2 The practice of CAT

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Much of the theory and practice of CAT is shared with other therapies. It is not, however, an eclectic salad: whatever is done is done in relation to the underlying model of therapeutic change. This involves the creation of a human relationship between the patient and therapist, devoted to the achievement of change, involving the joint creation of descriptions of the patient's harmful procedures which serve to enhance the patient's capacity for self-observation and control and to guide the therapist in ensuring that the relationship serves its therapeutic purpose. Within the technical framework of CAT, described below, each therapist, with each patient, will work out the best way to work together.

Responsibility of therapists

Therapy must be carried out in appropriate settings, with suitable patients, in ways governed by a professional code of ethics. Therapists should belong to appropriate professional and defence organisations. In CAT particular emphasis is placed on being explicit about the reasons for the rules and conventions governing therapy; these are designed to protect patients and also to make the work of therapists manageable. Patients should be encouraged to raise any difficulties with the therapist but should be aware that formal complaints procedures exist. Therapists should be in supervision at a level determined by their experience.

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Referral of patients

Cases referred for CAT will vary according to the settings. In hospital settings most will come from psychiatrists or from general practitioners. In mental health centres and other community resources, cases will usually be discussed at team meetings before being allocated. In general practice cases will be referred by, or discussed with, the patient's practitioner. In private practice some will be self-referred. Therapists need to pay particular attention to diagnosis and assessment before offering treatment where little prior consideration has been given to diagnosis and suitability for therapy.

Assessment and selection for treatment

The assessment procedure needs to answer the following questions.

1. Is the patient suffering from a problem which is appropriate for psychological treatment? A patient may be excluded because he or she is suffering from more or less normal responses to life events, in which case supportive counselling may be appropriate. Another reason for exclusion is when the patient is suffering from a condition needing medical treatment. Physical illness may present as fatigue, depression and vague somatic complaints. These symptoms should be investigated medically, and they should only be explained psychologically where there is positive evidence for a link with the patient's procedures. Where full investigation has shown no organic cause for symptoms but the patient presents only somatic symptoms, treatment can only proceed if the patient agrees to accept the possibility of a psychological cause and cooperates with self-monitoring etc. A third reason for exclusion is when the patient is suffering from a mental illness requiring pharmacological treatment. Uncommon examples would be an undetected paranoid illness or early schizophrenia and in case of doubt psychiatric advice should be sought. The most common condition will be depression of a level likely to interfere with the patient's capacity to work in therapy. Prior or simultaneous treatment with antidepressants is indicated because severe depression is associated with poor outcomes in psychotherapy. If patients refuse medication, a trial of therapy may be offered, but not continued if no change is evident in 3–4 weeks.

2. If the patient is suitable for psychological treatment, is CAT the appropriate approach? In general, CAT is a safe initial therapy for a wide range of neurotic and personality disorders. While CAT requires active patient participation, patients on first presentation need not be expected to be 'psychologically-minded'. There are, however, exceptions:

- Patients with a clear preference for a different approach should be helped to find what they want elsewhere.
- Patients with major behavioural and symptomatic problems may be unsuitable or may need prior treatment and management by other means, for example detoxification for substance abuse, behavioural treatment for severe obsessional or phobic symptoms. Many patients with relatively minor symptoms, however, can be treated with CAT; in some cases therapy can incorporate direct treatment of the symptoms (for example, cognitive methods for bulimia, exposure programmes for avoidance) while in other cases the symptom, having been linked with the procedural system in reformulation, will be largely ignored and attention will be focused on the interpersonal and self-management procedures with which it is associated.
- The range of severity of the patients offered treatment will reflect the setting and the experience of the therapist. Actively suicidal patients are best treated in hospital services which can offer contact and, if necessary admission, at any time, without the direct involvement of the therapist. All such patients should have a clear understanding of what is available and how to make contact, and some rehearsal of how to deal with powerfully destructive feelings is appropriate. This also protects the therapist from the controlling use of suicidal threats. The same considerations apply even more strongly to patients with a potential for violence. Such patients should only be taken on after discussion with colleagues and in settings where other staff are readily accessible.
- Some therapists find some kinds of patient particularly difficult to work with. Unless this can be resolved in supervision, referral to another therapist is appropriate.

Therapy contract

During assessment and at the time of offering therapy, the nature of the offer being made and the expectations on the patient should have been discussed. In many settings it may be a good idea to have a written contract setting out these issues. The agreement should include the length of sessions, the number of sessions offered, the (limited or absent) right to contact between sessions, the expectations of homework and arrangements about holidays, missed sessions etc.

Conduct of sessions

It is preferable to see patients at the same time and place each week, but this is not always possible in health service settings. The adequacy of the soundproofing, and standard of decoration and furnishing of the room, should be at least

decent, but this is not always possible in the current NHS. The patient should be seated at an angle which permits, but does not insist upon, eye contact, and a low table on which written and diagrammatic materials can be jointly perused should be provided. Note-taking during sessions is best avoided but, during the history-taking phase, may be necessary. Process records of the sessions should be kept, along with copies of the rather considerable amount of paperwork involved in CAT.

Audiotaping of sessions is a valuable basis for self-supervision and allows accurate process records to be kept; it should be part of the experience of all trainees. Excerpts can be taken to supervision. Patients should be permitted or encouraged to make tapes for their own use. The storage and ultimate disposal of the audiotapes should be treated with the same care as for written records; as an additional precaution patient's names should not appear on the tapes.

Sessions 1–3: gathering data and preliminary reformulation

The aim, in these early sessions, is to gain as extensive an understanding of the patient's experience as possible and to give the patient some experience of the kind of offer the therapist is making in order to recruit him or her to the work. The difficulties stem from the need to gather a full range of historical and diagnostic data, which encourages active questioning, while at the same time leaving choice of topic and theme as far as possible to the patient (because, as Balint says, if you ask questions all you get is answers). In addition, the problem procedures of some patients are likely to limit their capacity or willingness to reveal much about themselves.

At the first session it is best to say briefly what one has already gathered from the referral letter and invite the patient to expand on that. What they say and how they say it, supplemented by prompts to speak of particular phases or themes in their life or to talk about particular people, is usually enough to convey a fairly comprehensive view of the nature of the problem. It is always a good idea to rehearse the main themes at the end of the session to confirm that one has understood the story correctly; if possible it is also helpful to identify some underlying assumptions or recurrent procedural patterns. At the end of this session the Psychotherapy File (see Appendix 2.1) will be introduced, self-monitoring of recurrent moods or symptoms suggested and other work which may contribute to reformulation (e.g. life charts setting out the years of important events, previous illnesses or treatments, or family trees) may also be asked for. Where no previous psychological/psychiatric assessment has taken place, the gaps in the history and symptom profile gathered at this session should be noted and a small part of the next session should be devoted to covering the ground. Symptom questionnaires which may have been issued

before the patient was seen should be inspected and evidence of symptoms not discussed in the session should be explored.

Over the ensuing two sessions the history will be amplified and. increasingly, the pattern of the therapeutic relationship will begin to emerge. This will usually, and preferably, include a developing working relationship, but will also convey aspects of problem procedures in most cases. Over-compliance and placation engendered by the hope for help may be useful in the short run, but need to be named and later resistance anticipated. Failure to complete agreed tasks or evasiveness or silence in the room must, obviously, be addressed, but in the form of a procedural description, which can usually be linked with the presenting difficulties, rather than of a disciplinary admonition. Less overt aspects of the interaction may indicate problem-related feelings and attitudes and may evoke corresponding countertransference feelings in the therapist, contributing to the understanding to be recorded in the reformulation.

To a large extent conflict between the 'cognitive' and 'analytic' components of CAT is minimal as all that takes place is aimed at the accurate understanding of the patient and the initiation of the therapeutic work. Only if, by 'analytic', is implied an unyielding transference-centred interpretative mode is the cognitive component intrusive. However, as far as possible, the introduction and discussion of cognitive tasks should be timed in such a way that it does not over-structure the session and block exploration. Conversely, in the more open-ended and exploratory aspects of the meetings, the need to link the material not just to immediate associations but to the wider, overarching understandings of the emerging reformulation must not be forgotten. (The wish on the part of therapists for more exploration and more history is usually a wish not to have to think about the reformulation yet.) Where the reformulation is difficult owing to the patient's failure to provide much to go on, early reformulation, describing this in terms of a problem procedure (which can usually be linked to life problems) is indicated. Such early, high-level, general reformulation engenders, in most cases, a more active participation, with amplification of the material, a fact which is central to the practice of CAT. There is no place for the prolonged siege conducted with low-level interpretations. Even the very distanced, untrusting patient, or the patient in whom the definition of the self seems to rest on not doing what is required, can often be reached by a high-level description of what is going on in the room. One should always remember that the consulting patient, however apparently obstructive, is there in order to change; reformulation offers an explanation of why it is difficult and does not convey criticism.

The reformulation session

This session will have been described in advance as being of a special nature and, for the therapist, even though most of the issues will have been discussed to some degree, it requires considerable preparation. Therapists need to gather together the information that they have collected and all the impressions they have received in the course of the sessions so far. It may help to read through the Psychotherapy File with the patient in mind, as well as checking through the items identified by the patients and already discussed. The draft of the reformulation, in writing, should be read out in the session, and the patient's comments and responses to this should be carefully noted. Reactions are often intense and serve to confirm the understandings and the sense of a felt working alliance, but placatory responses must be distinguished from acceptance, and rejection of parts as inaccurate and needing correction must be distinguished from responses which are expressions of a dismissive or envious procedure. The finalised written version, prepared after this meeting, will take note of these responses. Any parts deemed important but not accepted by the patient should either be omitted or included but noted as not agreed.

The reformulation process, devoted to the formation of the central tool of the therapy, is at the same time a lived example of collaborative, respecting and thoughtful relationship. Good CAT involves recruiting the patient to the task by: (a) clearly describing its joint nature, (b) encouraging full discussion of homework tasks, (c) timing interventions, leaving gaps etc. in order to elicit the patients' views, (d) making all suggestions in ways inviting comment and possible dissent, and (e) inviting patients to answer questions for themselves, before replying. The work orientation of CAT should not be misapplied; pauses and silences and tact provide the spaces into which the patient pours the material from which the understandings of the reformulation are built.

The written reformulation

The written reformulation letter is based upon interviewing, patients' self-monitoring, the interchange in the room, the patient's use of the Psychotherapy File etc. Many of the elements of the reformulation will have been discussed over the first three sessions. Re-presenting the story put together in a letter is, however, a powerful moment, serving to cement the therapeutic alliance in most cases. The letter should do all the following things:

1. Describe the patient's past experiences and name simply and directly the difficulties and pains of the life. This serves to validate experiences which have often been partially denied and can clarify what the patient was and was not responsible for.
2. Describe the procedures used by the patient to cope. The word 'defence' is often felt to be critical and it is better to talk in terms of ways of coping or strategies.
3. Identify the currently operating Target Problems (TPs) and Target Problem Procedures (TPPs). These should be discussed in the letter, and should also be listed separately. An abbreviated list of TPs and TPPs will be transferred to the Rating Sheet.
4. Predict how the procedures may operate in the therapy relationship or describe how they may already have done so.

Target Problems and Target Problem Procedures

Target Problems (TPs) are descriptions of what is wrong. Listing the patient's own complaints, for example depression, fear of open spaces, difficult relationships, reminds us of what therapy aims to change; but we need also to list the problems which patients manifest but do not name, perhaps because they have come to see their distress as normal or their negative beliefs as true. Thus TPs may also describe problems such as 'never really enjoying anything' or 'being over-critical of myself'.

TPPs are an attempt to describe how the patient maintains the processes or creates the experiences which result in the TPs. A proper TPP description should indicate (a) what the person does, and (b) why revision has not taken place so far. Procedural description based on the Procedural Sequence Model would normally indicate the aim or intention (e.g. seeking intimacy, coping with daily life etc.) and descriptions should trace:

1. internal mental processes such as how things are seen and judged, the individual's intentions, predictions of capacity, choice of means
2. how the role or act is performed
3. external aspects such as other people's actions and responses, and the consequences of the acts.

Short-term summary versions of TPPs will be used on the Rating Sheet, but the fuller sequence should be clear from the letter or from the summary of TPs and TPPs at the end of the letter. Thus in the case of Traps, the circularity of the sequence—assumptions leading to actions, leading to consequences, leading to reinforcement of assumptions—should be spelt out. In the case of Dilemmas, it is important to note that dilemmas imply polarised choices to which the individual can see no alternative. Enactment of one pole serves apparently to confirm the narrow, polarised possibilities. In the case of external Snags the (often but not always false) assumptions of other people's

responses should be named. In the case of internal Snags the use of phrases like 'as if your success would hurt your father' should be used. Although patients commonly use the Psychotherapy File accurately, it can be tempting to agree quickly with a provided description without checking out the patient's direct experience and without spelling out the whole sequence. Remember that a procedural description of thought and action carries with it implications for feeling (which feelings? expressed or repressed?) and for communication with, and control of, others.

Use of TPPs

Once TPPs are listed they are pivotal to the therapy. After reformulation, patients must have explicit homework assignments designed to teach them to recognise the occurrence of these Problem Procedures. Therapists must know their patient's TPPs; if you cannot tell your supervision group what your patient's TPPs are you are very unlikely to recognise their occurrence in the therapeutic relationship (transference). The aims of therapy will normally be the relief of Target Problems and the replacement or modification of Target Problem Procedures. Banal 'exists' or options, such as 'to live happily' are of no value. If such options are to be listed at all, this should be done only when the patient has shown a real grasp of the TPP and has begun to recognise its occurrence reliably.

The weekly rating of change (of the TPs and TPPs) on the Rating Sheet (see Appendix 2.2) is best done by the patient at the end of the session. It is often best to rate *recognition* in the early stages. Once this is achieved the rating may be applied to *revision*. It is important that therapists should consider each item and challenge ratings that do not accord with the patient's reported experience or way of being in the session. While some 'halo effect' is inevitable (i.e. while all ratings tend to move in parallel), closer examination will often show that change occurs at different rates and on different items, and its differentiation may be important. This joint rating serves to remind both therapist and patient of the procedures being tackled in therapy and hence has a focusing or scaffolding function in the course of therapy. It also serves as an example of realistic appraisal which patients then learn to carry out for themselves.

It is important to ensure that patients really understand the TPPs and that they do identify examples correctly. Their conviction and their application of the TPPs will not be completed all at once. As these TPPs are reliably identified through homework and in the sessions, the Exits or Aims or Alternative Procedures can be elaborated.

Sequential Diagrammatic Reformulation—SDR

People often find diagrams, or a combination of verbal descriptions and diagrams, more powerful than words alone. The more complex and poorly integrated the personality, the more it is the case that diagrams can convey sequences in a way that words cannot. Diagrams are therefore optional for many patients, but essential for some. The complexity of a diagram will reflect the use to be made of it; in general, the simplest necessary form can be used with the patient, but full diagrams help therapists anticipate covert transference.

Traps, Dilemmas and Snags in diagrams

Diagrams demonstrate sequences with lines, arrows and words. The basic patterns of Traps, Dilemmas and Snags can all be conveyed diagrammatically as in Figure 2.1.

Linking different TPPs

The value of diagrams is even greater where there are a number of procedures of importance, the relations between which need to be established, as in the example in Figure 2.2.

The Procedural Sequence Object Relations Model diagram

This is the most complete representation of how problem procedures are generated, connected and maintained. The core of the diagram should list the individual's *repertoire of reciprocal roles*. These generate (a) reciprocal role procedures, (b) self-management procedures (SMPs), including (c) symptomatic or avoidant procedures which have replaced unmanageable or forbidden roles.

In constructing the core, we draw upon the patient's history, way of being with us, and on our own countertransference (what the patient seems to make us feel or tries to make us do). The core represents the rules and expectations about relationships derived from those originally developed by the immature child and may include quite distorted or exaggerated patterns of both negative and positive roles. Simpler diagrams may be based upon the identification of a single internal role such as the unduly critical parent or the bad guilty child, or may identify the 'core pain'. However, by describing the complementary roles of the reciprocal role repertoire we get a richer, more explanatory account,

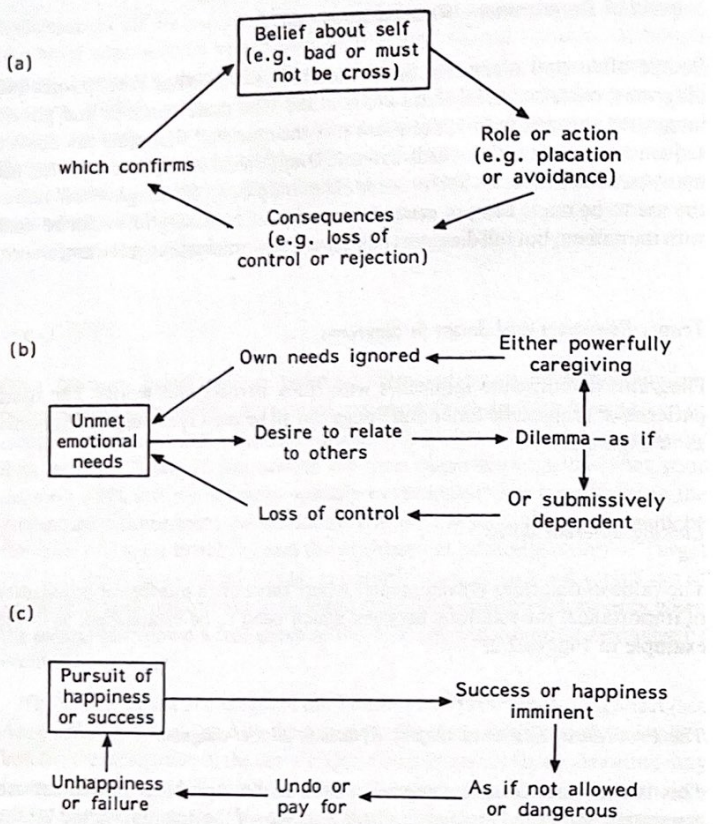

Figure 2.1: The basic patterns of (a) Traps, (b) Dilemmas and (c) Snags

and are less likely to identify the suffering roles but not the damaging ones. *The basic unit from which procedures are generated is a reciprocal role.*

Constructing sequential diagrams

The construction of the Sequential Diagram is based (a) on the history, (b) on identifying and describing manifest procedures (self-management, reciprocal role, defensive and symptomatic) and (c) on elaborating a core state model. Different people approach this task in different ways, but it is usually best in

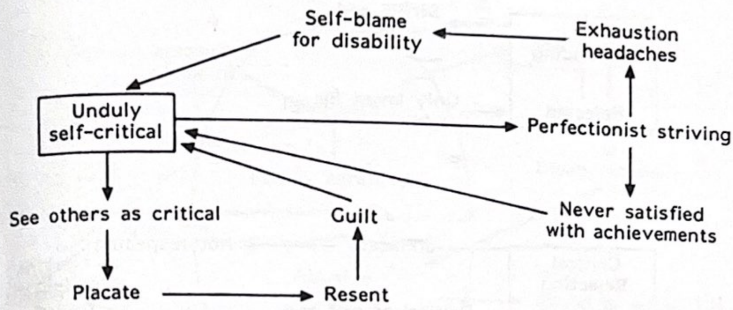

Figure 2.2: Example of linked procedures

working with patients to complete the prose reformulation and the preliminary list of TPs and TPPs and/or diagrams of individual procedures before trying to build a complete diagram. In selecting the procedural loops to include in the diagram, try to produce the most economical version possible (some SDRs look like maps of Birmingham's road system). These will usually include:

1. the dominant 'coping mode' (e.g. placation, perfectionism, avoiding closeness)
2. the main SMPs (e.g. self-neglect, avoidance of emotions, symptomatic procedures)
3. the dominant RRPs (e.g. 'powerful care taker to submissive need' or 'contemptuous to contemptible').

Examples are given in Figure 2.3 of coping mode, interpersonal and symptomatic procedures plotted in this way.

Splitting: multiple self-states

Subjectively we are all aware of having different facets or sub-personalities but these are not unduly dissonant and we can usually mobilise the version of the self appropriate to the situation. In neurotic patients, such as have been discussed above, the main problem is one of an exaggeration or elimination of aspects of the range of procedures; e.g. no access to anger or only conditional self-acceptance. In more disturbed people showing a borderline personality structure there are usually two related problems: first the operation of more extreme procedures, and secondly the emergence of strongly contrasted alternative versions of the self. A common structure found in such people is summarised in the 'broken egg' diagram (Figure 2.4).

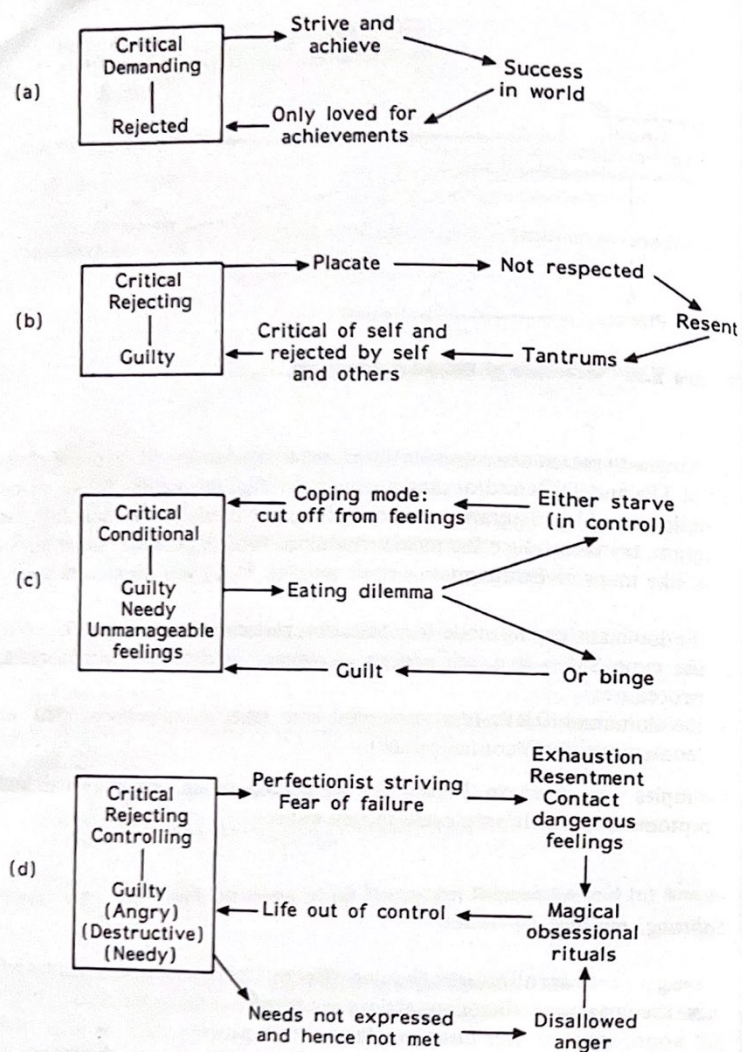

Figure 2.3: Examples of procedures: (a) coping mode, (b) interpersonal, (c) and (d) symptomatic

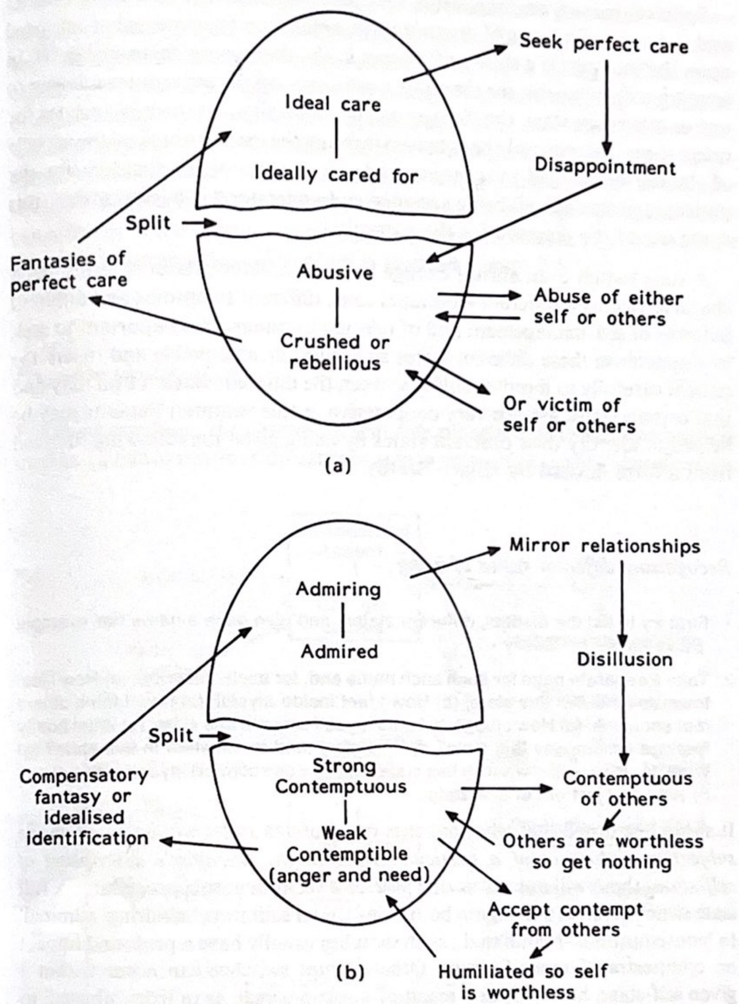

Figure 2.4: Examples of (a) borderline personality, and (b) narcissistic personality

Splits of this sort are manifest in very polarised experiences and behaviours and in a subjective sense of discontinuity which may be witnessed or imposed upon the therapist if a state shift occurs in the therapeutic relationship. If, in treating such a patient, the therapist works only on the procedures relating to one or other core state, the therapy will be ineffective, for the basic need is for integration. This can only be achieved through the experience of all the aspects of the self being held in awareness (this is the use of the diagram for the patient) and through all being accepted and understood in a relationship (this is the use of the diagram for the therapist).

A state switch is an abrupt change between different states of being, each characterised by a different emotional tone, different symptoms and different patterns of self-management and of relating to others. It is important to seek to characterise these different states as accurately as possible and to ask the patient carefully to monitor shifts between the different states. (You may find that certain states are not very cooperative in this venture!) Patients may be helped to identify their different states by being given the following (derived from a form devised by Hilary Beard):

Recognising different states of being

1. First try to list the distinct, different states, and give each a name (for example 'Sulky Linda' or 'Bossy').
2. Take a separate page for each such name and, for each, describe: (a) How I feel towards others in this state; (b) How I feel inside myself; (c) How I think others feel about me; (d) How I judge or value myself when in this state; (e) What bodily feelings accompany this state? (f) What do I tend to do when in this state? (g) What do I try to avoid when in this state? (h) How do I comfort myself in this state? (i) How do I get out of this state?

It should be noted that what patients recognise as *states will be based on the subjective experience of a particular role. In the therapist's description of self-states* these will appear as one pole of a reciprocal role procedure. A full state switch involves a change in both poles, as in a shift from 'admiring–admired' to 'contemptuous–humiliated'; such switches usually have a profound impact on countertransference feelings. Other abrupt switches can occur within a given self-state, however, as a result of a role reversal, as in from 'abused' to 'abusing', or representing a change between alternative responses to a stably perceived reciprocal role, for example from 'compliant' to 'defiant' in relation to another seen as 'domineering'. The identification of separate self-states in terms of their reciprocal role repertoire is essential.

Once such states are defined, the transitions between them deserve particular attention, that is to say the sequential diagram must indicate state sequences

as well as procedural sequences. Some of the procedures generated from one state can be seen to lead to a state shift, as in the broken-egg diagram. In many borderline patients a number of separate self-states can be identified. Commonly a main state reflects early experience, for example: 'Abusive contempt–humilated or rebellious'. Other patterns encountered are: 'ideal care–ideally cared for'; 'Emotionally blank zombie–unavailable or rejecting'; 'Unfeeling overactivity–threatening or critical'. But it is essential to work with the patient to describe the individual range. Remember that patients can enact either pole, and hence can attempt to elicit either reciprocal role (action, feeling) in you. An example of a Self State Sequential Diagram is given in Figure 2.5.

Projective identification

For some purposes, the core reciprocal role repertoire may be more usefully used as a guide to relationship patterns seen in terms of projective identification;

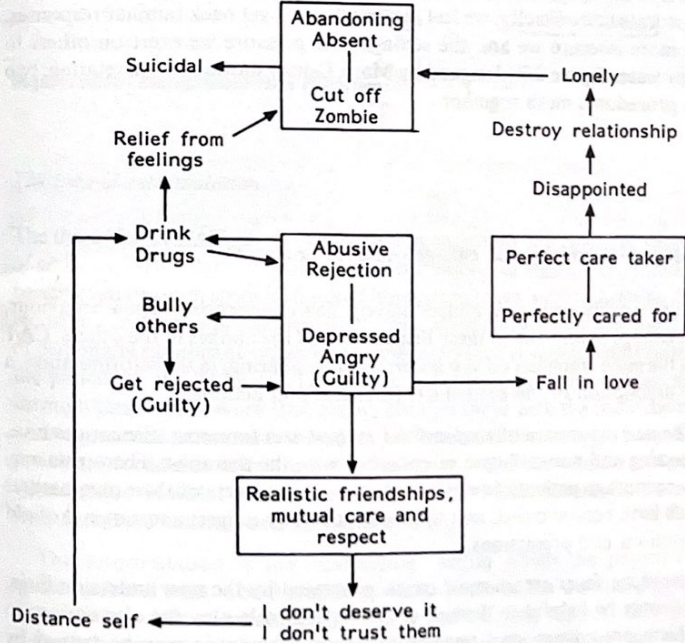

Figure 2.5: Diagram showing four core states

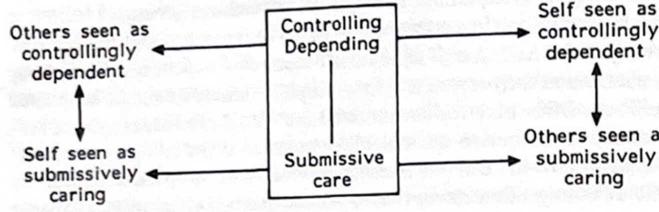

Figure 2.6: Diagram of core repertoire indicating two patterns of projective identification

i.e. by demonstrating the way in which the various roles may be allocated to important others. The projected roles of a core state described as inner parent–inner child reciprocal roles are shown in Figure 2.6. This may be a helpful way of anticipating countertransference.

Any interaction between two people involves the 'meshing' of two matching RRPs. If the match is imperfect there will be some pressure on the other to reciprocate more exactly: we feel secure when we get back familiar responses. The more insecure we are, the stronger the pressure we exert on others to reciprocate. Figure 2.7 (designed by Mark Dunn) shows how, in relating, two role procedures mesh together.

Sessions 5–16: therapeutic change—general principles

Change is achieved by new understanding, new experience and new behaviour, with change in any one of these being reflected in changes in the others. CAT puts the main emphasis on *new understanding*, offering, in the reformulation, a new description of the patient's experiences and actions.

The *new experience* offered in CAT is, first and foremost, the cooperative, respecting and non-collusive relationship with the therapist. Therapists may also encourage patients to explore situations or aspects of their own natures which have been avoided, and will more generally suggest a testing out of old restrictions and predictions.

New behaviours are, in most cases, generated by the new understandings, but it may be helpful to discuss or rehearse in role play the alternatives to problem procedures, and revising avoidant behaviours may be helped by working out a formal programme of graded exposure.

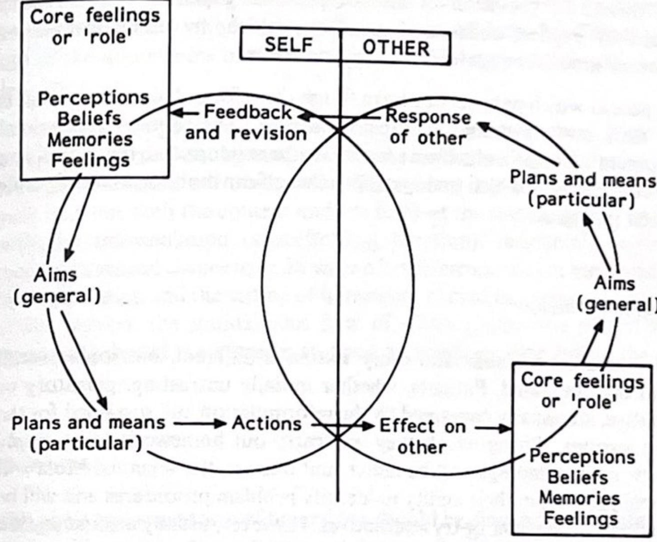

Figure 2.7: Reciprocal role diagram

The uses of reformulation

The three 'Rs' of CAT are reformulation, recognition and revision, and much of sessions 5–16 will be concerned with the second of these. Recognition will be achieved through specific, focused homework tasks, such as keeping diaries recording particular procedures (e.g. a placation diary) or by keeping a diary of personally significant events or experiences which is subsequently linked by the patient to the TPPs or SDR. Some patients can achieve change simply through this kind of work, but many, notably those with the more disturbed and fragmented personality disorders, will need the therapist to recognise the problem procedures as they occur in the room, when they can be named and where collusion with them can be avoided or quickly corrected. Collusion can lead to missed sessions and premature termination.

The reformulation is the 'scaffolding' within which the patient's new construction is built. The therapist leaves as much of the work as possible to the patient, while maintaining the shape and offering support through the reformulation and the relationship. Here, as earlier, there is no conflict between the 'cognitive' and 'analytic' aspects of the task, for both are involved

in the therapist's provision of an interpersonal experience, guided and described by explicit understandings, from which, by internalisation as competence grows, intrapsychic change is achieved.

The pace at which patients can learn to use the reformulation varies (but is faster than most dynamic therapists believe). The 'zone of proximal development', in respect of self-awareness, is often extensive, so the acquisition of new concepts with which to think about the self can mobilise a considerable untapped potential.

The course of therapy

No two therapies are alike and every session is different, but some overall patterns may be noted. Patients, whether initially untrusting, placatory or cooperative, are usually contained by the reformulation and sustained for the ensuing sessions, during which they will carry out homework tasks, apply their new understandings and be active and open in the sessions. Most will make real progress in their ability to identify problem procedures and will be able to begin to consider or try alternatives. However, usually around session 10–12, the approach of termination, inevitable shortcomings on the part of the therapist and the realisation that only so much has been achieved lead to a shift in mood and attitude and to the mobilisation of negative procedures. This may be presented in straightforward criticism, but will more often take the form of more subtle changes in atmosphere and of indirect or non-verbal messages. Their emergence will have been anticipated in the reformulation but this will not prevent the occurrence of covert countertransference collusion (e.g. maintaining a falsely positive idealised relationship, or by not acknowledging but conveying counter-hostility). The worst outcome is a missed session or a premature termination, the best is the subtle but insistent use of the reformulation to describe, in non-judgemental terms, what has happened. In the latter case a return to a basically positive but more realistic relationship will follow, and the return of negative feelings at termination can usually be accommodated in the same way. It is always important to note and permit or anticipate negative feelings at termination.

Some specific tasks and issues

Reviewing and rating progress—the Rating Sheet

The revised rating sheet now in use allows progress in *recognition* of TPPs to be rated in the early stages, with rating of *revision* following once this is secure.

When therapy is conducted in relation to the SDR, ratings can be made of the frequency/intensity with which problem procedural loops have been followed and of the occurrences of negative state shifts where multiple self-states are described.

There are two good reasons for carrying out ratings at every session. The first is that, carried out by the patient in discussion with the therapist, it is an exercise in accurate self-observation. The second is that it offers a chance to look back on both the content and the form of the session and to link these with the reformulation (a scaffolding function), incidentally giving the therapist a second chance to make sense of transference and countertransference feelings. Rating and the setting of homework should be carried out at the end of the session, the spontaneous flow of which (unless the patient is very distressed) should therefore be stopped an adequate time before the end.

Homework

The point and exact form of homework should be discussed with patients and the results, or the patient's non-completion, should always be considered at the next session. The main focus of homework in the first four sessions will have been on mood shifts, symptoms, behaviours; after reformulation the main focus will be on the recognition of problem procedures in everyday life.

Making procedural links in the session

A large proportion of what patients bring to the session in the form of memories, stories or dreams will turn out to be illustrations of their main procedures, and sooner or later most of their problem procedures will be manifest in the therapy relationship, either in behaviours such as lateness, disarming chat, direct anger or criticism, discounting what has been done and failures to do agreed homework, or in covert shifts in mood, conveyed indirectly and non-verbally. These may affect a whole session or set of sessions or they may emerge as a 'state shift' in the course of the session. The recognition of these transference manifestations may not be instantly possible and sometimes the pattern is only apparent in retrospect at the end of the session or after the session (or in supervision). Whenever recognised, all such links need to be discussed.

Making such links is a subtle task. I would like to acknowledge the work of Dawn Bennett in developing the following 'ideal' account of the stages:

1. The therapist acknowledges the expressed feelings of the patient or describes his/her sense of the feelings.
2. The nature of what is felt is explored and clarified in an open way.
3. The therapist invites the patient to link the feelings with the reformulation, or proposes how they might be linked. This may be amplified by linking the episode to earlier examples in the therapy, to relationships with others or with the childhood memories, *but the link with the reformulation will be the main focus*.
4. In the earlier stages, the patient's acceptance that a link exists needs to be amplified. Doubts and objections must be explored (*negotiation*), a resolved agreement reached (*consensus*) and the relation of the identified procedure to the whole reformulation, or to the SDR core procedural repertoire, should be established (*extension*).
5. Once recognition is achieved, alternatives to the identified procedure, already exemplified by the collaborative work, can be further explored through discussion, role play and so on, and this may lead to the identification of 'exits' from the current pattern.

Stagnation

Sometimes therapies which seem to go well lose their momentum; understandings are not translated into felt experiences or into new actions. At such a moment a review of the course of the therapy should be carried out, looking for possible collusive countertransference avoidance of difficult feelings and considering how far the history, for example of incomplete mournings or of unmanageable trauma, may indicate the need for a direct search for missing affects. The therapist may offer a safety within which the lost feelings can be explored or a relationship which can serve as a metaphor for the unresolved past (notably, termination serves this purpose in unmourned loss). In other cases possible ways of making feelings bearable can be discussed. Exploratory writing to the unmourned dead or confronting the abuser in imagination or through writing and other imagery can be helpful. Some ritual marking of the completion of the process may be suggested. These patients can evoke powerful countertransference feelings, as the therapist feels the feelings the patient cannot bear, and this may enable the load to be shared. In general, patients will only go as far as they can bear to go, and may be encouraged to explore, but, especially where major trauma or abuse have occurred, the therapist must be sensitive to the patient's ability to face their feelings and should never force the pace. Even in the absence of major loss or trauma some patients have great difficulty in translating their new understanding into new behaviour, either in the world of daily life or in the room with the therapist. Therapists will need to call upon a range of techniques to achieve movement,

including 'shaking the transference tree', the explicit naming of countertransference, the use of role play or empty chair techniques or other non-verbal techniques. Some patients in this category may achieve useful understanding but little change from CAT; reviewing them at follow-up may show further change, but for others referral to alternative treatment to complete the work is appropriate; for example art therapy, psychodrama or group therapy may be indicated.

Difficult transference

Transference feelings can be difficult to deal with when they are very intense, when major dependency needs are expressed in a sexualised way, when feelings seem to be of a delusory intensity without evident awareness of their inappropriateness, and/or when they are aimed too unerringly at the therapist's countertransference vulnerabilities. To be able to contain such transference feelings in relative calmness and to show their relationship to central problem procedures is very therapeutic, but not easy. Any therapist faced with a very intense transference or aware of his or her unusual vulnerability to or preoccupation with a patient or noticing departures from the normal rules and limits of therapeutic practice should seek supervision urgently.

Termination and the goodbye letter

Therapy is often a profound and moving experience for both therapist and patient and termination is never easy. Nonetheless, in a time-framed therapy like CAT, there are very few indications for changing the contract. The fact of termination should be kept in awareness throughout the therapy by naming the number of each session, but its reality can still be experienced by patients as a desertion or betrayal. Such feelings may be expressed, but more often they are hidden or only hinted at. Failure to allow and deal with them lessens the chance of therapy being mourned in a way allowing the internalisation of a real but incomplete experience.

The goodbye letter from the therapist is a means of offering a realistic estimation of the changes achieved and of the work remaining; it should be accurate, linked with specific evidence, and should be discussed with the patient. The patient's goodbye letter is similarly an experience of self-evaluation. The therapist's letter should also name or predict the element of disappointment, sadness or anger, while at the same time 'permitting' the patient to take away a realistic memory of the therapist and a clear account of the understandings reached; in brief therapy the patient must continue to be a therapist to him or

herself, and an ongoing internal conversation with the therapist should be encouraged. The period between termination and follow-up is an important one, in which it becomes clear how far the understandings have been taken on board, and decisions about the need for further follow-up, more CAT or other treatments are best left until this time, which is usually after three months. In cases evoking particular anxiety, a shorter interval or spaced sessions may be helpful without depriving the patient of the experience of termination.

The follow-up session

Anticipation of the follow-up can assist some patients to deal with termination and learn how much they have taken away from therapy. Quite a large proportion, however, do not attend, as much in cases that seemed to have gone well as in those with problems. This may reflect inadequate attention being paid to negative feelings at termination. For the therapist, it is an important opportunity to review the work of the therapy, free from the 'hello–goodbye' effects present at termination.

The semi-structured post-therapy interview used at Guy's CAT clinic is a good model for obtaining a reasonably accurate impression. Each of the presenting problems described in the reformulation and referral letter is discussed in turn, with detailed examples of any changes being elicited. In the course of this some patients will refer to their reformulation, but in all cases the details of the TPPs or SDR should be enquired after, both to see how far they are accurately remembered and/or are still being consulted, and also to seek evidence, in detail, as to whether they have been revised. Any new problem or important life event should also be discussed. On the basis of this interview the therapist should rate change and also ask the patient to give an overall rating for changes (a) in the problems and (b) for procedural change, on five-point scales (much better, better, unchanged, worse, much worse). General comments on the therapy may also be invited, and the patient should be asked if they feel they need further treatment.

Patients with residual difficulties who are still working with the therapy tools may be reviewed at a second follow-up, or may be helped with two or three 'top-up' sessions. Patients who have made good use of CAT in terms of understanding but whose access to feeling or ability to relate differently on the basis of their new understandings is little changed may be referred for group therapy (CAT allows little 'working through' time and some patients are socially too isolated to be able to apply the lessons of therapy in ongoing relationships) or to some other mode. If long-term individual therapy is available, some patients will be suitable for this. Patients who have made no

real progress or who are worse should be reassessed, preferably by the team or individual who recommended them for therapy initially.

Psychometric testing

Apart from its research use, psychological testing before and after therapy has much to recommend it. The limitations of such tests are, of course, well known, but they remain of value (a) in indicating, crudely, the severity and type of difficulty of the patient group treated, and (b) in giving measures of change. The current battery of tests in use at Guy's CAT clinic consists of (i) the Beck Depression Inventory—BDI (Beck et al., 1961), (ii) the Symptom Check List—SCL 90/4 (Derogatis, Lipman and Covi, 1973), and (iii) the Inventory of Interpersonal Problems—IIP (Horowitz et al., 1988). The SCL 90/4 samples a range of symptoms, and discussing the highly scored items with the patient may amplify the history. The IIP's individual items are often worth discussing at the reformulation stage and the overall score gives an indication of the level of interpersonal difficulty and distress. Failure of elevated scores on these questionnaires to fall in the course of therapy strongly suggests an unsuccessful therapy, but it is also the case that scores can fall without all the issues being resolved. In institutional settings the audit of therapy services would normally need to include some psychometric tests.

Of other paper-and-pencil tests. Repertory grid testing, used extensively in CAT in relation to research (see Chapter 10), may also have clinical applications, and with the widespread availability of computers is quite within the reach of the interested therapist.

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Appendix 2.1 The Psychotherapy File—An aid to understanding ourselves better

We have all had just one life and what has happened to us, and the sense we made of this colours the way we seen ourselves and others. How we see things is for us, how things are, and how we go about our lives seems 'obvious and right'. Sometimes, however, our familiar ways of understanding and acting can be the source of our problems. In order to solve out difficulties we may need to learn to recognise how what we do makes things worse. We can then work out new ways of thinking and acting.

These pages are intended to suggest ways of thinking about what you do; Recognising your particular patterns is the first step in learning to gain more control and happiness in your life.

Keeping a diary of your moods and behaviour

Symptoms, bad moods, unwanted thoughts or behaviours that come and go can be better understood and controlled if you learn to notice when they happen and what starts them off.

If you have a particular symptom or problem of this sort, start keeping a diary. The diary should be focused on a particular mood, symptom or behaviour, and should be kept every day if possible. Try to record this sequence:

1. How you were feeling about yourself and others and the world *before* the problem came on.
2. Any external event, or any thought or image in your mind, that was going on when the trouble started, or what seemed to start it off.
3. Once the trouble started, what were the thoughts, images or feelings you experienced.

By noticing and writing down in this way what you do and think at these times, you will learn to recognise—and eventually have more control over—how you act and think at the time. It is often the case that bad feelings like resentment, depression or physical symptoms are the result of ways of thinking and acting that are unhelpful. Diary-keeping in this way gives you the chance to learn better ways of dealing with things.

It is helpful to keep a daily record for 1–2 weeks, then to discuss what you have recorded with your therapist or counsellor.

Patterns that do not work, but are hard to break

There are certain ways of thinking and acting that do not achieve what we want, but which are hard to change. Read through the lists on the following pages and mark how far you think they apply to you.

Applies strongly + +   Applies +   Does not apply 0

TRAPS

Traps are things we cannot escape from. Certain kinds of thinking and acting result in a 'vicious circle' when, however hard we try, things seem to get worse instead of better. Trying to deal with feeling bad about ourselves, we think and act in ways that tend to confirm our badness.

Examples of Traps

1. Fear of hurting others Trap

Feeling fearful of hurting others* we keep our feelings inside, or put our own needs aside. This tends to allow other people to ignore or abuse us in various ways, which then leads to our feeling, or being, childishly angry. When we see ourselves behaving like this, it confirms our belief that we shouldn't be aggressive and reinforces our avoidance of standing up for our rights.

++	+	0

**People often get trapped in this way because they mix up aggression and assertion. Mostly, being assertive—asking for our rights— is perfectly acceptable. People who do not respect our rights as human beings must either be stood up to or avoided.*

2. Depressed thinking Trap

Feeling depressed, we are sure we will manage a task or social situation badly. Being depressed, we are probably not as effective as we can be, and the depression leads us to exaggerate how badly we handled things. This makes us feel more depressed about ourselves.

++	+	0

3. Trying to please Trap

Feeling uncertain about ourselves and anxious not to upset others, we try to please people by doing what they seem to want. As a result (1) we end up being taken advantage of by others which makes us angry, depressed or guilty, from which our uncertainty about ourselves is confirmed; or (2) sometimes we feel out of control because of the need to please, and start hiding away, putting things off, letting people down, which makes other people angry with us and increases our uncertainty.

++	+	0

4. Avoidance Trap

We feel ineffective and anxious about certain situations, such as crowded streets, open spaces, social gatherings. We try to go back into these situations, but feel even more anxiety. Avoiding them makes us feel better, so we stop trying. However, by constantly avoiding situations our lives are limited and we come to feel increasingly ineffective and anxious.

++	+	0

5. Social isolation Trap

Feeling under-confident about ourselves and anxious not to upset others, we worry that others will find us boring or stupid, so we don't look at people or respond to friendliness. People then see us as unfriendly, so we become more isolated from which we are convinced we are boring and stupid—and become more under-confident.

++	+	0

6. Low self-esteem Trap

Feeling worthless, we feel that we cannot get what we want because (a) we will be punished, (b) others will reject or abandon us, or (c) as if anything good we get is bound to go away or turn sour. Sometimes it feels as if we must punish ourselves for being weak. From this we feel that everything is hopeless, so we give up trying to do anthing—which confirms and increases our sense of worthlessness.

++	+	0

DILEMMAS (False choices and narrow options)

We often act as we do, even when we are not completely happy with it, because the only other ways we can imagine, seem as bad or even worse. Sometimes we assume connections that are not necessarily the case—as in 'if I do *x* then *y* will follow'. These *false choices* can be described as either/or or if/then *dilemmas*. We often don't realise that we see things like this, but we act as if these were the only possible choices.

Do you act as if any of the following false choices rule your life? Recognising them is the first step to changing them.

Choices about myself
I act AS IF:

1. Either I keep feelings bottled up or I risk being rejected, hurting others, or making a mess. [++ | + | 0]
2. Either I feel I spoil myself and am greedy or I deny myself things and punish myself and feel miserable. [++ | + | 0]
3. If I try to be perfect, I feel depressed and angry: If I don't try to be perfect, I feel guilty, angry and dissatisfied. [++ | + | 0]
4. If I must then I won't; it is as if when faced with a task I must either gloomily submit or passively resist (other people's wishes, or even my own feel too demanding, so I put things off, avoid them). [++ | + | 0]
5. If I must not then I will; it is as if the only proof of my existence is my resistance (other people's rules, or even my own feel too restricting, so I break rules and do things which are harmful to me). [++ | + | 0]
6. If other people aren't expecting me to do things, look after them etc., then I feel anxious, lonely and out of control. [++ | + | 0]
7. If I get what I want I feel childish and guilty; If I don't get what I want, I feel frustrated, angry and depressed. [++ | + | 0]
8. Either I keep things (feelings, plans) in perfect order, or I fear a terrible mess. [++ | + | 0]

Choices about how we relate to others
I behave with others AS IF:

	++	+	0
1. Either I'm involved with someone and likely to get hurt, or I don't get involved and stay in charge, but remain lonely.			
2. Either I stick up for myself and nobody likes me, or I give in and get put on by others and feel cross and hurt.			
3. I'm either a brute or a martyr (secretly blaming the other).			
4. (a) With others either I'm safely wrapped up in bliss or in combat.			
(b) If in combat, then I'm either a bully or a victim.			
5. Either I look down on other people, or I feel they look down on me.			
6. (a) Either I'm sustained by the admiration of others whom I admire, or I feel exposed.			
(b) If exposed, then I feel either contemptuous of others or I feel contemptible.			
7. Either I'm involved with others and feel engulfed, taken over or smothered, or I stay safe and uninvolved but feel lonely and isolated.			
8. When I'm involved with someone whom I care about, then either I have to give in or they have to give in.			
9. When I'm involved with someone whom I depend on, then either I have to give in or they have to give in.			
10. As a women, either I have to do what others want or I stand up for my rights and get rejected.			
11. As a man, either I can't have any feelings or I am an emotional mess.			

SNAGS

Snags are what is happening when we say 'I want to have a better life, or I want to change my behaviour but . . .'. Sometimes this comes from how we or our families thought about us when we were young; such as 'She was always the good child', or 'In our family we never . . .'. Sometimes the snags come from the important people in our lives not wanting us to change, or not able to cope with what our changing means to them. Often the resistance is more indirect, as when a parent, husband or wife becomes ill or depressed when we begin to get better.

In other cases, we seem to 'arrange' to avoid pleasure or success, or if they come, we have to pay in some way, by depression, or by spoiling things. Often this is because, as children, we came to feel guilty if things went well for us, or felt that we were envied for good lick or success. Sometimes we have come to feel responsible, unreasonably, for things that went wrong in the family, although we may not be aware that this is so. It is helpful to learn to recognise how this sort of pattern is stopping you getting on with your life, for only then can you learn to accept your right to a better life and begin to claim it.

You may get quite depressed when you begin to realise how often you stop your life being happier and more fulfilled. It is important to remember that it's not being stupid or bad, but rather that:

1. We do these things because this is the way be learned to manage best when we were younger.
2. We don't have to keep on doing the now we are learning to recognise them.
3. By changing our behaviour, we can learn not only to control our own behaviour, but also how to change the way other people behave to us.
4. Although it may seem that others resist the changes we want for ourselves (for example, our parents, or our partners), we often under-estimate them. If we are firm about our right to change, those who case for us will usually accept the change.

Do you recognise that you feel limited in your life:

	++	+	0
1. For fear of the response of others? (for example, success *as if* it deprives others, *as if* others may envy me, or *as if* there are not enough good things to go around.)			
2. By something inside yourself? (For example, I must sabotage good things *as if* I don't deserve them.)			

DIFFICULT AND UNSTABLE STATES OF MIND

Some people find it difficult to keep control over their behaviour and experience because things feel very difficult and different at times. Indicate which, if to blank them off and feel emotionally distant from others.

	++	+	0
1. How I feel about myself and others can be unstable; I can switch from one state of mind to a completely different one.			
2. Some states may be accompanied by intense, extreme and uncontrollable emotions.			
3. Other states may be accompanied by emotional blankness, feeling unreal, or feelng muddled.			
4. Some states are accompanied by feeling intensely guilty or angry with myself, wanting to hurt myself.			
5. Other states are accompanied by feeling that others can't be trusted, are going to let me down, or hurt me.			
6. Yet other states are accompanied by being unreasonably angry or hurtful to others.			
7. Sometimes the only way to cope with some confusing feelings is to blank them off and feel emotionally distant from others.			

Appendix 2.2 The Rating Sheet

Patient's name:

Therapist's name:

Date:

TP
Target Problem:

TPP
Target Problem Procedure

		S4	S5	S6	S7	S8	S9	S10	S11	S12	S13	S14	S15	S16	f-up
A RECOGNITION Rate how skilled and quick you are at seeing the pattern	more														
	same														
	less														
B STOPPING AND REVISING Rate how far you are able to stop the pattern and/or replace it with a better way	more														
	same														
	less														

AIM
Alternatives or exits: