

## Chapter 8

# THE DETAILED CAT MODEL OF THERAPIST INTERVENTIONS AND ITS USE IN SUPERVISION

### SUMMARY

*CAT differs significantly from traditional psychoanalytic therapy in its focus on description (as opposed to interpretation) of current maladaptive RRP. It differs from CBT in its understanding of the social and interpersonal origins of dysfunctional RRP and in the emphasis placed on recognising and not reciprocating these. Process research has confirmed the validity of the technique of reformulation and has demonstrated the importance of therapist competence in developing and using reformulation tools. An empirically refined model of the resolution of RRP enactments in therapy has been developed involving acknowledgement, exploration, explanation, linking, negotiation, consensus, further explanation, contacting hitherto unassimilated feelings, discussion of aims and exits. The successful use of this approach, even with a psychologically unsophisticated patient, is illustrated. This model provides a basis for accurate supervision, in particular when sessions are audiotaped.*

An alternative title for this chapter might be 'Does it matter what we do?'. Frank (1961) argued that many different kinds of influence, including that of various therapies, could be explained as the result of common persuasive elements, notably the effect on morale of being attended to by a recognised expert offering new perspectives. Luborsky et al. (1975), referring to the Dodo race in 'Alice', made a similar point in their paper entitled 'Comparative studies of psychotherapies; Is it true that everyone has won and all must have prizes?'. This

'equivalence paradox'—the embarrassing failure of research to establish clearly that any one model of therapy works better than any other—remains far from resolved despite the further 25 years of research reviewed by Roth and Fonagy (1996).

However, this should not be taken to indicate that therapy has no effect, nor that specific techniques are necessarily without value. Patients are smart enough to make use of a whole range of interventions. The Dodo phenomenon can be understood in terms of CAT theory; thus (1) procedures are related hierarchically, so that changes in a low level tactical procedure such as stopping smoking can both influence and be influenced by a change in assumptions about the value of the self; the former might be achieved by a behavioural programme, the latter by existential psychotherapy; (2) in terms of the procedural sequence model the continual cycle means that change in any one phase (involving either perception, appraisal, choice of action, enactment, consequences or the consideration of consequences) may lead to a revision of the whole sequence. Thus different therapies, focusing on different levels and on different phases, may achieve equivalent results.

In time, and given the present emphasis on the need for evidence-based practice, it may become possible to distinguish between the elements common to different approaches and the specific effects of detailed techniques on particular conditions, but it remains both important and difficult to measure clinically and humanly significant phenomena and to identify the factors relevant to service providers such as case selection and treatment costs. In the case of CAT, the model is a general one which can be applied with some modifications to a wide range of conditions and in different modalities. These include couple therapy, group therapy and work in contexts such as mental health centres (Dunn and Parry, 1997) and in therapeutic communities (Kerr, 2000); it may also have a role in coordinating treatment plans involving other kinds of treatment. Research evidence for its clinical effectiveness will accumulate from studies of different patient groups and in different settings rather than from a definitive demonstration that 'CAT works'. On the basis of the present, very incomplete, evidence it can be said that relatively well-integrated patients, suffering from disturbances of mood related to difficulties in work or personal relationships, who can benefit to some extent from any therapy offering the common factors within a respecting human relationship, respond well and rapidly to CAT. When we consider more damaged and disturbed patients, however, the particular value of CAT methods in establishing and maintaining therapeutic relationships is becoming well established.

### **CAT, PSYCHODYNAMIC PSYCHOTHERAPY AND COGNITIVE-BEHAVIOUR THERAPY (CBT): A COMPARISON OF PRACTICE**

Good practice in both dynamic therapy and in CAT depends first of all on the therapist applying an exploratory, non-directive approach to the patient's

reports and enactments. The agenda is set by what the patient brings and by the therapist's initial comments being open-ended and designed to evoke further details and associated feelings. This active empathic listening is usually well done, being part of the prior training of most CAT therapists. But what is learned from these exploratory conversations must, in CAT, be used from the beginning to identify and describe the recurrent patterns of problematic reciprocal role procedures and subsequently to link new material to these patterns. The essential act is *description* and is quite different from the interpretive interventions of traditional psychodynamic psychotherapy which may propose underlying, unconscious conflicts, memories or fantasies as the source of current problems. Insight, in CAT, seeks to answer the question 'what am I doing and what are the consequences?', not 'why am I doing this?'. Once established, this insight leads on to considering 'what else might I do?'. In practice, answering this will usually only be considered after the necessary prior stages of description and recognition have been completed.

In many cases the collaborative creation and application of the revised descriptive understandings are enough to allow the patient to explore alternatives. Some particularly entrenched maladaptive beliefs or behaviours may be challenged through the use of specific cognitive or behavioural techniques, but the premature or exclusive use of these can place the therapist in the expert teacher role, as described in Chapter 4, which assumes that patients are rational and requires them to be compliant and which can reinforce existing internalised critical or controlling voices. The traditional assumptions and structure of CBT can, in these ways, block the more fundamental work of exploring and changing underlying beliefs and values about the self. An example of this negative effect will be found in the description of a case (Susan) of obsessive-compulsive and panic disorder in Chapter 9.

The radical difference between CAT and traditional CBT can be described in terms of the kind of scaffolding provided. In CAT the emphasis is always on the place and meaning of symptomatic, mood, behavioural and relationship problems within the context of the individual's overall meanings, values and self-organisation. A premature or exclusive focus on individual symptoms, behaviours or beliefs can block the wider exploration of these central issues. Modifications in CBT involving links with interpersonal theory (Safran and McMain, 1992) or attachment theory (Perris, 1994, 2000) go some way to meeting these reservations.

## EVIDENCE FOR THE SPECIFIC EFFECTS OF CAT TECHNIQUES

Early research into the impact of the developing CAT model provided some evidence for the specific effects of its methods. Ratings of change in the jointly specified goals of therapy were paralleled by related changes in measures derived from repertory grids (Ryle, 1979, 1980) and such grid changes, predicted at the start of therapy, were significantly greater in patients receiving CAT

compared to controls receiving a psychodynamic intervention (Brockman et al., 1987). More recently, a series of studies of psychotherapy process, carried out by Dawn Bennett, has provided firm support for our belief that central aspects of CAT practice are of importance. These studies will now be summarised:

1. Bennett and Parry (1998) demonstrated that a CAT therapist and a patient with BPD created a diagram which contained all the main themes identified by two separate analyses of audiotapes of the early sessions using well-validated methods, namely the CCRT (Luborsky and Crits-Christoph, 1990) and the SASBY-CMP (Schacht and Henry, 1994). Bennett subsequently replicated this on three further cases (Bennett, personal communication).
2. The method of microanalysing transcribed excerpts of therapy sessions, of which early examples were given in Ryle (1997a), had relied upon a 'Therapist Intervention Coding' (TIC) based on a preliminary model of competent practice. In further work, Bennett (1998) refined this model of practice on the basis of a 'Task Analysis' of good outcome cases to produce an 'empirically refined model of RRP enactment resolution'. This research focused on how threats to the therapeutic alliance were resolved. Its refinement involved the serial revision of a provisional, staged model, based on analysing audiotaped records of good outcome cases, using independent raters to judge how far identified threats to the therapy alliance had been resolved. The model was revised accordingly and applied to further cases until no further revisions were called for.
3. Revised versions of the TIC were then applied to the supervision of therapists, using transcribed excerpts, and were also used by the therapists themselves, and Bennett then modified and quantified the TIC for use by observers (the TIC-O). This was shown to have good inter-rater reliability when applied to either transcribed excerpts or to the rating of whole session audiotapes. This yielded a measure of therapist competence which was shown to be correlated with an independent measure of the therapy working alliance. Using this method, Bennett demonstrated that therapists in good outcome therapies had recognised 80% of in-session enactments of problem procedures and had linked most of these to the diagram, whereas in poor outcome cases the rate was 30%. She also showed that experienced therapists received significantly higher ratings on the TIC-O than did trainees and that the ratings of trainees in supervision improved in the course of a therapy. Bennett's original and meticulous research is reported in documents submitted to the Mental Health Foundation and in a number of papers currently in preparation.

## **THERAPIST INTERVENTIONS IN CAT**

Drawing on the research summarised above it is now possible to propose some overall guidelines. It should be emphasised that these should not be regarded

as a prescriptive practice 'Manual'. Microsupervision has demonstrated clearly that therapists having a wide range of personal styles can apply the model and that each patient-therapist pair develops a shared language which manualisation could distort. Supervision using the TIC involves the retrospective application of general rules and principles to recorded material and its main aim is to heighten the awareness of therapists to what they are and are not doing; in this way it strengthens their capacity for self-reflection, acting much as reformulation does for patients.

The TIC, based on Bennet's 'empirically refined model of reciprocal role procedure enactment resolution', can be applied to any discrete episode in the course of therapy. It describes an overall sequence but may involve repetitions and tangents, ultimately going through the following stages:

1. *Acknowledgement*. To have others know and validate one's existence and experience is a primary human need without which any help offered may be irrelevant and is likely to be experienced as having something done to one rather than with one. Full acknowledgement involves an authentic and empathic acknowledgement of the experience of the other and will involve
2. *Exploration* on the basis of which,
3. *Explanation* and *linking* may be worked at. This needs to be engaged in with each new reported or enacted event, using the tools of reformulation. For this to be of meaning to the patient a process of,
4. *Negotiation* leading on to,
5. *Consensus* is necessary. The aim will be to relate the particular issue to the underlying general procedural patterns, usually by locating it on the diagram. This linking becomes real to the extent that the understanding is not imposed on the patient and is associated with emotion.
6. *Further explanation* can show how this linking can be understood. This may involve rehearsing the individual's history and how it contributed to the formation of the procedural repertoire. The difficulty in revising established patterns can be explained in a non-blaming way and the opportunity to reconsider these patterns can be emphasised.

The sense of being heard and understood and the repeated consideration of issues in these ways can lead on to:

7. *Contacting hitherto unassimilated feelings*. Supported by the new understandings and the safety of the therapy relationship, repressed and dissociated memories and feelings may be accessed and assimilated. This stage often follows the achievement of a shared understanding when, in Bennett's words, there is a 'lull in the engagement' and patient and therapist recognise what they have been through and that they remain connected. Once recognition is established, alternative procedures can be explored.
- Thus,

8. *Exits/aims* will be discussed in terms of procedural control and revision and by exploring alternative roles involving new ways of experiencing, judging and acting, both in the therapy relationship and in daily life.

These stages will now be illustrated in more detail.

### **Acknowledgement, exploration and linking**

A therapist's possible interventions may be illustrated in relation to an example: The patient has just given a bald, factual account of a friend's grief over the terminal illness of her mother. Possible therapist explorations might include:

1. An expectant silence.
2. Direct questioning; for example: 'When your friend was crying when she told you about her mother what did you feel?'
3. Parallel linking; a reference to a possibly similar episode already discussed, for example 'Do you think the way you could not respond to her sadness was connected with the way you yourself cut off from your feelings after your father's death?'
4. Naming empathic countertransference: 'You gave a very matter-of-fact account of your friend's grief but I found myself feeling sad. Do you think I was picking up something you find it hard to allow yourself to feel?'
5. Linking to the reformulation. Early on in a therapy this might take the form: 'This seems to me to be another example of the dilemma we identified; how you move away from strong feelings as if you fear being overwhelmed'. (This could be summarised as *either cut off or overwhelmed*.) Do you think that is so? At a later stage, when reformulation is complete, the patient would be invited to make the link unaided.
6. Suggesting a transference link: 'Do you think that the fact that we have only three more sessions makes you wish to avoid thinking about anything to do with endings? Looking at your diagram where might we be?'

Any of the responses described above may lead on to further explorations involving the following stages.

### **Negotiation, seeking consensus, explanation and contacting unassimilated feelings**

In the example above, the third response of making a provisional link to another reported experience, could, in the early sessions, be an important step in the process of descriptive reformulation, as it will introduce the idea of seeking for common patterns. It may also allow important differentiations to be made. For

example in this case, the patient might go on to explain how he could now feel grief for his father but was aware of having been angry with his mother for her depending on him in ways which had allowed him too little space or support for his own feelings. This understanding could lead on to the exploration of his evident role in relation to his mother; this might be one of his basic role procedures identified, for example, as *'submissively but resentfully caring'*. If the patient recognised this, other examples might follow, for example, 'I was always the one left in charge of my little sister'. The next step would be to explore the reciprocal to the caring role. This might be *'weak'* or *'weak but controlling'* or *'selfish'*. Further exploration and explanation could serve at this point both to reach a clear consensual understanding of the particular procedural pattern which determined the patient's relationship patterns and management of emotions and to convey a wider understanding of how reciprocal role patterns are formed and sustained. This understanding could be enlarged and its emotional significance brought home by the therapist's account of being made to feel sad (countertransference); feelings which the patient's resentment had blocked might now be experienced and this in turn could initiate an 'exit' from the old procedural system.

Moves of this sort over the first half or more of therapy are frequently the source of a general mood of sadness which is painful but valued, representing mourning for what is now seen to have been missing in the past. In this case, a recognition of the loss of access to emotion and its maintenance by the established procedural pattern, combined with the shared 'in the room' feelings, would open the way for revision which could lead to changes in current relationships. Termination (whether in brief or long-term therapy) is an opportunity to experience a loss directly, neither denying sadness nor protecting the therapist from anger and disappointment; for many patients this is the enactment of a new role and can represent the most powerful transforming moment.

## APPARENTLY PSYCHOLOGICALLY UNSOPHISTICATED PATIENTS

Not all patients are able to embark on self-reflection right away; they may need more educational approaches and the early exploration or modelling of alternative ways of proceeding ('exits'), but this does not mean that procedural understanding and change are not achievable, as the following case shows.

### **Case example: Grace (Therapist Michelle Fitzsimmons)**

Grace's childhood had involved degradation and neglect; as an adult she had experienced violent sexual and physical abuse from two different partners; she had more recently terminated her relationship with a third partner who had been relatively kind. She was currently allowing herself to be used exploitively

by two of her adult children who lived with her but gave her no practical help and stole from her; one was drug addicted and criminal and one had been diagnosed as schizophrenic.

In her early sessions Grace spoke in an uninterruptible monologue, cataloguing alternately her blaming anger with others and her dismissive contempt for herself as having 'bad blood'. She described how, when walking down the street, if anyone acknowledged her, she felt 'honoured'.

The audiotape of the seventh session was listened to by the supervisor. When the therapist managed to speak, her comments were emphatically positive (and not exactly in the formal negotiating CAT manner!) and they included proposing a description of a cycle of placation followed by explosive rage. This was drawn in a preliminary diagram. The therapist offered a consistent rebuttal of the patient's self-denigration and a consistent encouragement and celebration of change. The upper part of the final diagram (Figure 8.1), which was drawn in red, spelt out the origins of the 'bad blood' and traced how a snag and trap originating in this sense of self left her either sabotaging herself or placating others, in both cases leaving her needs unmet. Alternatives to these patterns were later

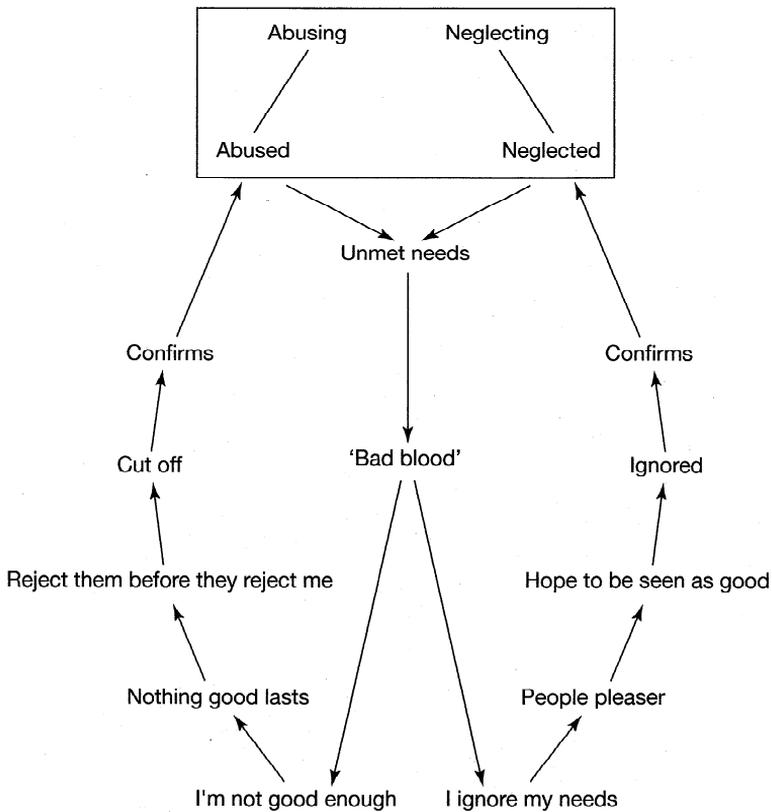


Figure 8.1 Sequential diagram for Grace

spelled out (in green) in the form of rehearsed self-statements. She repeated these to herself and soon began to revise her behaviour in current situations.

At session 12 her diagram was reviewed as follows:

*Therapist:* Do you understand this? These exits are all the things you told me in your own words.

*Grace:* Oh yes. It's getting better. It sounds terrible when you read all that (the trap and snag). I'm really doing well on these (the green). My son is out on bail at present. What he's doing is blaming everyone apart from himself for what he does—he says it's because he came from a broken home. I said that was a poor excuse because no matter what my parents have done, if I do wrong it's my doing.

Grace's therapy was interrupted and shortened because of her therapist's illness. She coped in a way which demonstrated that, despite her initial apparent impenetrability, Grace had learned to see and manage herself in a new way, and to recover when she relapsed in any way. Her weekly self-ratings showed consistent improvement.

Grace's goodbye letter read:

*'I have really found our therapy sessions helpful in making me the much stronger person that I am today. I am at last enjoying my life and I'm no longer worried about upsetting people. If I think they are not doing their job properly I will confront them with it as now I know I am as good as anyone else ...'*

At follow-up, Grace reported an example of this in her successfully getting herself a long-delayed outpatient appointment in relation to some long-term physical symptoms.

The therapist's goodbye letter was accompanied by an elegant plastic card on one side of which the diagram was reproduced, in red and green, with an additional quotation from Grace: 'I am a snake which has shed its skin—I'm in control.' The reverse side of the card read as follows: 'If I have a day when I lapse I know it won't ruin things for me. I have broken the cycle of long and hard patterns of behaviour. I can recognise and stop things from affecting me like they used to in the past by: \*Stop as soon as I recognise the old pattern. \*Look at the problem. Think about the situation causing it (the trigger). \*Listen to what I am saying to myself. Then ask myself: Is this what I want? Am I behaving in the way I want? If not, then ask myself: Where did it start to go wrong? When did it start to go wrong? Why did it start to go wrong? and How did it start to go wrong?' The card concluded, in green: 'Then think about how to break the pattern. Remember what I have learnt—in my own words! I can control it before it gets out of hand. Remember I am good enough.'

This example of unconventional CAT, in which rehearsed self-talk was applied to the understanding and control of specific interpersonal and

intrapersonal procedures, produced significant change. This also reflected the therapist's genuine and warmly communicated respect for the patient, her explicit refusal to collude with the patient's largely self-directed destructiveness, her capacity to match the patient's verbal flow and her ability to build on the patient's own descriptions to make an accurate and user-friendly diagram. An originally unpsychologically-minded, uneducated and damaged woman was able to make remarkable use of the help she was given; at follow-up six months after termination she reported that her gains were maintained and in some respects extended. There had been one episode of uncontrolled drinking.

### SUPERVISION OF THERAPISTS IN CAT

Therapy is aimed at the patient's ZPPD and the developed model of interventions described above can be understood as defining the appropriate scaffolding for CAT. There are many parallels between the therapist-patient and supervisor-supervisee relationship. The scaffolding role of the supervisor in training CAT therapists can be considered in the light of the same theory as that considered earlier in relation to therapists. Supervisors are working in the supervisee's zone of proximal development (ZPD) in their transmission of the methods and values of the model and, given that the relevant skills involve the formation and management of a personal relationship, they are also to some extent working in the zone of proximal personality development (ZPPD) – both the supervisee's and their own.

The discussion in Chapter 4 of the different styles of scaffolding is of some relevance here. The 'superaddressee' of this supervision dialogue is clearly the psychotherapy community and its official institutions and the particular features and structures of CAT. A trainee seeking recognition as a CAT therapist must follow the procedures and understand the principles of the model. Where conformity to these requirements and values is in question, the supervisor may correctly adopt the 'Magistral' voice, being the officially designated conduit of the organisation. However, given the variety and complexity of both patients and supervisees, the Socratic mode is generally preferred, in which rules and assumptions may be questioned and in which increasingly joint explorations of the detailed meanings of particular events can take place. In dislodging obstacles to understanding or failures to grasp the point, in challenging rigid adherence to inadequate versions of the model or in confronting limits and errors in the model itself, either supervisor or supervisee may indulge in 'Mennipean' humour—with a serious core.

Supervisors are simultaneously alert to adherence to the model and to the nature of the therapy relationship, where transference-countertransference manifestations may have been missed or where forms of collusion with negative procedures may have gone unnoticed. Provided supervisees have understood the model, failure to follow it is usually a manifestation of countertransference.

## AUDIOTAPE SUPERVISION

Detection of these unrecognised processes, especially where collusion takes the form of not addressing certain topics or of settling into an inert truce, is far more likely to be recognised if audiotaping of sessions is employed. In such cases it may be the case that the significant procedure, commonly involving passive resistance in some form, has not been clearly identified in the diagram. The report of any significant event which cannot be located on a diagram points to the need to revise it. Listening to audiotapes of whole sessions or even of parts of sessions through the whole course of therapy is too time-consuming under normal NHS pressures; as a workable compromise therapist in training may be encouraged or required to audiotape all sessions and listen to them before supervision and to transcribe or play selected passages.

Experience is being accumulated of a less time-consuming form of audiotape supervision, based upon the rating of excerpts on a short version of Bennett's Therapist Intervention Coding (TIC-O). Listening to a number of taped sessions had shown that failures to intervene according to the model were common in respect of two key elements, namely linking new material to the reformulation and noting and linking transference manifestations. In an ongoing exploratory project, trainee therapists are required to listen to the audiotapes of their sessions before supervision. They are required to devote the last few minutes of the session to a recapitulation of the main themes. In this recapitulation, links to the diagram of reports of transference enactments should be made or repeated. These sections are transcribed and brought to supervision where they are discussed and coded. Despite the clear focus (and despite the unapologetically Magistral scaffolding being imposed by the supervisor), a proportion of therapists continued to omit these key interventions for several sessions. Therapists found the method exposing but usually reported that it had served to improve their practice. A study of the relation of these ratings to TIC-O analyses of whole sessions and to outcome is currently under way.

## GROUP SUPERVISION

Most CAT supervision of trainee therapists takes place in groups of three or four supervisees and the ideal is to allow 30 minutes of supervision time weekly for each patient. There are many advantages in the group format, both in terms of learning from the work of others and because the authority of the supervisor is more likely to be challenged. Different previous trainings, cultural perspectives and life experiences among the supervisees enrich discussions and benefit all, including the supervisor.

## **'PARALLEL PROCESS'**

The emergence in supervision of feelings and role patterns originating in the patient or the therapist–patient relationship is understood in CAT as the manifestation of transmitted reciprocal role procedures (RRPs). Thus, the therapist's identifying and reciprocal countertransferences, which, whether acknowledged and recognised or not, reflect the patient's RRP, may be re-enacted in the supervisee–supervisor relationship. In group supervision, different members may respond to different aspects. In these ways unvoiced feelings and unrecognised RRP may be recognised or at least considered. However, it should be noted that the traditional psychoanalytic concept of 'parallel process' is complex and poorly validated (Carroll, 1996), and such phenomena should be treated as a prompt to enquiry rather than as representing any exact mirroring or re-enactment.

## **DISTANCE SUPERVISION**

An expanding interest in CAT training from people in remote areas of the UK and in other countries around the world has been met in part by developing fax and e-mail supervision, sometimes supplemented by telephone contact. Unless there has been some face-to-face contact the arrangements should be provisional until both supervisor and supervisee are satisfied that it works. Supervisees must have clinical experience and must be prepared to study the main CAT texts and supervisors must discover how far the potential trainee is able to convey the feel and content of sessions. If the trial is satisfactory then a weekly exchange may be set up, the sessions being reported and drafts of letters and diagrams being sent for comment. This arrangement has been surprisingly successful in a number of cases and reading the supervision records can contribute to the formal accreditation of the supervisee. In a current instance, three experienced and diligent Australian therapists supervised in this way also meet weekly for an hour's shared phone supervision. The addition of e-mailed voice recordings of the five-minute recapitulation at the end of sessions further strengthens the supervision. In time, the group will rely increasingly on peer group support. With further developments in technology more elaborate links may be available but these basic methods have proved effective and supervisors are able to take up transference–countertransference issues as well as issues to do with technique to a surprising extent.

(Information about distance learning and supervision can be obtained from the ACAT Office, Division of Psychiatry, Third Floor, South Wing, St Thomas' Hospital, London SE1 7EH, or via the website: [www.acat.org.uk](http://www.acat.org.uk).)