment of an adult male who has a history of IPV.

Client introduction

Mr A is a 25-year-old man with a diagnosis of paranoid schizophrenia and a history of drug misuse. He is detained in a low secure mental-health hospital in the UK. At the time of his IPV offence, there was evidence of acute psychiatric relapse.

Mr A, who has two brothers, described his biological father as a black Jamaican who misused cocaine. His parents separated when he was under five years old. There was on-going domestic violence towards Mr A's mother from her various male partners. There is a history of criminal behaviour and psychiatric problems in the extended family (diagnoses unclear).

Mr A's mother had another relationship with a man for five years during his childhood. Mr A's father and stepfather were body builders who abused steroids. Mr A described his childhood as "*sad*". His mother was constantly at work and there was an atmosphere of physical violence perpetrated by his father and stepfather. Discipline was exerted by threats of violence. Mr A denied any history of sexual abuse.

Mr A has previously reported that his teachers told him that he had a 'learning difficulty' from the age of four. Mr A said that he found it difficult to concentrate in the classroom environment from the age of ten onwards, disrupting the environment and being suspended. He had few school friends. His level of educational attainment was predicted to be poor but he did pass some exams, leaving education at the age of

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sixteen. He has worked in manual jobs but was unemployed for around a year prior to this hospital admission, having been made redundant. Mr A was reliant on state benefits and selling drugs as his sources of income.

Mr A has previously been in relationships with women. Mr A did not describe these relationships as being emotionally intimate. Mr A has disclosed controlling behaviour and violence towards one previous partner. He was in a relationship with the current victim for around one year prior to the serious offence that precipitated this hospital admission. Mr A describes this relationship as being 'on and off'.

Forensic history

Mr A has prior convictions for theft, failure to surrender to custody, possession of amphetamines, breach of community order, and criminal damage.

There is a documented history of suspected IPV perpetrated by Mr A against his ex-partner (and current victim) during their relationship. Suspicions arose following attendance of various agencies at Mr A and the victim's shared house. This included Police attendance following the victim alleging she had been assaulted by Mr A. Allegations included threats of weapon use and possession of a knife, where Mr A's ex-partner did not wish to proceed with Police charges. In addition, during routine visits, community psychiatric staff observed injuries on the victim that were considered to be consistent with IPV.

Mr A has disclosed having been violent towards other males in the past, including stabbing a male in the leg during an altercation. He also disclosed that he sold drugs to make money. The onset of violent behaviour preceded diagnosis of psychiatric illness.

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In relation to this inpatient admission, Mr A pleaded guilty to offences of assault, affray, and burglary. Consequently, other matters that he had originally been charged with were discontinued (he was originally also charged on two counts of false imprisonment). This 'plea bargaining' approach is not uncommon internationally, whereby if the perpetrator admits the charges, lesser charges are filed against them.

The index offence involved Mr A pulling his partner to the floor, banging her head several times against the bath. He made threats to kill her whilst he was holding a weapon. The affray offence relates to a few weeks prior to the assault, whereby Mr A went to the victim's ex-husband's house with a hammer and threatened his ex-partner and her ex-husband.

Method

Assessments

Wechsler Adult Intelligence Scale (WAIS-IV; Wechsler, 2008)

Mr A's cognitive ability was assessed in order to inform treatment planning. Mr A's general cognitive ability, as estimated by the WAIS-IV (Wechsler, 2008), was found to be within in the 'extremely low' range. His general verbal comprehension abilities were in the 'extremely low' range, and his general perceptual reasoning abilities were in the 'borderline' range. Mr A's ability to sustain attention, concentrate, and exert mental control was found to be within the 'extremely low' range. His ability to process simple or routine visual material without making errors was considered to be within the 'borderline' range when compared to his peers. Assessment of cognitive ability was completed to ensure that the intervention was designed to meet Mr A's learning needs and also to work with his clinical team to ensure that his cognitive functioning was supported on a day-to-day basis.

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Spousal Assault Risk Assessment (SARA; Kropp, Hart, Webster & Eaves, 2008)

The SARA (Kropp, Hart, Webster and Eaves, 2008) is a clinical checklist of risk factors for spousal assault that can be used to help guide treatment and case prioritisation and consists of twenty factors, grouped into five content areas; *criminal history, psychosocial adjustment, spousal assault history, index offence* and *other considerations*. In order to collate information to inform the formulation, Mr A's case was assessed using the SARA.

Two of the twenty SARA items were assessed as not present, seventeen of the items were assessed as present, one item was omitted and none were partially present.

Items that were used to guide risk management and reduction included *employment problems, substance misuse problems, relationship problems, suicidal/homicidal ideation, psychotic symptoms, extreme minimisation, weapon use* and *attitudes condoning spousal abuse*.

Pre-treatment initial case formulation and treatment approach

There is limited empirical research relating to case formulation and its impact on clinical outcomes (see Ghaderi, 2011), however one practical consideration to enhance the utility of case formulation is to draw on different models to encourage practitioner flexibility (Eells & Lombart, 2011). This case study applied functional analysis, which can be considered an important part of cognitive-behavioural case formulation (Persons, 2008) as well as a CAT informed approach to formulation. For example, the intervention involved identification of RRPs and a CAT reformulation narrative letter, which is a therapy tool that is argued to be central to CAT (Newell et

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al., 2009) whereby clients are supported by the therapist in transforming their existing understanding of their presenting problem into a more explanatory and useful form.

Functional analysis is an assessment approach used to establish the function of a behaviour by exploring the relationship between an individual and their environment, often referred to as an A:B:C analysis (Sturmey, 2008). The A:B:C in functional analysis refer to *antecedents* (A), *behaviour* (B) and *consequences* (C). Antecedents can be distal (historical) or proximal (current). It is important within functional analysis to consider reciprocal determination, which is the concept of environment, behaviour and consequences being interrelated or interactive. For example, a consequence could become an antecedent for a future behaviour and consequence cycle.

A multiple sequential functional analysis (MSFA) is a series of functional analyses that link together to account for complex historical behaviour chains (Gresswell & Hollin, 1992). Mr A's case was formulated using the MSFA approach (see Table 1), which was used to guide treatment. These MSFA hypothesise that parental influence, substance misuse, and paranoid ideation contribute to IPV.

<Insert Table 1 here >

Intervention

Description

The twelve one-hour session, individualised CAT and CBT informed psychological intervention sessions were delivered weekly, and took place after several assessment/motivation sessions.

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Session 1

Mr A's relationships with significant others were explored, with a view to gathering information that could be used to inform identification of RRPs. Transference and countertransference were discussed in the context of CAT and RRPs, in particular in the context of a potential role of **pleasing/impressing→pleased/impressed** he had already identified.

Sessions 2-5

These sessions focussed on Mr A's relationships with others in order to further explore RRPs and to inform a CAT reformulation letter. Controlling / controlled, impressing/impressed and humiliating /humiliated were discussed as possible reciprocal roles.

Session 6-7

These sessions involved the therapist reading out the CAT reformulation letter and discussing this. A self-exploration/self-esteem exercise was set as out of session work.

Session 8

An exercise on identifying the emotions of others through facial expression was undertaken, using pictures from magazines as a starting point. An exercise on 'bottling up' feelings was completed from a CBT perspective (**event → thoughts/feelings/behaviour → consequence**) whereby Mr A was encouraged to identify how 'The Incredible Hulk' may have felt and thought before he transformed into 'The Hulk' from the man he was before, and what may have contributed to this change in his behaviour. This was discussed in relation to Mr A's violence. RRP recognition was also discussed.

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Session 9

This session focussed on recapping/expanding on the work completed in the previous session and also covered a current feelings and behaviour cycle that was similar to previous unhelpful cycles.

Session 10

Mr A's thoughts, feelings and behaviour within the index offence and in other IPV were explored and discussed. Themes including jealousy, anger and drugs were explored. Through this a possible RRP was identified (rejecting / rejected). The victim 'no-send' letter Mr A had completed was discussed.

Session 11

This session explored a 'victim no-send' letter, and was used to review RRPs and prepare for the end of therapy. An out of session task to complete an end of therapy letter[1] was set for both patient and therapist to complete.

Session 12

Mr A had not prepared his end of therapy letter but talked through related thoughts. The therapist's end of therapy letter was read out. Mr A's progress and the future were discussed.

Results

General engagement

Mr A attended all twelve intervention sessions and completed out of session tasks. Mr A's progress in the individual sessions was considered alongside his out of session work and his behaviour outside of sessions. Direct observation of Mr A

[1] [1] This is a CAT tool designed to facilitate ending therapy. It is recommended that when writing this the therapist considers: feelings on ending, achievements, relationship, expression of hope, warm and engaging, exits, language used, life/learning after therapy (Turpin et al., 2011).

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outside of the therapy sessions by the therapist was not possible, although staff observation were available. Pre and post-treatment psychometric assessments were considered.

Qualitative description of progress

Mr A worked well in exercises that built on his strengths, for example exercises using creative means. Although possessing a limited repertoire of words to describe emotions, he demonstrated an ability to recognise emotions from facial expression within an exercise using visual aids. Mr A also completed a self-esteem exercise exploring his life and identity by creating a collage.

Mr A developed some insight into some RRPs and behaviour cycles. For example, he recognised that his tendency to give others what they want in order to impress or please them can leave him feeling used, and that when this happens, he does not talk to people about his feelings. This happened within his relationships with partners and other people. He recognised that he still does this in hospital; however, he does not feel that this is problematic, and consequently he did not develop exit strategies or options to address this. Mr A recognised that fearing rejection contributes to this tendency, and he explored how this may link to his early childhood experiences relating to early separation from his father and his father's subsequent inconsistent parenting.

Mr A talked through his offence, recognising that 'bottling up' emotions contributed to his behaviour within the offence and also within other previous incidents of IPV. He was able to label the feelings he had immediately preceding the offence not just as anger, but also as loneliness and feeling unwanted. He recognised that he feared the victim rejecting him by being unfaithful or ending the relationship.

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Mr A showed awareness of what could happen if people keep their emotions inside and self-isolate, linking this back to his offence.

Mr A explored some of the consequences of his behaviour on others. One of the biggest pieces of work he completed during treatment was his 'victim no-send letter'. The aims of this exercise was to explore his understanding of his relationship with the victim, the offence itself, his feelings about the offence and victim, and also what he thought she might feel. This was talked about during sessions, along with his desire to be seen as a 'good' person by showing the victim that he had changed. This was also linked back to his tendency to try to please/impress others. Risk issues were addressed as part of this and strategies for managing feelings associated with not being able to show the victim that he had changed were examined. The letter, and discussions around it, demonstrated that he has some recognition of how the victim might have felt at the time of the offence and also now, particularly if she saw Mr A again. Despite this, Mr A did not demonstrate insight into the longer-term victim impact.

Mr A demonstrated awareness of substances having a negative impact on his mental health, and although he said he did not wish to use drugs in the future, his awareness appeared inconsistent. He recognised that dysfunctional emotional coping contributed to his substance misuse, for example taking amphetamines to cope with feeling low about not helping his mother with the bills. He recognised that wanting to have big muscles like his father, and sibling competitiveness, contributed to his steroid use; however, he did not fully explore the related RRPs, which he could do if he engages in treatment in the future

Behavioural observations

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Mr A's documented behaviour outside of sessions was consistent. Ward staff often described his behaviour as 'settled'. He engaged well in the hospital regime and community activities with no evidence of drug or alcohol misuse.

The single documented incident of note could be related back to his identified role of pleasing others, resulting in not getting his needs met. During the course of treatment, it was Mr A's birthday. He met his mother and brother on escorted leave for a 'birthday meal' and said to his family that he did not want to go to a certain fast food outlet because the last time he had eaten there he was sick. His brother and mother asserted that this was where they should go, and so Mr A agreed to go. The three of them (and the hospital escort) went to this fast food outlet and Mr A sat with his brother and mother who eat their meals, but Mr A did not order any food as he was afraid of being sick. He therefore did not eat at his 'birthday meal'. The person reporting this situation felt that Mr A had not got his needs met, however Mr A's perspective was that he had experienced a good birthday because he had seen his mother and brother. He did not feel there were any difficulties or problems in this situation. Although Mr A's perspective and feelings are paramount, and he did not report any problems with the situation, enacting and maintaining this RRP involving pleasing others and not getting his needs met appeared to link to the dysfunctional roles that were present within the IPV. Had he recognised this role, and expressed his view and feelings assertively, he may have got his needs met in this situation. This does not necessarily directly link to his level of risk of violence, however this situation demonstrated that he could benefit from developing further insight into the way he relates to the world around him.

Psychometric assessment

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Mr A was assessed using a variety of psychometric measures (see Table 2). Where the required information was present in relation to each scale, *clinically significant change* and *reliable change* were assessed according to Jacobson, Follette and Revenstorf's (1984) methodology. According to this methodology, *clinically significant change* can be considered as change that has taken the individual from a problematic, dysfunctional, patient, client or user group to a score typical of the 'normal' population. *Reliable change* relates to whether an individual changed to an extent that is unlikely to be due to simple measurement unreliability.

< Insert table 2 about here>

It is of note that for the majority of the scales, Mr A scored in the 'non-dysfunctional' or 'non-clinical' range pre-treatment as well as post-treatment, and post-treatment his scores on some scales changed *against* the desired direction of change. The impression management scale of the Pauhus Deception Scales (1999) indicated the possibility of '*faking good*' both pre and post-treatment. Mr A's pre-treatment score pattern on the Paulhus sub-scales indicates that he might be aware of his shortcomings yet wants to be seen in a positive light, resulting in self-report being overly positive. This fits with the psychological treatment itself highlighting that *pleasing* or *impressing others* is a behavioural tendency for Mr A, showing a link between psychometric findings and behavioural evidence. Given that his responses may have been distorted, despite the comprehensive test battery used, little weight was placed on the psychometric findings in assessing outcomes.

Given the clinical issues in Mr A's case, one particular score is of particular interest. This is the Anger Control-Out (AC-O) subscale of the STAXI-2 (Spielberger, 1999). On this scale, higher scores are typically desirable (controlling outward manifestations of anger), and Mr A scored in the 'high' range. On the surface, this

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means that pre-treatment he was already scoring in a functional range on this subscale and that post-treatment he had changed against the desired direction of change. However, a high score could also be considered problematic for some clients because over-control can lead to passivity, depression, and withdrawal. Consequently, depending on the client, a reduction in score is desirable and given Mr A's tendency to hold his feelings of anger in, resulting in a later outburst, it could be considered that his pre-treatment high score on this scale is not desirable. As a result, Mr A's post-treatment clinically significant (but not reliably) lowered score could be considered as movement in the desired direction. This hypothesis should be considered with caution, due to Mr A's possible distorted responding as per the Paulhus scale findings.

In summary, psychometric assessment did not reveal particularly problematic areas of functioning within the constructs assessed by the scales both pre-and post-treatment for Mr A. There was some movement against the desired direction of change on some psychometric sub-scales, however where this did occur Mr A's score remained in a non-problematic rage. The Paulhus scale revealed the possibility of overly positive self-report and so it is possible that his pattern of responding to the questions within the psychometrics was distorted. In light of this finding, and clinical evidence supporting this tendency to try to please others, psychometric assessments were considered with caution.

The therapist recommended that some future intervention focussing on the importance of assertiveness may assist Mr A in getting his needs met. It was considered that if he was willing, future psychological treatment focussing even more on his RRPs (particularly on *revising* RRPs), exploring emotion recognition and expression, and working on developing intimacy skills may also facilitate positive well-being and risk management.

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Discussion

Integrative CAT and CBT approach to offender treatment

This case study used an integrative CAT and CBT approach to the treatment of an adult male with schizophrenia who had perpetrated IPV. Pollock (2006) puts forward that CAT can be a useful form of psychotherapy in a forensic setting because one of its objectives is '*to scaffold the offender's acquisition of the psychological tools to promote self-knowledge, insight and the ability to self-reflect, developing a mental model of the connection between both personality and crime… the meaning of the offence and its predictable recurrence are overt features of the therapy*' (pp324-325). This case study has demonstrated that this worked well in practice, because although through twelve sessions Mr A did not revise all of the RRPs identified, he developed some insight into his relationships and behaviour within these. CAT was a useful framework that facilitated identification of dysfunctional behaviour patterns. Some of the CAT tools were easier than others to adapt to meet Mr A's learning needs, and a slow pace of therapy was needed to facilitate Mr A's understanding of key CAT concepts such as RRPs. Mr A responded well to CBT informed exercises that explored thoughts and feelings linking to behaviour in given situations, however this approach did not necessarily address the causes of his high risk thoughts and feelings. More than twelve sessions would have better met Mr A's needs, however hospital resources did not allow for this. Consequently, clear recommendations for follow-up intervention were made. Follow-up intervention may be particularly important for Mr A given that risk of violence may be higher for those who experience schizophrenia and comorbid substance-misuse (e.g. Fazel et al., 2009).

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Transference and counter-transference can be understood within CAT in terms of enactments of RRPs, with transference being awareness of the client inducting the therapist into a particular role and counter transference being the therapist's awareness of pressure to enact the role into which they have been inducted (Pollock & Stowell-Smith, 206). This was particularly relevant in Mr A's treatment in relation to his 'impressing' role, whereby it would be easy as a therapist to be induced into the 'impressed/pleased' role. As Ryle (1997) highlights, such collusion could reinforce the maladaptive RRP and result in maintaining the fragmented structure of the client's personality. In this case, this could have reinforced the benefits of Mr A holding in or 'bottling up' his true feelings, behaving in a way designed to impress others, ultimately maintaining the cycle of not getting his needs met. Supervision aided the author in identifying and managing the potential for the client to 'pull' the therapist towards colluding with these patterns.

Within this case study, outcome was difficult to assess. Firstly, impression management limited psychometric assessment. Secondly, the in-patient environment is restricted, adding to the inherent difficulties of assessing a patient who generally holds in their feelings. Consequently, assessment of progress is largely subjective. This highlights the importance of a multi-disciplinary approach to risk management.

Twelve sessions did not fully address Mr A's areas of need. As this case study has highlighted, treatment applying approaches such as CAT may be difficult to adapt for clients with lower intellectual functioning, and adapted treatment may take longer to deliver than treatment designed for a client without additional learning needs. However, in services where time and resources are finite, lengthier intervention could be difficult to achieve. Despite this, given that that the aim of treatment was to develop Mr A's insight into his index offence and to understand the development of

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dysfunctional roles or patterns of behaviour for him, in order to reduce or help manage associated risks, this could be considered a successful treatment. Taking this forward with another patient it is therefore recommended that a CAT informed intervention involves more than twelve sessions, and that consideration is given to how other models and influences can be incorporated into the treatment, such as the theories based on attachment (Fonagy, 1999).

Conclusions

This case study has demonstrated CAT informed treatment in practice. Mr A exhibited behaviours in treatment that suggested insight and reduced risk. There is limited research available on the effectiveness of CAT with forensic clients and this case study is encouraging with regard to this vulnerable client group. Pollock (2006) puts forward that CAT is conducive to risk, need, and responsivity principles (see McGuire, 1995) with respect to 'what works' with offenders, and that CAT shows many of the components of a valid forensic psychotherapy. Future research will further inform the position, and in an economic climate where services strive to gain value for money by providing treatment that is deemed to be effective, the importance of research to inform evidence based practice is further emphasised.

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Using an integrative, Cognitive Analytical Therapy (CAT) approach to treat intimate partner violence risk

Abstract

Aims: There is limited research on Cognitive Analytic Therapy (CAT) in forensic contexts; this case study therefore significantly contributes to the knowledge base. This case study presents the assessment and treatment of an adult male offender with a diagnosis of schizophrenia. The client's offence involved intimate partner violence and was committed at a time of acute psychiatric relapse.

Method: Twelve sessions of Cognitive Behavioural Therapy (CBT) and ~~Cognitive Analytical Therapy (~~CAT~~)~~ informed treatment were individually designed to meet the needs of the client, delivered in an in-patient setting in the UK. The client's progress was assessed using psychometric, observational, and narrative/descriptive methods.

Results: Psychometric evidence was limited by distorted responding. However, narrative/descriptive assessment indicated that progress had been made in some areas. Recommendations for further treatment were made.

Conclusions: Twelve sessions did not meet all of the client's needs. The use of CAT as a model that his team could use in understanding his violence was conducive to risk management. Overall, insight gained through CAT based psychological intervention contributed to risk reduction.

Originality: This case study demonstrates the applicability of CAT to forensic settings.

Keywords:

Cognitive Analytic Therapy, Violence, Risk, Treatment, Intimate Partner Violence, Offender

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Introduction

Intimate Partner Violence (IPV)

Pro-feminist theories view IPV as a reflection of the patriarchal organisation of society as a whole, where men use violence when they feel their dominance is threatened (see Gondolf, 1998). ~~Pence and Paymer (1993).~~ Pence and Paymar (1993) discuss this in the context of Duluth 'power and control wheel' where power dynamics linked to socialisation are proposed to link to IPV. However, pro-feminist theory has been criticised for over-emphasising socio-cultural factors, resulting in exclusion of individual factors. For example, Dutton (1994) critically enquires how men can be held individually accountable for their IPV if it is a result of patriarchal society and Lawson (2003) questions how pro-feminist theory accounts for IPV within a same-sex relationship.

~~Cognitive behavioural theory puts forward that behaviour modification requires change in perception and interpretation (Beck & Weishaar, 2008) and can be used to frame IPV. Deeper held beliefs relating to male dominance remain relevant here as factors that may impact on perception and interpretation. Cognitive Behavioural Therapy (CBT) has become a favoured approach to offender treatment (McGuire, 2003; Gilbert & Daffern, 2010) as it lends well to identifying IPV intervention approaches. Despite this, group based CBT interventions have been criticised for lacking individuality (Howells & Day, 2002) and for not being sufficient to overcome automatic thoughts or learned behaviour (Walker & Bright, 2009), suggesting that more is needed to address the psychological processes involved in IPV.~~

Family systems theory views the family as a dynamic organisation, with interdependent components, where the recurrence of behaviour of a family member is

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affected by other family members' responses. This theory promotes a family-level approach to IPV intervention (Gelles & Maynard, 1987) this approach may promote the view that the victim is to blame. Attachment theory, which places an emphasis on the reciprocity between individuals in a relationship, provides the perspective that IPV can be seen as an exaggerated response of a disorganised attachment system linked to disorganised attachment in infancy (Fonagy, 1999).

Cognitive behavioural theory puts forward that behaviour modification requires change in perception and interpretation (Beck & Weishaar, 2008) and can be used to frame IPV. Deeper held beliefs relating to male dominance remain relevant here as factors that may impact on perception and interpretation. Cognitive Behavioural Therapy (CBT) has become a favoured approach to offender treatment (McGuire, 2003; Gilbert & Daffern, 2010) as it lends well to identifying IPV intervention approaches. Despite this, group based CBT interventions have been criticised for lacking individuality (Howells & Day, 2002) and for not being sufficient to overcome automatic thoughts or learned behaviour (Walker & Bright, 2009), suggesting that more is needed to address the psychological processes involved in IPV.

These differing approaches, and their criticisms, demonstrate the need to go beyond one model in the treatment of IPV.

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Cognitive Analytic Therapy (CAT), an integrative approach underpinned by psychoanalytic, cognitive and personal construct theory suggests that through early care relationships, individuals develop a range of reciprocal role procedures (RRPs) that determine how they relate to others and themselves, and some of these can be problematic (Ryle, 1997). It is suggested that offending behaviour can be a result of

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problematic RRPs, and RRP focussed interventions can be useful for offenders (Pollock, 2006).

Schizophrenia and psychosis have been found to be associated with general violence, with increased risk found with substance abuse comorbidity (Fazel et al., 2009). It has been suggested that the paranoia experienced by those with schizophrenia is similar to the hostile attribution involved when people experience anger or aggression (Chadwick, Birchwood & Trower, 1996). In relation to IPV, '*recent psychotic symptoms'* is an item recognised within the Spousal Assault Risk Assessment (SARA; Kropp, Hart, Webster & Eaves, 2008) as being associated with poor coping skills and increased interpersonal stress, and therefore IPV. It has also been highlighted that establishing whether violence precipitates schizophrenic symptoms is useful in treatment planning (Howells, 1998), as treatment providers can target psychological/psychiatric approaches accordingly. A range of factors can contribute to the development and maintenance of criminal behaviour, therefore it can be argued that an integrative approach is needed to explore and address these factors (Krampen, 2009). This case study draws upon both CAT and CBT in the psychological treatment of an adult male who has a history of IPV.

Client introduction

Mr A is a 25-year-old man with a diagnosis of paranoid schizophrenia and a history of drug misuse. He is detained in a low secure mental-health hospital in the UK. At the time of his IPV offence, there was evidence of acute psychiatric relapse.

~~**Psychosocial background of client**~~

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Mr A, who has two brothers, described his biological father as a black Jamaican who misused cocaine. His parents separated when he was under five years old. There was on-going domestic violence towards Mr A's mother from her various male partners. There is a history of criminal behaviour and psychiatric problems in the extended family (diagnoses unclear).

Mr A's mother had another relationship with a man for five years during his childhood. Mr A's father and stepfather were body builders who abused steroids. Mr A described his childhood as "*sad*". His mother was constantly at work and there was an atmosphere of physical violence perpetrated by his father and stepfather. Discipline was exerted by threats of violence. Mr A denied any history of sexual abuse.

Mr A has previously reported that his teachers told him that he had a 'learning difficulty' from the age of four. Mr A said that he found it difficult to concentrate in the classroom environment from the age of ten onwards, disrupting the environment and being suspended. He had few school friends. His level of educational attainment was predicted to be poor but he did pass some exams, leaving education at the age of sixteen. He has worked in manual jobs but was unemployed for around a year prior to this hospital admission, having been made redundant. Mr A was reliant on state benefits and selling drugs as his sources of income.

Mr A has previously been in relationships with women. Mr A did not describe these relationships as being emotionally intimate. Mr A has disclosed controlling behaviour and violence towards one previous partner. He was in a relationship with the current victim for around one year prior to the serious offence that precipitated this hospital admission. Mr A describes this relationship as being 'on and off'.

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Forensic history

Mr A has prior convictions for theft, failure to surrender to custody, possession of amphetamines, breach of community order, and criminal damage.

There is a documented history of suspected IPV perpetrated by Mr A against his ex-partner (and current victim) during their relationship. Suspicions arose following attendance of various agencies at Mr A and the victim's shared house. This included Police attendance following the victim alleging she had been assaulted by Mr A. Allegations included threats of weapon use and possession of a knife, where Mr A's ex-partner did not wish to proceed with Police charges. In addition, during routine visits, community psychiatric staff observed injuries on the victim that were considered to be consistent with IPV.

Mr A has disclosed having been violent towards other males in the past, including stabbing a male in the leg during an altercation. He also disclosed that he sold drugs to make money. The onset of violent behaviour preceded diagnosis of psychiatric illness.

In relation to this inpatient admission, Mr A pleaded guilty to offences of assault, affray, and burglary. Consequently, other matters that he had originally been charged with were discontinued (he was originally also charged on two counts of false imprisonment). This 'plea bargaining' approach is not uncommon internationally, whereby if the perpetrator admits the charges, lesser charges are filed against them.

The index offence involved Mr A pulling his partner to the floor, banging her head several times against the bath. He made threats to kill her whilst he was holding a ~~sharpened vegetable peeler~~weapon. The affray offence relates to a few weeks prior to the assault, whereby Mr A went to the victim's ex-husband's house with a hammer and threatened his ex-partner and her ex-husband.

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Method

Assessments

Wechsler Adult Intelligence Scale (WAIS-IV; Wechsler, 2008)

Mr A's cognitive ability was assessed in order to inform treatment planning. Mr A's general cognitive ability, as estimated by the WAIS-IV (Wechsler, 2008), was found to be within in the 'extremely low' range. His general verbal comprehension abilities were in the 'extremely low' range, and his general perceptual reasoning abilities were in the 'borderline' range. Mr A's ability to sustain attention, concentrate, and exert mental control was found to be within the 'extremely low' range. His ability to process simple or routine visual material without making errors was considered to be within the 'borderline' range when compared to his peers. Assessment of cognitive ability was completed to ensure that the intervention was designed to meet Mr A's learning needs and also to work with his clinical team to ensure that his cognitive functioning was supported on a day-to-day basis.

Spousal Assault Risk Assessment (SARA; Kropp, Hart, Webster & Eaves, 2008)

The SARA (Kropp, Hart, Webster and Eaves, 2008) is a clinical checklist of risk factors for spousal assault that can be used to help guide treatment and case prioritisation and consists of twenty factors, grouped into five content areas; *criminal history, psychosocial adjustment, spousal assault history, index offence* and *other considerations*. In order to collate information to inform the formulation, Mr A's case was assessed using the SARA.

Two of the twenty SARA items were assessed as not present, seventeen of the items were assessed as present, one item was omitted and none were partially present.

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Items that were used to guide risk management and reduction included *employment problems, substance misuse problems, relationship problems, suicidal/homicidal ideation, psychotic symptoms, extreme minimisation, weapon use* and *attitudes condoning spousal abuse*.

Pre-treatment initial case formulation and treatment approach

There is limited empirical research relating to case formulation and its impact on clinical outcomes (see Ghaderi, 2011), however one practical consideration to enhance the utility of case formulation is to draw on different models to encourage practitioner flexibility (Eells & Lombart, 2011). This case study applied functional analysis, which can be considered an important part of cognitive-behavioural case formulation (Persons, 2008) as well as a CAT informed approach to formulation. For example, the intervention involved identification of RRPs and a CAT reformulation narrative letter, which is a therapy tool that is argued to be central to CAT (Newell et al., 2009) whereby clients are supported by the therapist in transforming their existing understanding of their presenting problem into a more explanatory and useful form.

Functional analysis is an assessment approach used to establish the function of a behaviour by exploring the relationship between an individual and their environment, often referred to as an A:B:C analysis (Sturmey, 2008). The A:B:C in functional analysis refer to *antecedents* (A), *behaviour* (B) and *consequences* (C). Antecedents can be distal (historical) or proximal (current). It is important within functional analysis to consider reciprocal determination, which is the concept of environment, behaviour and consequences being interrelated or interactive. For example, a consequence could become an antecedent for a future behaviour and consequence cycle.

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A multiple sequential functional analysis (MSFA) is a series of functional analyses that link together to account for complex historical behaviour chains (Gresswell & Hollin, 1992). Mr A's case was formulated using the MSFA approach (see Table 1), which was used to guide treatment. These MSFA hypothesise that parental influence, substance misuse, and paranoid ideation contribute to IPV.

<Insert Table 1 here >

Intervention

Description

The twelve one-hour session, individualised CAT and CBT informed psychological intervention sessions were delivered weekly, and took place after several assessment/motivation sessions.

Session 1

Mr A's relationships with significant others were explored, with a view to gathering information that could be used to inform identification of RRPs. Transference and countertransference were discussed in the context of CAT and RRPs, in particular in the context of a potential role of **pleasing/impressing→pleased/impressed** he had already identified.

Sessions 2-5

These sessions focussed on Mr A's relationships with others in order to further explore RRPs and to inform a CAT reformulation letter. Controlling / controlled,

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impressing/impressed and humiliating /humiliated were discussed as possible reciprocal roles.

Session 6-7

These sessions involved the therapist reading out the CAT reformulation letter and discussing this. A self-exploration/self-esteem exercise was set as out of session work.

Session 8

An exercise on identifying the emotions of others through facial expression was undertaken, using pictures from magazines as a starting point. An exercise on 'bottling up' feelings was completed from a CBT perspective (**event → thoughts/feelings/behaviour → consequence**) whereby Mr A was encouraged to identify how 'The Incredible Hulk' may have felt and thought before he transformed into 'The Hulk' from the man he was before, and what may have contributed to this change in his behaviour. This was discussed in relation to Mr A's violence. RRP recognition was also discussed.

Session 9

This session focussed on recapping/expanding on the work completed in the previous session and also covered a current feelings and behaviour cycle that was similar to previous unhelpful cycles.

Session 10

Mr A's thoughts, feelings and behaviour within the index offence and in other IPV were explored and discussed. Themes including jealousy, anger and drugs were explored. Through this a possible RRP was identified (rejecting / rejected). The victim 'no-send' letter Mr A had completed was discussed.

Session 11

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This session explored a 'victim no-send' letter, and was used to review RRPs and prepare for the end of therapy. An out of session task to complete an end of therapy letter[1] was set for both patient and therapist to complete.

Session 12

Mr A had not prepared his end of therapy letter but talked through related thoughts. The therapist's end of therapy letter was read out. Mr A's progress and the future were discussed.

Results

General engagement

Mr A attended all twelve intervention sessions and completed out of session tasks. Mr A's progress in the individual sessions was considered alongside his out of session work and his behaviour outside of sessions. Direct observation of Mr A outside of the therapy sessions by the therapist was not possible, although staff observation were available. Pre and post-treatment psychometric assessments were considered.

Qualitative description of progress

Mr A worked well in exercises that built on his strengths, for example exercises using creative means. Although possessing a limited repertoire of words to describe emotions, he demonstrated an ability to recognise emotions from facial expression within an exercise using visual aids. Mr A also completed a self-esteem exercise exploring his life and identity by creating a collage.

[1] [1] This is a CAT tool designed to facilitate ending therapy. It is recommended that when writing this the therapist considers: feelings on ending, achievements, relationship, expression of hope, warm and engaging, exits, language used, life/learning after therapy (Turpin et al., 2011).

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Mr A developed some insight into some RRPs and behaviour cycles. For example, he recognised that his tendency to give others what they want in order to impress or please them can leave him feeling used, and that when this happens, he does not talk to people about his feelings. This happened within his relationships with partners and other people. He recognised that he still does this in hospital; however, he does not feel that this is problematic, and consequently he did not develop exit strategies or options to address this. Mr A recognised that fearing rejection contributes to this tendency, and he explored how this may link to his early childhood experiences relating to early separation from his father and his father's subsequent inconsistent parenting.

Mr A talked through his offence, recognising that 'bottling up' emotions contributed to his behaviour within the offence and also within other previous incidents of IPV. He was able to label the feelings he had immediately preceding the offence not just as anger, but also as loneliness and feeling unwanted. He recognised that he feared the victim rejecting him by being unfaithful or ending the relationship. Mr A showed awareness of what could happen if people keep their emotions inside and self-isolate, linking this back to his offence.

Mr A explored some of the consequences of his behaviour on others. One of the biggest pieces of work he completed during treatment was his 'victim no-send letter'. The aims of this exercise was to explore his understanding of his relationship with the victim, the offence itself, his feelings about the offence and victim, and also what he thought she might feel. This was talked about during sessions, along with his desire to be seen as a 'good' person by showing the victim that he had changed. This was also linked back to his tendency to try to please/impress others. Risk issues were addressed as part of this and strategies for managing feelings associated with not

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being able to show the victim that he had changed were examined. The letter, and discussions around it, demonstrated that he has some recognition of how the victim might have felt at the time of the offence and also now, particularly if she saw Mr A again. Despite this, Mr A did not demonstrate insight into the longer-term victim impact.

Mr A demonstrated awareness of substances having a negative impact on his mental health, and although he said he did not wish to use drugs in the future, his awareness appeared inconsistent. He recognised that dysfunctional emotional coping contributed to his substance misuse, for example taking amphetamines to cope with feeling low about not helping his mother with the bills. He recognised that wanting to have big muscles like his father, and sibling competitiveness, contributed to his steroid use; however, he did not fully explore the related RRPs, which he could do if he engages in treatment in the future

Behavioural observations

Mr A's documented behaviour outside of sessions was consistent. Ward staff often described his behaviour as 'settled'. He engaged well in the hospital regime and community activities with no evidence of drug or alcohol misuse.

The single documented incident of note could be related back to his identified role of pleasing others, resulting in not getting his needs met. During the course of treatment, it was Mr A's birthday. He met his mother and brother on escorted leave for a 'birthday meal' and said to his family that he did not want to go to a certain fast food outlet because the last time he had eaten there he was sick. His brother and mother asserted that this was where they should go, and so Mr A agreed to go. The three of them (and the hospital escort) went to this fast food outlet and Mr A sat with

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his brother and mother who eat their meals, but Mr A did not order any food as he was afraid of being sick. He therefore did not eat at his 'birthday meal'. The person reporting this situation felt that Mr A had not got his needs met, however Mr A's perspective was that he had experienced a good birthday because he had seen his mother and brother. He did not feel there were any difficulties or problems in this situation. Although Mr A's perspective and feelings are paramount, and he did not report any problems with the situation, enacting and maintaining this RRP involving pleasing others and not getting his needs met appeared to link to the dysfunctional roles that were present within the IPV. Had he recognised this role, and expressed his view and feelings assertively, he may have got his needs met in this situation. This does not necessarily directly link to his level of risk of violence, however this situation demonstrated that he could benefit from developing further insight into the way he relates to the world around him.

Psychometric assessment

Mr A was assessed using a variety of psychometric measures (see Table 2). Where the required information was present in relation to each scale, *clinically significant change* and *reliable change* were assessed according to Jacobson, Follette and Revenstorf's (1984) methodology. According to this methodology, *clinically significant change* can be considered as change that has taken the individual from a problematic, dysfunctional, patient, client or user group to a score typical of the 'normal' population. *Reliable change* relates to whether an individual changed to an extent that is unlikely to be due to simple measurement unreliability.

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It is of note that for the majority of the scales, Mr A scored in the 'non-dysfunctional' or 'non-clinical' range pre-treatment as well as post-treatment, and post-treatment his scores on some scales changed *against* the desired direction of change. The impression management scale of the Pauhus Deception Scales (1999) indicated the possibility of '*faking good*' both pre and post-treatment. Mr A's pre-treatment score pattern on the Paulhus sub-scales indicates that he might be aware of his shortcomings yet wants to be seen in a positive light, resulting in self-report being overly positive. This fits with the psychological treatment itself highlighting that *pleasing* or *impressing others* is a behavioural tendency for Mr A, showing a link between psychometric findings and behavioural evidence. Given that his responses may have been distorted, despite the comprehensive test battery used, little weight was placed on the psychometric findings in assessing outcomes.

Given the clinical issues in Mr A's case, one particular score is of particular interest. This is the Anger Control-Out (AC-O) subscale of the STAXI-2 (Spielberger, 1999). On this scale, higher scores are typically desirable (controlling outward manifestations of anger), and Mr A scored in the 'high' range. On the surface, this means that pre-treatment he was already scoring in a functional range on this subscale and that post-treatment he had changed against the desired direction of change. However, a high score could also be considered problematic for some clients because over-control can lead to passivity, depression, and withdrawal. Consequently, depending on the client, a reduction in score is desirable and given Mr A's tendency to hold his feelings of anger in, resulting in a later outburst, it could be considered that his pre-treatment high score on this scale is not desirable. As a result, Mr A's post-treatment clinically significant (but not reliably) lowered score could be considered as

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movement in the desired direction. This hypothesis should be considered with caution, due to Mr A's possible distorted responding as per the Paulhus scale findings.

In summary, psychometric assessment did not reveal particularly problematic areas of functioning within the constructs assessed by the scales both pre-and post-treatment for Mr A. There was some movement against the desired direction of change on some psychometric sub-scales, however where this did occur Mr A's score remained in a non-problematic rage. The Paulhus scale revealed the possibility of overly positive self-report and so it is possible that his pattern of responding to the questions within the psychometrics was distorted. In light of this finding, and clinical evidence supporting this tendency to try to please others, psychometric assessments were considered with caution.

The therapist recommended that some future intervention focussing on the importance of assertiveness may assist Mr A in getting his needs met. It was considered that if he was willing, future psychological treatment focussing even more on his RRPs (particularly on *revising* RRPs), exploring emotion recognition and expression, and working on developing intimacy skills may also facilitate positive well-being and risk management.

Discussion

Integrative CAT and CBT approach to offender treatment

This case study used an integrative CAT and C~~D~~BT approach to the treatment of an adult male with schizophrenia who had perpetrated IPV. Pollock (2006) puts forward that CAT can be a useful form of psychotherapy in a forensic setting because one of its objectives is '*to scaffold the offender's acquisition of the psychological tools to promote self-knowledge, insight and the ability to self-reflect, developing a*

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mental model of the connection between both personality and crime… the meaning of the offence and its predictable recurrence are overt features of the therapy' (pp324-325). This case study has demonstrated that this worked well in practice, because although through twelve sessions Mr A did not revise all of the RRPs identified, he developed some insight into his relationships and behaviour within these. CAT was a useful framework that facilitated identification of dysfunctional behaviour patterns. Some of the CAT tools were easier than others to adapt to meet Mr A's learning needs, and a slow pace of therapy was needed to facilitate Mr A's understanding of key CAT concepts such as RRPs. Mr A responded well to CBT informed exercises that explored thoughts and feelings linking to behaviour in given situations, however this approach did not necessarily address the causes of his high risk thoughts and feelings. More than twelve sessions would have better met Mr A's needs, however hospital resources did not allow for this. Consequently, clear recommendations for follow-up intervention were made. Follow-up intervention may be particularly important for Mr A given that risk of violence may be higher for those who experience schizophrenia and comorbid substance-misuse (e.g. Fazel et al., 2009).

Transference and counter-transference can be understood within CAT in terms of enactments of RRPs, with transference being awareness of the client inducting the therapist into a particular role and counter transference being the therapist's awareness of pressure to enact the role into which they have been inducted (Pollock & Stowell-Smith, 206). This was particularly relevant in Mr A's treatment in relation to his 'impressing' role, whereby it would be easy as a therapist to be induced into the 'impressed/pleased' role. As Ryle (1997) highlights, such collusion could reinforce the maladaptive RRP and result in maintaining the fragmented structure of the client's personality. In this case, this could have reinforced the benefits of Mr A holding in or

'bottling up' his true feelings, behaving in a way designed to impress others, ultimately maintaining the cycle of not getting his needs met. Supervision aided the author in identifying and managing the potential for the client to 'pull' the therapist towards colluding with these patterns.

Within this case study, outcome was difficult to assess. Firstly, impression management limited psychometric assessment. Secondly, the in-patient environment is restricted, adding to the inherent difficulties of assessing a patient who generally holds in their feelings. Consequently, assessment of progress is largely subjective. This highlights the importance of a multi-disciplinary approach to risk management.

Twelve sessions did not fully address Mr A's areas of need. As this case study has highlighted, treatment applying approaches such as CAT may be difficult to adapt for clients with lower intellectual functioning, and adapted treatment may take longer to deliver than treatment designed for a client without additional learning needs. However, in services where time and resources are finite, lengthier intervention could be difficult to achieve. Despite this, given that that the aim of treatment was to develop Mr A's insight into his index offence and to understand the development of dysfunctional roles or patterns of behaviour for him, in order to reduce or help manage associated risks, this could be considered a successful treatment. Taking this forward with another patient it is therefore recommended that a CAT informed intervention involves more than twelve sessions, and that consideration is given to how other models and influences can be incorporated into the treatment, such as the ~~Duluth model~~theories based on attachment ~~(~~(Fonagy, 1999).~~Pence & Paymar, 1993).~~

Conclusions

This case study has demonstrated CAT informed treatment in practice. ~~and through this~~ Mr A exhibited behaviours in treatment that suggested insight and reduced risk. ~~However,~~ T~~t~~here is limited research available on the effectiveness of CAT with forensic clients and this case study is encouraging with regard to this vulnerable client group. Pollock (2006) puts forward that CAT is conducive to risk, need, and responsivity principles (see McGuire, 1995) with respect to 'what works' with offenders, and that CAT shows many of the components of a valid forensic psychotherapy. Future research will further inform the position, and in an economic climate where services strive to gain value for money by providing treatment that is deemed to be effective, the importance of research to inform evidence based practice is further emphasised.

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Table 1: MSFA of early development, origins of offending, and current IPV offence sequence

Functional analysis: Early development	Functional analysis: Origins of offending behaviour	Functional analysis: Current offence sequence
A: Separation from father, inconsistent visits from father Mother out working a lot Violence within the family home (witness/possible victim) Family do not discuss feelings Father and stepfather bodybuilding/karate Father misusing drugs	A: Experiences from sequence (1) Left school with few qualifications Unstable employment Unsuccessful intimate relationships Unsuccessful at fighting/bodybuilding Idolising father On-going violence in the home from stepfather Onset of psychotic illness	A: Experiences from sequences (1) and (2) Relapse of psychotic symptoms Partner left for several days Partner stealing from him (drugs and money)
B: Behavioural difficulties at school Early substance misuse Idolised father Rejection	B: Feeling rejected, angry, low self esteem More body building Substance misuse (to body-build and for self esteem) Selling drugs to fund substance misuse/lifestyle Suspicious of people Violence during conflict with others Try to impress others with material things	B: Worry about rejection, increased anger about rejection Thinks that partner has had sex with her ex-husband Feeling angry at being used Violence against partner
C: Wanted to be like his father – bodybuilding/fighting Violence within the home and to achieve status became normalised No emotional outlet/support – does not talk about feelings Few friends	C: Status among peers Addiction Relationships without emotional intimacy Owe others money (for drugs) Fear rejection in intimate relationships and in general General violence in life linked to drug dealing No emotional support/outlet	C: Prison/hospitalisation
Key Learning Outcomes:	Key Learning Outcomes:	Key Learning Outcomes:
1. Violence normal within the home 2. Development of using maladaptive coping strategies (drugs, behavioural	1. Learned that drugs and bodybuilding help his self-esteem. 2. Learned that he can impress others/avoid rejection	1. Learned that he continues to be rejected despite providing material things. Experienced increased anger due to

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difficulties at school).	if he has material possessions/money.	perception that partner had been having sex with her ex-husband. 2. Being violent was a way of expressing emotions and trying to avoid rejection.
Hypothesis:	Hypothesis:	Hypothesis:
The behaviour that was linked to parental separation and feelings of rejection led to circumstances that reinforced the feeling of rejection (behavioural difficulties at school, few friends). Violence as a means of discipline/control within the home and within an intimate relationship became normalised, as did substance misuse. He looked up to his father (including father's physique, material possessions) but feared the rejection he experienced when father visited only occasionally.	Mr X's offending behaviour progressed into selling substances, which in part was to fund his lifestyle. The lifestyle itself involved violence relating to drug dealing. He learned to avoid rejection by impressing others with money/possessions and this helped him achieve several girlfriends although these relationships lacked intimacy. Mr X was suspicious of others because of his lifestyle (he owed people money), because he feared rejection (in any relationship) and because of his schizophrenic illness.	From this sequence it can be hypothesised that Mr X's offences against his partner were driven by build-up of emotions due to fear of, and perception of, being rejected and used. This build up of emotions was also fuelled by psychotic symptoms.

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Table 2: Pre and post treatment psychometric assessments including assessment of reliable and clinically significant change

Psychometric	Subscale and desired direction of change[1]	Mr X's scores				Norms		Change[2]			
		Pre-treatment		Post-treatment		Functional mean (SD[3])	Dysfunctional mean (SD)	Reliable change criterion	Reliable change?	Clinically significant change criterion	Clinically significant change?
		Score	Range[4]	Score	Range						
Aggression Questionnaire (AQ; Buss & Warren, 2000)[5]	AQ total ↓	47 (38T)	Low	67 (49T)	Average	73.3 (24.9)	76.9 (25.0)	16.91	NO	75.10	NO
	Physical aggression (PHY) ↓	13 (47T)	Average	18 (52T)	Average	15.8 (7.7)	17.3 (7.0)	7.39	NO	16.59	*YES*
	Verbal aggression (VER) ↓	6 (34T)	Low	14 (54T)	Average	11.8 (4.3)	12.7 (4.7)	5.84	*YES*	12.23	*YES*
	Anger (ANG) ↓	9 (40T)	Low-average	11 (46T)	Average	15.1 (5.7)	14.8 (5.8)	7.41	NO	N/A	N/A
	Hostility (HOS) ↓	13 (47T)	Average	15 (51T)	Average	17.1 (6.6)	19.6 (7.0)	7.76	NO	18.31	NO
	Indirect aggression (IND) ↓	6 (28T)	Very low	9 (42T)	Low average	13.5 (4.8)	12.4 (5.4)	7.16	NO	N/A	N/A
	Inconsistent responding (INC)	1	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
State-Trait Anger Expression Inventory (STAXI-	State Anger (S-Ang) ↓	15	Low-moderate	15	Low-moderate	19.3 (6.9)	22.7 (8.5)	5.76	NO	20.82	NO

[1] Arrows indicate the desired direction of change, however for some scales/subscales, totals in the high *or* low extreme can be indicative of problems in that area.
[2] *Reliable change criterion* for each scale calculated according to methods originating in Jacobson, Follette and Revenstorf (1984), amended by Christensen and Mendoza (1986) and later described in Jacobson and Truax (1991) and Evans, Margison and Barkham (1998). *Clinically significant change criterion* for each scale calculated according to methods originating in Jacobson, Follette and Revenstorf (1984). Change in the desired direction is listed in **bold (YES)**, change against the desired direction in *itialics (YES)* in the 'change' columns.
[3] SD = Standard Deviation
[4] Range as specified in psychometric manual
[5] Internal consistency (alpha coefficient) values were only available for the AQ non-dysfunctional sample, therefore reliable and clinically significant change values based on functional sample. Dysfunctional mean lower than functional mean on ANG and IND subscales, as desired direction of change is down this results in inability to calculate clinically significant change criterion for these subscales.

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2, Spielberger, 1999)[6]											
	S-Ang/Feeling anger (S-Ang/F) ↓	5	Low-moderate	5	Low-moderate	7.1 (2.8)	9.2 (4.0)	3.30	NO	7.97	NO
	S-Ang/Feel like expressing anger verbally (S-Ang/V) ↓	5	Low-moderate	5	Low-moderate	6.4 (2.7)	7.7 (3.6)	3.11	NO	6.96	NO
	S-Ang/Feel like expressing anger physically (S-Ang/P) ↓	5	Low-moderate	5	Low-moderate	5.8 (2.1)	6.0 (2.1)	2.17	NO	5.90	NO
	Trait Anger (T-Ang) ↓	16	Moderate	12	Low	18.4 (5.4)	20.1 (5.9)	5.86	NO	19.21	NO
	T-Ang/Angry temperament (T-Ang/T) ↓	6	Moderate	5	Moderate	6.4 (2.5)	6.9 (2.9)	2.56	NO	6.63	NO
	T-Ang/Angry reaction (T-Ang-R) ↓	5	Low	4	Low	8.7 (2.6)	9.6 (3.2)	3.51	NO	9.10	NO
	Anger Expression– Out (AX-O) ↓	11	Low	10	Low	15.4 (3.7)	15.7 (4.1)	5.16	NO	15.54	NO
	Anger Expression- In (AX-I) ↓	10	Low	11	Low	16.4 (4.0)	18.3 (4.7)	5.80	NO	17.27	NO
	Anger Control-Out (AC-O) ↑	29	High	27	Moderate	23.5 (5.0)	21.1 (0.2)	0.23	*YES*	21.19	NO
	Anger Control-In (AC-I) ↑	26	Moderate	21	Moderate	22.6 (5.8)	21.4 (6.1)	5.10	NO	22.02	*YES*
	Anger Expression Index (AX Index) ↓	14	Low	21	Low	33.7 (13.1)	39.6 (14.0)	16.42	NO	36.55	NO
Barratt Impulsivity Scale (BIS-11; Patton, Stanford & Barratt, 1995)	Motor ↓	14	N/A	17	N/A	15.0 (4.2)	18.0 (7.0)	N/A	N/A	16.13	*YES*
	Cognitive/Attention ↓	19	N/A	22	N/A	16.3 (5.3)	19.0 (7.0)	N/A	N/A	17.46	NO
	Non-planning ↓	25	N/A	24	N/A	17.8 (4.9)	22.0 (9.0)	N/A	N/A	19.28	NO

[6] Higher scores on the AC-O subscale of the STAXI-2 are typically desirable (controlling outward manifestations of anger) however a high score can be considered problematic for some clients as over-control can lead to passivity, depression and withdrawal. Consequently, depending on the client, a reduction in score is desirable.

	Total Score ↓	58	N/A	63	N/A	64.9 (10.2)	69.7 (11.5)	13.19	NO	67.16	NO
Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; Core Systems Group, 1998; Evans et al., 2000)[7]	Well-being ↓	1.00	N/A	0.00	N/A	0.91 (0.83)	2.37 (0.96)	N/A	N/A	1.59	NO
	Problems/symptoms ↓	0.50	N/A	0.83	N/A	0.90 (0.72)	2.31 (0.88)	N/A	N/A	1.53	NO
	Functioning ↓	0.75	N/A	0.58	N/A	0.85 (0.65)	1.86 (0.84)	N/A	N/A	1.29	NO
	Risk ↓	0.00	N/A	0.00	N/A	0.20 (0.45)	0.63 (0.75)	N/A	N/A	0.36	NO
	Total (all items) ↓	0.56	N/A	0.50	N/A	0.76 (0.59)	1.86 (0.75)	N/A	N/A	1.24	NO
	Total (all non-risk items) ↓	0.68	N/A	0.61	N/A	0.88 (0.66)	2.12 (0.81)	N/A	N/A	1.44	NO
Paulhus Deception Scales (PDS BIDR Version 7; Paulhus, 1998)[8]	Impression Management (IM) ↓	12 (69T)	Much above average, may be invalid (faking good)	11 (66T)	Much above average, may be invalid (faking good)	6.7 (4.0)	5.3 (3.6)	3.99	NO	N/A	N/A
	Self-Deceptive Enhancement (SDE) ↓	4 (57T)	Slightly above average	8 (71T)	Very much above average	2.2 (2.3)	2.2 (2.7)	3.96	*YES*	N/A	N/A
	PDS Total ↓	16 (74T)	Very much above average	19 (83T)	Very much above average	8.9 (3.7)	7.5 (3.5)	3.63	NO	N/A	N/A
The Self image Profile for Adults (SIP-AD; Butler & Gasson, 1994)[9]	Self-image (SI) ↑	102	Not below cut-off	118	Not below cut-off	127.2 (17.5)	Not normed	15.49	**YES**	N/A	N/A
	Self-esteem (SE) ↓	56	Not above cut-off	65	Not above cut-off	35.2 (15.4)	Not normed	N/A	N/A	N/A	N/A
	Self-satisfaction	11	N/A	7	N/A	8.4 (6.7)	Not normed	N/A	N/A	N/A	N/A

[7] Reliability figures not available for CORE-OM therefore reliable change could not be calculated using the methods originating in Jacobson, Follette and Revenstorf (1984), although cut off scores were available in the CORE-OM manual, which indicated that the client was in non-clinical range both pre and post intervention.
[8] Dysfunctional mean lower than functional mean on IM subscale and PDS total, as desired direction of change is down this results in inability to calculate clinically significant change criterion for these scales. SDE subscale: functional and dysfunctional means are the same for SDE subscale therefore clinically significant change criterion cannot be calculated.
[9] Dysfunctional norms were not available for the SIP-AD therefore reliable change is based on a functional sample and the clinically significant change criterion cannot be calculated. Internal consistency value was only available for the SI subscale.

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	(SS) ↑										
	Self-certainty negative (SCert-ve) ↓	4	N/A	1	N/A	0.1 (0.6)	Not normed	N/A	N/A	N/A	N/A
	Self-certainty positive (SCert+ve) ↑	7	N/A	7	N/A	3.6 (4.0)	Not normed	N/A	N/A	N/A	N/A
	Outlook (O) ↑	4.5	N/A	4.0	N/A	4.1 (0.9)	Not normed	N/A	N/A	N/A	N/A
	Consideration (Con) ↑	3.9	N/A	4.6	N/A	4.3 (0.8)	Not normed	N/A	N/A	N/A	N/A
	Social (S) ↑	3.4	N/A	4.2	N/A	4.4 (0.8)	Not normed	N/A	N/A	N/A	N/A
	Physical (P) ↑	0.7	N/A	1.3	N/A	4.4 (1.2)	Not normed	N/A	N/A	N/A	N/A
	Competence (Com) ↑	3.4	N/A	3.0	N/A	3.8 (0.8)	Not normed	N/A	N/A	N/A	N/A
	Moral (M) ↑	3.6	N/A	1.0	N/A	4.5 (0.8)	Not normed	N/A	N/A	N/A	N/A

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