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4 Treating eating disorders using CAT: two case examples

Francesca Denman

This chapter recounts the experiences of a group of therapists at a major psychiatric hospital who have been treating patients presenting with severe eating disorders, using Cognitive Analytic Therapy (CAT). Two patients who had different presentations and underlying target problem procedures (TPPs) are discussed. The cases illustrate the range of difficulties encountered by CAT therapists in managing the different presentations.

Background

Eating disorders are now a relatively common problem in psychotherapeutic practice, but no approach to treatment has gained clear pre-eminence. These patients can be among the most challenging to treat and their symptoms can be of life-threatening proportions. CAT was thought a possible approach to try because, while both psychodynamic and cognitive–behavioural approaches appear to have something to offer, they also both present distinctive difficulties. CAT, insofar as it integrates both these approaches, might be able to offset the weaknesses of one approach against the strengths of the other.

Cognitive–behavioural treatments seemed to be good at achieving symptomatic improvements in some patients but frequently appeared to leave emotional issues untouched. Furthermore, things could go wrong in these treatments because the therapist could be seen by patients as a coercive parent and was, in consequence, liable to reproduce some common aspects of their

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family background. On the other hand, psychodynamic treatments addressed emotional and motivational issues well but frequently symptoms did not improve and therapists could appear uninterested in the acutal physical deterioration of their patients.

CAT combines insights from psychodynamic therapy (particularly object relations theory) with techniques and insights from cognitive therapy. It achieves this combination by using a distinct theory of human behaviour, thought and feeling called the Procedural Sequence Model (PSM) (see Ryle, 1990 and Leiman, 1992). Normal goal-directed behaviour and pathology are discussed in terms of procedural sequences, and therapeutic efforts are directed to altering maladaptive procedures in a beneficial direction. CAT neglects neither behaviour nor emotions nor thought; rather, all three are incorporated within the procedural concept.

The context in which the two cases described below were treated was of a specialist treatment centre which takes tertiary referrals from around the country. In consequence patients tended to be at the more severely unwell end of the spectrum of eating disorders, and many had to travel a considerable distance for their therapy sessions. The unit has both outpatient and inpatient services and this is well known to most patients. As a result some patients may be thought by their therapists to be angling for admission, while others whose weight loss or electrolyte levels become medically threatening may be considered to need admission rather than continuing outpatient treatment.

The therapists on the unit were all experienced in managing eating-disordered patients. As therapists they mainly had experience of using cognitive and behavioural interventions. They were all in the process of learning how to use CAT, but none was a complete beginner and none had fewer than three previous CAT cases. CAT was regularly supervised by a relatively experienced CAT supervisor (C.D.) at weekly intervals in a small supervision group of three or four members.

Because of their sensitive nature, these cases have been extensively disguised. Both patients were female.

CASE 1: Severe anorexia

N's anorexia had started gradually two years before referral, following an illness which involved vomiting and weight loss and a visit to an aunt with anorexia who had told N how terrible she looked. N had also suffered a series of losses in the years leading up to her illness. Her brother and current lover had been killed in a car crash some years previously. Then N had an abortion which she had concealed from everyone except her GP. More recently her best friend had died and she had herself been involved in a serious car crash. N's anorexia was now very severe.

She had been treated locally by psychiatric services and then by the local eating disorders unit, to no avail, and was now referred to the unit. N was severely under-weight. She starved herself rigorously, and although she did not binge or induce vomiting she was often spontaneously sick after eating.

N's relationship with her parents was complex. Her parents' marriage was strained and at times it seemed that they were on the point of separating. N's mother would frequently give up work to look after N, watching her eating and ensuring she could not vomit after meals. N complained bitterly about being chaperoned in this way, but covertly she colluded in her mother's over-concern by losing weight sharply whenever her mother was not present. At a family meeting before therapy, N's mother alternated between an adult but over-concerned mode of relating to her daughter and a complicit, giggly, childish one—leaning over and whispering to N that things would be all right. Her father, while more realistic about the seriousness of the situation, limited his involvement to practical help and declined emotional involvement. It is also possible that he drank rather too much.

At work N was under-achieving. She felt put upon by her boss but was unable to confront him. Often she would agree to perform tasks she knew she would be unable to complete in time because she could not bear to say No. Her subsequent failures to deliver were then held against her. N kept her eating disorder a secret at work and this often precluded her from attending or enjoying office functions of various sorts. N's social life was also restricted in other ways. She had had a variety of short-lived relationships with men which left her feeling 'picked up and put down'.

The therapy

N found it difficult to address psychological issues. If she did address them, she showed a remarkable capacity to dissociate. For example, one week she discussed the death of her brother and became upset and terrified by the force of her feelings, but this seeming breakthrough was entirely negated the following week when she said she did not remember the content of the previous session. N restricted her involvement in therapy. She was invariably late for sessions and often doodled during them. If she was challenged about her lack of progress and involvement in the therapy she would blandly promise to get better by next week!

N's therapist felt a number of things towards her patient. She sometimes felt confused, as though she had not got a grip on the case; or she could feel practical and technical, advising N but also subtly minimising the extremity of N's misery and distress. At other times the therapist felt as though her patient was 'quite a little madam' and wanted to shake her, feeling contemptuous and thinking of her as a weak, silly and spoiled girl.

In therapy the therapist's understanding of N's story was embodied in a diagram (Figure 4.1) which was discussed with N.

N was able to see that the diagram might apply to her and she did then begin

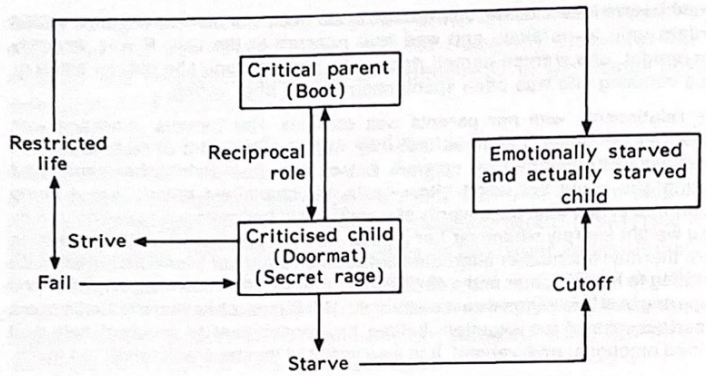

Figure 4.1: The SDR of 'N'

to make some modest gains in weight. However her progress was limited. At the end of therapy, the therapist suggested in her goodbye letter that N might be feeling 'picked up and put down' in a therapy which had not got to the heart of things, just as she sometimes felt in relationships with men. Importantly, N was, at that point, able to say that she had hoped that her case would be serious enough to warrant admission to the inpatient unit and that she had felt that outpatient treatment had belittled the severity of her condition and, in some way, branded her as making a fuss. N and her therapist then became aware of the dynamic force of N's split off, longing for perfect care and her need to avoid the repeated disappointment of that need, even at the cost of forfeiting success.

Follow-up

N subsequently had a period of treatment on the inpatient unit and gained weight rather well at that point. While her CAT therapy was not successful in helping her to gain weight, it did begin a process of psychological awareness which allowed her to use inpatient admission in a way which would probably not have been possible before therapy.

Comment

N is typical of one group of patients who present to the eating disorders unit and who have the anorexic picture of low weight and low body mass index.

They may also have some bingeing or vomiting behaviours but these are not severe. Psychologically the most prominent features are restriction of psychic life because of an evident terror of, or need to avoid, emotions; perfectionistic striving; and a reciprocal role procedure of 'perfectly self-denying care giver (doormat) to perfectionistic luxuriating and demanding recipient (boot)'.

The extreme restriction of psychic life is accompanied by a major lack of psychological mindedness and this presents a considerable obstacle to a psychologically based therapy. The typical feel which these patients give to their therapist is one of 'heavy going'; every gain seems achieved only after trudging for some time through an arid desert. The way that CAT approaches these cases is to try to identify the procedures by which emotionality is avoided, restricted and denied. CAT aims to describe these procedures in relation to the childhood atmosphere in which they were fashioned. It tries to show how the procedures were originally an adaptive attempt to cope with an emotionally difficult or overwhelming situation, but now have become restrictive, and inapplicable. The therapist tries to make plain the 'as if' nature of assumptions that emotions cannot be dealt with in a supportive atmosphere, which may in itself help to contradict those assumptions.

It is important to gain an understanding of the procedures which result in requests for more therapy of various sorts. If further therapy is sought only because of the failure of the current approach, then progress is unlikely. This is because complaints by the patient that they are starving need to be met (gently) with a demonstration of the fact that they have been starving themselves, rather than with the provision of more food which they can refuse. While effective self-starving continues it does not really matter how much more food or therapy is offered. However, sometimes further therapy is sought as a result of a new insight. This was the case with N and in such cases there may be progress. This is especially likely if the new insight includes greater awareness of the fact of, and reason for, emotional and physical self-starving.

CASE 2: Bulimia nervosa with an unintegrated personality

J was living in the house of one of her previous therapists, and concurrently with her CAT she was receiving acupuncture, herbal remedies and long-term psychodynamic psychotherapy. She was still under the care of a psychiatrist who had referred her to the eating disorders unit because she was complaining to him that the treatment offered to her by his unit was not making her better. J's long-term psychotherapist was represented by her as being keen for her to receive help for her eating disorder so that he could get on with other aspects of her therapy. The ex-therapist with whom J was cohabiting had taken her into his house in order to help J with her eating disorder. However, J said that her ex-therapist did not know

that she was still bingeing and vomiting about three times a day. As a result she kept secret her CAT sessions at the eating disorders unit. Unfortunately this meant that periodically J had to cancel her CAT sessions in order to take her ex-therapist, who was himself chronically unwell, to hospital for treatment of one sort or another.

The therapy

Understandably J's CAT therapist was extremely unclear what sort of help she could offer. She felt overwhelmed by the amazing variety of care givers in J's world, and was by no means entirely sure if it would be wise to add to them. J's therapist felt, in her own countertransference towards J, an uncharacteristic urge to slap J and bring her to her senses. This urge was provoked by the contrast between (a) J's repeated avowal that CAT therapy was the best thing she had ever had and surely doing her huge amounts of good, and (b) her lack of tangible progress, her failure to do any of the assigned out-of-session tasks, and her habit of cancelling sessions. In addition to J's therapist's countertransference, the supervision group and supervisor had a further countertransference towards J which would best be described as impotent curiosity in relation to J's platonic but rather irregular relationship with her previous therapist.

J did not initially talk much about her family background, and so reformulation at session 4 was completed without details of her past life. The therapist was, however, amply provided with direct experience of J which allowed the construction of an SDR (see Figure 4.2).

J was, as one might expect, immediately hugely impressed by the diagram, instantly announcing it the most helpful thing she had ever seen. Sadly, though, J contrived to leave the SDR behind in the therapist's office! However J did, after a while, begin to make some changes. She spoke for the first time about her family background, which not surprisingly (because abuse is so common in these patients) contained a story of physical abuse tinged with sadomasochistic sexuality by her middle-class father, and of an uncaring and detached mother who had her own health troubles—which she visited on her daughter.

The SDR, based mainly on countertransference, can be seen to be fairly concordant with J's history. The therapist's countertransference paralleled to some extent the role of the father in relation to the patient, while the patient's adoring transference towards the therapist reflects the wish for an ideal carer. In the supervision group we felt we were in the role of useless watching mother in relation to the role of the previous therapist, who himself partly embodied the roles of abusing father and of sick mother. Other ineffective mothers were scattered around the helping network. J's chief symptomatic procedures issuing from and maintaining this set of states included angry sabotage

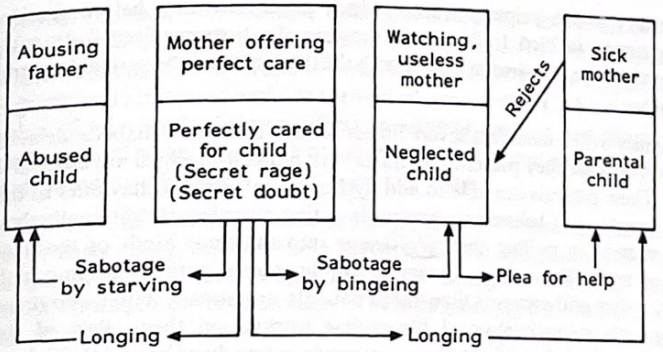

Figure 4.2: The SDR of 'J'

(although the rage was well concealed) of the seemingly good parent, and rapid uncritical acceptance of the food offered by that parent without true assimilation because of the repressed doubt engendered by the unconscious awareness that the good parent was grotesquely over-idealised.

After the second session in which the diagram was used, J did begin to make some changes. The therapist was able to show how accepting the diagram uncritically and then sabotaging it by leaving it behind were actions which the diagram itself could predict. After that session J went home and told her ex-therapist about her continuing bingeing and vomiting. Usefully she received a sensible response which, while not being rejecting, was also not over-involved. J allowed her long-term therapist and her CAT therapist to communicate with one another, so reducing the fragmentation of mother figures which was such an effective part of J's sabotaging behaviour. J also began to take the diagram around with her and was able to think about the way she was living her life using the diagram. Her bingeing and vomiting did decrease (but not stop).

Comment

J's case is fairly typical of a group of patients who have bulimic symptoms and also suffer from marked personality disorganisation, although she is not a particularly severe example. Other cases seen by the unit include patients with severe self-harming behaviour, patients who have made apparently false allegations of sexual abuse against a sequence of therapists, and patients who have features of Münchausen's syndrome. In all such cases the approach taken by the CAT therapist is to emphasise the severe lack of integration in the

personality as the primary feature which needs attention before specific procedures are tackled. In J's case the drawing of a diagram of self-states with a few procedures sketched in helped both the therapist and the patient towards this aim.

Bulimics with concurrent severe illness such as asthma or diabetes deserve mention because they present therapists with difficulties which are especially acute. These patients are able to add dysfunctional illness behaviours to the usual repertoire of behaviours present in eating disorders. Additionally they often succeed in pulling their physicians into the same kinds of loops of coercion and collusion as ordinary eating-disordered patients get into with their families and carers. Often these patients are already bitter about the damage which their physical illness has worked on them. Part of the motivation which drives both their continuing eating disorder and their abuse of medication is an enraged urge to spoil. Because of this, therapy has to take up the work of mourning for the damage already done. Also, the time limit means that limitation must be faced by the therapist (as much as the patient) very early in therapy. Limitation is a useful break on the dynamics of therapeutic omnipotence and despair that can easily infect these cases.

Discussion

Both these cases presented typical problems to their therapists in assessing levels of insight and motivation, and in working out how to increase them. Because therapy is an exercise in which a motivation to change (at least at some level) is a prerequisite, the most important task facing CAT therapists in dealing with these patients is to find some area of motivation and to mobilise it. Therapists also need to identify the reasons why insight is lacking in order to help increase it.

With anorexic patients the level of motivation for treatment is often very low. Young anorexics may have been pushed into therapy by family pressure, and so their motivation for treatment may be bound up in a very literal way with family dynamics which are implicated in the causation of their illness. This may be the reason why family therapy could be the most helpful intervention (Dare et al., 1990). Anorexics lack insight into the practical aspects of their condition, such as realistic weights to attain and body image, but they also lack insight of a more conventional sort in the form of psychological mindedness.

In the successful cases of this kind that were seen at the eating disorders unit, the common feature was the establishment of some kind of joint relationship with the therapist combined with some moves in relation to the

external situation—for example talking in a new way to mother or father. Patients who did well seemed to seize on that aspect of the reformulation which meant most to them and to make it their own in some way. This feature is gratifyingly in accord with the theoretical stress within CAT on the use and value of joint tools (Leiman, 1992) as ways of creating and shaping new psychological meanings, which can then act both as the sources of motivation and as centres of insight.

However, in relation to some of the most severe anorexic patients—and particularly those who combine severe anorexic symptoms with bulimic pathology—CAT, at least as practised at the eating disorders unit, does not, so far, appear to be very successful. These patients appear unable to tolerate the timetable of therapy. They come to some appointments, then cancel several, then promise to turn up, and finally drift away. The writing of either simple reminder letters, or interpretive letters or supportive and encouraging ones, does not help them to return. One feature of at least some of these patients treated unsuccessfully at the eating disorders unit was a combination of distance from the unit and extremely severe life circumstances. One patient had a dying mother, and another patient laboured under the double disadvantage of extreme poverty and employment difficulties.

In such cases an active brief therapy like CAT may be too demanding on the patient, who feels over-stretched; but possibly any therapy conducted at such a distance would have the same unsatisfactory outcome. It is tempting to draw an analogy with the idea of a baby who is too hungry to think and, in consequence, needs a mother to think for it. This analogy in some form lies behind the urge to admit the patient for feeding or to offer more intensive psychotherapy. Such efforts can be successful; but often the problem is that these patients have procedural sequences in place which perpetuate the chronic starvation, which then in turn destroys the capacity to make the mental space needed for the revision of the procedural sequences maintaining the starvation. In keeping with this idea, it is striking that in these severe patients the pressure for admission which characterised some of the anorexics was not there; rather, they just drifted away.

In contrast to the procedural causes which characterise lack of insight in the anorexic group, the lack of insight in multi-impulsive bulimics arises from their lack of personality integration. This gives rise to a range of personality states that are occupied sequentially, each of which lacks to some degree the moderation, complexity and flexibility of a fully integrated self. Consequently in such patients insight and motivation may vary depending on the current state, and because of incomplete access to new learning between states therapists may 'successfully' treat a state only to find their work abolished by a state shift that is precipitated, for example, by the end of therapy. This was the

case with J whose first reaction to and acceptance of the SDR was shallow, and abolished by a state shift as she left the session. Personality integration must precede other interventions. For this reason the treatment of multi-impulsive bulimics with CAT does not differ very much from the treatment of other kinds of patients with unintegrated personalities.

The stress must be on obtaining a reasonably accurate and empathic description of the sequential states occupied by the patient and the reasons for shifts between them. Key pieces of evidence used in delineating these states include the therapist's countertransference experiences, descriptions of encounters with others, and the patient's history. Once the states have been described the patient is encouraged to try to learn how to identify them using a variety of techniques. Clearly such an activity is in itself insight-promoting, and furthermore it is, in the words of one patient, 'off the diagram'. The use of this joint tool and activity contributes (it is to be hoped) to the building up of a new state or situation with a more general overview.

Two central features of CAT are that (a) it is undertaken as a consciously joint exercise by patient and therapist, and (b) it stresses the concept of procedures as units of goal-directed action. The aim of this chapter has been to demonstrate how both these features of CAT work out in the practice of treating patients with eating disorders. A central theme has been to show how CAT's stress on joint activities and on procedural thinking is helpful in work with patients whose motivation and insight are most often ambivalent or lacking.

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5 CAT in groups

Norma Maple and Ian Simpson

As both practising CAT therapists and group analysts, our experience of working with patients within the NHS and in private practice has shown us that brief individual CAT is a very good preparation for longer-term group therapy. Patients who have followed this path tend to stay longer in their groups and have good insight into the psychological mechanisms which lie behind their difficulties. They are more self aware, less likely to act out and can use the richer, interactional dynamic of the group to put into practice learning from the earlier dyadic relationship with their CAT therapist. After an individual CAT and an appropriate gap, a patient can take the opportunity in a group to explore the meanings of their procedures in a dynamic environment where they receive instant feedback. In a long-term group they are also given the opportunity to experiment with new ways of being and thus consolidate new behaviours into more successful interpersonal procedures outside the therapy setting.

This led us to wonder, along with other CAT colleagues, whether there was not a place for even further integration of the models: whether CAT understandings, tools and practice developed successfully in brief individual therapy could be combined with the theory and practice of group analysis into one integrated model. We were aware of some of the common features of both models:

1. a basic psychotherapeutic stance with the objective of providing a safe setting within which troubled individuals are able to explore their difficulties with the help of (an) empathic other(s)

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