Chapter 6

THE REFORMULATION SESSIONS

SUMMARY

The early sessions in CAT focus on the joint creation of written and diagrammatic descriptive reformulations of a patient's overall picture of distress and dysfunction and its developmental origins. These become central to the subsequent work of therapy. Reformulations focus principally on the acquisition and enactment of reciprocal role procedures. A written, narrative, reformulation letter is followed by a diagrammatic one, although in order to contain more disturbed patients it is helpful to attempt even a rudimentary diagrammatic reformulation as early as possible. These documents serve as 'tools' which promote a powerful therapeutic alliance by providing a means of understanding and mapping an integrated picture of often highly maladaptive role enactments, especially those which may constitute threats to the therapeutic alliance. Revision of these inevitably provisional documents may well be required during the subsequent course of therapy. Constructing a reformulation is a clinical skill which requires practice, supervision and an ability to remain empathic towards the patient whilst also thinking reciprocally. These principles are illustrated by case material.

This chapter describes the defining activity of the CAT therapist. To those unfamiliar with the approach it will repay careful reading, because the ideas and practical tasks are relatively complex.

CASE FORMULATION AND CAT REFORMULATION

Psychotherapists of all persuasions make case formulations of their patients, a process involving the selection and arranging of data according to their

theoretical understanding of the issues to be addressed in therapy. In CAT the account will seek to identify the personal meanings accorded to their experience by patients and to describe the problem procedures and evidence of poor integration of the procedural system which are responsible for maintaining their dysfunction and distress. CAT practice differs from that of most other models in a number of respects:

1. Therapists work collaboratively with the patient from the start. This involves patients in activities such as self-monitoring and reading the Psychotherapy File and therapists in sharing their provisional understandings with their patients and inviting their ideas, comments and modifications.
2. Therapists make use of writing and diagrams to make their understandings explicit and 'portable', allowing patients time to test out their accuracy and usefulness and to contribute to their revision.
3. In order to demonstrate how problems have been formed and maintained, therapists offer both a 'narrative reconstruction' of the patient's story, in the form of a letter tracing the links between past experience and current procedures, and a verbal summary or diagrammatic model of the patient's current role procedures.
4. The reformulation, once agreed, is recorded in written and diagrammatic form. It provides a common agenda for the work of therapy and a conceptual tool of use to both patient and therapist. And it offers a global, 'top down' perspective, setting the range of symptoms and costly behaviours in the context of a preliminary understanding of the patient as a particular person living a life in particular life circumstances.

THE PROCESS OF REFORMULATION

Reformulation, which may have started in the assessment meeting, is usually completed at the fourth or fifth session. Therapists explain that the aim will be to achieve an agreed understanding which will be presented in writing at that session. The sessions leading up to the presentation of a provisional reformulation are devoted to largely unstructured interviewing combined with the use of the Psychotherapy File. Symptom monitoring, the construction of family trees and other tasks to be completed between the sessions may also be suggested. The File items identified by the patient will be discussed and examples asked for. For unreflective or emotionally disorganised patients (and for insecure therapists) these tasks introduce the practice of applying thought to feelings. Passively resistant patients will demonstrate their ways by non-completion of agreed tasks, thus alerting therapists to a procedure which is likely to have a considerable impact on therapy, while for patients who are more reserved or defended the need is to explore the felt meanings behind their more factual

accounts. Possible procedural patterns recognised by the therapist should be presented in a tentative way for discussion. Throughout these sessions the therapist should be alert not only to the content of what is said but also to the form in which it is said and to attitudes or behaviours expressed directly or indirectly. It is important to distinguish idealisation from cooperation, cooperation from compliance, reasonable criticism from contemptuous dismissal, fear of exposure from control and so on. The aim through all this is to get to know the patient, to attempt to achieve an understanding of what this patient has experienced, done and learned in the course of his or her life, to demonstrate in these ways a genuine and accurate empathy, to engage the patient in active collaboration and to offer preliminary new ways of understanding and conducting life.

Everything that is discussed will be presented more formally at the designated reformulation session, usually the fourth. The understandings will be presented in two main forms, one a reformulation letter and the other a sequential diagram; these will be described in detail below. After discussion and, if necessary, modification, these written and drawn conceptual tools define the agreed agenda and shared understandings which are the basis of the therapy. As the process is primarily descriptive not interpretive and as patients are encouraged throughout to comment on, challenge or revise what is said or written out, the danger of imposing false understandings is slight. An adequate grasp of key issues is usually achieved, unless the patient is largely unavailable through a procedure such as passive resistance or emotional blankness. In those cases reformulation needs to focus on this therapy-undermining procedure, which will usually be an example of a more general one related to the presenting problems. If events arise later in the therapy which cannot be linked to the verbal descriptions of target problem procedures (TPPs) or cannot be located on the diagram, the reformulation should be revised. In most cases, but especially in more disturbed or poorly integrated patients, the formation of the diagram may involve a series of provisional or incomplete versions which will be corrected or clarified in discussion.

THE EFFECTS OF REFORMULATION

The impact of jointly fashioning and beginning to apply the conceptual tools described in the reformulation is complex and various. The experience of being attended to by a thoughtful other and the preliminary glimpse of how new understandings may be helpful is often unique and powerful, especially for deprived or abused patients, so in nearly every case the process serves to raise patient's morale and strengthen a working alliance. The understandings themselves, even before they are fully grasped and integrated, are containing, relieving confusions and uncertainties, reducing the need for anxiety- or guilt-avoiding procedures and hence allowing greater access to memories and increased awareness of emotion. Symptoms begin to be understood and

become less preoccupying. The creation of a meaningful story out of incoherent accounts of distress contributes to the extension of personal meanings which is an essential element in the achievement of psychological well-being (Crits-Christoph, 1998). And for the therapist the understandings serve to make collusive reciprocations to problem procedures more avoidable or remediable.

The different elements of the reformulation are commonly carried out over the same time period. The reformulation letter is often presented first, serving to establish the therapist's grasp of what it has been and is like to be the patient, but in more disturbed patients recognising the damaging reciprocal roles needs to start in the first session if inadvertent collusion is to be avoided. These may be listed or represented in partial and provisional diagrams for discussion with the patient, an activity which may be the best way to demonstrate what therapy can offer.

For the purposes of this chapter the reformulation letter will be discussed first, followed by a description of sequential diagrammatic reformulation (SDR); the latter will include a preliminary consideration of the reformulation of partially dissociated borderline patients but a fuller consideration of this will be postponed to Chapter 10.

THE REFORMULATION LETTER

This section will begin with an example—another was given in Chapter 2—and will then summarise the principles on the basis of which letters are constructed.

Case example

Beatrice, aged 28, was referred by a psychiatrist after 14 months' treatment of depression; she was currently taking tricyclic antidepressant medication, which had improved her sleep to some degree. At the interview she gave a clear account of herself. She looked tired and unhappy and wept on three or four occasions but was also able to respond with smiles and even a laugh. Beatrice was the youngest by five years in a family of four children. Her father had left her mother when she was aged six months and there had been no contact since. She saw her mother as resenting her, describing her as cold and concerned only with appearances. She was sent to boarding school aged 9 where she became a rebel and was finally expelled aged 12. Nobody seemed concerned with the reasons for her behaviour. At the age of 16 she was sent to visit her oldest sister in Canada; a letter followed from her mother asking the sister to keep her, but she refused to stay. She left school and took a secretarial training and at 18 set off alone around world, paying her way by typing as she went. She finally settled for six years in Japan, learning the language and making friends. While there she started her first deeply passionate sexual relationship with an

Englishman; when he returned to the UK she followed him, but within a few months he backed off, leaving her desolate. This had led to her seeking help.

Beatrice completed the Psychotherapy File after the first session, identifying the following items as applying to her:

Traps: Depressed thinking; trying to please; avoidance.
Dilemmas: *Either* trying to be perfect and angry and depressed or not trying and being guilty and dissatisfied. *Either* I get what I want I feel childish and guilty, *or* I do not and I feel frustrated and angry. *Either* involoved and likely to get hurt *or* not involved, in control but lonely.
Snag: I sabotage good things as if I do not deserve them.

At the second session Beatrice discussed a number of painful details from her past and she reported a dream of seeing herself wrapped in plastic among the frozen chickens in a supermarket. At the third session the following draft reformulation letter was read out (comments on it are written in square brackets):

Dear Beatrice,
Here is the letter I promised you; it is my attempt to understand your past life and how it has affected you now. We will discuss it and you will be able to alter any aspects which are wrong or do not make sense.

[It is important to stress the provisional nature of the letter, to discourage passive acceptance and to ensure that the final version will be 'owned' by the patient.]

You had a very desolate early life. You were much younger than your sisters and were probably not a planned pregnancy, and your mother was faced with your father's desertion soon after your birth. Because of that (and perhaps for other reasons we have not discussed) you remember her as a remote and unaffectionate figure; you felt she was concerned with appearances but not with your feelings.

[This is a bald summary of what had been discussed, naming clearly what seemed to have been the impact of childhood events. While it is important to avoid accepting patients' accounts as objective history—hence 'you remember' and 'you felt'—it is also important to fully acknowledge their subjective experience.]

Boarding school provoked your first rebellion but your expulsion did not seem to make anybody concerned about how you were. At 18 you set off alone and ended up making a success of work in Japan and making two or three good woman friends.

[This is perhaps an inadequate acknowledgement of the patient's strengths, a risk due to the focus in CAT on problems and problem procedures.]

Your first powerful (almost overwhelming) attachment to a man was with Richard; for the first time ever you felt securely loved. When he returned to the UK you followed, only to be rejected after a few months, leaving you desperately unhappy. Your depression stems from that time; although recently you have struggled to return to work and go to your evening classes you find life exhausting and joyless.

[Having summarised the story the letter goes on to propose some ways of linking the past with her present state. These links will have been explored verbally but often they are more clearly described in the letter.]

I feel that very early on you learned to expect little from others; it was safer to manage on your own. But, as you indicated when completing the File, you still find yourself trying to please others in the hope of getting acceptance, only to be used by them, which makes you hate yourself. Richard was the first person with whom you experienced the depth of your need for affection. Maybe what you hoped for was unrealistic or maybe, meeting abroad, it was difficult to judge what was possible. Or perhaps he was just not ready for commitment. Whatever the reason, his leaving was a terrible blow, and since then you have experienced the abandoned and uncared feelings which, I feel, you had learned to put aside in your early life.

[The letter now considers what has been learned in the first sessions. The inclusion of the patient's own metaphors or images in the letter anchors the reformulation in personal experience while extending and making explicit the understandings which they contain.]

After our first meeting you had the distressing dream you told me about, seeing yourself wrapped in a plastic bag among the frozen chickens in a supermarket. This disturbing image seemed to me to stand for the feelings of the forlorn child you have always carried within you, despite your achievements and strengths. In therapy we will be trying to thaw the chicken, to go through and beyond your hopelessness and the negative feelings you have about yourself (the target problems). To do this we will need to work on the patterns of thinking and acting which continue to make you vulnerable.

[Descriptions of the target problem procedures will now be proposed, bringing the focus of therapy onto current patterns described as traps, dilemmas and snags.]

You recognised in the File how, feeling uncertain of your worth or your rights, you try to do what others want and as a result feel used and resentful and still more uncertain about yourself. I also think that your mother's seeming indifference to your emotional needs left you with the belief that you must either be totally self-sufficient or emotionally involved and doomed to be abandoned. Having managed your life without deep involvements, the experience with Richard seemed to brutally confirm the truth of this dilemma. I also wonder how far you may have felt you deserved the difficulties of your childhood and whether this and the brief rebellion at school may be the source of your irrational guilt. I certainly have the impression that you often act as if you were guilty and ought not to be happy so you sabotage things that do go well.

[The work of therapy is now described and the possible effects of the patient's procedures on the therapeutic relationship are spelled out.]

During therapy we will work on recognising and controlling these negative patterns as they recur in daily life. We will also need to be alert to how they may arise in your relationship with me. For example, you may feel you need to please me to be accepted—and hence you may feel angry with yourself and with me because of that. You may feel that being exposed and vulnerable is too dangerous to risk. The time limit means you will certainly be 'abandoned' at the end of our 12 further weeks; this may make you

reluctant to be involved, although it will also protect you from feeling overwhelmed by dependency. And your irrational guilt may make it hard for you to accept the help that you need. We must try to face and resolve these feelings if they arise.

No therapy and no relationship can make up for the lacks you experienced as a child but I believe that working together for the next three months will give you enough support for you to revise the damaging ways you have relied on up to now. It can give new understandings and a manageable loss and by building on your strengths can free you to find the good that is available in others and in yourself.

General principles of writing reformulation letters

Most letters can follow the form of the above example, drawing upon (but often saying more clearly) what has been already discussed. The following points must be borne in mind:

1. Make it clear that the letter is a provisional one, open to revision by the patient.
2. Give an outline account of what brought the patient to therapy and a summary of the significant points in the life history. There is no point in rehearsing the whole story.
3. Show how the patterns evident in the present were derived from this past history, representing either repetitions or restrictive replacements of negative patterns.
4. Provide a summary account of the present problems (TPs) and a list of the current damaging procedures (TPPs), either in terms of traps, dilemmas and snags or of problematic reciprocal role procedures.
5. Consider how these may be manifest in the therapy.
6. Offer a realistic, not blandly optimistic, suggestion of what may be achieved.

It can be daunting to write such an account after only three or four hours' conversation, even when this has been supplemented by the patient's use of the File and self-monitoring. Trainees at first need to spend a lot of time on the task and supervision is essential.

The accounts of early life will nearly always provide a key to current issues; reciprocal role patterns from that time may still be evident and most symptoms or ineffective procedures may be understood as continuations or replacements of such patterns. Reading through the File with the patient in mind can help link, under a few general descriptions, a range of patterns presented in a variety of ways. From the first minute, the patient's reactions to the therapy arrangements or the therapist may well be illustrations of a problematic procedure. With experience, recognising countertransference feelings can become an immediate way of identifying the patient's expectation of reciprocating procedures or attempts to elicit them.

Despite the difficulty of the task, in the great majority of cases therapists produce moving and accurate letters which are received by the patient with relief and emotion, sometimes profound. Letters do not have to be exactly right for, by stating clearly what their understandings are, therapists offer their patients an opportunity to suggest changes where the account does not fit; in that sense being 'wrong' can serve to clarify the story and can provide the experience of collaboration. In practice, it is often best to read the letter out at one session and give a written copy to the patient to be studied and brought back with amendments at the following session. After any necessary changes the final version is copied and retained by both therapist and patient.

DIAGRAMMATIC REFORMULATION

The reformulation letter concludes its developmental, historical account with a verbal description of current problem procedures. These descriptions may focus on the unrevised sequences described as traps, dilemmas and snags and on key reciprocal role patterns, and in less disturbed patients these offer adequate working tools. There are, however, important limitations; verbal descriptions of sequences and of relationships can become too complicated to remember and the interrelations between different identified problem procedures may not be clear. This is where diagrams prove of particular value. Both written and diagrammatic reformulation greatly increase the ability of patients to recall subsequently understandings which are reached during sessions.

Simple flow diagrams

The sequences described as traps, dilemmas and snags can be expressed as flow diagrams: such part diagrams can be sketched roughly during sessions as a way of clarifying sequences and of gauging the patient's capacity to think diagrammatically; in the event, nearly all are capable and many are enthusiastic. Examples are given in Figure 6.1. Such provisional part diagrams may lead on to more detailed self-monitoring of sequences which are not fully understood. During the development of diagrams the listing of central subjective difficulties or the spelling out of individual procedural loops demonstrating the reinforcing consequences of maladaptive procedures generates an active and often moving working alliance and provides a basis for further correction or development. Partial diagrams remain, however, like the verbal descriptions, unable to demonstrate links between different problem procedures or to demonstrate clearly reciprocal role patterns. With the development of the Procedural Sequence Object Relations Model, a more complex and formal way of constructing diagrams evolved.

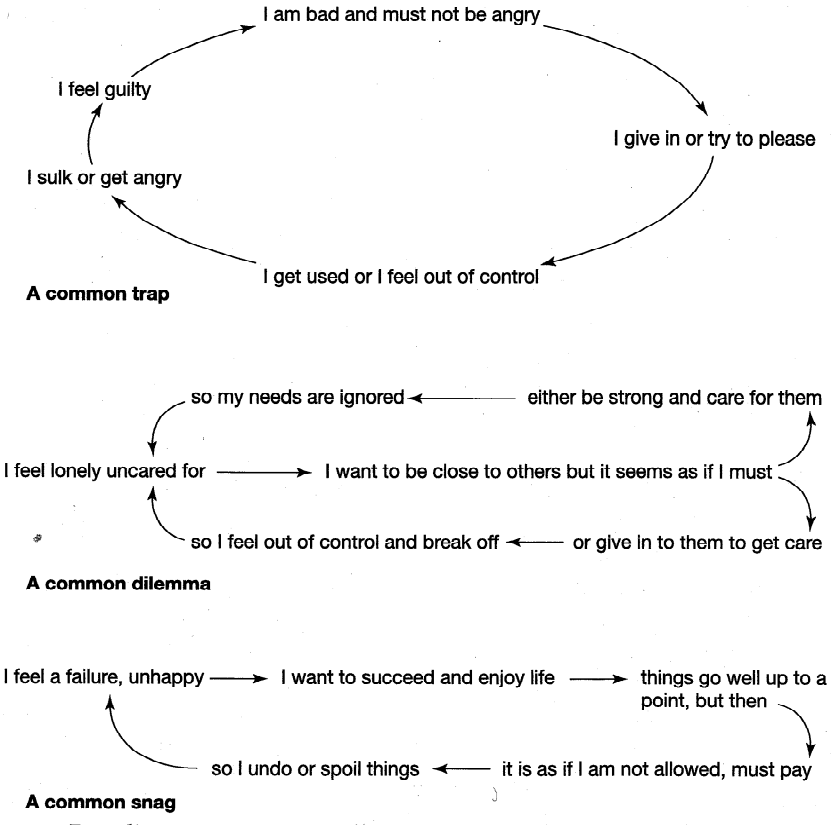

Figure 6.1 Part diagrams: sequences illustrating traps, dilemmas and snags

The principles of sequential diagrammatic reformulation

Sequential diagrammatic reformulation (SDR) sets out to describe the core reciprocal role repertoire which was derived from the past and which is now repeated in current role procedures. This repertoire is deduced by the therapist from the direct and defensive procedures which patients report and manifest. It is a theoretical construct, not an account of experience. To avoid confusion it is best to confine the use of the word 'core' to this core of the diagram and to describe deep and postulated unaccessed feelings and memories as 'unmanageable' or 'hard to reach'; in time, these can usually be identified as concerned with unmet need or deep pain or rage. The description 'core pain', which is equivalent to James Mann's (1973) concept of 'chronically endured pain', as well as being liable to be confused with the core of the diagram, is often accompanied by an under-emphasis on the reciprocal role of, for example, hurting or abandoning, which the patient may perceive in the therapist and also enact.

The diagram's core is essentially an explanatory, theoretical device. The descriptions of the central repertoire of reciprocal roles are generalisations

deduced from the range of reported and manifest procedures. Describing these patterns in general terms provides a basis for identifying the same patterns as they present (differing in detail) in later reports or enactments. In the diagram, enacted and experienced procedures are drawn as loops generated from the hypothesised central repertoire of role procedures and are traced out so as to demonstrate their outcomes—outcomes which in the case of problematic procedures will often reinforce the basic role repertoire, a fact indicated by drawing the loop as returning to the core of the diagram where this is described. For example, a pattern of *critical* to *striving* may be reinforced by hypersensitivity to any hint of criticism from others, or may generate perfectionist efforts which may lead to exhaustion and real or perceived failure, which in turn mobilises the self-critical voice. Or a *controlling* to *guilty submissive* pattern may generate placation with accompanying resentment. This in turn may lead to ineffective outbursts which serve to increase the guilt and reinforce the pattern of guilty submission to self and others.

In constructing a full SDR the procedures in relation to both self and others which are (or might be) generated from both poles of each reciprocal role pattern should be considered.

Diagrams constructed in this way embody clinically important basic theoretical concepts by (1) emphasising the reciprocal nature of procedures, (2) showing how each role is implicitly or explicitly directed to its reciprocal, (3) showing how the reciprocal may be a part of the self or another, and (4) demonstrating how a given reciprocal role pattern may be manifest in procedures described in either pole.

Sequential diagrammatic reformulation; practical procedures

In constructing SDRs therapists are called upon to remain empathically 'in tune' with the patient while thinking developmentally, sequentially, reciprocally and structurally. Here, as in the whole of CAT practice, feeling and thinking are supportive of each other. Patients will be involved in tracing particular sequences or patterns, but constructing the final integrated diagram requires experience and will have to be done by the therapist. Its use and accuracy will, however, be tested jointly and may lead to revisions or to the construction of simplified versions highlighting key therapy issues.

The construction of the diagram can start in different ways. One approach is to 'think reciprocally' from the start, seeking to identify key reciprocal patterns from the experiences which were described as significant in childhood, from current patterns of self-management or of relationships with others, from the patient's responses to the Psychotherapy File and from early transference–countertransference manifestations. It may be helpful to consult the list of common reciprocal patterns in Table 6.1 with the particular patient in mind. Once the reciprocal role repertoire is listed the key procedures generated from

Table 6.1 Common childhood-derived reciprocal role patterns

Parent-derived roles	Child-derived roles
Ideal care-giver	Ideally cared for / fused dependency
Over-involved	Over-dependent, suffocated
'Good enough'	Appropriate autonomy and trust
Incomplete, unreliable	Premature autonomy, fragile, needy
Conditional accepting or loving	Striving, performing
Dependent / uncaring	'Parental child'
Dependent / controlling	'Parental child'
Rejecting / controlling	Deprived / guilty or rebellious
Abusive / exploitive	Crushed or angry

it will then be drawn as procedural loops which trace the consequences of the enactment. For some patients it may be best to start with listing their key self-descriptions, possibly in the form of an invitation to describe their inner 'subjective self', and then to work out the reciprocal roles they relate to. All the experiences, actions, expectations, memories and symptoms described by the patient can be considered in terms of their roles and of the corresponding reciprocals as played by others or by aspects of the self. Symptoms will be located in the diagram either as accompaniments of particular roles, as when *striving* in relation to *perceived critical demand* generates anxiety, or as substitutions, as when situations where assertion or anger might be appropriate are dealt with by submissive behaviour accompanied by somatic symptoms and depression.

Procedural loops should aim to show the expected, perceived or experienced consequences of enacting a role, including the elicited reciprocations. The underlying role pattern will be described in a box (the core of the diagram) from which enacted procedures will be described on sequential loops; maladaptive, unrevised procedural loops will be drawn as returning to this core, indicating how the basic role repertoire has remained unmodified or has been reinforced. If there are also positive outcomes to some procedures they should be recorded; for example, *guilty perfectionist striving* in relation to *critical demand* could lead to exhaustion but also to achievement.

Patients find that descriptions of 'inner parent–inner child' reciprocal role patterns, based on recollections of childhood, are accessible, acceptable and often helpful, but simple equivalences between these and current procedures should not be assumed. Other significant sources, misinterpretations of experience and fantasy may all contribute to the final repertoire. It is a mistake to tie role descriptions in diagrams to the particular individuals in relation to whom they may have been formed as this may limit generalisation to other relationships and to self-management.

With experience, reformulation becomes a manageable task because key interpersonal and self-management procedures involve variations on a small number of themes, largely concerned with giving and receiving care, with lack or a loss of acknowledgement or care, with closeness or distance, with control

and submission or with abuse and victimisation. These overall patterns will be repeated in a wide range of detailed interactions.

To illustrate the process the construction of the diagram in the case of Beatrice (see above) will now be described.

Case example (continued)

The information from Beatrice's history and the reformulation letter given above were developed into a diagrammatic form. The final SDR is reproduced in Figure 6.2. It was developed with the aim of illustrating the sources of her current deep unhappiness and previous long-standing avoidance of emotional involvement.

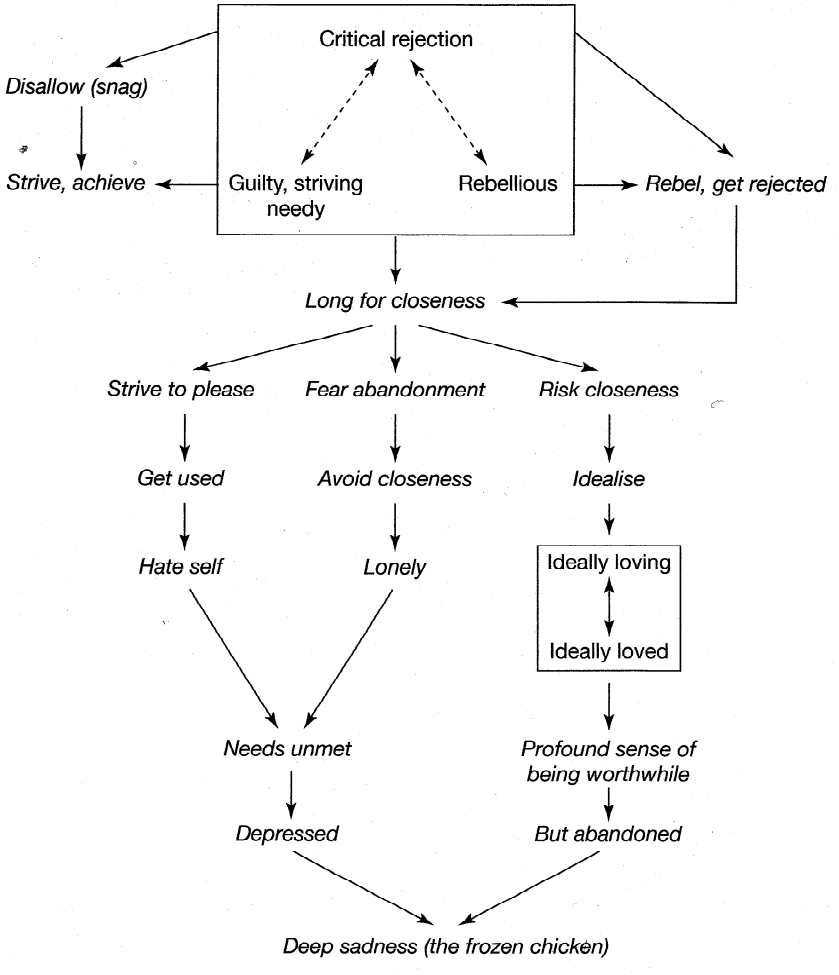

Figure 6.2 Beatrice—self states sequential diagram

The dominant reciprocal role pattern which stood out from the account of her early years was described initially as *'critical rejection* in relation to *guilty, striving and needy'*. This pattern was placed in the core at the centre of the diagram. The mother-derived critically rejecting role was seen to operate in relation to herself in self-blame (manifest in the snag identified from the File). The child-derived guilty, striving and needy role was seen to generate two main problematic procedures: (1) feeling needy and undeserving, so trying to please, leading to feeling used and to self-hate (i.e. feeling critical and rejecting of herself) and so reinforcing the core pattern; (2) striving (trying to avert anticipated critical rejection). This led to achievement, but left her deprived and emotionally uncared for, maintaining the core needy role. However, this description failed to incorporate her rebellious assertions at school and her refusing to stay in Canada, so the child-derived core reciprocal role was redescribed as a dilemma between two possible responses to critical rejection, namely: either *guilty, striving, needy* or *rebellious*. Neither achieving nor rebelling did anything to satisfy her unmet emotional needs, nor did avoiding closeness. One other powerful reciprocal role pattern (RRP) was exemplified uniquely by the relationship with Richard. Put simply, this was an example of a relationship seeming to offer all that was missing in childhood; it was described as ideally loved to ideally loving. The contrast between this relationship and all past experence and the fact that it was unique and only mobilised with Richard was described by placing this pattern in a separate core box. The link between the two cores was then traced; a longing for closeness linked with a fear of abandonment had led to placation followed by self-hate (critical rejection) or to the avoidance of emotional closeness (prior to meeting Richard). Taking the risk of involvement and his subsequent withdrawal had repeated the experience of being rejected, reinforcing the first core pattern and leaving her desolate.

The final SDR of Beatrice showed how her seeking closeness had been constrained by her narrow range of options, as summarised in the procedural repertoire, and how the experience of finding and then losing a deeply felt relationship had led to her current extreme unhappiness.

Single or multiple cores in diagrams

In the example of Beatrice the problematic childhood pattern was condensed into a single RRP description. In many cases a range of associated reciprocal roles, derived from one or both parents and possibly also involving rivalry with, or care for or from, siblings, can be described within a single core box in the diagram, indicating that the roles are compatible and that transitions between them are smooth and appropriate. In the case of Beatrice, the ideal role pattern was described in a different core box because it referred to procedures enacted in different phases of life and with only one person. In patients with

borderline personality structure, however, there may be a range of alternative, partially dissociated reciprocal role repertoires ('self states'), only one of which is operating at a given time; a similar pattern may be evident in psychotic disorders. This is manifest in markedly discontinuous behaviours and variations in self-awareness which provoke powerful but confusing and contradictory countertransference feelings in the therapist. (The term 'self state' refers to the CAT Multiple Self State Model of BPD.) These patients, because of their discontinuities, present their stories in a jumbled manner, showing what Holmes (1998b) called 'narrative incompetence'; for such patients the reformulation letter, even if incomplete, has a powerful impact in that it offers a preliminary sequential account in place of this confusion.

Contrary to a widespread assumption about the role of 'the unconscious', many patients can give clear and informative accounts of their shifting between states, although these are often not volunteered as they may be felt to indicate 'madness'. The use of screening questionnaires, as described in Chapter 10, is therefore helpful. When the presence of dissociated states is suspected, patients should be asked to record what they know about their states of mind and should monitor switches between them. Once states of mind are reliably identified, the reciprocal patterns need to be recognised. The therapist should help the patient to describe not only the dominant mood or behaviour of each state but also the sense of self and of others, the degree to which feelings are accessed or cut off and the accompanying symptoms. Finally, the therapist will need to assemble these data, locating each state as an aspect of a role and identifying the reciprocal. It is often the case that both poles of the reciprocal role pattern will be described as subjectively experienced states, as when both an abuser and a victim state are recognised, but in other cases only one pole will have been recognised as experienced subjectively, perhaps because the reciprocal is always perceived in, or elicited from (or in psychoanalytic terms 'projected into'), others.

Diagrammatic reformulation in these cases requires the recognition and characterisation of these separate 'self states', for each of which separate core boxes need to be drawn. This can be aided by discussion of the patient's replies to the Personality Structure Questionnaire (see Appendix 3) or to the last section of the Psychotherapy File, followed by self-monitoring by the patient. Partial dissociation between RRPs is indicated diagrammatically by locating core repertoires in separate boxes which define the separate self states. 'Self state', it must be emphasised, is a theoretical construct and should be clearly distinguished from the terms 'state' or 'state of mind 'or 'state of being' which describe the subjective experiences associated with playing a particular role in relation to others or to an aspect of self.

When in a given self state characterised by a particular reciprocal role pattern the patient may enact either of the roles, perceiving or eliciting the reciprocal in others. Abrupt state switches are a common feature of BPD, reflecting three types of instability which may be differentiated in the diagram:

1. Response shifts in relation to the same reciprocal, as in Beatrice's switch from trying to please to rebellious in response to critical rejection.
2. Role reversals while in a given self state, for example from victim to abuser.
3. Self state switches, for example Beatrice's switch from the self state *'ideally loved* to *ideally loving'* to the self state in which once more she felt critically rejected.

A full consideration of reformulation in BPD will be presented in Chapter 10.

Sequential diagrams and self state sequential diagrams—a recapitulation

Diagrams offer an abstraction, setting out reciprocal role repertoire(s) in one or more boxes. This repertoire is a heuristic, a theoretical construct, it does not refer to a bit of the brain or to experience. It is derived from, and is designed to make sense of, what is manifest in experience and behaviour. Listed in this way the repertoire is placed in the core of the diagram from which procedures can be seen to be generated. As argued above, descriptions of the profound feelings, which are often described as 'core pain' and which are related to Mann's description of 'chronically endured pain', should use words like profound or unmanageable so as to avoid confusion with the diagram's core. Descriptions of behaviours, symptoms and experiences should be located on the procedural loops.

Patients will describe their states largely in terms of moods and behaviours; such states are the subjective accompaniments of enacting or being drawn into a given role. The therapist's job is to explore and describe the feelings, acts and perceptions associated with each role and to define the implicit or explicit reciprocals.

How many cores in a diagram?

There are various degrees of complexity in constructing the core or cores of diagrams. The aim is to describe all major problematic role procedures in general terms. The decision about whether to list reciprocal role patterns in one, two or several cores is a clinical and a practical one. Everybody has a range of ways of being; in that sense the self is a confederacy of states rather than a single nation. The pragmatic issue is to decide how best to describe the level of their integration. The patterns illustrated in Figure 6.3, demonstrate ways in which the integration of the core repertoire may be displayed. The procedural loops are not described.

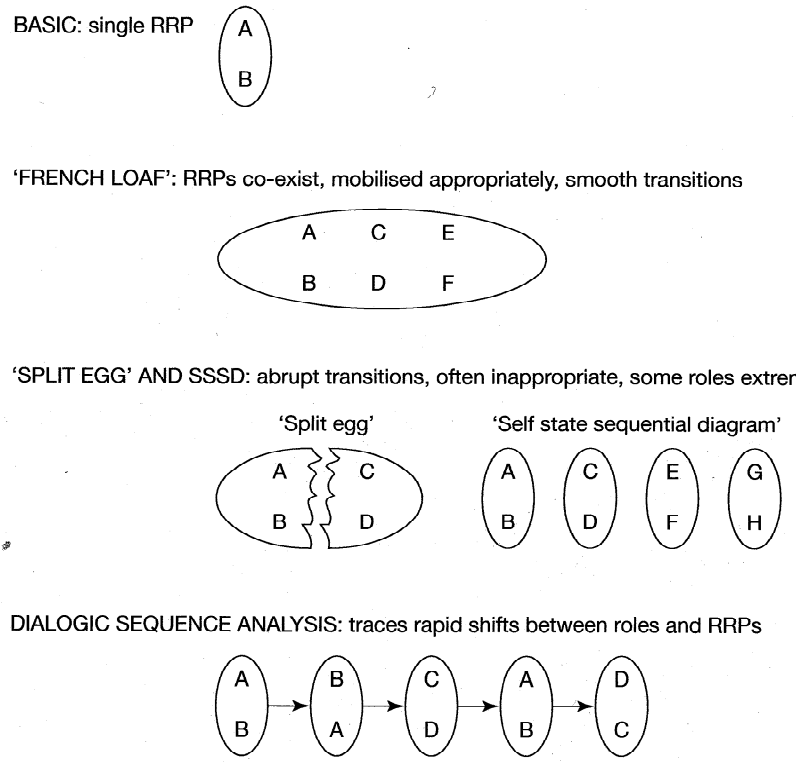

Figure 6.3 Types of cores in sequential diagrams

Basic: A single reciprocal role pattern offers adequate understanding.

The 'French loaf' diagram: A number of reciprocal role procedures are listed within the core; these may be mobilised separately or together.

Self states sequential diagrams (SSSD): One form is the 'split egg' diagram, which was the first version of divided diagrams used in CAT. There is a division into two clear self states. In BPD the common pattern is of *abuse and neglect* in relation to either *abused, deprived and guilty* or *revengeful anger* in one part. The other dissociated role pattern is commonly some version of *ideal care* in relation to *ideally cared for*. In narcissistic personality disorder (NPD) the 'split egg' patterns are more in the form of *grandiose contemptuous dismissal* in relation to *humiliation and envy* in one self state and *seeking special care and admiration* in relation to *being special and admired* in the other. These patterns are evident as alternations between grandiosity and shame. In many cases borderline and narcissistic patterns are combined. Examples will be found in Chapter 10.

'Split egg' diagrams may be satisfactory but in most cases a more complete way of mapping borderline structures is needed. In these, the early *abusing–abused*

pattern is shown to lead to some direct re-enactments or experiences and to some defensive, coping procedures involving symptoms, avoidance and so on; in either case the outcome may be to confront the individual with unmanageable levels of unmet need, sadness or anger. These may be experienced as echoes or repetitions of the original abusive experiences which led to dissociation. This 'flashpoint' or 'crossroads' may be indicated on the diagram (as in the diagram of Rita (Figure 7.1) near the end of Chapter 7), as the point at which switches to other self states occur. At times this leads to the expression of primitive rage, leading to violence or self-harm, and at times to dissociative symptoms such as perceptual distortions, depersonalisation and derealisation. Most frequently it provokes a rapid switch to an established more manageable alternative self state. This may be a 'zombie' state, in which perceived threat or abandonment are responded to by emotional blankness (*emotional withdrawal* in relation to *abandoning or threatening*), to a state characterised by *frenetic, highly focused but emotionally blank activity* in relation to *anxiety-provoking threat*, or to the search for an *ideally caring* to *safely cared* for state.

An important, overall distinction may be made between the processes (described as 'ego' defences in classical psychoanalysis) where emotional restriction is one aspect of limited role procedures, derived from the internalisation of critical, controlling relationship patterns and self-organisation marked by disorganisation and discontinuities where no continuous, central or coherent pattern exists. Flexibility in making and revising diagrams is important and the above styles are not exclusive or mandatory. The diagram made of Beatrice, described above, does not exactly match the examples for, while there were two distinct self states, these did not show the typical borderline features of frequent and abrupt alternations, being activated at different times in her life.

THE ORDER OF REFORMULATION

In the early practice of CAT the use of the File and the listing of TPs and TPPs was carried out initially, followed by writing the letter and then, as RRPs were recognised, by the construction of diagrams. This meant that the descriptions of dilemmas, traps and snags were linked later to diagrammatic descriptions of the underlying reciprocal roles. This linking often shows how a single role pattern underlies a number of TPPs; in this way diagrams offer a more succinct and general understanding. For example, the RRP *critical* in relation to *guilty* could be at the root of a placation trap or a depressed thinking trap, a perfectionist dilemma, a dilemma such as 'either blaming others or blaming myself' or of a snag whereby any success is undermined. In our opinion there are many advantages in thinking in terms of reciprocal role patterns from the start, noting (1) descriptions of past and present relationships, (2) how the self is cared for, managed and judged, and (3) the emerging relationship with the therapist. This may be apparent from overt statements and behaviour and from the therapist's

'educated countertransference' (see Sheard et al., 2000). General patterns deduced from these sources can be suggested and described provisionally, perhaps in preliminary diagrams, from the earliest sessions. Further discussion with the patient, detailed procedural monitoring and the integration of information from the File allows the final diagram to be constructed in this way, in most cases by around session 6. While there are no absolute rules in this, except to find what works best for the patient, it is our conviction that thinking reciprocally from the start and incorporating this understanding in the reformulation process offers the best preparation for the work of therapy. Because of the dominance of monadic, individualistic assumptions in our culture some therapists have to work very hard to acquire a reciprocal perspective.

THE IMPACT OF REFORMULATION

Patients respond to their completed diagrams in three main ways. Some are relieved to have a new understanding of why it has been so hard to change. Others feel sad or appalled to realise how they have boxed themselves in and fear there will be no way out; this is a common enough response in any therapy at the point at which patients realise their own contribution to their problems. For them, it is important to emphasise that these are maps of problematic procedures and not of the whole person, and important to emphasise that description is the first step, to be followed by recognition and change. A third, less common, response may be confusion. Therapists need to be careful not to impose overcomplex diagrams on their patients, even if they may need them themselves. Simplified maps describing the most damaging sequences are of more use than are brilliant reconstructions of the whole psychopathology, and leaving out many connections in the pursuit of readability is preferable to the creation of interlocking mazes resembling a street map of Birmingham.

EXITS

In general, it is best to leave the drawing in of alternative, more effective procedures ('exits') until the use of the map for a few weeks has made it familiar and well understood; recognition is the first task and only when it is reliably achieved can patients begin to explore alternatives on their own. The exception to this is where symptoms or other procedures threaten the patient's staying in therapy or where serious self-harm is a possibility; in these cases working on provisional exits located on incomplete diagrams is the priority.

In CAT, individuals are understood to be inherently motivated and socially formed rather than being rational information processors or at the mercy of unconscious and conflictual forces. The role of reformulation is to illustrate and challenge the negative consequences of the individual's particular social formation and to support the patient in the recognition and revision of what has not

gone well but was previously not recognised. Diagrams indicate in a non-judgemental way both how restrictions were maintained and how they may now be overcome and, by extending awareness of different aspects of the self, contribute to integration and control.

FURTHER READING

Case formulation methods used in a range of therapies, including CAT, are presented in Eells (1997). Examples of CAT letters and diagrams, some demonstrating earlier forms, will be found in Ryle (1990, 1995a), Ryle, Spencer and Yawetz (1992), Mitzman and Duignan (1993) and Cowmeadow (1994). Dunn (1994) describes the use of pictures in a sequential diagram made with a very disturbed patient. The diagrammatic reformulation of borderline patients is presented in Ryle and Beard (1993), Ryle and Marlowe (1995), Pollock (1996) and Ryle (1997a) and of an offender in Pollock and Belshaw (1998). The therapeutic impact of CAT reformulation is discussed in Ryle (1994). Schacht and Henry (1994) and Luborsky and Crits-Cristoph (1990) describe research-oriented ways of modelling relationship patterns.