Criminal Behaviour and Mental Health
18: 145–152 (2008)
Published online in Wiley InterScience
(www.interscience.wiley.com) DOI: 10.1002/cbm.694

Editorial
Flying a kite – observations on dual (and triple) diagnosis

ROB HALE[1,2] AND RAJEEV DHAR[2], [1]Psychoanalyst, Consultant Psychotherapist, Portman Clinic, Tavistock and Portman NHS Trust, London, UK; [2]Consultant Forensic Psychiatrist, Bracton Centre, Oxleas NHS Trust, Dartford, UK

In recent years there has been recognition that many people who are resident in secure hospitals or hospital units in the UK can most appropriately be categorized as falling into at least three diagnostic categories. Drawing on the multiaxial classification of the fourth edition of the American Diagnostic and Statistical Manual (DSM-IV), this usually implies that they have an Axis 1 diagnosis of schizophrenia, an Axis 1 diagnosis of alcohol and/or illicit drug addiction and an Axis 2 diagnosis of personality disorder – the latter usually from cluster B (Taylor et al., 1998; Blackburn et al., 2003; Dolan and Davies, 2006). Blackburn et al. (2003, p 134) comment 'The evidence that Axis 1 and Axis 2 disorders are more likely to coexist than to occur alone among mentally disordered offenders indicates that multiple psychiatric problems will be the rule rather than the exception'. The three diagnoses are often seen as co-existing and largely independent of one another, although co-morbidity is recognized as influencing both behaviour and treatment outcome. In clinical practice there is often argument over which is the 'true' diagnosis on the basis that the existence of one excludes the existence of the other.

This brief contribution proposes a different theoretical model, a single entity, which I think more accurately makes sense of the observable phenomena. The basis on which it is made is that for the past 12 years I have provided weekly clinical discussion groups for medical, nursing and psychology staff groups at six medium (and high) secure hospitals. I have thus had presented to me upwards of 2000 case histories and I have developed this explanatory model from what I have heard. This has been an iterative process with constant challenge and discussion from the supervision groups, and particularly Dr Rajeev Dhar. It could not have happened in any other way. An essential part has also been the observation of how the clinical and management teams function as a way of understanding the psychopathology they contain.

The typical life trajectory that I have observed for a proportion of those who end up in forensic psychiatric institutions is presented in Figure 1.

The starting point is the primary dyadic relationship between mother and child which, in these cases, is characterized by maternal depression or other major

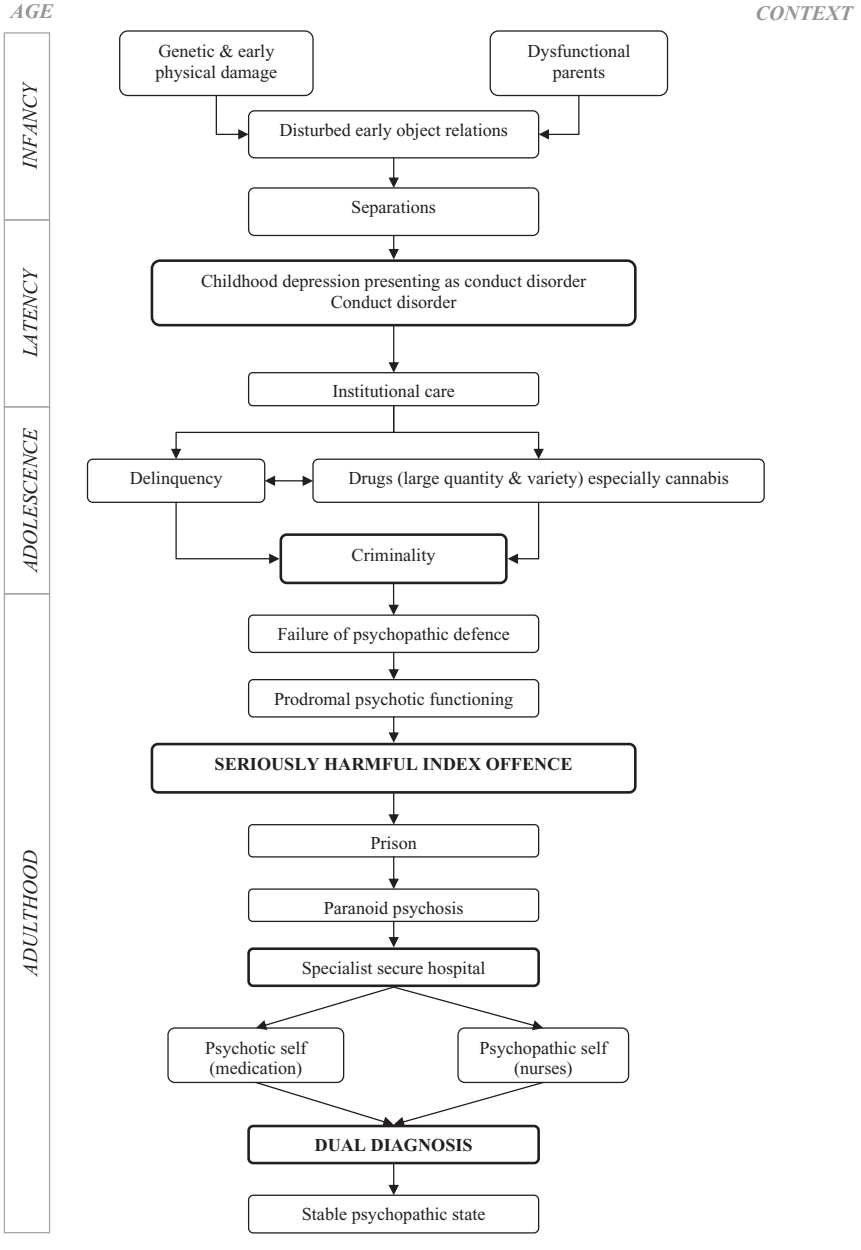

Figure 1: A typical life-course trajectory for people becoming patients in a specialist secure facility

DOI: 10.1002/cbm

psycho-social problems, in turn often resulting in a marked ambivalence towards the child and leading to the parents not being equal to the task of caring for the child ('acopia'). Sometimes the child has inherent vulnerabilities, but these are often hard to detect as such parents may not be accurate observers. Outside agencies often become concerned and involved. Early marital breakdown and separations are common as is early delegated childcare (in African-Caribbean migrants often to the grandparents). Family migration and dislocation are frequent features, leading to a further feeling of cultural hybridity, alienation or isolation.

At worst the child is taken into care, sometimes as a result of neglect of the child, sometimes because there is recognition of frank abuse. Being taken into care represents a complete breakdown in the mother–child relationship, whether temporary or permanent. Worse still, this may confirm that such a relationship barely existed in the first place. Symington (1980), writing on 'psychopathy', comments 'The psychopath's loss has occurred at the earliest stage, when the infant is still stretching for his object and holding it to himself in a tactile way, and before he can internalize it within the unconscious. The psychopath has suffered a loss when mother and child were still a unit. In Kleinian language, the infant has sustained a loss while in the paranoid-schizoid position. The projective and introjective mechanisms by which the infant separates himself from mother have not yet completed their work. The infant, thus, has not just lost mother but also a part of himself'. This failure of physical and psychological containment may be revealed in adult life through the Adult Attachment Interview (AAI), which shows an attachment pattern categorized as either anxious avoidant or disorganized (McGauley and Rubitel 2006). The discontinuity of experience and lack of coherent explanation of events passively experienced leads to an absence of consistent narrative; memory is scant, and, where present, made up of a series of isolated snapshots. All of these are features clearly reflected in their adult relationships and their index offence; these are themes I will expand on later.

As the child grows older (I am avoiding the word 'matures') and enters the so-called stage of latency, behavioural disturbances become apparent and they are identified as having a conduct disorder. Significantly they may be seen as being disturbed by their peers – perhaps the first evidence that psychopathy only becomes evident in a social situation. What the externally visible evidence of disturbance and the capacity to alienate others obscures is the lingering internal suffering of the child, and his or her inability to express it in any more acceptable way.

If institutional care is part of their history, patients are likely to report that they were rejected by their peers – they were the outcasts in group of outcasts, they were part of a dysfunctional peer group. Frequently there is a history of sexual abuse by an older boy or by a member of staff, hardly surprising given the child's vulnerability and need for affection, sex being the apparent solution. Within the complex nature of sexual abuse is the experience of an exploitative

DOI: 10.1002/cbm

and deceptive relationship in which the child is the victim, a system which his later life actions will constantly aim to reverse and triumph over using the self same means which made him the victim.

Sometimes, however, as adults, they will in retrospect identify one member of staff in the children's home who showed them particular kindness, consistency (which provides a feeling of being respected) and concern. These people are remembered as beacons in an otherwise dismal and unhappy childhood of misfortune, neglect, corruption and deception.

Later on in the latency period, bullying and stealing are socially sanctioned and reinforced by being accepted within a seriously delinquent peer group which is already starting to reject and fail in education. The defiance conceals an underlying fear of failure, humiliation and rejection.

Adolescence is a time of turbulence for all children but these individuals are not only unusually delinquent but also turn to drugs and alcohol at a very early age. Again the reasons for taking drugs are complex but one cannot ignore the possibility that they provide a form of pharmacotherapy to control unacknowledged anxiety and depression. They offer a shield from reality and a womb-like cocoon into which the young person can retreat. In the most part, however, internal conflicts are externalized; conscious suffering is avoided and projected into those around them. This leads to further rejection and alienation – the last thing they need but the very thing with which they are most familiar. For the disturbed adolescent the 'fault' is seen as residing in the outside world around them. Their own confusion is projected into others as is their anger. Those in any position of authority or responsibility find themselves indifferent or antagonistic to the patient, tricked and provoked into retaliation in a way which makes them feel ashamed of their response. This then makes them hate the young person all the more.

My own belief is that the defining characteristic of psychopathy is this capacity to bring out the worst in me or in the institution to which I belong. I see psychopathy as a defence mechanism in which the person holds on to some degree of psychic equilibrium by projecting their feelings and their own experience of badness into others; in this sense, distorting reality to protect their sense of sanity. Current events and problems are described with a disconnected insouciance, without affect, causal relationship or personal responsibility; again a series of snapshots to protect themselves from facing the reality of who they are, and more importantly, who they are not – an integrated person. It is a psychic survival mechanism, albeit a pathological one because ultimately it is they who suffer and who are the losers.

Drugs and alcohol have already been centrally implicated in the process, but it is cannabis which I believe is the most dangerous. Smoking large amounts of cannabis initially, like many substances, is taken to reduce anxiety (and perhaps guilt) buffering the person from external (and internal) anxiety. With continued

DOI: 10.1002/cbm

and excessive use, and a progression to more powerful forms of the drug however, the ego boundaries start to dissolve and the outside world which could previously be regarded with disdain, antagonism and contempt now takes on an increasingly different complexion. It is now perceived as powerful, malign and vengeful. An active paranoid state is starting to establish itself – a prodromal psychotic state. The response is self medication with yet more cannabis. This is reflected somewhat in the scientific literature; Moore et al. (2007) found that cannabis users are 40% more likely to develop a psychotic illness, however the authors did not posit a causal link, nor is there evidence that use of cannabis is associated with a long-term diagnosis of schizophrenia; a view confirmed by Crome's (2007) review of the evidence.

What we are observing is the failure of the psychopathic defence to ward off underlying psychotic persecutory anxieties which gradually break through as paranoid delusions. In this psychotic state the individual eventually encounters a situation which to him mirrors his unconscious worst feared fantasy or complex of fantasies. These will be primitive fantasies based on very early traumatic experiences such as rejection and alienation, intentional harm, the wish that the person should not exist in the first place, humiliation and self loathing, thoughts being known and controlled by others, etc. etc. The current situation mirrors the past for the individual but is only recognized as having current relevance and the current threat responded to by physical attack on the persecutory object. Thus the current psychotic state allows and even requires a symbolic attack apparently to rectify the current injustice but really to reverse the traumatic experience of infancy. A wished for revenge is now made possible by psychotic functioning. The victim of course is not the true victim but the person who happens to fit the bill in the current situation. This then is the index offence.

In prison, or indeed a secure environment of any kind, the physical constraints give even less opportunity for psychopathic acting out and the psychotic state now becomes all the more prominent. Imprisonment/confinement itself is the embodiment of loss of any personal control to a malign force. No one is to be trusted. It is at this point that the psychiatrist enters the scene encountering a patient who currently fulfils a sufficient number of the criteria (acute rather then chronic/negative) to justify a diagnosis of paranoid schizophrenia. Transfer to a secure hospital ensues.

On the ward the psychotic state continues and neuroleptic drugs are prescribed by the psychiatrists often bringing about a rapid improvement; this may be aided if there is an environment relatively free of illicit drugs. At this point the psychopathic state reappears and it is the nursing staff who bear the brunt. It could be said that psychopathy is a diagnosis in the countertransference and will be made by those with the closest and most constant contact with the patient – the nursing staff. It is not unusual at this point for the nursing staff, over-

DOI: 10.1002/cbm

whelmed by the psychopathy, to question the previous diagnosis of schizophrenia. A compromise is then struck in the classification of dual or multiple diagnoses. As the psychosis recedes, the psychopathic state predominates again. Nursing staff may then suggest that the patient was 'acting mad' in order to escape the judicial process and advocate that the patient be returned to prison. The patient may respond by advancing a similar description of their previous state of mind, or alternatively simply collude with the staff view in denying psychosis and claiming it was all made up; however, the dominant psychopathic state may actually drive an attempt to feign psychosis. Thus any diagnostic division between the psychiatrists and the nurses actually represents different parts of the patient's mind – the psychotic and the psychopathic; the patient at this point is likely to side with the nurses since the psychopathic defence is what, over the years, they have learned to know and to 'trust'. It is far less frightening than the paranoia of psychosis. Control using the long established manoeuvres of coercion and corruption is re-established. Allegiance may be given to the corrupting dominant antisocial/psychopathic or drug culture of the ward. There is a risk that the patient then assumes the role of the 'drug baron' or the 'toughest psychopath', and he rather than the ward manager may end up controlling the ward. The stable psychopathic defence is once again doing its job. Equally our countertransferential reaction to psychotic as opposed to psychopathic patients is the central theme of Hinshelwood (1999). This characteristic of different staff in an institution to identify with and represent different aspects of the patient's psychopathology is well described by Davies (1996).

When psychosis dominates the clinical picture there is no opportunity for the establishment of a therapeutic alliance – there is no available ego. Equally the dominance of psychopathy or the drug culture now precludes such an alliance. Both ensure the patient remains in institutional care. Paradoxically should an event occur which necessitates seclusion, a small window of opportunity may appear. The patient is removed from the deviant ward culture and the effects of the illicit drugs but not caught in the psychotic world. It is at this point they may be available for some kind of realistic emotional contact. Sadly all too often the timing of return to the ward is based solely on the level of 'physical' risk and such emotional contact does not become established. Instead the psychopathic battle continues back on the ward.

Should the psychotic state continue in hospital one has to ask the same question as before the index offence – 'what is its purpose?' Here Sohn and Minne make a very important contribution proposing that the continuing psychosis protects the individual from experiencing guilt and post-traumatic stress to their own index offence. As the psychosis gradually recedes, a picture of post-traumatic stress disorder emerges – a change which they regard as a clear therapeutic advance – a degree of achievement of the 'depressive position'.

If the observations I am reporting have some validity and give a reasonably accurate account of the whole life trajectory of the young person, how does it

DOI: 10.1002/cbm

affect the diagnosis? My proposal would be that the underlying state is the psychosis of a chaotic infancy from which the person has never really progressed. S/he has, however, constructed a pathological defence – psychopathy – which apparently serves him/her well to an extent, but actually leads to failure to establish any meaningful relationships, to misery and ultimately to self destruction in a social and often physical sense. As Cleckley (1964) so accurately describes, it is 'the mask of sanity'. Relief from the fear that this defensive structure is failing is sought through the use of drugs and alcohol which paradoxically promote the very breakdown they are desperately seeking to avoid.

This is a personal account. It attempts to draw together various conceptual frameworks. It challenges any concept of separate diagnoses, positing instead an underlying primitive psychotic state experienced in infancy from which there is no real progression and to which the person will always be vulnerable. The defences employed are psychopathy and drug/alcohol addiction. Each is an apparent and partial solution but each has within it the capacity to destroy its own function as a defence mechanism. When they fail, frank psychosis ensues.

The overall proposal is then of one condition with three elements, psychosis, psychopathy and substance misuse, all being causally related. Perhaps this requires a paradigm shift in the way we classify mental disorder, but such a shift could allow for more appropriate expectations of a patient's capacities and of change with treatment; it may avert despair. My hope is that others will challenge and develop the ideas I have put forward.

References

Blackburn R, Logan C, Donnelly J, Renwick S (2003) Personality disorders, psychopathy and other mental disorders: co-morbidity among patients at English and Scottish high-security hospitals. *The Journal of Forensic Psychiatry & Psychology* 14: 111–137.

Cleckley HMD (1964) *The Mask of Sanity* (4th edition). St Louis, MO: Mosby.

Crome IB (2007) An exploration of research into substance misuse and psychiatric disorder in the UK: what can we learn from history? *Criminal Behaviour and Mental Health* 17: 204–214.

Davies R (1996) The inter-disciplinary network and the internal world of the offender. In C. Cordess C, Cox M (eds) *Forensic Psychotherapy*. London: Jessica Kingsley Publishers vol. 2, pp. 133–145.

Dolan M, Davies G (2006) Psychopathy and institutional outcome in patients with schizophrenia in forensic settings in the UK. *Science Direct* 277–281.

Hinshelwood R (1999) The difficult patient. *British Journal of Psychiatry* 174: 187–190.

McGauley G, Rubitel A (2006) Attachment theory and personality disordered patients. In Newrith C, Meux C, Taylor PJ (eds) *Personality Disorder and Serious Offending*. London: Hodder Arnold pp. 69–80.

Minne C (2003) Psychoanalytic aspects to the risk containment of dangerous patients treated in high security hospital. In Doctor R (ed.) *Dangerous Patients. A Psychodynamic Approach to Risk Assessment and Management*. London: Karnac.

Moore THM, Zammit S, Lingford-Hughes A, Barnes TRE, Jones PB, Lewis G (2007) Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review. *The Lancet* 370: 319–328.

Symington N (1980) The response aroused by the psychopath. *International Review of Psychoanalysis* 7: 291.
Taylor PJ, Leese M, Willams D, Butwell M, Daly R, Larkin E (1998) Mental disorder and violence. *British Journal of Psychiatry* 172: 218–226.

Address correspondence to: Rob Hale, Psychoanalyst, Consultant Psychotherapist, Portman Clinic, Tavistock and Portman NHS Trust, London, NW3 5NA, UK. Email: rhale@tavi-port.nhs.uk

DOI: 10.1002/cbm