Chapter 5

SELECTION AND ASSESSMENT OF PATIENTS FOR INDIVIDUAL CAT

SUMMARY

CAT is applicable to a wide range of disorders of varying severity and in a range of contexts. It is important to undertake a thorough assessment with prospective patients in order to establish the nature of their problems, the presence of any risk factors, and their particular suitability or wish for this form of therapy. The experience of an assessment interview should give patients an impression of the style of CAT and contribute to their motivation and 'psychological mindedness'. In CAT these are not seen as 'all or nothing' phenomena nor prerequisites for therapy but rather as something which therapy may cultivate and expand. Some problems may require other or additional forms of treatment, including pharmacotherapy. There may be reasons not to undertake therapy at a given time due to, for example, active substance abuse, threat of violence or active psychotic disorder. Assessment may be amplified by use of questionnaires such as the Personality Structure Questionnaire (PSQ) as well as, increasingly in the UK, the 'CORE' questionnaire. These issues are illustrated by six brief case presentations.

REFERRAL

CAT offers a general model of psychotherapy applicable to a wide range of diagnoses and severity but each patient needs to be considered in relation to both their disorder and the treatment context. Patients reach psychotherapists by a number of routes and therapists work in a number of settings; the kinds of patients seen in forensic settings, in hospitals or community Mental Health

Centres or in general practice are likely to be of diminishing severity, but severe disturbance will be encountered in all. In some settings there may be a range of therapy options available, in others there will be little choice. In long-established outpatient departments the referrers will have learned which patients are suitable, but there will still be inappropriate referrals. Where psychotherapy is carried out in the more hostile environments offered by some psychiatric departments inappropriate referrals may represent the dumping of difficult cases, usually personality-disordered or somatising patients or examples of the 'treat that if you dare' referral of hopeless cases designed to demonstrate that therapy is useless. Whatever the referral route, therapists have to make their own decisions about which patients to accept for treatment. Therapists working privately and with essentially self-referred patients will need to be particularly alert to the presence of psychiatric illnesses and to the assessment of potential risk from more disturbed patients.

ASSESSMENT DATA

Certain cases may be unsuitable for psychotherapy, at least at the time of assessment. These include those with acute psychotic disorders, active and continuous substance abuse or serious, acute physical disorders. Those individuals who pose an active risk of violence based on either past history or present behaviour should be taken on only with due circumspection and regard for safety. Depending on the context and referral route, a proportion of patients will be unsuitable for psychotherapy and may need to be referred for psychiatric assessment. Therapists should be alert to, and able to identify or refer for a further opinion, conditions such as severe depression (particularly if an individual describes serious self-harm intentions), bipolar affective disorder (manic depression), schizophrenia and delusional/paranoid disorders, early dementia and other organic, especially neurological, disorders which may present as psychological impairment. Many of these disorders may still be amenable to and helped by psychological treatment, but will require particular consideration, caution and usually collaboration with other health professionals. In addition it is always wise for psychotherapists to enquire routinely about drug use, whether illicit or prescribed. Basic teaching on these topics should normally be offered on any psychotherapy training and these conditions are described in any student psychiatric textbook.

In cases suitable for therapy the following questions need to be answered: Is individual, as opposed to group or couple or family therapy, indicated? Are there contraindications (possibly amenable to prior treatment) in the form of psychiatric illness or substance abuse? Are the patient's current social and personal situations sufficiently stable to allow therapeutic work? Is there an unacceptable risk of violence (assessed in relation to the treatment context) or of suicide and if some such risk is evident are psychiatric facilities available if

needed? In addition to these factors the assessor, when responding to the patient's story or commenting on the way the interview has been coped with, will propose explanations and links which will give some idea to the patient of what is being offered; the style of the interview should already provide an experience of a collaborative 'doing with' approach. How patients engage in this will provide some idea of their ability to make use of the treatment but this does not imply that CAT requires patients to be already 'psychologically minded'; it is their response to appropriately delivered interventions and explanations that determines treatability. Greater psychological mindedness can be one outcome of the assessment interview.

A further, useful discussion of the assessment process and of case formulation from a CAT perspective is offered by Denman (1995).

THE CONDUCT OF THE ASSESSMENT INTERVIEW

Before meeting with the patient the therapist should read the referral letter and any other clinical notes and psychometric test results. These may convey important information such as suicidal preoccupations or abuse histories about which patients are reluctant to speak. Patients should be told what information has been received but in general should be invited to retell the story in their own words; any reluctance to speak at this stage should be noted but accepted. The purpose and duration of the assessment meeting and the role of the assessor should be made explicit; thereafter the interview should be largely unstructured, because what the patient chooses to say and how it is said may convey as much as the content, but the therapist needs to be aware of his or her implicit agenda and may use prompts or direct questions to open important aspects which are not volunteered and to explore the feelings and meanings associated with reported facts.

Towards the end of the interview the assessor should rehearse the main 'headlines' of the story and propose possible links and patterns between reported events. He or she should offer provisional descriptions of the main issues and should seek the patient's comments; any ways in which the patient's problem procedures have been evident 'in the room' during the interview should be noted. This recapitulation and linking show the patient that the story has been attended to and provide a sample of what therapy can offer; it also allows the therapist to gauge how far the patient can make use of such comments. The patient's own understanding about the nature of his or her problems and expectations of therapy should be clarified and the response to the interview should be asked for. An outline of the CAT therapy model explaining the time limit, the reformulation process and the expectation of homework and indicating how the patient's particular problems might be helped should be given. The nature of the therapy relationship and the ways in which the patient's problem procedures might affect it are also explained.

Alternative treatments, if available, should be described so the patient can make an informed choice. Practical arrangements and an account of what is to happen next should be clarified at the end of the meeting.

Assessment interviews are not technical exercises; they call for the full range of therapy skills and for an ability to respond to individual patients in ways enabling them to reveal significant aspects of their lives and problems, even if they had no clear prior idea about what is expected. What is learned in the course of the interview needs to be related to the conceptual model and fed back to the patient in a way which contributes to the establishment of a shared language. Such comments need to be tentative and the patient's understanding and comments sought and considered, exemplifying the collaborative nature of the therapy. Areas where knowledge remained incomplete should be noted and occasionally a second assessment meeting may be needed.

In writing up assessment interviews it can be a valuable but time-consuming exercise for trainees to describe in detail the evolving process of the meeting. It is more accurate and more revealing to audiotape and replay the session. With experienced assessors it is enough to record the main content and themes, the feel and process of the meeting and the assessor's judgements and countertransference. The account can then be re-cast in the order:

1. Referred by whom and reason for referral.
2. Process of session and impression or countertransference.
3. Main problems and why they have led to coming at this time.
4. Early history, other life events, current relationships and social situation. This should not take the form of a detailed biography, the need is to identify and describe key themes.
5. A diagnostic formulation covering (a) any psychiatric illnesses and (b) a provisional reformulation of how present problems are derived from procedures developed in coping with past events, and which notes how these procedures may influence how current life difficulties and underlying issues such as unresolved mourning are coped with.
6. The treatment plan. In team situations final decisions about the treatment plan will be made by the team meeting, a procedure which guards against the influence of unrecognised countertransference on decisions.

This formal account of assessment procedures fails to convey the density and complexity of a satisfactory meeting or how much powerful feeling may be evoked by the often horrific life experiences and often admirable efforts at survival reported by patients. A more live impression may be given by the following selection of vignettes of assessments carried out in an outpatient CAT clinic. As with all case material these will be modified to avoid recognition. The provisional identification of key reciprocal role procedures given in these summaries would suggest issues to pursue and clarify in therapy and would not be considered in any way final.

The cases will be summarised under the six headings suggested above and a brief retrospective comment on the issues illustrated by the case will be added.

Nora

1. A 28-year-old London West Indian referred by an experienced GP counsellor whom she had consulted on account of her inability to show affection and her increasingly aggressive feelings towards her daughter.
2. She appears as intelligent, articulate and insightful and her survival of a very difficult life is impressive.
3. She is increasingly concerned with how she treats, and sometimes beats, her nine-year-old child; she knows it is in part because she is like her father and in part because 'she is too much like me'. The child was by the first of three relationships, the last of which she has recently ended; in all three she was clearly dominant, refusing any hint of being controlled or abused but also intolerant of her partner's displays of affection and at times being 'vicious and revengeful'.
4. She was raised in a chaotic family, the only reliable figure being one older sister (out of a total of 'about 15' offspring of her mother, father and stepfather). She indicated that there were experiences she did not feel ready to talk about at this interview. Despite this background she did well at school and attended a Further Education College until her first pregnancy. She is now working part-time and attending further education classes.
5. Apart from the older sister's care she seems to have derived from childhood a pattern of *defiant coping* in relation to *neglect and abuse*. To her distress, she enacts the abusing role to her daughter and expresses contempt for most others, especially men, although she has one intimate woman friend. Under her tough coping mode there is probably a degree of self-contempt.
6. Despite this history she was frank and open in the interview and I believe she will work hard in therapy to understand herself better but, as her main coping mode has been to avoid emotional exposure, she will find it difficult to risk contacting her childhood pain and may well be dismissive of the therapist.

Comment: Admiration for this woman's evident strength needed to be tempered with a realisation of how hurt and angry she was. Therapy, if she became involved, would mean contacting and expressing powerful feelings of anger and deprivation and losing the safety her emotional distancing provides. The therapist would need to be ready for a rough ride and should anticipate this in the reformulation; survival of this could be the most important aspect of non-collusion. The time limit may make risking this exposure tolerable to her, however. The GP and practice counsellor were aware of her anger with the child and at this time there seemed no need to involve Social Services.

David

1. David, aged 27, was seen at the request of his psychiatrist. He was an inpatient, detained under the Mental Health Act, having been brought in by the police after threatening to jump off a Thames bridge.
2. He struck me as a compliant, anxious young man, saying he wanted to have therapy, but it was difficult to get a strong impression of who he was.
3. He had been depressed since early adolecence, and had had two hospital admissions at the ages of 18 and 20. Since that time there had been phases during which he drank heavily and I gathered from the notes that he had also used a lot of cannabis. The recent depression was associated with the end of a three-year-long gay relationship, an ending provoked by his drinking. He had also recently lost his clerical job due to poor time keeping.
4. He described his father as a very authoritarian man; for much of his early life his maternal grandfather was his main support. This was especially the case after he was upset and felt rejected following the birth of his sister when he was aged six. His grandfather was also the only one in the family who accepted his announcement of his homosexuality.
5. A main thread in his life would seem to be his wish not to resemble his father in any way. He understands that this makes him over-placatory and that the ensuing resentment leads to depression and drinking. The basic role pattern derived from his relationship with father would be something like *resentful placation* in relation to *harsh control*. The suicidal acts seem to have followed sudden and extreme mood changes, perhaps better described as state shifts, representing a switch from depressed placation and resentment to angry defiance, and there remains some risk of this anger leading to an impulsive suicide. He is currently on antidepressants and will remain under psychiatric supervision.
6. Contraindications to therapy include my feeling that he was compliant rather than frank in the interview and the incompletely declared history of substance abuse. Therapy should be conditional on controlling this. It might be wise to offer a provisional 4–6 sessions before committing to a full course. On the positive side he has a reasonable work record and did sustain a relationship for three years and his grandfather provided some real care which he still remembers. If he can engage in therapy he might be best referred on to group therapy after 8–12 sessions of individual CAT.

Comment: There were a number of doubts about how far this patient could be engaged in therapy. It might have been wiser to have suggested a prior period of outpatient support to see if he could remain substance free. On the other hand, starting therapy at a moment of crisis can often promote rapid engagement at the level of underlying self processes and can allow fundamental change rather than the restoration of defensive or coping compromises. In this

case it seemed important to offer treatment while accepting that there was an above average likelihood of him not completing the course.

Nick

1. Nick, a 31-year-old lecturer, was referred by his GP on account of a long-standing low-grade depression (with no biological features) and episodes of loss-of-control anger.
2. He was close to tears during the interview and seemed highly motivated to make better sense of his life.
3. He described an increasing sense of dissatisfaction with his life, feeling that others saw him as a resource but never remained as friends. His second marriage had recently been under strain when he felt ignored by his wife but they are now on better terms again. He gets unreasonably angry.
4. Nick is the eldest of two children from a working class family in Scotland. Following the birth of his sister when he was five his mother became psychiatrically ill and she remained unstable thereafter. Father was impatient with her and devoted himself to his daughter and Nick became his mother's main practical and emotional support. He did well academically and went to university where he met and married his first wife. She was described as clingingly dependent and he left after two years. His present wife, in contrast, is a strong, independent woman. He manages his working relationships and enjoys the performance of lecturing but feels others to be bewilderingly inconstant. He could agree with my suggestion that maybe he was inconstant in how he saw them. He described how, in addition to the performance mode, he had three distinct states, one the thoughtful one he was in today, one a state of maudlin self-pity and one a state of being out of control.
5. It seemed that his mother had been dependent on him and his father had been unavailable to him as a support or model (*neglected* in relation to *needy and unsupported*). His first marriage had been a repetition of his relationship with his mother, suggesting a pattern such as *needy, unsupported caretaking* in relation to *controlling dependency*. His second marriage avoided a repetition of this but he acknowledged that he sometimes resented his wife's admired strength and social ease. He was clearly anxious to understand better his own contribution to his difficulties. He gave a clear description of differentiated states and state shifts. He did not meet full borderline personality disorder diagnostic criteria.
6. He clearly has real strengths and should make good use of therapy. I suggested he should discuss with his wife whether a session together might be helpful at some stage.

Comment: This man made the decision to seek therapy on the basis of unhappiness and the realisation that he was at least in part the author of his misfortunes;

this suggests that he is likely to be a rewarding patient. Essentially he was someone who had been trapped in the caretaking role he had acquired in childhood and had repeated in his first marriage. No longer having to be the dutiful caretaker he is now, it seems, more aware of being the neglected one, and he elicited from me a concerned, fatherly countertransference. He is now suffering from the distance he creates between himself and most people and from intrusions of the unhappy and angry feelings he had never expressed in the family situation. Therapy can give him a chance to mourn what he never had in the way of care and to free himself from the historically rooted anger, while experiencing focused care and manageable disappointment.

Debby

1. Debby, aged 26, was referred from the Accident and Emergency (A&E) department where she had been psychiatrically assessed after overdosing on paracetamol.
2. She told her story with clarity and some urgency and made me anxious. This was mitigated to some extent by the use she had made of her recent meeting with the referring psychiatrist and which she seemed to make of this session.
3. Her overdose followed a row with her current boyfriend. They have lived together for a year and she recognises a negative spiral in which her possessiveness and threats provoke him to increasingly rejecting behaviours. She had recently opened a window and threatened to jump; he had pulled her back angrily and this had provoked the overdose.
4. Her father had shot himself when she was six. Since then until last year she had lived with her mother and older sister. Unlike her sister she said she had no clear memories or feelings about her father, knowing only what she was told by her mother, from which it seemed he had been unstable and quarrelsome. However, in telling me how her mother broke the news of his violent suicide to her and her sister, she cried. After a number of transient relationships Debby fell desperately in love at the age of 19. A year later her boyfriend confessed to an infidelity; her response was to threaten to jump from the window. He dragged her from the window sill and phoned her mother 'who came and took her away to cool things off'. Two days later she was contacted and told that he himself had jumped to his death from a high building. She was unable to face going to his funeral and had remained deeply obsessed with his memory for the next three years.

   She was quite aware of the spiral of possessiveness provoking rejection which had characterised that relationship and was evident in her current one, but she felt she really could not bear to be left. I tried to explore how one might understand her story, linking the history of two relationships with men marked by intense possessiveness and the terror at abandonment with

her apparent absence of memory or feeling about her father's death. This link with her father was something she seemed not to have thought of before.

5. Since the recent crisis she has stayed in close touch with her mother and is continuing to work in her civil service job. It did not seem that there was an immediate threat of suicide—a view shared by the psychiatrist who had interviewed her in the A&E department. The underlying dilemma could be simply summarised: 'it is as if, if I am deeply involved with a man, then he is bound to leave me'. A more explanatory description might be a reciprocal role pattern derived from the unmourned loss of her father, for instance *desperately seeking love but fearing abandonment and therefore quickly angry* in relation to *apparently loving but inevitably abandoning*.
6. I urged her not to have the means of self-harm to hand and to make use of the A and E department (in which she had confidence) if the impulse to self-harm returned. She would like therapy and it will be set up as soon as possible.

Comment: The history of at least toying with a violent means of suicide was certainly anxiety-provoking, particularly given that her first boyfriend and father had both chosen violent methods of killing themselves. It was as if the only safe relationship was one of fusion and the only coin available to deal with its loss was a lethal one. Despite the somewhat macabre feel to the story, there was no indication for compulsory treatment and I felt that she was relieved to have discussed the situation with the psychiatrist in the A&E department and to have committed herself to therapy in order to understand better the origins of her behaviour.

Evelyn

1. Evelyn was a graphics designer aged 32 referred by her GP. She had requested the referral following a year in which she had experienced many disturbing feelings and intrusive memories after taking 'ecstasy'. She had taken no drugs since that time.
2. She arrived breathless and late and for the first part of the session was speaking under great pressure and somewhat incoherently. By the end I felt I had built up a fairly clear but incomplete picture of what she was wanting from therapy.

3 and 4. The effects of the drug had been to open her to periods of intense feelings associated with childhood. These centred on her relationship with her mother who, she felt, 'had been overinvolved with me emotionally and unable to set any realistic boundaries'. Evelyn began to use alcohol and drugs in early adolescence, preferring cannabis because it calmed her. A brief unsatisfactory sexual relationship with a man at 17 was followed by an

intense but confusing relationship with a woman. Since that time she had had a number of short-term sexual relationships with men, 'preferably boring ones with whom she could avoid emotional closeness'; she also referred to elaborate forms of sexual fantasy which we did not discuss. In her work life she has set up and run successfully her own business. Two previous attempts at therapy (in early adolescence and in her mid-twenties) had not been helpful.

5. Her fear of emotional closeness can clearly be associated with her mother's overinvolvement and lack of boundaries and was probably reinforced by her intense, confusing lesbian relationship. This suggests a reciprocal role pattern something like *overwhelmed but with own needs neglected* in relation to *invasively overinvolved*. Men are still felt to be safer than women and she emphatically requested a male therapist. The possible advantage of therapy from a woman—the more feared gender—was discussed, but it seemed that initial engagement might be too difficult and her request was agreed to. Her main coping strategies have involved hyperactivity and the avoidance of closeness.
6. She now wants to know herself better and has clearly been flooded with memories of childhood which point to the source of her difficulties. Therapy will confront her right away with the urge to avoid feeling involved but I feel there is a real chance that she will be able to use it.

Comment: The success of therapy will depend on establishing a manageable working relationship which can be sustained as she faces the fears and angers associated with closeness. As these are clarified the nature and significance of her undisclosed sexual fantasies may become apparent. CAT is particularly appropriate because of the containing effect of reformulation and the clear time limit.

Diana

1. Diana, aged 33, was referred by a social worker attached to her GP's surgery with an eight-month history of nightmares, depression and fits of uncontrollable weeping.
2. She told her painful history in a way which was dignified and intensely moving.

3 and 4. She was clear that her present state dated back to her five-year-old adopted daughter starting at school. This had brought back intense recollections of how, at that age, her parents had separated and she had been put in care. She had stayed in a very large, harsh institution until she was 13. No emotional closeness between the children was permitted; she had had a brief relationship with an older caring girl which was forbidden. The dormitories were locked with no access to toilets and wetting the bed was punished by being paraded in the wet sheet.

Leaving there aged 13, she was rejected in turn by her mother and by her father and stepmother. From 15 she had managed on her own and trained in dressmaking. At the age of 24 she married an inarticulate but reliable man in whom she has little sexual or emotional interest, especially since she was found, after extensive investigations, to be infertile. She is intensely loving of her adopted daughter and expressed the fear that, from fear of hurting her, she may not set appropriate limits.

5. The story and its telling put me in mind of Winnicott's notion of how adults may need to have the breakdown that they could not experience in childhood; Diana's grief and nightmares were appropriate expressions of what she had been too unsupported to bear to experience fully as a child. Given that her early life could be summarised as involving little more than the pattern *lonely coping* in relation to *depriving, abandoning and hurting*, it was an achievement to have found her way to a job and a relationship and to have survived the disappointment of her infertility. Her adopted daughter's starting school was both a separation from her most loved other and a reminder of her own deprivation. She shows concern for the child in the middle of her own pain (and no evidence of the destructive envy certain object relations theorists might insist on interpreting).
6. I was moved and impressed by her ability to have survived a bleak life and by her ability now to experience and communicate her released feelings. I think she will make very good use of CAT and might be particularly helped by a mature female therapist, given the absence of any maternal figures in her past.

Comment: Diana exemplifies those patients who seem to have found the strength to survive with very little help from others and who can make very good use of what help they are given.

The six cases

No two stories are alike and no simple classificatory system can group patients in ways relevant to psychotherapy, but the six case vignettes together illustrate many of the issues which need to be considered in the assessment interview. All six were considered to have psychological problems potentially amenable to CAT. Only David had a significant, associated, psychiatric condition—depression and a history of alcohol dependency—for which he was receiving medication. None met the full criteria for borderline personality disorders but all had long-standing evidence of damaging patterns of self -management and of relating to others. Provisional reformulation of the underlying reciprocal role patterns suggested that current disturbed patterns often combined repetitions of childhood patterns (as in the uncontrolled anger in Nora and Nick and the uncontrolled mood variations in Evelyn) with enduring alternative procedures

in the form of emotional distancing (in Nora, Nick and Evelyn) and of substance abuse (in the case of David and Evelyn). Possible contraindications to therapy included David's recent substance abuse and the risk of suicide in David and Debby. Evidence of at least one valued, emotionally significant relationship in childhood is usually taken to be a basis for a positive therapy relationship; in this respect Nora had her caring sister and one friend, David had his grandfather and one three-year relationship, Nick had his second marriage, which represented an escape from the childhood compulsive caring role, and Diane had one brief supportive relationship in the children's home. Evelyn was basically still avoiding repetition of the smothering closeness experienced with her mother. Debby seemed to have a reasonable relationship with her mother; she presented an unusually violent consequence of an unresolved mourning reaction, but early instability in the parents' marriage and the unremembered attachment to her father may have generated the reciprocal role pattern described above. The fact that all six had fairly stable work histories is a good prognostic sign in that those who can cope with employment are more likely to cope with the work of therapy.

OTHER CONSIDERATIONS

To complement the discussion of the six cases some issues which are relevant to making the diagnosis and assessing suitability for CAT in different clinical settings and with different diagnostic groups will now be discussed. In contrast to most brief therapy models, the use of CAT is not restricted to less severe disorders and change in central self processes (personality) is the common aim. Both clinical (mental) disorders (Axis I in DSM IV) (American Psychiatric Association, 1994) and personality disorders (Axis II in DSM IV) may be amenable. But there are important distinctions to be made, with implications for treatment, between the restrictions and distortions of Axis I disorders, usually regarded as departures from the longer-term characteristics of the patient and defined as clinical disorders (as if they are 'illnesses'), and the more enduring traits and structural problems of Axis II personality disorders (see also discussion in ICD 10, World Health Organisation, 1992). The 'state–trait' distinction is, in practice, not always clear; episodes of distress and dysfunction which occur in response to new situations often represent the 'de-compensation' of flawed but normally adequate ways of coping. It is also the case that the personality disorders identified by standard diagnostic criteria are hardly ever found in isolation; patients frequently meet criteria for more than one of them and they are virtually always accompanied by Axis I disorders. The concept of 'co-morbidity' is of little value; it seems better to think in terms of the range and intensity of symptoms (Axis I) and of the degree to which self processes are distorted and poorly integrated (Axis II), both of which result from genetic predisposition and adversity in childhood.

Psychotherapists will encounter many patients who could be diagnosed in Cluster B of the DSM classification; those with borderline personality disorder (BPD) are the most demanding and the treatment of these patients with CAT has been studied systematically. Establishing a working therapeutic relationship is difficult because they repeat their general tendency to mistrust, disrupt or idealise their relationships with their therapists and all too easily provoke collusive reciprocations, eliciting offers of ideal care or rejection. These interactive patterns, and abrupt switches between them, frequently occur during the assessment interview as the patient experiences the assessor as intrusive, unconcerned, critical or rescuing; such events need to be identified as early as possible, even to the extent of drawing provisional part diagrams during the assessment interview. The recognition of personality factors at a single assessment meeting is aided by noting the often powerful and confused countertransference feelings which they induce, but many have developed socially acceptable modes of self-presentation which can make them seem relatively integrated and for that reason the routine use of screening questionnaires, described later in the book, is recommended.

CAT is primarily directed at the understanding and modification of high level processes concerned with the management of self and most common behavioural and symptomatic problems are understood to be low level manifestations of more general patterns. In milder disturbances any respecting therapeutic input can be helpful, through the influences common to all approaches as discussed by Frank (1961), although the collaborative nature and high level focus of CAT may lead to more rapid change. In more difficult cases with borderline features the assessment and reformulation methods of CAT offer particular advantages, contributing to the quick establishment of a therapeutic, rather than a collusive or irrelevant or failed, relationship. Preliminary verbal or diagrammatic understandings suggested during the assessment session(s) can identify, anticipate and control those procedures which are otherwise likely to lead to dropping out.

The treatment of other, less common Axis II conditions with CAT has not so far been systematically studied but it appears that the basic approach, which allows considerable flexibility, is of value in the full range. In cases where there is doubt about the capacity of the patient to engage, a 3–4 session assessment, aiming to arrive at a provisional reformulation, will usually make it clear whether CAT or some other treatment is indicated.

COMBINING CAT WITH OTHER TREATMENT MODES

While many symptomatic disorders can be treated by the basic CAT approach, by identifying and modifying the problematic self-management and relationship procedural repertoire, there are some which require treatment in their own right, either because of their direct impact or because they may make patients

inaccessible to psychological treatment. In these cases prior or concurrent treatment by other means may be indicated. Even where such treatments directed at symptoms are necessary, and even where there may be good evidence for the role of genetic predisposition in the symptomatic condition being treated, it is helpful to indicate the role of the treatment within a general procedural understanding. The predominant medical assumptions and the pressures of the pharmaceutical industry tend to mean that psychologically maintained problems are all too easily regarded as equivalent to somatic illnesses and their origins in problems of living ignored. One of the values of symptom monitoring during the early phases of treatment is that it helps patients become aware of the way situations, thoughts, behaviours and feelings are associated with the symptom and it is often appropriate to initiate such monitoring at the assessment interview.

The use of medication or other symptomatic treatments often needs to be considered at the assessment meeting, because some patients will already be taking prescribed medication and others will have symptoms which may be amenable to such treatment. Nearly all psychotherapy patients suffer from some degree of anxiety, depression and associated physical symptoms, as is witnessed by their scores on symptom inventories.

Depression

If depressive symptoms are severe enough to impair sleep and concentration or include other evidence of biological changes it is usually best to combine medication with the therapy; severely depressed patients are unable to participate in therapy. In marginal cases, especially if the patient is reluctant to accept medication, the response to the first few sessions of therapy will indicate whether or not medical treatment is needed.

Anxiety

Pharmacotherapy for anxiety symptoms is best avoided except in the short-term management of severe disturbance. It should otherwise be postponed, or if already in use should be slowly withdrawn; it is more useful to identify and control the sources of anxiety than to suppress the symptom. Dependency on anxiolytic drugs is easily established and once the procedural and situational associations of the symptoms have been worked out medication is usually unnecessary. In some cases behavioural approaches to control symptoms offer the quickest relief, for example in the treatment of phobic avoidance, after which the need for CAT for associated interpersonal problems can be assessed.

Obsessive-compulsive symptoms

The same considerations apply to much obsessive-compulsive symptomatology, but in long-established and severe cases the need for both behavioural and pharmacological treatments may need to be considered.

Somatisation

The common somatic accompaniments of anxiety and depression are usually relieved by the revision of self-management and relationship procedures but long-established psychosomatic disorders, where other factors such as allergy may play a part or where structural changes may have developed, may need parallel medical management. Psychological associations with physical symptoms need to be positively identified and demonstrated, not asserted.

It is important to bear in mind that any symptoms, whatever the underlying cause, may be associated with, or constitute the means of, interpersonal control. For this reason a procedural understanding and the possible involvement of psychologically significant others in CAT or systems theory therapy should always be considered. In this respect, CAT understandings are close to those of systems theory.

IMPLICATIONS OF SOME SPECIFIC DIAGNOSES AND BEHAVIOURS

Some diagnoses indicate the need for modifications of CAT methods or their integration into broader management systems. The treatment of personality disorders is reviewed in Chapter 10 and the CAT treatment of a number of specific conditions for which there is some accumulating experience and evidence, either published or in preparation, is reviewed in Chapter 9. These include eating disorders, substance abuse, psychotic illness, deliberate self-harm, poor self-management of diabetes and asthma and issues related to age and gender.

ASSESSING THE RISK OF SUICIDE

Many patients referred for psychotherapy will have a history of deliberate self-harm or attempted suicide, as did David and Debby described above. Such patients, especially where there have been multiple episodes, have an above average risk of successful suicide. Self-harm can involve a range of behaviours from superficial scratching to deep cutting and from taking a few extra tablets

to potentially lethal overdosing. It always needs to be assessed in relation to a full understanding of the patient's procedures and current life situation. Unless the cause is an untreated major depression, psychotherapy is the only intervention likely to be of help.

Patients reporting an untreated, deepening depression with heightened self-blame and marked physiological symptoms affecting sleep, energy and concentration and patients reporting detailed plans for suicide need urgent psychiatric treatment and are not accessible to therapy. Excluding these cases, assessors may accept patients for CAT who have a history of attempted suicide or current suicidal preoccupations. In doing so they need to be clear in their own minds, and make it clear to their patients, the limits of the therapist's availability and of their tolerance for anxiety. Realistically, therapists cannot be continually available in person or by telephone and in any case to attempt to provide such care would feed idealisation (and in due course disillusion) and undermine the patient's autonomy.

The risk of suicide is greater in patients who have no close relationships or whose key relationships are deeply disturbed. If a patient is determined to die, nobody can stop them and making this clear establishes that therapists cannot be controlled by threats. Patients who fear that they cannot control self-harming impulses should be encouraged to keep a list of, and be prepared to use, available resources such as psychiatrists in local A&E departments, telephone contact with friends or with the Samaritans and any other sources they may have already identified. If, at assessment (or later during therapy) the threat of suicide seems active, and if the therapist is not working in a Community Mental Health Centre or other professional structure, it may be advisable to arrange to share management with psychiatric services from the beginning.

Despite the fact that therapy often involves accessing very painful memories and feelings, and despite the rapidity with which this may happen in time-limited CAT with deeply disturbed patients, serious suicidal incidents in the course of therapy are extremely rare. It is probably the case that reformulation and the early bonding of the therapy relationship which it encourages provide a safe containment and within this most patients will access feelings and memories only when they feel safe enough to do so.

ASSESSING THE POTENTIAL FOR VIOLENCE

The assessment of potential violence is not easy. The main predictor is the history of past violence, but episodes of uncontrolled anger (such as were reported by Nora and Nick) are common, especially in patients with borderline personality disorder, and in many patients these may have involved inflicting serious injury on others. In forensic practice there may well be a history of murder or the infliction of grievous bodily harm. Classical psychopathic individuals showing no remorse and professional killers are unlikely to seek or be

referred for therapy, but many treatable borderline patients have escaped inflicting serious or lethal harm during outbursts of out of control rage more by luck than judgement.

Part of the decision about offering treatment to potentially violent patients must depend on the setting; such patients should only be seen in institutional settings with the agreement of the other staff members and appropriate safety arrangements. Therapists need to include a direct consideration of violence and its possible mobilisation in the reformulation letter and therapy will, of course, be conditional on the control of threatening behaviour. Accessing memories of victimisation in childhood in the course of therapy can sometimes mobilise dangerous anger in such patients, sometimes associated with switching into dissociated states in which the therapist is confused with past abusers. It is important to be aware that there is a death rate among therapists and others who are drawn into working intensively with violent patients.

Current disagreements about the treatability of personality disorders and about the respective roles of police and psychiatry, combined with the shortage of resources, means that many seriously disturbed patients end up in the care of clinical or custodial staff lacking appropriate training and facilities for any therapeutic approach. We are sceptical of the value of behavioural anger management in patients whose underlying pathology is one of fragmentation and dissociation and we believe that the scope of CAT in direct treatment and in supporting management, to be discussed later in the book, deserves wider evaluation.

ASSESSING MOTIVATION

It is not a CAT requirement that patients for therapy must have an already established ability to think about their own procedures. In many more disturbed and deprived patients there is little obvious capacity for this. However, the development of increased self-reflection through the joint work of developing and using the conceptual tools created during reformulation can be surprisingly rapid. This being so, there is no call for a separate programme of 'motivational enhancement'. Motivation is not a separate faculty, it does not depend on a motor being wound up and it is not something which can be simply taught; people will proceed to involve themselves in a task when the task makes sense to them. The early sessions of CAT are motivating because they induce or enlarge self-understanding and the capacity for self-reflection and have as their explicit aim the extension of awareness and control. The few patients who cannot be recruited to the work of therapy in the course of assessment and early exploratory sessions may be better served by more directive methods.

OTHER THERAPEUTIC MODES

Most patients referred and assessed for individual CAT are suitable for it and are happy to accept it, but there may be alternative approaches available, at least in some settings. Cognitive-behavioural therapists working alongside CAT therapists would probably define some cases as better served by CBT (panic and phobia, obsessive-compulsive disorders, some simple depressions, for example) and there are clearly many cases suitable for either approach, or for combinations of the two. Some patients may prefer and be suitable for group therapy as an initial treatment and others may benefit from it after individual CAT has helped to define the problem procedures but has not seen the patient through their revision. Involving partners at some point in an individual therapy may be valuable, especially when desirable changes in the individual may expose or provoke strains in the couple's relationship patterns. Where a relationship is the main arena for an individual's difficulties and where both accept it, joint work may be helpful either instead of, before or after individual CAT. In most settings the range of available alternatives is small, however, and systematic study of what is best, alone or in combination, remains to be done. In so far as there are choices, however, the patient should be involved in making them on the basis of a realistic consideration of what is involved, which may require some correction of the versions described in the media.

PAPER AND PENCIL DEVICES

Self-report inventories can be taken as approximate indications of patient pathology and there are strong arguments for including them as a part of the initial assessment. They provide baseline data on which to compare different patient samples and changes between pre- and post-therapy measures can contribute to the clinical audit of the performance of the service.

Of the many self-report tests available those which have been used over time in different populations and are relatively crude are the most suitable for routine use. Unfortunately many of these have now been patented and payment is demanded for their use, a practice which is contrary to the old humane assumptions in medicine whereby all findings of potential value and usefulness were regarded as in the public domain. Fortunately the recently developed 'Core Battery' (Barkham et al., 1998), which appears to have considerable clinical utility, has been explicitly not copyrighted (it is 'copyleft'). This offers, on the basis of some 30 questions, an overall score and scores on four subscales, and is suitable for repeated administration through the course of treatment. It is likely to become the standard instrument in the UK. The Personality Structure Questionnaire (Pollock et al., 2001) was designed on the basis of the CAT 'Multiple Self States Model' of borderline personality disorder (BPD) with the particular aim of identifying patients' awareness of having

distinct self states. This is reproduced in Appendix 3 and its use is described in Chapter 10. It yields an overall score which correlates with the diagnosis of BPD and with measures of dissociation. Rather than defining a diagnostic cut-off point, patients scoring 28+ should be asked to elaborate on their experiences. If they describe distinct states and state shifts involving contrasting perceptions of self and others rather than just mood changes they will require reformulation and treatment methods developed for BPD. The Core Battery, the PSQ and any other tests administered should be scanned before the assessment session, as some patients acknowledge symptoms of importance which they do not easily report at interview.

TREATMENT CONTRACTS

If, when the assessment process is completed, the patient is accepted for CAT and chooses to pursue it, the offer made and the expectations from the patient may be summarised in a treatment contract. This can ensure that issues such as the proposed duration of sessions and of the therapy, the use of audiotaping, the limits of confidentiality and arrangements concerning absences and missed sessions are unambiguously spelled out. Failures to abide by the contract by either the patient or the therapist can only be used to explore therapy-related issues if a clear statement of this sort is available.

CONCLUSIONS

It will be clear that the assessment interview makes heavy demands on the interviewer. The main aims are to get to know enough about the patient to make sensible decisions about therapy and to give the patient an experience which provides some idea of what therapy would involve. The means whereby these aims may be achieved in a single interview should not include the use of a structured question-and-answer approach, however; as Balint famously said, 'if you ask questions all you get is answers'. If the ground has not been covered in the time allowed—and this may with advantage be 90 rather than 60 minutes—the choice is either to arrange a second meeting, which may be difficult under service conditions, or to note what has been left undone so that the therapist can supplement the assessment details.