Working with Antisocial Personality Disorder

Seán Manning

Abstract

The antisocial personality has long been dismissed by analysts and psychotherapists as unresponsive to psychotherapy. This paper explores reasons for this, using the idea of Ego and Shadow. Transactional Analysis theory is presented to construct a theoretical foundation from which psychotherapeutic work can usefully proceed. The negative role of therapist empathy, the reasons why successful programmes are often run by non-professionals, and indicators for treatment are explored.

Introduction

One of the pairs of polar opposites in Jung's work is the idea of ego balanced by shadow (Hyde & McGuinness, 1992). He applied this idea to societies as well as individuals – ego and shadow – in the collective sense. Thus a society which experiences sexual liberation will bring to light the shadow of an organised sexual abuse industry. Economic liberation, coupled with a cult of the individual and a value system based on individual rights will show us a shadow side represented by psychopathic, criminal, antisocial individuals.

It is consistent with this hypothesis to imagine that the thing we fear most is in some sense the shadow we create. We enjoy the pleasures of an economic liberation, the rights to live as we wish, where and how we wish, unfettered by any particular "place" in society, or any particular occupation. If we are to have a society which so values individual rights, perhaps we must also live with what appears to be an explosion of crime against that society, motivated by the same basic ideas on individual freedom, and carried out by large numbers of people who appear to fit the criteria for antisocial personality disorder (ASPD). The

primary criteria for this "disorder" are all aspects of "... a pervasive pattern of disregard for and violation of the rights of others ..."[1] which may be seen as an extension of the individual rights mentioned above. Indeed, many of our most celebrated and successful citizens may be said to display such a pattern.

It is noticeable that middle class backgrounds rarely suit a person to work with this group, at least until the therapist has moved away from the middle class value system.

We would expect a different ego-shadow pattern in another cultural belief system, and we find that Māori approaches to criminal behaviour differ somewhat from Pākehā approaches. The New Zealand film *"Once Were Warriors"*, based on Alan Duff's bestseller, often provokes shocked reactions among Pākehā. This compares sharply with the reactions of Māori, most of whom take it more or less in their stride. Māori and bi-cultural approaches to antisocial behaviour are more embracing and tend to valueāroha and iwi, while pākehā approaches value exclusion, containment and punishment.

To work with a syndrome apparently composed largely of shadow elements, perhaps we need a different ego-shadow alignment than that common to those who best make use of the benefits of the direction our society is taking. Psychotherapy training is lengthy and expensive and thus, so far, a predominantly white middle class occupation. It is not surprising therefore that this client group is not regarded hopefully by most psychotherapists – to the middle class, who make profitable use of the individual-centred value system, that is, incorporating it in a social ego, destructive antisocial behaviour by definition lies in their shadow area.

We appear to be much more comfortable working with victims than with perpetrators, or at least framing our work that way. If we can recognise a client's pain and inner conflict, if we can empathise, we are comfortable enough to develop a therapeutic approach. In this way the treatment of some personality disorders has been brought within our frame of reference. However, although antisocial people often have terrible childhoods – physical, sexual and emotional violence and neglect – resembling closely the aetiology of borderline and dissociative patterns, they characteristically display a disconcerting lack of either pain or conflict, and to regard them as victims is not a useful starting point for therapy.

1 DSM-IV, page 649 - the other criteria refer to age distinctions and the exclusion of other disorders.

I begin therefore with the recognition that these clients represent our nightmares, and that *we* often are *their* victims, but with a desire to penetrate the nightmare and accept the responsibility of dealing with the creation of our creation.

Therapy and conflict

It is very easy to find quotations like the following.

Manfield (1992), introducing his book on personality disorders:

> "In contrast to the eleven categories listed in the DSM-lll-R, the personality disorders will be divided here into three categories: borderline disorders, narcissistic disorders, and schizoid disorders, each with a distinct pattern of internal psychic organisation. *A possible fourth category, the antisocial disorder, is not addressed in this book because of the lack of an effective treatment method for these patients."* (p xviii) (Italics added)

Similarly, Ivey, Ivey and Simek-Morgan (1987):

> "Nowhere is the importance of underlying mechanisms of defence more key than in your understanding of the antisocial personality. This diagnostic classification is often considered the most difficult to treat." (p 167)

And Gabbard (1994):

> "Antisocial patients are perhaps the most extensively studied of all those with personality disorders, but they are also the patients that clinicians tend to avoid the most. " (p 527)

Certain difficulties arise when a person who fits the criteria for ASPD enters counselling or psychotherapy, particularly if the therapist's model follows an approach emphasising a combination of empathic response and minimal intervention. Manfield (1992, p xix – xx) emphasises, when working with certain personality patterns, empathic attunement is difficult. First, the client's experience is beyond the experience of the therapist, and second, an implicit understanding that is beyond the client's may frighten them away. The client cannot be relied on to experience anything similar to what the therapist experiences (unless the therapist has a similar history). Where the therapist might experience anxiety, pain or anger upon hearing a story of torture in childhood, the teller of the story may be experiencing boredom, amusement, or irritation with the therapist for continually getting it wrong. An attempt at empathic response will produce a disruption and a distancing between therapist and client. Treatment which involves a lot of these disruptions

will be quickly terminated by an even mildly paranoid, non-compliant client, often after a single session. The therapist is left wondering what happened, or with a reinforced idea that this kind of problem is untreatable, or that the client was not "ready". Also, our usual identification with the victim will place the therapist in the client's target group.

The approach recommended by Brandchaft, described by Jenny Rockel (1996) in a recent NZAP newsletter is relevant:

> "His view ... is that unwavering immersion in the affective content of a client's experience risks obscuring both therapist's and client's view of the underlying mental processing by which that experience is defined."

When the therapist is attuned to the peculiarities of the client's reactions, therapy based on empathic response can become collusive. The therapist's needs for affirmation and for excitement are easily exploited by the antisocial client, who will act out vicariously the therapist's fantasies, at the same time as stroking the therapist for staying with them, and offering an illusion of therapeutic relationship. White (1997) discussing the difference between "surface" and "character" relationships, points out that,

> "Often they can be very adept at moving at the surface level from the individual self to the relationship self and back. This can lead others to believe there is a relationship of some depth when in fact this is not the case.

When the therapist is fooled by these manoeuvres, the client will happily return for session after session, but without noticeable change. White:

> "The therapist will merely become another person who is experienced by the client as a "thing" in the environment."

In the rare instances where therapist and client are prepared to pursue therapy with an awareness of these difficulties, the transference problems which emerge can become a powerful obstacle. The therapist will have to put up with alternately being vilified, being one of *them,* being a target (for instance having items stolen from the office), and being idealised as the *only one who understands.* As with the treatment of borderline conditions, this powerful transference makes it difficult to maintain an accurate picture of what is going on psychologically.

A common clinical observation is that people with anti-social personalities display a lack of conflict. A client may approach therapy genuinely though

temporarily, seeking change because of a current crisis, or may pretend remorse in order to escape punishment, to get a lighter sentence from the court and accept therapy as part of the deal. Certainly, a reasonably bright antisocial will realise that sooner or later he had better change the pattern or else be prepared to die young, serve a long time in prison, or become so brain damaged or physically damaged that he has to slow down. This is obvious to both client and therapist. The difference between the antisocial and other clients is that there is no *sense* of conflict, outside of the immediate dilemma. Even where depression is a factor, as it often is, recovery from the depression will simply be a return to the original unconflicted state.

Therapists, depending on their persuasion, may respond by pushing the client through a cognitive skills programme, in the hope that something might rub off, prescribing drugs on the basis of a psychiatric diagnosis, often not hard to find[2], sit back in the analytic style and wait for developments, or for the client to go away, or simply refuse to see the client. Lack of progress is ascribed to the client's lack of motivation. For motivation, read conflict. There is not enough conflict, not enough anxiety for the therapist to work with.

So what do we have here? A psychological position that forever resolves conflict? No wonder it is hard to shift! This lack of conflict is the first of two questions to be answered in the formulation presented here.

Background[3]

This work developed out of twelve years of group therapy, in Moana House, a therapeutic community in Dunedin specialising in the treatment of clients who have significant criminal histories, often with violence and addiction. Many clients are serving an alternative to a prison sentence. Histories of childhood neglect, physical and sexual abuse, and of abusing others, are common. Both men and women have been in the programme, but for significant periods over the past twelve years, Moana House has taken only men. As well as a therapy group, I provide staff supervision, act as one of a governing consultative triad known affectionately as the 'Star Chamber', and under certain conditions I have residents in one-to-one therapy.

Since most of my clients in this area have been men, I will refer to men in the following, always using the masculine pronoun. I am open to the idea that the

2 I recently conducted an imaginary survey of "antisocial clients I have known" and found that all of them could be diagnosed as borderline, narcissistic, depressed or drug addicted, and some could be adult ADD.

3 The following has already been described elsewhere (Manning 1995). I here present a brief review.

experience of women is different, though Gabbard (1994) suggests that while men predominate in the antisocial personality group, this may be because women are more frequently misdiagnosed:

> "Clinicians may overlook the diagnosis in females because of sex role stereotypes. A seductive and manipulative woman who exhibits considerable antisocial activity is much more likely to be labelled hysterical, histrionic, or borderline." (p 532)

I began to formulate these ideas after exploring a series of very similar early scenes using psychodramatic methods. These scenes appeared to have the following seven elements in common;

1 The scene is from the man's life at around age four to seven, sometimes later. It belongs to the stage described by Fanita English (1977) as the "scripter", when earlier decisions about self, others and life are integrated into a more or less complete script, or life plan.

2 The scene involves an oppressive or abusive experience.

3 The scene is vividly remembered. There is often an acute awareness in the client, both of his own experience and that of the auxiliary egos (the other actors assisting in the enactment). The protagonist knows the scene well, though he is often not aware that it is important before the drama.

4 The initial scene is perceived by the protagonist, though not necessarily by others, as similar to an ongoing series of experiences in the protagonist's life up to that point, although the outcome is different. These experiences involve verbal, physical or sexual abuse, frequently a combination of these. Characteristically, men will describe verbal and physical abuse more readily than sexual abuse (Grubman-Black, 1990). The latter may not be apparent when a scene is enacted, but may emerge later, particularly in the sharing phase, when other group members react to the work, or in one-to-one discussion later.

5 The abuse history, as well as the scene itself, is remembered and easily identifiable. It is not vague, confused, or dissociated.

6 The scene involves a sudden and dramatic shift from a position of powerlessness to a position of power. Often the protagonist defies or confronts an authority figure. A new role emerges, incorporating fight/flight behaviour (Bion 1961), a triumphant payoff, a feeling of power,

a dulling of physical and emotional pain and a lot of energy, fuelled by a release of adrenaline. This feeling is experienced many times in the client's subsequent history.

7 There is a peer group somewhere in the background which will consolidate this new role by permitting membership and encouraging role development by modelling, coaching and positive feedback.

The seventh element, the presence of a supportive peer group, determines the scene's far reaching social consequences. The fourth element, the similarity to earlier scenes, suggests that we are witnessing a resolution to an old problem. This and the other five – the developmental stage, the role of abuse or oppression, the clarity of memories, both of the scene and earlier memories, and the sudden release of energy which will be repeated over and over, all invite further speculation.

Psychodynamic formulation – a detour in analytic country

What might a traditional psychodynamic view come up with? Gabbard (1994:530), drawing on Kernberg, suggests that antisocial personality is actually a subdivision of narcissistic personality and speculates as follows (Gabbard appears in places to use the terms "antisocial" and "psychopath" interchangeably):

> "Antisocial patients frequently have a history of childhood neglect or abuse by parental figures. ... psychopaths clearly have not attained the developmental level of object constancy ... Like patients with a narcissistic personality disorder, they form a pathological grandiose self. This structure differs, however, from that of the narcissistic patient in one important way ... In the psychopath ... the "ideal object" is an *aggressive* introject ... Unlike the self-objects of Kohut's self psychology, this version reflects an experience of the parent as a stranger who cannot be trusted and who harbours malevolence toward the infant. This threatening, internalised figure may derive from real experience of parental cruelty and neglect."

However, a childhood environment of parental cruelty and neglect is quoted as a precursor to several clinical presentations; for instance the borderline pattern, post-traumatic stress disorder (p 468 ff) and dissociative disorders (p 293 ff) Celani, writing on Fairbairn's work with the borderline pattern:

> "The self that emerges after a prolonged childhood of frustration-deprivation is bad for three separate reasons, two psychological and one reality based:

> first, because it is associated inexorably with the rejecting object and is therefore bad as well; second, because the child has taken the "badness" of the object into itself to keep the parent "good"; and finally, because the hurt, abandoned, ignored child feels demeaned and not worthy of goodness." (Celani 1993:19)

He also notes the mechanism of the negative introject:

> "The borderline patient manifests an inversion of the normative developmental process. Instead of taking in the positive object relations unit and rejecting the negative object relations unit, he takes in the negative object relations unit and rejects the positive object relations unit." (p 75)

Fairbairn, noted that children from the Edinburgh slums, from homes "in which drunkenness, quarrelling and physical violence reigned supreme" would only rarely be induced to admit that their parents were "bad objects", and would never volunteer this.

Fairbairn described this position, in which a child would rather be bad than admit that their parents were bad, as the "moral defence" – a decision that it is better to be bad oneself than to have bad people on whom one depends.

> "*It is better to be a sinner in a world ruled by God than to live in a world ruled by the devil.* A sinner in a world ruled by God may be bad; but there is always a certain sense of security to be derived from the fact that the world around us is good ... In a world ruled by the devil the individual may escape being a sinner; but he is bad because the world around him is bad. Further, he can have no sense of security and no hope of redemption." (op. cit. p 18) (Italics added)

Jenny Rockel (1996) again, reporting on the work of Bernard Brandchaft (Rockel exclusively uses the feminine pronoun):

> "Brandchaft recognised that the "pathological accommodation" such an infant must make for her survival is profound and enduring. She must learn, and quickly, to put aside her impulses towards self-discovery and self-delight and turn her attention towards becoming and remaining whatever her caregivers need her to be. ... Her sense of self and innate potentiality, her entire subjective experience, are all subsumed by the imperative of maintaining the needed tie, at all costs."

These formulations are descriptions of adjustment to childhood experience involving parental neglect, cruelty, violence and a disregard for the emerging

self of the child, and we can find here several elements common to the antisocial pattern; a negative parental introject, identification with the abuser and a self that is bad could all apply to either group. However, at some point the antisocial man has clearly departed from this formulation. Using Fairbairn's metaphor of the moral defence, he has moved away from the pathological accommodation of the "sinner in a world ruled by God" and somehow decided to live in the Devil's domain. How this comes about is the second question I am addressing in this paper (the first being the lack of conflict noted above).

Clearly there must be a certain level of integration already present to achieve this development. The consequences of the antisocial position are fearful in terms of punishment and rejection. A child who is still very dependent will cling, as Fairbairn and Rockel suggest, to an option which keeps the parental figures good. The antisocial position abandons this strategy. Therefore the crucial change may not occur before age about 5, and sometimes much later. This would explain why the scenes described above take place around this age or later, and why there are clear memories, both of the history and the scene itself. All the stories tell of a time before the present pattern began. All can recall a definite point of change, which I will refer to as a decision point.

So, allowing that we have an idea of the antecedents, and that a change in direction emerges at a certain point of development, not before, what happens to cause the change?

Psychodynamic Formulation – using Transactional Analysis.

Transactional Analysis describes the developmental sequence in somewhat different terms from the object relations and self psychology models, although many concepts from the latter are incorporated into integrative versions of TA theory. A central concept is that a "script" or unconscious plan for life, an observable behavioural pattern that a person will more or less stick to, is *decisional*. That is, as a child develops, the various issues that confront it are met by a series of decisions in the child. We are not passively programmed, but decide, at an unconscious level, with whatever capacities and information we have at the time, how we are going to meet each issue, how best to survive, to live in the world.[4] Early decisions are global, about life itself, about basic trust. Later decisions are about exploration, power, self-expression, our relationships to others. By a certain age, perhaps somewhere between five and seven, a more

4 The idea of making decisions, or choices, is not unique to TA. For instance, Symington (1993:13); "The ego ... is active ... you could say that choices take place at a very deep level."

or less complete picture has been formed, needing only elaboration, detail and reinforcing memories to keep it congruent with experience. A part of this picture will be an existential position concerning the child's relationships to others. Either I am generally OK, or I am not. Either you are OK or you are not. This gives us the famous "OK Corral" (Ernst 1971) illustrated in Figure 1.

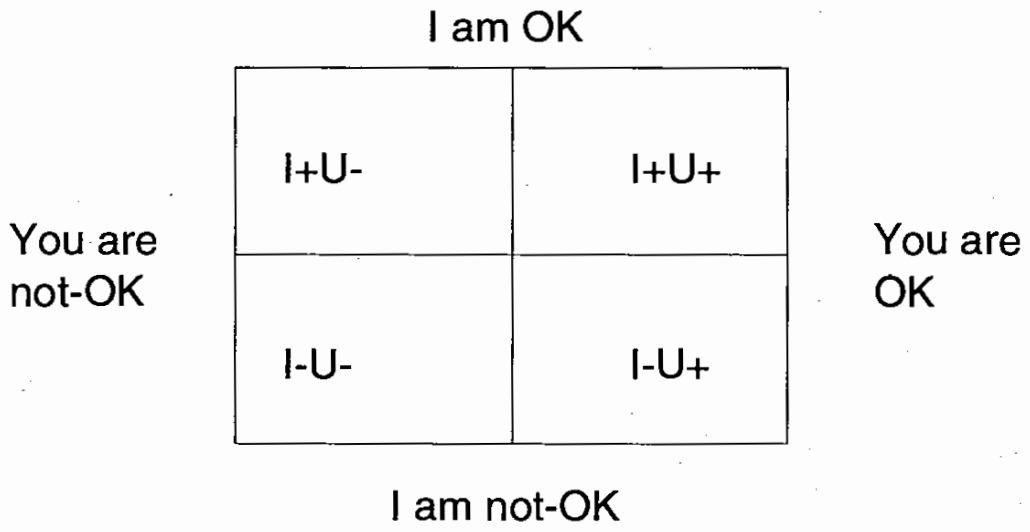


Figure 1

The scene described above appears to relate to an important script decision. At this stage, a normal child has already made many different kinds of decisions about themselves, others, the world and the relationships between these elements (English, 1977). Introjects are still split, but constancy is an achievable goal[5]. The little person is in the process of forming the more or less coherent picture of themselves, others and the world which will determine his life experience for some time to come, but at this point the picture is not complete. In TA terms, the script is still being written. Global existential decisions about how much "OK-ness" is attached to the little person, to others and the world are still being processed.

So far, history has loaded considerable "not-OK-ness" on the little person's view of himself, predictive of a "I'm not-OK, you're OK", or an "I'm not-OK, you're not-OK" existential position. However, this is not what happens. Instead, we see an elegant piece of problem solving which will leave him with much more "OK-ness" than he might otherwise have decided on. The result

5 For a discussion of TA theory on introjects, see Blackstone, 1993.

is not exactly an "I'm OK" decision, rather an "I'm still not OK, but you're more not-OK than me", which feels a lot better. (For developments of Ernst's "OK Corral", see White, 1994).

Phillips (1975) details the relationship between introjection of the early relationship (the "symbiosis") and script development. He describes the introjection of relationships between the big person and the little person in the form of an internal relationship between the little person's Parent and Child ego states.[6] (For these purposes the Parent ego state can be regarded as a recording of significant others, similar to a collection of introjects, and the Child ego state as a recording of the child's experience.[7]) The position before the crucial change is described by Figure 2a. Here the cluster of experiences, internal decisions, practised actions and memories which we may call the "victim" predominates in the little person's reaction to neglect and cruelty which is seen as originating in the big person's Child ego state.

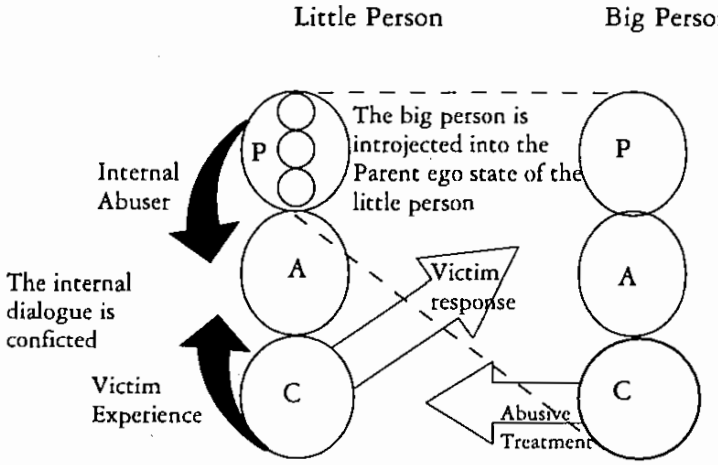


Figure 2a: The introjection and the internal dialogue

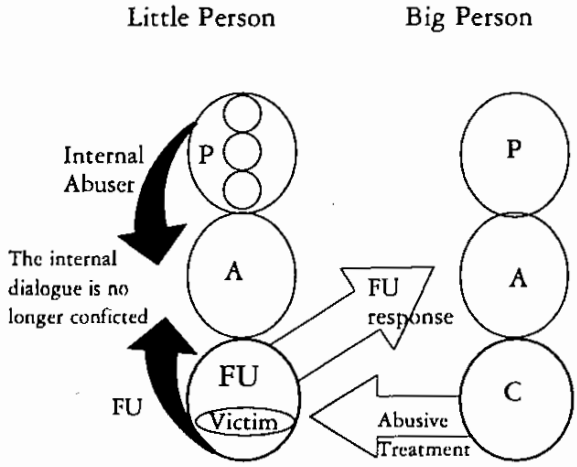


Figure 2b: The FU and the internal dialogue

Returning to the scene, I suggest that what happens is that a new role, which I am calling the FU (for "Fuck You"), has suddenly emerged[8]. It will be based on modelling from the abuser, and often resembles the abuser in language, tone of voice, gestures and other behaviour. Because of this resemblance, there

6 For an elaboration of the basic elements in Transactional Analysis used here, particularly the constructs of Parent, Adult and Child ego states, the reader is referred to Stewart and Joines (1987) and Berne (1961, 1977).

7 The TA convention is that, when spelt with a capital letter, "Parent", "Adult" and "Child" refer to ego states. Otherwise the terms retain their usual meanings.

8 I am using the concept of role in its psychodramatic sense - a behavioural/ thinking/ feeling cluster - for a discussion, see Clayton (1993, 1994).

is little difference between this new role in the Child ego state and the other side of the now internalised dialogue, stored in the Parent ego state. Prior to this, there was a conflicted dialogue between the Parent and Child ego states, one an abuser, the other a victim, who had produced the pathological accommodation referred to by Rockel. Now, because of the emergence of the FU role, there has been a sudden resolution of internal conflict. This is the origin of the lack of conflict which we notice later when this little person presents for therapy. After the decision, the internal victim becomes hidden, disowned, while a powerful new complex dominates the little person's reaction. The changed situation is represented in Figure 2b.

At the same time, we witness a massive release of energy, which is very reinforcing, and which may also help explain the clarity of later memories. There are a number of possible explanations for this.

1 A reduction in conflict, as already mentioned, is reinforcing, and allows more energy to be available for outward action.

2 The new FU role is by nature active, while the old victim role was passive, using now redundant internal mechanisms of defence. The enacted FU is by nature fight/flight, producing a sudden release of adrenalin, a physiological mechanism which will reinforce the role again and again in the future. Oppression becomes excitement.

3 The presence of peers, another factor in the scene, suddenly becomes important. Bearing in mind that we are considering a stage when peers carry a lot of potential for influence, when children are intensely interested in each other, the FU behaviour will immediately capture the imagination, and often the applause, of other children. This provides a massive external validation for the new role.

4 The dulling of physical pain naturally follows prolonged physical punishment. The FU role is likely to be followed by punishment, which in other little people might inhibit the role's reproduction. Physical punishment will have little effect on one inured to pain, and being made to feel "bad" will have no effect at all, as it is has been this little person's familiar state all along. The punishment which will follow FU behaviour will be processed as "strokes" – a further reinforcement.

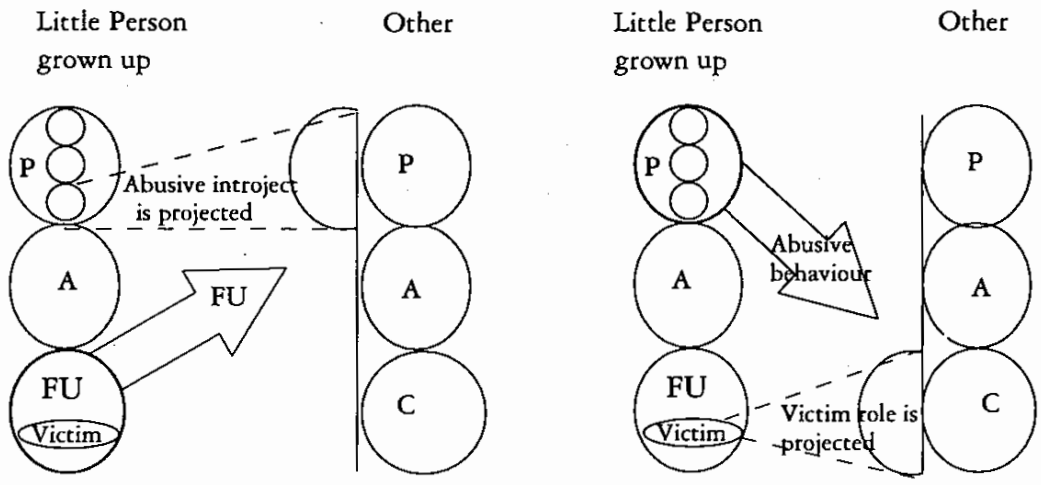
5 At this age, children are rapidly learning all manner of interpersonal and practical skills, and having learnt something new, will practise it interminably, taking pleasure in the experience of doing something new. If, as I have suggested, this event (actually more likely to be a series

> of events, though one may be remembered as significant) occurs at a time when script formation is almost complete, we could suggest that the FU role, reinforced by peers and by internal experience and practised over a number of opportunities, becomes the decision which puts the script together. This is the nature of the FU behaviour which emerges in the archetypal scene, where, as noted already, it seems to be a solution to an old problem.

Following any script decision a new role emerges. If it "works", if it provides more "OK-ness" for the little person, it will be developed further. In this case it "works" dramatically, drastically reducing anxiety and conflict. This decision will involve openly rejecting the perceived source of survival. From now on, punishment, together with peer approval and admiration, plus a pattern of hedonistic self gratification and adrenalin release, become good enough sources of strokes for survival. Hence the need to reach a stage of development when the risks are worth the reward; rarely before age five, and sometimes as late as ten, or even early teens. Where the abuse and neglect is more extreme, the decision will be made earlier. Such people will rarely come to, or stay in therapy, more frequently being found in prisons because their behaviour will be more extreme, their lack of capacity for relatedness makes therapy a scarcely conceivable idea, and they are truly fearful to most therapists. The exceptional therapist who is prepared to work long term in a prison environment (Thomas 1992)or in a specialised therapeutic community linked with the justice system may achieve good results with this group, but this level of commitment to such difficult and specialised work is rare, and most prisons do not offer such a facility.

The development of the antisocial pattern

As this pattern becomes habitual, two projection patterns can be observed. These are illustrated in Figure 3, drawing from the work of Moiso (1985). In the first, the abusive introject is projected, usually onto an older authority figure, and the FU response is directed towards this person. The antisocial's response to real or imagined authority figures is the observable result of this mechanism. In the other instance, the hidden victim, disowned but still present, is projected, usually onto a figure seen as weaker, smaller, or younger, and the response is an acting out of the old abusive introject. Abusive behaviour towards partners and children is one outcome.



3a: Projection of the Parent introject. 3b: Projection of the Victim role.

Figure 3: The mechanisms of projection (after Moiso, 1985)

After many repetitions, over a series of confrontations, dramas, excitements, adrenalin rushes, the FU role will develop complexity in cognition, feeling response and action, becoming a finely tuned response to many situations.

Similarity attracts, and as the little person matures, he will recognise others who have come to similar conclusions about life, about how to respond to a hurtful world. In this context, the FU role becomes sanctified and idealised in a set of values adopted by a criminal culture. A cognitive map of the treacherous environment and a corresponding code of ethics is constructed. With a pain response by now conditioned almost out of existence, cruelty, disregard for others, is congruent, understandable.

Thus we come full circle, from an individual centred, materialistic culture with God on its side, in the shadow of which we find parenting styles based on hedonism and impulsive self-centredness, producing in the following generation a shadow culture, still individual centred and materialistic, but on the side of the Devil.

The methods of working

Later in life, behaviour resulting from the FU decision will be considered dysfunctional by others – parents, others in authority looking after a delinquent child, then police, judges, therapists, probation officers, who must cope with the consequences of antisocial adult behaviour. Ultimately, it may become dysfunctional to the protagonist.

When a man with the antisocial pattern does come to therapy, a method is required which is at the same time dispassionate and engaging, which avoids boredom, but keeps the therapist out of the line of fire. Also, it must be an approach which raises the level of inner conflict which the client experiences as a result of contemplating enacting antisocial behaviour. Finally, it is probably a good idea if the therapeutic method recognises the nature and origin of the early decision.

Many action methods work very well like this. The two chair model for impasse clarification and resolution described by the Gouldings (1979) and the various psychodramatic methods (Clayton, 1993, 1994) serve to set the therapist aside, almost as if they are not a real person at all, more something like, as Charlotte Daellenbach (1991) puts it, a "traffic cop", directing, but not involved in the action. The client interacts with his own internal objects, or self-objects, not with the therapist. After a psychodrama or a piece of two chair or gestalt work, the protagonist is often left unaware of what the therapist, or director, has been doing. They may have no memory of having received certain instructions, which they obeyed during the action.

Another advantage is that there is always something going on. While avoiding destructive transference, the therapist is very active and confronting. The therapy is interesting. The client always has something to do. Men who have developed a strong FU defence are prone to boredom. FU behaviour, from either end of the relationship, is very active, exciting, and produces a lot of adrenalin. Activities which do not are often boring by comparison. This includes most one-to-one counselling approaches. The FU defence produces immediate results, so approaches which require patience and hard work, or which seem unstructured, leaving the client to work things out for himself, will not be attractive. Group methods are therefore more likely to be successful. Since the antisocial pattern as described above is pervasive in many areas of life, residential approaches may have more chance of success than weekly or daily programmes. Similarly, in a residential setting where there is always something going on, one-to-one therapy may be more successful.

Methods which involve only one hour a week will rarely work well, and antisocials do not go to workshops. There are three treatment environments of choice. The first is a cognitive skills programme. These are offered by the Community Corrections Department, and are based on development of cognitive processes in making decisions. These programmes can be regarded as working to strengthen the Adult ego state, building up the individual's

ability to circumvent the destructive projective mechanisms originating in the Parent and Child, but essentially leaving them untouched. The second are the many excellent addiction programmes, both in- and out-patient. These characteristically offer education, addiction counselling and group therapy, often in the context of a philosophy, like the 12-step programmes, or their competitor, the Rational Recovery programme (Trimpey 1992, 1994). The therapy groups often include action methods. The inclusion of a philosophy which structures these programmes may be an advantage, as by the time the client reaches therapy, the FU role has assumed a cognitive complexity resembling a philosophy. If it is to be displaced, an alternative philosophy is likely to help. Also, the group methods used in addiction programmes are often very active.

Therapeutic Community Treatment

The third approach, with which I am most familiar, is therapeutic community (TC) treatment. Essentially this is a reparenting programme. TCs differ from hospital-based and other professionally run programmes in two important respects. First, they are based on programmes which have been developed by non-professionals. Typically these are run by, or have significant input from, graduates of the same or similar programmes. Secondly, they use more innovative and often more confrontational methods than will be tolerated in hospital programmes. TCs appear to be successful with a wider range of clients, including antisocial people, and show improvements in a wider range of symptoms than other approaches, though they take much longer. More attention is paid to generating the conflict that is missing through approaches which generate empathy for the victim, and include the client in altruistic activity, such as working for the community at large. There is an emphasis on "script cure"; far-reaching changes in lifestyle, belief systems, thinking styles, as well as focusing on specific symptoms such as addiction. For this reason, and because of the confrontational methods favoured by the former clients who work there, TCs are often best run by their own graduates rather than by professional staff, though there are a number of models which use both, such as Odyssey and Moana House.

I have referred to therapeutic communities as reparenting programmes. Noce (1978) suggested a model based on two bipolar variables, derived from the idea of the Parent ego state, in the sense of a collective Group Parent. These are defined as Collective Nurturing Parent (CNP), and Collective Controlling

Parent (CCP). (This derives from the "functional model" in TA, where the Parent ego state is divided into Nurturing Patent and Controlling Parent.) Noce suggests that these functions can be represented as bipolar axes, one running between "appropriate structure" and "excessive persecuting" (CCP), the other from "appropriate permission" to "excessive rescuing" (CNP). He suggests eight possible environments as shown in Figure 4.

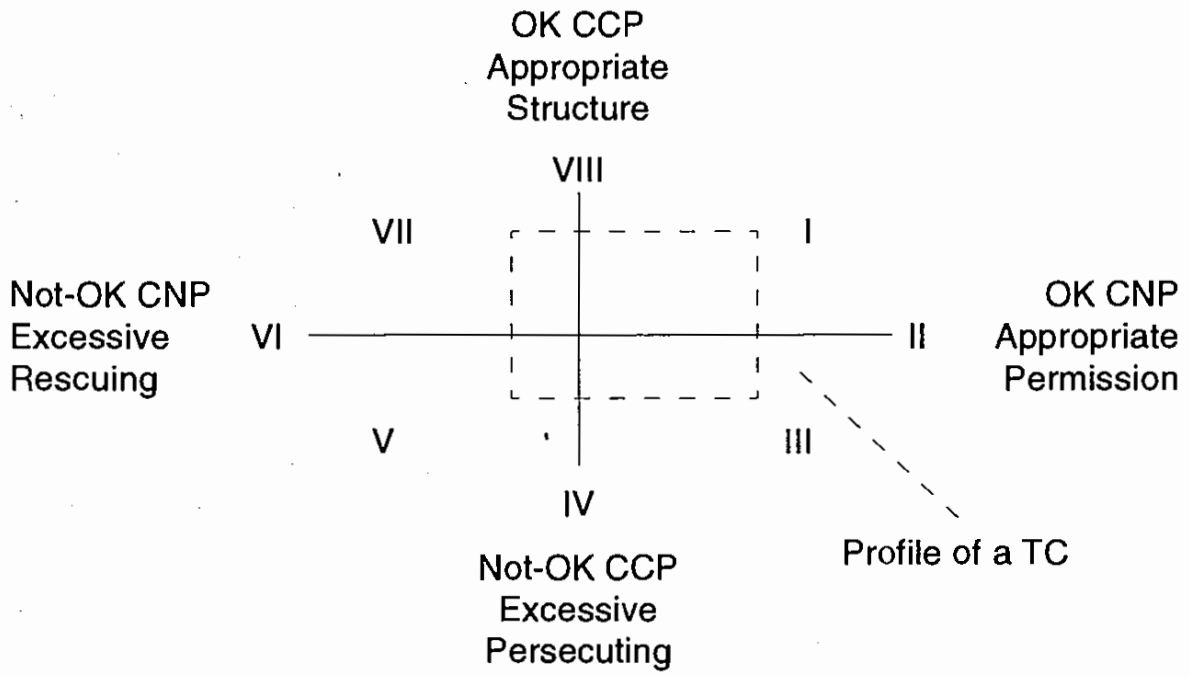


Figure 4

I Maximum positive potency	[appropriate permission, appropriate structure]
II Free school (free child)	[excessive permission, no structure]
III Strict, overly family-oriented (dependency)	[appropriate permission, excessive structure]
IV Prison-oriented	[no permission, excessive structure]
V Crazy-maker (double bind)	[excessive permission, excessive structure]
VI Chaos-oriented	[excessive permission, no structure]
VII Crisis-oriented	[excessive permission, appropriate structure]
VIII Rule-oriented (easy time)	[no permission, appropriate structure]

Caution

The ideas presented here are not intended to imply that psychodynamic group or individual therapy or psychodrama are sufficient treatments for these clients. The Moana House programme is a highly structured therapeutic community and includes education, work, a cognitive-behavioural stopping violence programme, development of empathy for victims, goal setting and monitoring, financial controls, voluntary restrictions on freedom, stages of increasing responsibility, co-operation and PR with the surrounding community and a graduation process. The preferred length of stay is six months to two

years (usually eighteen months to two years to graduate). Graduates are favoured for employment in the programme. All of these elements are considered essential.

A further cautionary note comes from the introduction to DSM-IV:

> "A common misconception is that a classification of mental disorders classifies people when actually what are being classified are disorders that people have." (p xxii)

Although I have referred above to "antisocials", "antisocial behaviour" and "the antisocial pattern", my experience with these men is one of contact with distinct individuals. These terms describe aspects of experience and behaviour which many of them have in common. They do not begin to describe the unique individuals who willingly provided the raw material for this paper.

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