

Chapter 2

THE MAIN FEATURES OF CAT

SUMMARY

The practice of CAT is based on a collaborative therapeutic position, which aims to create with patients narrative and diagrammatic reformulations of their difficulties. Theory focuses on descriptions of sequences of linked external, mental and behavioural events. Initially the emphasis was on how these procedural sequences prevented revision of dysfunctional ways of living. This has been extended more recently to a consideration of the origins of reciprocal role procedures in early life and their repetition in current relationships and in self-management. This model—the Procedural Sequence Object Relations Model—has been further modified by the introduction of Vygotskian and Bakhtinian ideas on the social formation of mind. Practice involves early reformulation followed by work designed to recognise and then revise dysfunctional procedures in daily life and in the therapy relationship. The model of practice is illustrated by a brief case history.

This chapter will describe the development of CAT and will introduce most of the 'technical' terms employed. Although it was not defined and named as a separate model until the mid-1980s, it was derived from practice and research carried out during the previous twenty years. As this pre-history explains many of its features, this chapter will begin by summarising these sources.

Thirty years ago, there was hardly any evidence to show whether psychodynamic therapy worked. To measure the effectiveness of therapy it is necessary to declare at the start what the aims are, a task easily accomplished by behaviourists where these are defined as the relief of symptoms or modification of behaviours, but more difficult for psychodynamic therapists whose aims are

complex and are often poorly articulated or only emerge in the course of the therapy. Two small studies were carried out to address this problem. The first involved a careful reading of the notes of a series of completed therapies with the aim of finding out how early in therapy the key problems had been identified. This revealed that most therapies were concerned with only one or two key themes and that these had usually been evident early on, often in the first session. It also showed that much of the work of therapy had been directed to trying to understand why the patient had not revised the ways of thinking and acting which maintained these problems. On this basis the 'dynamic' aims of therapy could be defined early on as the revision of the identified, repetitive, maladaptive patterns of thought and behaviour.

Three patterns explaining this non-revision were identified; these were labelled dilemmas, traps and snags. Dilemmas prevent revision because the possibilities for action or relationships are seen to be limited to polarised choices; the only apparent options are to follow the less objectionable choice or to alternate between them. Traps represent the maintenance of negative beliefs by the way they generate forms of behaviour which lead to consequences (usually the responses of others) which appear to confirm the beliefs. In snags, appropriate goals are abandoned or sabotaged, because (or as if) it is believed that their achievement would be dangerous to self or others or otherwise disallowed.

The second study involved the use of repertory grid techniques. (The basic principles of this technique are summarised in Appendix 4). At the start of therapy patients completed such grids by rating how far a range of descriptions (constructs), partly elicited and partly supplied, were true of a range of elements consisting of significant people. In the case of the dyad grid (Ryle and Lunghi, 1970) the elements are the relationships between the self and significant people. Analysis of such grids provided a number of measures of the individual's way of construing self and other. Measures that reflected the issues which had been noted clinically and described in psychodynamic terms could be identified and the changes in these seen to be desirable in terms of the aims of therapy could be specified. Repeating the grid after therapy showed how far such changes had occurred. Through the use of such repertory grids, described in Ryle (1975, 1979, 1980), it became possible to derive measures of change between pre- and post-therapy testing indicating how far dynamic aims had been achieved.

What started as an exercise designed to provide evidence of the effectiveness of dynamic therapy was therefore successful; outcome research could now be based on identifying and measuring change in patients' 'dynamic' problems, described as patterns of traps, dilemmas and snags at the start of therapy, and on measuring change in the associated repertory grid measures. But the main effect was incidental to this aim, for this process, which involved explicit, joint work with the patient to identify and describe problems, had such a powerful positive effect on the course of therapy that conventional dynamic therapy was abandoned. The joint reformulation of the patient's problems became a key feature of what developed into CAT.

THE EARLY DEVELOPMENT OF CAT PRACTICE

The first specific CAT tool was developed at this stage, the 'Psychotherapy File'; a version of this is reproduced in Appendix 2. This is usually given to patients to take away at the end of the first session. It gives explanations and examples of dilemmas, traps and snags and invites patients to consider which may apply to them; these will be discussed with the therapist at the next session. The File also gives instructions in self-monitoring of mood changes and symptoms, based on cognitive therapy practice, and contains screening questions concerning instability of the self; positive answers to these suggest borderline features. The use of the File introduces patients to active participation in the therapy process and initiates them to the task of learning self-reflection. At this point readers may find it useful to go through the File with a patient, and perhaps with themselves, in mind.

Practice diverged from the psychodynamic model and was now based on the active, joint creation and use of the reformulation. Thereafter, daily life and the evolving therapy relationship were understood in terms of this reformulation and patients were involved in homework on issues related to recognition and revision of the identified patterns. Self-monitoring of symptoms and behaviours to identify when they were activated contributed to the creation of a written list of target problems (TPs) and target problem procedures (TPPs), the latter in the form of dilemmas, traps and snags. Changes in TPs and TPPs were rated by patients on visual analogue scales and discussed at each session. This procedure was not popular with therapists from psychodynamic backgrounds, but for them and for many patients it served to maintain the focus and it contributed to the accuracy of the patient's self-observation.

Despite the introduction of these 'cognitive' practices the main form of early sessions was exploratory and unstructured and particular attention was paid to transference-countertransference events and feelings and to their relation to the identified patterns. Change in therapy was seen to be the result of the patient's heightened, conscious, focused ability to recognise and in due course revise the negative patterns and of the therapist's ability to avoid reinforcing them. In addition, within the framework defined by the descriptive reformulation, a wide range of specific techniques might be employed towards the revision of problem procedures and their integration.

THE THEORETICAL MODEL

The theoretical basis of practice was now formalised in the Procedural Sequence Model (PSM). This offered a general model of how events are responded to, how intentional aims are pursued and of how revision might or might not occur. The procedure or procedural sequence became the basic unit of description, providing the understandings needed to elucidate repetitive circular

patterns of activity, including those problematic ones (dilemmas, traps and snags) which were not revised. The sequence traces out and describes the following stages:

1. External factors: events, cues and context.
2. Mental processes: (a) appraising the situation and the possibilities for action, (b) relating these to (possibly conflicting) existing beliefs, values and aims and (c) the selection of a response or action plan or role on the basis of predictions of its efficacy and outcome.
3. Action, including playing a role in a relationship.
4. Mental processes: (a) evaluating the consequences of the role or action, (b) confirming or revising the aim and/or the means used.

This model (described in Ryle, 1982) was compatible with current cognitive models but offered a more comprehensive description of the ways in which problem procedures remained unrevised. Affect, cognition, meaning and action were seen to be intimately linked and were not studied in isolation from each other and the individual was understood in relation to past and present relationships with others. Many psychoanalytic concepts, including the relation of development to structure, could be restated in terms of it. But it differed from both cognitive and analytic theories in its emphasis on the way in which the individual's engagements with others constantly reflect and largely maintain their self processes.

This basic theory needed further development in order to explain the formation of the self in early life and to clarify the problems in self-management and relationships which are the main concern of psychotherapy. This initially involved bringing into the model ideas derived from object relations theories. All procedures involve predicting or seeking to achieve certain outcomes. In seeking relationships with another, one plays a role based on the expectation of, wish for, or the attempt to elicit, one particular outcome, namely their acknowledgement and reciprocation (see Ryle, 1985). These procedures were therefore named reciprocal role procedures (RRPs), and this concept became of key importance in the revised model—the Procedural Sequence Object Relations Model (PSORM). It should be emphasised that 'role', as used here, implies action linked to memory, meaning, affect and expectation. The subjective experience of playing a role can be described as a state of mind or state of being, terms which must be distinguished from reciprocal role procedure, which is essentially a theoretical construct.

THE DEVELOPMENT OF THE BASIC MODEL OF PRACTICE

The habit of showing patients the accounts of their assessment interviews and of writing down the agreed list of identified problems and problem procedures

had been established from the beginning as part of the attempt to be as open and non-mysterious as possible. This led on to the present practice of covering the same ground in a reformulation letter addressed directly to the patient. (These were initially referred to as 'prose reformulations' to distinguish them from the TP and TPP lists—not because verse was an option!) These letters are reconstructions of the often jumbled narratives told by patients. They summarise key events in the past and suggest, in a non-blaming way, how the negative patterns learned from early experiences are being repeated or how alternative patterns developed in order to avoid these early ones have themselves become restrictive or damaging.

Working on the basis of the PSORM, the patterns identified as traps, dilemmas and snags will be linked to the individual's repertoire of reciprocal roles. In some cases deriving the dilemmas, traps and snags from the history and the discussion of responses to the Psychotherapy File is the best way to start the reformulation process. In other cases, an immediate consideration of the role patterns evident in the patient's account of early experiences and current relationships and of 'in the room' feelings and enactments is more effective.

THE DEVELOPMENT OF SEQUENTIAL DIAGRAMMATIC REFORMULATION

The description of problematic sequences is a central aspect of reformulation but clear verbal descriptions of complex processes can be difficult to construct and remember. With experience, they were increasingly supplemented or replaced by the use of sequential diagrammatic reformulation (SDR). Detailed discussion of the construction of these diagrams, with illustrative examples, can be found in Chapter 6. In their simplest form they are flow charts, which may arise from an initial, joint sketch of a patient's core 'subjective self', linking aims to outcomes and indicating how problem procedures fail to achieve the intended aim. With the development of the PSORM they came to be drawn in a way which demonstrated the generation of problem procedures from the patient's reciprocal role repertoire, which was listed in a box as the core of the diagram.

An idea of hierarchy was implicit in the model, in that the very general patterns described in reformulation were seen to be manifested in a variety of detailed actions and roles. (The patterns themselves are, of course, generalisations arrived at during reformulation from the consideration of such detailed examples.) Also implicit was the assumption that procedures were mobilised appropriately in terms of the situation and according to the individual's aims, through the largely unconscious operation of metaprocedures which also served to link together and harmonise the array of available procedures.

That harmonious and appropriate mobilisation does not always occur, however, became clear through work with patients with borderline personality

disorder (BPD). Many borderline features are best explained as the result of the partial dissociation of the patient's core reciprocal role repertoire, dissociation being understood as discontinuities in, and incomplete access between, different reciprocal role procedures. These are seen to be due to the disruption or maldevelopment of the metaprocedural system in subjects genetically predisposed to dissociate (see Chapter 10). This borderline structure is depicted in diagrams by describing separate cores to the diagram indicating what are best described as dissociated RRP's (self states). This clumsy title helps to prevent confusion between the theoretical concept of the self state and the subjective experience of a state of mind or state of being. At any one time, a borderline individual's behaviour and experience are determined by only one of these self states. The switches between, and the procedures generated by, these discrete states are mapped in self state sequential diagrams (SSSDs). Similar structures are found in many patients who do not meet full criteria for borderline personality disorders (see the case at the end of this chapter).

Recognising and describing the reciprocal role repertoire provides a new basis for the patient's self-reflection and is of particular value in helping therapists to avoid reciprocating (colluding with) the patient's damaging role procedures. In contrast to most short-term therapies, CAT does not select a limited focus but seeks rather to identify and describe these general, high level procedural patterns. Such 'strategic' patterns will have been formed by, and will be manifest in, a range of detailed 'tactical' behaviours. People are often only dimly aware of these general patterns, which are developed in early childhood, but they are not 'dynamically repressed' (that is, their inaccessibility does not have the function of avoiding painful or forbidden memories and desires) and their description and recognition can allow rapid change over a wide spectrum. An essential CAT therapist skill during reformulation is to be good at seeing what overall patterns are suggested by detailed events or repetitions; discussing with a patient whether a particular episode is an example of a more general pattern nearly always elicits parallel examples which may confirm or modify the pattern.

Verbal or diagrammatic descriptions of these patterns must be made in joint work using, as far as possible, the patient's own words and images. These are essentially descriptions abstracted with the therapist's help from the patient's witnessed or reported strategies. It is often possible to identify the repertoire without discussing early developmental history in any detail, although therapists may make suggestions such as 'do you think this pattern comes from your relationship with your father?' The recollected patterns of interaction in the childhood family (even though their historical accuracy may be uncertain) are often the clear precursors of key current procedures. The aim of historical inquiries is not to reconstruct the past so much as to explore what conclusions have been drawn from it, conclusions which may be based on partial or distorted memory but are seldom pure fantasy. CAT therapists base their comments on what can be seen or has been reported; they do not offer interpre-

tations of 'the unconscious', although comments like 'you seem to act as if everyone is bound to leave you' might well be appropriate. The vast majority of relevant mental processes are unconscious, but claiming to know what the patient could not know, as in so-called 'deep' interpretations, plays no part in CAT practice. Such interpretations are likely to be reflections of theory at least as much as they are linked to the patient's processes. They are in any case redundant because relevant unconscious processes causing restrictive and damaging procedures will be manifest in the shaping or blocking of activity, in omissions from memory or perception or in intrusions into consciousness, all of which can be described.

THE COURSE OF THERAPY

By the end of the first four sessions a sequential model of problem procedures and a narrative reconstruction of their origins in the reformulation letter has usually been jointly constructed and recorded. This demanding and often intense phase usually creates a strong working alliance. As patients feel understood and 'contained' by the reformulation they are frequently able to recall memories and experience feelings which have been muted or denied. Such memories, feelings or dreams may be supplemented by biographical writing or other forms of exploration such as drawing. Direct challenges to avoidant behaviours are seldom called for and the phrase 'coping strategy' is preferable to the potentially pejorative word 'defence'. Symptoms, mood swings and unwanted behaviours which had been monitored since the first session are increasingly understood in terms of their relation to the identified procedural patterns which are in need of revision. At this stage the need to recognise the problem procedures as they are manifest is emphasised and the focus of self-monitoring and diary keeping shifts from recording symptoms or moods to the identification of enacted problem procedures. The three Rs of CAT are, in order, Reformulation, Recognition and Revision. It is important to establish recognition before directing attention to revision, for one cannot reflect on or change what has not been identified.

The phase of uncomplicated commitment to the tasks of therapy usually fades out around the tenth session out of sixteen, as termination becomes a more real prospect and as disappointments in the limits of what has been achieved in the therapy accumulate. Both the early cooperation and this emergence of negative feelings need to be identified and named and linked to the reformulation. Failure to discuss and accept transference feelings and failure to link them to the reformulation is a wasted opportunity and is associated with dropping out and poor outcome, while the matter-of-fact acceptance, description but non-reciprocation of hostility or emotional withdrawal—and equally of idealisation—and are powerfully healing.

TIME LIMITS

The time-limited nature of CAT owed a lot to the work of James Mann (1973) and his emphasis on the importance of naming the session number, especially as termination approaches, is a part of CAT practice. Working to predetermined time limits is not the same as using long-term techniques for a short time. The process is heightened and most of the problems addressed in long-term dynamic psychotherapy can be satisfactorily dealt with. Indeed some patients with more severe disorders are more responsive and more safely helped in time-limited work where the dangers of over-dependence are much reduced and where the realistic disappointment which allows separation is evident from the beginning.

Termination is always an issue, however, and the last sessions are seldom easy for the patient or the therapist. In CAT, the practice was introduced of exchanging 'goodbye letters' at the penultimate or last session. The aim of the therapist's letter is to offer an accurate (not blandly optimistic) account of what has and has not been achieved in terms of modifying problem procedures and relieving problems and to identify where further work is needed. The existence of disappointment despite what has been achieved is expressly noted or predicted. This letter gives the patient a reminder of the unidealised person of the therapist and of the tools of the therapy and is intended to help the internalisation of the experience. In the same way the letter from the patient (always suggested but not always produced) invites accurate reflection and plain speaking. Follow-up at about three months is usually arranged; in most cases change is maintained more thoroughly than either therapist or patient expect. If this is not the case further follow-up or 'top up' sessions may be arranged. Decisions about further treatment of whatever kind are best postponed until the effects of the therapy have become stabilised and the experience of termination has been completed.

THE DEVELOPMENT OF A VYGOTSKIAN OBJECT RELATIONS THEORY

By the mid-1980s the CAT model of self processes incorporated ideas concerning procedural sequences linking internal (mental) and external events, but the origins of these in early development were not clearly described. Current theories appeared unsatisfactory. On the one hand, the dominant object relations school, largely derived from theory-based hypotheses based on the psychoanalysis of adults, emphasised innate conflicting drives, neglected the role of experience and paid little attention to the expanding body of observational studies of early development. On the other hand, simple cognitive descriptions, such as were included in the original procedural sequence model, while useful as guides to identifying negative patterns did not offer an adequate understanding of structure or of development.

The introduction into CAT of Vygotsky's understandings of the social and historical formation of higher mental processes and of the key importance in human learning of sign mediation, linked with Bakhtin's illuminating understandings of the role of interpersonal and internal dialogue, allowed a radical restatement of object relations ideas. The theoretical language now referred to reciprocal role relationships learned in interaction with caretakers and others and mediated by signs which are used first in outer and then in inner dialogue. The theory supported the use of the concrete mediating signs created in the reformulation process in CAT, such mediation being the medium of the internalisation through which transformation of the patient's internal structures could be achieved. Informed also by Bakhtin's explorations of literature, the theory replaces the traditional model of an internal world peopled by objects or part objects derived from ego and others and operating like little 'ghosts in the machine' with a model of internal 'voices'. These have been learned in activity and conversation with others but are now equally involved in external and internal communication and control—the model of the 'dialogic self'. Fuller accounts of the development of CAT will be found in Ryle (1995a) and Leiman (1994a). The introduction of Vygotsky's ideas is described in Ryle (1991) and Leiman (1992). The relation of Vygotsky to current developmental psychology is discussed in Wertsch and Tulviste (1992) and reviewed in Burkitt (1991). Holquist (1990) provides an introduction to the ideas of Bakhtin.

THE SCOPE OF CAT

Time-limited CAT is by no means a superficial treatment for mild disorders. It has a wider scope and at least as great an impact as do most currently available longer-term models. There is no reason to believe that, for most people, open-ended dynamic psychotherapy, from which there is a massive drop-out in the course of the first year, achieves more and there is reason to believe that CAT is a better intervention for more fragmented and disturbed patients. The CAT therapist works with the therapeutic relationship in a way which is more immediate and accessible to patients than are psychoanalytic interpretations and uses understandings which are not available to most cognitive therapists. Decisions to offer long-term work are best made after the impact of a time-limited intervention can be assessed.

The aims of CAT therapists are, in a sense, modest: we seek to remove the 'roadblocks' which have maintained restriction and distress and have prevented the patient's further growth and we assist in the development of more adequate route maps. But we do not offer to accompany the patient along the road. Obstacles to change are of three main kinds: self-reinforcing ineffective procedures, restricted, avoidant or symptomatic procedures and disconnected, dissociated self processes. Unlike some psychoanalysts, we do not seek to explain, let alone claim to share or replace, the wisdom and creativity of

artists, writers and philosophers. As well as being modest in our aims we are pragmatic: knowing that resources will always be limited, our main aim is to give the minimum sufficient help to those in need. In an inner city outpatient service CAT seems to be a satisfactory treatment for over two-thirds of patients and of some benefit to many of the remainder. Some of these go on to further treatment such as more CAT, group therapy or cognitive-behavioural work on unrevised procedures (Dunn et al. 1997). CAT might be more effective for some patients if given over a somewhat longer time or in separate blocks with intervals. Its combination or alternation with other interventions such as art therapy or psychodrama or group work would almost certainly be helpful for patients who are hard to engage emotionally or who need more time to explore alternatives. The paucity of such resources has not allowed these possibilities to be explored systematically so far.

Which aspects of CAT are the effective ingredients in successful therapy has not been fully demonstrated, but research summarised later in the book has shown that the reformulation process can produce accurate summaries of key issues and that systematic linking of transference enactments to the reformulation is associated with good outcome. Our belief is that the two main factors are (1) the joint creation and use of reformulation tools and their availability in written and graphic form and (2) the internalisation of these as the signs developed in the course of a collaborative and non-collusive relationship. These factors cannot be isolated from the other features of the theory and practice which allow intense but contained connections between patients and therapists.

To end this chapter we present an abbreviated and revised account of a typical CAT therapy in order to illustrate its stages and the use of the various tools.

CASE HISTORY: BOBBY (Therapist Steve Potter)

Bobby, a mature student in his early thirties, presented to a lunchtime on-call session at a student counselling service with depression and 'agitation'. Since the break-up of a four-year relationship over the previous two years he had been sleeping badly, drinking and smoking excessively despite having asthma, eating irregularly and neglecting his studies while indulging in fantasies of becoming a famous musician. He had had two previous experiences of therapy and felt he would need it always.

Background

Bobby was the youngest of a large family, alternately spoiled (especially on the many occasions when he was ill) and neglected; in part this was because his mother was frequently away in hospital. He recalled frequently lying in his bed

calling quietly for his mother, crying into his pillow and feeling inconsolable but afraid of a telling-off from his brother, by whom he was frequently bullied. He was also bullied later on at school although he had one best mate there with whom he shared fantasies of becoming a famous pop star.

Assessment and reformulation

After two assessment sessions he was offered 16 sessions of CAT. He was given the Psychotherapy File (see Appendix 2) and he started to keep a symptom diary. The Psychotherapy File and some of his diary keeping confirmed the initial patterns he had described and also set him thinking that perhaps he was not as bad as he used to be. We identified what he wanted to change (target problems) and how his patterns of relating to others and self-neglect and self-comfort fed into these. By session 4 Bobby felt much improved in morale. He had used the provisional diagram, begun self-monitoring and was keeping a diary.

At session 4, a letter was read to him which is reproduced in part:

Dear Bobby,

Here, in writing, is what we have talked about in recent weeks. I hope it can help us keep on track in the weeks ahead and serve as a reminder to you of what we have been working on.

... One thing you remember of your childhood is either feeling especially loved and treasured, or being a nuisance and ignored and smacked and told to shut up and go to sleep (for example by your brother). You felt you were cared for if ill but otherwise ignored by your older brothers and sisters. You tried to please them and win them over but always felt scared.

This pattern seems to have been echoed in your close relationships with women and with a therapist previously, as well as in the way you either neglect and ignore your own needs or seek comfort through drink or smoking dope ... You are usually neglectful of your body and have not seen a doctor or got proper care (for asthma and other ailments) ...

We have named a number of patterns of feeling, thinking and behaving:

- 1. You long for special care but fear it won't last, so you tend to cling anxiously and alienate others (as with Elizabeth your partner), leaving you still uncared for.*
- 2. Feeling depressed leads you to drink or smoke dope and ignore problems which then build up making you feel low and even more depressed.*
- 3. You receive care, but only if 'special', so you strive to create special claims but feel you must suffer to deserve it and so neglect yourself and become 'agitated' and drink or smoke dope.*

These patterns undoubtedly arose from the ways you coped with the limited options of your childhood; they seem to have given you some intimacy and relief but they have been costly ...

Already in our relationship we have seen how you push to get me to provide comfort and hold you through this difficult time when you are no longer in a relationship with a woman who will rescue you. By learning to recognise these patterns in therapy you will be better able to explore more satisfactory ways of doing things.

You have said you have been impressed with my help (a bit like the honeymoon phase in one of your relationships), but I suspect it will be hard to imagine how short and limited

our relationship is (16 sessions), and how you will cope with tolerating the disappointment when I cannot meet your current pattern of neediness ...

Our aims in therapy will include:

- learning to be less clinging and demanding in relationships*
- getting help with your health*
- focusing on working for your degree and on more concrete 'out there' activities and achievements.*

With best wishes

He was moved and tearful as the letter was read out. He said he had learnt more in five sessions than in four years of previous therapy. He began to see his helplessness within a wider emotional narrative. The state of forlorn 'agitation'—which seemed deeply part of him and just swept over him, especially at night-time, had hitherto seemed beyond his understanding. Now it began to be seen as part of an emotional story. However, he did not like the ending being mentioned in the letter. He asked if he would be better after 16 sessions.

The course of therapy

Before the next session he left a note in which he said his relationship with Elizabeth his partner was definitely over and could he have an extra session? I said I couldn't see him for an additional session and he later left a letter saying he wanted to stop the therapy:

I think I am going to have to stop the therapy for now. It has been very revealing but is too much at the moment and I must concentrate on my studies. I am writing so you can allocate tomorrow's session to someone else but if you would like to see me I am on the phone. If not, then I 'd like to thank you for all your hard work and for helping me to see so many things about myself which need to be changed.

On the telephone I said I felt strongly that we should have one session to review how his wish to end fitted into the patterns we had already identified. At the next session he said that he had felt very relieved by my telephone call. He wanted to continue and had had a 'breakthrough' by seeing all the places on the diagram where he could do different things. In particular he had made a feature of having 15 minutes' self-care time when he felt most agitated. He had other plans of self-care such as going to the gym and not smoking at night. He described what he called his third person perspective as a way of standing back and looking at himself: not being in a state but looking at the state he was in. A simplified version of the diagram showing the enactment of a key reciprocal role procedure is shown in Figure 2.1.

From session 4, Bobby had rated his progress on his aims of recognising and revising his identified problematic procedures (TPPs). Figure 2.2 shows a rating sheet for the first of these.

18 THE MAIN FEATURES OF CAT

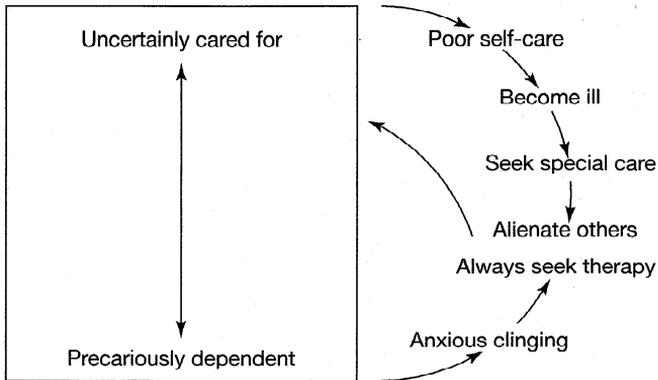


Figure 2.1 Simplified version of SDR for Bobby showing one key RRP

TP
Target problem

Patient's name: Bobby

TPP 1.
Target problem procedure

Longing for special care but fearing it won't last, so tending to cling anxiously and alienate others, leaving you still uncared for

Therapist's name:

Date:

A RECOGNITION Rate how skilled and quick you are at seeing the pattern	more																		
	same																		
	less																		
B STOPPING AND REVISING Rate how far you are able to stop the pattern and/or replace it with a better way	more																		
	same																		
	less																		
		S4	S5	S6	S7	S8	S9	S10	S11	S12	S13	S14	S15	S16	S17				

AIM 1.
Alternatives or exits:

Learning to be less clinging and demanding in relationships

Figure 2.2 Rating sheet for target problem procedure 1 for Bobby

Termination

In session 11, he noted he had five more sessions and asked if I could spread them out to make them last. We talked about his continuing health problems (a recurring theme) and wondered if he might now seek medical help. We looked at it in terms of the diagram and linked this to the old pattern of having to suffer to achieve or get love. We discussed how he could continue to work after therapy on how my 'abandonment' might be a helpful experience. He seemed helped by the idea of asking for realistic care from self and others. We wondered what a realistic 'okay' relationship with Elizabeth might be like. He talked about me abandoning him and how maybe he could learn from it. He paid detailed attention to his not sleeping pattern and noted that the 'agitation' was provoked by thoughts about how forlorn and neglected he was. We wondered what he could do to change his going to bed routines and how to promote self talk whenever he did wake in the night so as to dispute the forlorn feeling.

Bobby rang two days before the final session asking if it had to be the last. I restated that it was tough, but asked how he would learn about managing on his own, using what he had learnt with me, if he did not end the therapy. In the final session, as he read out his goodbye letter, he was in tears and had to stop several times. He wrote:

I can see how I throw myself in and expect too much. I don't know how to hold back. I tried to rope you in to make it impossible for you to reject me, but you were having none of it and I appreciate that. I can't give my whole self to people and expect to be looked after. I have to look after myself. I am beginning to look after myself. The few months we have been seeing each other have seen possibly the biggest changes in me, at least in my way of thinking. I have worked hard at it and will continue to do so because I have seen that it is possible to change. I'm feeling more able to live in the 'external reality' and this seems to have come from protecting my 'self' a bit more.

Follow-up

In the follow-up session after his final exams, Bobby said he could now see the revised diagram in his head and use it. He could now tolerate shifts in mood, which still came but were now less extreme. There had been some tough times and he had rung Samaritans once just to talk to someone. Things were not all resolved and there were still times of despair, but he felt he could survive and work his way out of, or into, relationships with more mutual understanding.

He had seen his GP and was seeing the asthma nurse regularly. He had resumed a more balanced relationship with Elizabeth, was sleeping better and living a more healthy, self-caring lifestyle. He had been able to sustain academic work with a more normal sleep pattern, obtained a degree and had a more realistic career goal not based on fame. He no longer thought he needed long-term therapy and was on better terms with his mother, brother and sisters.

FURTHER READING

Key papers marking the evolution of CAT are Ryle (1979, 1985, 1991, 1997b) and Leiman (1992, 1997). The main developments are reviewed in Leiman (1994a). The early integration of cognitive and behavioural ideas and the transformed account of some psychoanalytic notions incorporated in the Procedural Sequence Model is described in Ryle (1982). Further CAT critiques and modifications of psychoanalytic ideas are presented in Ryle (1991, 1994, 1996, 1997b). The present volume is the last of a series in which the initial process of integration has been followed by the increasingly clear articulation of a distinct theory and practice. To date, no systematic critiques of CAT have been published. Many other integrative models exist, of course, the majority being described in Stricker and Gold (1993).