Chapter 7

THE THERAPY RELATIONSHIP: WORKING AT CHANGING

SUMMARY

The tools of reformulation are used to guide subsequent work during which a range of other specific techniques may be used. However, the fundamental work of CAT involves continual reference back to and focus on these reformulations, which should describe and illuminate enactments of key RRPs both out of and in session. Therapists need, above all, to avoid reinforcing (colluding with) dysfunctional RRPs and must be alert to the state switches which occur in more disturbed patients. Monitoring and working on revising the enactment of such roles continues to demand high levels of concentration and intense work from both therapist and patient. This work is assisted by use of aids such as rating sheets and, possibly, other forms of 'homework', and may involve other techniques such as graded exposure or writing of 'no send' letters. Therapist responses to the patient are described in CAT in terms of personal *and* elicited *countertransference. The latter is further divided into* identifying *and* reciprocating *varieties. Awareness of these enactments is critical in avoiding collusion, particularly in working with difficult or personality-disordered patients. Sequences of patient RRPs and their associated dialogic 'voices' may also be mapped by the technique of* dialogical sequence analysis *developed by Leiman, an example of which is given. Finally, further enactments and difficulties are to be anticipated towards termination and these are explicitly considered by both patient and therapist through the writing of 'goodbye letters'.*

With the creation and revision of the written reformulation and diagram the first phase of therapy is complete; the therapist has acknowledged and explored the patient's experience and together a new way of understanding has been

negotiated and agreed. At this point there is a change of gear; the descriptive tools which have been created and recorded must now be applied actively to the task of change. This change involves two overlapping phases; the first involves the deliberate use of the tools to recognise each time the problematic patterns of behaviour or thinking recur, the second is devoted to their control or replacement.

In this chapter the main issues and techniques involved in this phase will be considered; a more fine-grained consideration of therapist interventions will be provided in the next chapter. It is important to recognise that, in all but the simplest problems, the work of therapy involves much more than the use of the reformulation tools under the didactic guidance of the therapist; it requires the skilful continuing development of the therapeutic relationship. The therapist's focused attention and concerned curiosity have been, for many patients, a new experience generating a new optimism but change is not easy and old patterns reassert themselves. Wider issues concerning the sense of self and meanings of others will be brought to the therapy relationship and will be addressed by the formal tasks but also and crucially by the human quality of the relationship as it evolves and is thought about. The early clarifications offered by reformulation encourage patients to think about changing but also serve to create an opportunity for mourning of past experience of losses and reflection on missed opportunities and unfulfilled potential. Here therapists need to be capable of attuned silences and of active exploratory methods such as empty chair techniques and responding to and exploring the patient's painting or imaginative writing. In these ways, while focusing on the recognition and revision of maladaptive procedures, therapists also convey a trust in the patient's capacity for further growth and individuation in the ways emphasised by humanistic and Jungian approaches (Samuels, 1985; McCormick, 1990).

THE WORKING ALLIANCE IN THE ZPPD

Vygotsky was describing the teaching of intellectual skills when he defined the the zone of proximal development (ZPD) as the gap between current ability and the level of learning which the individual has the capacity to attain if provided with the support of a more competent other. As discussed in Chapter 4, good teaching aims to operate in this zone and, by analogy, good therapy should aim to address the zone of proximal personality development (ZPPD). Because the idea of self-reflection, in the sense of thinking about one's own thought processes, is an unfamiliar activity for many people, one task of therapists is to provide concepts and experiences supporting the development of this capacity. Using the Psychotherapy File and taking part in the collaborative process of reformulation are ways in which CAT therapists are active in their patients' ZPPD, and many so-called 'pre-contemplative' patients (Prochaska et al., 1994) are able to rapidly extend the scope of their self-reflection. However, the wish to

undertake therapy and change one's life in some way does undoubtedly depend in some measure on an individual's experience of a sense of personal crisis, whether focal or at an existential level. Motivation, in CAT, is not seen to represent an innate quality of the patient but is rather seen to be the result of experiencing a helpful and meaningful relationship in which an understanding of unhelpful role procedures is generated.

As discussed earlier, the therapist is not a teacher in the ordinary sense of the word. Wood et al. (1976) described the teacher's role as the provision of a 'scaffolding' of necessary concepts which become the intellectual tools used by the pupil. This metaphor is transferable to therapy and reformulation exemplifies it, but the emphasis is different. The creation and transfer of the conceptual tools needed for self-reflection represents only one aspect of therapeutic learning. The child's learning about the self and others is conveyed by the mode in which his or her explorations of the world are supported by parents and other caretakers. Earlier learning may have been conveyed by constricting, authoritarian ('Magistral') straitjackets rather than by scaffolding, or the individual may have been left largely unsupported. Where the assumptions about the values and meanings accorded to self and others are concerned, the levels of respect, acceptance, acknowledgement and control provided by caretakers is more important than any direct instructions about values or behaviours. For example, an authoritarian parent may proclaim benign beliefs and liberal values but will be present in the child's mind as a source of instructions to be obeyed. It is important that therapists do not convey their understandings in a similar style. Nor will the child of emotionally unavailable or mystifying parents get help from a therapist who offers silence or incomprehensible interpretations. Forceful therapists may succeed in shouting the parental voice down, sending the patient away obeying a better set of internal instructions; in other cases, given world enough and time, patients may finally discover something useful from obscure or baffling therapists. The aim in CAT is to offer a more equal, exploratory, explicitly collaborative (Socratic) relationship which can generate a thoughtful, accurate, accepting and generous internal conversation. Understood in this way the creation and maintenance of a good working alliance requires the full range of sensitivities and skills. The tools and techniques of CAT are intended to support the therapist in maintaining such a generative relationship even in the face of all the ways in which patients may withhold trust and undermine change.

The working alliance of therapy is therefore a special and unfamiliar form of relationship, combining teaching and learning with the provision of an arena for the manifestation of the patient's procedures. Observing the relationship as it evolves in this arena allows a different kind of learning: the capacity to sustain relationships is developed by the therapist's recognising and not reciprocating destructive patterns and encouraging the patient to participate in a new form. Therapeutic 'technique' is aimed at generating and living through an intense, reconstructive relationship.

TRANSFERENCE AND COUNTERTRANSFERENCE

In every relationship people bring their own repertoire of reciprocal role procedures and expect or attempt to engage with others in terms of one or other of their familiar patterns. They (we) will usually seek out others who have, or whom they believe to have, a matching repertoire, with shared or reciprocal features. If they do not get the expected and desired reciprocations they may attempt to extract them forcibly or they may give up. In close, emotionally significant relationships the reciprocal roles will usually repeat patterns evolved in early personality development and reflecting basic assumptions about trust, acknowledgement, care and power.

PSYCHOANALYTIC UNDERSTANDINGS

A major contribution of Freud's early work was his recognition that, when his patients demonstrated feelings and behaviours which he felt were inappropriate to the situation, they were manifesting assumptions originating in childhood. This 'transference', first thought of as an obstacle, was soon seen to present a direct opportunity to address the patient's problems by recognising, interpreting and not responding in the ways expected or wished for by the patient. The origins of psychoanalysis in hypnosis, with the patient recumbent and (in Freud's case) with the analyst being out of sight, combined with the classical analyst's principled denial of ordinary conversational responses, means that a particular form of transference is liable to be elicited, typically one in which initial dependent idealisation is followed by anger and a regression to more childish modes. This supposedly neutral stance of the analyst was claimed to be the necessary way of achieving an understanding of unconscious processes and over the course of the last century many influential schools of psychoanalytic practice have proposed an increasingly exclusive and intensive attention to the regressed relationship evoked by the technique. However, the traditional assertion that cure may be effected through interpretation alone of such a transference neurosis has not been substantiated. Indeed there is evidence that therapeutic outcome may be inversely related to frequency of transference interpretations (Piper et al., 1991). Recently, however, more attention has been paid to the limits of this approach and the focus has shifted to addressing what Stern et al. (1998) describe as 'implicit relational knowledge'.

A related understanding concerns the responses of the analyst; this 'countertransference' was seen initially as the contamination of the analytic stance by the analyst's neurotic reactions (an idea leading to increasingly prolonged training analyses, the value of which has never been demonstrated) but emerging from this was a realisation that countertransference was also a specific response to what the patient was conveying. With this understanding the trained awareness of countertransference became an important source of information about

the patient and greater attention is now paid to the intersubjective nature of the analytic relationship.

CAT UNDERSTANDINGS OF TRANSFERENCE AND COUNTERTRANSFERENCE

In linking transference and countertransference, psychoanalysis, especially in object relations theories, developed a more interactional model of therapy. But it remained largely concerned with the particular form of unequal, regressed relationship generated by the rules governing psychoanalytic practice. In CAT, transference and countertransference are seen to be one particular example of the general model of relating through the meshing of reciprocal role procedures. To focus exclusively on this is, from the CAT perspective, curious and unhelpful. Freud's original observation that what patients bring into the relationship with the therapist is news about them and offers a therapeutic possibility is fully accepted in CAT, but the belief that change can only be achieved by means of deliberately inducing regression is not. The conventional analytic reciprocal role pattern locates power in the analyst and could be summarised (or perhaps caricatured) as *'unself-revealing omniscient interpreter* in relation to *recumbent, regressed, interpreted object of interpretation'*. CAT, being a time-limited therapy, has not time to reduce patients in this way but, more importantly, there is no need to. The use of information about the patient's past and present relationships and evident sense of self on the one hand, and the therapist's cultivated sensitivity to what the patient is imposing or seeking on the other, allow a reformulation of the central problematic role procedures to be arrived at in a few sessions in most cases. This can both account for the problems for which therapy is sought and predict what is likely to emerge in the therapy relationship.

Patients can use this understanding to recognise and change their everyday relationships and self-management procedures, and many do so, but learning is more immediate in the therapy relationship, where recognition can be linked to non-reciprocation and the exploration of alternatives. Failure to recognise negative procedures operating in the therapy relationship, whether hostile, avoidant or idealising, will inevitably block progress. Conversely, the use in CAT of the same concepts to consider the therapy relationship and the relationships of daily life aids generalisation of what is learned from the lived understanding of transference and countertransference to daily life.

The therapy relationship is not characterised by one single transference–countertransference relationship; many changes may occur in the course of a therapy or indeed of a session as different RRPs are mobilised. Early listing and mapping of the repertoire of reciprocal role procedures and continuing use of the diagram to trace what is happening during sessions is one of the major contributions of CAT technique; it enables therapists to become skilled at

recognising the meanings of the range of feelings evoked during their time with each patient. Reformulation indicates the patient's likely pressures and invitations to collude; it can be a useful exercise to trace how countertransference varies according to where the patient is located on the sequential diagram. In the case of borderline patients which events or remarks from the therapist provoke state switches and which states are signalled by symptoms can only be identified and clarified by meticulous use of the diagram.

PERSONAL AND ELICITED COUNTERTRANSFERENCE

It is useful to distinguish two sources of countertransference. One, which may be called personal countertransference, will reflect the therapist's particular range of role procedures. These are bound to be idiosyncratic even after, and perhaps partly because of, years on the couch! They may include unhelpful vulnerabilities such as an undue wish to be depended on or to control or a tendency to avoid anger or trivial personal quirks like a dislike of fat people. Whatever they are, patients will seem to be remarkably skilled at eliciting them; trainee therapists need to use supervision to become aware of their particular tendencies; in due course one can learn to recognise the 'temptation' to collude and use it as evidence about the patient's procedures. Such personal countertransference is not totally distinct from the specific reactions evoked by the particular patient, which can be called the elicited countertransference, for the individual threshold for different feelings and behaviours is bound to vary.

IDENTIFYING AND RECIPROCATING COUNTERTRANSFERENCE

Within elicited countertransference reactions there is another useful distinction to bear in mind, that between identifying countertransference and reciprocating countertransference. This distinction bears some similarity to the historic concepts of concordant and complementary countertransferences described by Racker (1968). This distinction in CAT stems logically from the model of the dialogic self. A person enacting one pole of a RRP may either (1) convey the feelings associated with the role to others, in whom corresponding empathic feelings may be elicited, or (2) seek to elicit the reciprocating response of the other. These processes may involve direct speech and action but are often powerfully conveyed non-verbally by tone, posture and expression.

In the course of therapy, therapists can use their identifying countertransference to explore feelings which the patient is conveying non-verbally but does not acknowledge or experience consciously. This does not need to be done mysteriously or omnipotently; it is enough to say something like: 'in the last few minutes, while you have been talking, I have felt an undercurrent of anger

(or sadness, or pain etc.); maybe it is your tone of voice or the way you are sitting. Am I picking something up from you?' Silences are often occasions when such indirect communications can be identified.

As regards reciprocating countertransference, the need is to recognise the pressures and to avoid reinforcing (collusive) responses. Here too quite straightforward comments can be made, such as: 'As this is the third week you have not brought the diary you and I had agreed it would be helpful for you to keep, I feel you are needing to show me that you are in control or are angry in some way. What do you think?' Or: 'Could your telling me how much help you had from your herbalist, your neighbour and from the article in the colour supplement and your dismissal of the Psychotherapy File as being too elementary to be of use be your way of telling me that you do not think much of this therapy and of me?' When negative feelings or intentions are picked up, especially when they are directed at an actual vulnerability, it is important that therapists avoid (or admit to) covert expressions of countertransference hostility in the comments they make. It is also important to know and acknowledge the possibility that the patient is reacting to an actual deficiency or error on the part of the therapist.

Either identifying or reciprocating countertransference may indicate feelings in the patient which contradict what is overtly said or done and may express feelings which the patient has not been able to acknowledge; naming and exploring these makes them available to the patient for reflection. To further add to the complexity of the therapist's task, different forms of countertransference may co-exist as, for example, when one feels distress on seeing or hearing of a patient's self-harm or self-deprivation (empathic identification with the victim) and at the same time feels angry in response to what they have done to themselves (reciprocating anger evoked by their undermining of their lives and of the therapy). The most confusing patients are those with borderline personality disorder (BPD), because of their abrupt switches between states. This is particularly the case when anxiety provoked by touching on feared subjects leads to 'whirlpooling', a continuous process of rapid switching between states. When this happens, therapists need to impose a pause for thought which may be linked with getting the patient to try physical relaxation. The therapist then needs to examine one segment of the patient's behaviour or narrative at a time. A clearer understanding can be achieved by using dialogic sequence analysis (Leiman, 1997), of which the following is an example.

DIALOGIC SEQUENCE ANALYSIS

Case example: Alistair

Alistair was a 52-year-old solicitor who had recently been asked to resign from his firm after he had been involved in some shady financial dealings and had

narrowly escaped prosecution. His self states sequential diagram described two dissociated reciprocal role patterns, one 'arrogant contempt A in relation to scum B' and the other 'admiring C in relation to admired D'. This represents a typical narcissistic personality disorder pattern. This notation is used to trace the role reversals and self state shifts as follows:

Alistair arrived 10 minutes late for his sixth session, a little out of breath, and explained he had stopped to chat with an acquaintance near the hospital (Alistair A to therapist B) and adding that he had run up the stairs, which showed how superbly fit he was despite smoking and drinking too much (Alistair C to self D). He launched into an account of his holiday abroad; he had angered his wife by his arrogance (Alistair A to wife B) which he attributed to her failure to show concern for him (wife's failure to be C to Alistair D) when he had been infuriated at the airport by the incompetent airline (Alistair A to airline B) and by the rude, idiotic French fellow passengers (Alistair A to French passengers B). Where they stayed the other English guests had been a dreary lot (Alistair A to the English B) but there were two charming Irishmen (the therapist was Irish; Alistair C to therapist D). They were very free in their behaviour; doubtless the therapist had had numerous affaires? (Alistair A and C to therapist B and D).

TRANSFERENCE, COUNTERTRANSFERENCE AND THE WORKING RELATIONSHIP OF THERAPY

A therapist's response to a patient is, of course, evoked by the full range of the patient's characteristics, communications and behaviours, not all of which are transference manifestations derived from childhood and not all of which are problematic. Some are evoked by the unfamiliar way therapists behave and this points to the need for therapists to be explicit about their role and to invite and respond accurately to questions and arguments about it. There is no reason to believe that opaque, vague or emotionally blank therapists have a particular access to transference, for patients, like all of us, repeat their patterns wherever they go. Therapists doing CAT should be open about how they understand their role, preserving the right to limit their availability and to maintain their own privacy but able also, within the clear boundaries established through reformulation, to offer direct human responses. Therapist and patient roles are not symmetrical but they are of equal value and the aim should be to base them on openness and mutual respect.

CAT is a demanding model for therapists and patients. Because it involves a high level of participation from patients a common transference response is one of initial commitment followed by withholding or disappointment; the successful holding on to the working relationship through these threats to the alliance is a key therapeutic task. Because it is intense and brief, dealing with loss and disappointment is a necessity, but one which, with the support of the reformu-

lation tools and goodbye letter, allows the internalisation of the work done together.

In the discussion of technique which follows it is assumed that every kind of activity occurs in the context of, and has implications for, the developing therapy relationship. The working alliance is an alliance between the therapist and the patient which depends on the rapid extension of the patient's ability to experience and feel and to think and reflect on the self. Jellema (2000), from an attachment theory perspective, suggests that patients whose tendency is to avoid accessing feeling need a different approach from those who have difficulty in thinking about themselves. But in many, if not most, patients both kinds of difficulty are met with, and the therapeutic response needs to address both, bearing in mind that it is often the 'cognitive' aspects of CAT which provide the safety within which feelings can be accessed. Where patients have little faith in their capacity to reflect it may be important, once the scaffolding of the basic reformulation tools has been constructed, for therapists to avoid being too busy, so as to allow space for initiative and experimentation, and to remember that silence may be the appropriate form of activity at times, even in time-limited therapy.

TECHNICAL PROCEDURES

Following the completion of the reformulation phase the first ('honeymoon') sessions are usually characterised by the patients' active involvement, buoyed up by a new optimism and a developing understanding of the sources of their problems. This mood may include an element of magical hope or of idealisation of the therapist who has brought them to this point, or may be expressed in compliant or placatory participation in the work. In the very short run these attitudes may serve to collect information and initiate new forms of diary keeping, but the procedures and their predictable, ultimately negative, outcomes should always be noted.

RATING PROGRESS

When verbal descriptions of target problems and procedures are employed, change can be rated on visual analogue scales the mid-point of which represents the state at the point that therapy starts (see Chapter 2 for an example). In the case of target problem procedures ratings may initially be made of recognition rates and only when recognition is reliably present should ratings of change be made. Where diagrams are the main reformulation tool used, ratings can be made of the frequency or intensity with which particular procedural loops are enacted; in BPD the frequency with which problem procedures and switches into negative self states occur can be noted.

The use of rating scales is disliked by a few patients and by rather more therapists and may have to be replaced by alternative methods. Regular review is, however, important. It has two functions: one is to build up the patient's capacity for realistic self-evaluation, the other is to ensure that both patient and therapist keep in mind the whole array of problem procedures and confront those in which no change has occurred.

RECOGNISING PROCEDURES AS THEY OCCUR

By the end of the reformulation phase, diary keeping and work in the sessions has usually located the place of symptoms, mood switches and unwanted behaviours in the procedural structure. The patient's attention has usually shifted from these once-automatic and apparently spontaneous experiences to the recognition of the newly identified problem procedures with which they are associated. In the case of borderline patients, the recognition of states and state switches will be the priority. Diagrams are the best basis for this monitoring and many patients keep them in their handbags or wallets or pinned over the bathroom mirror for ready consultation. The diagrams need to be as simple as possible and memorising them is helped if the core patterns and procedures are colour-coded. Borderline patients commonly choose predictable colours for their states and procedural loops, such as pink for idealising, black for depression and red for rage. Simple diaries of significant events can be kept for each day and colour coded by the patient; not infrequently the colour becomes the mnemonic device; so, for example, a patient may report 'I was feeling she was really wonderful—the kind of girl I had always hoped to meet. But then I realised that I hardly knew her ... so I saw that yet again I was off into my pink state'. Such colour coded 'maps' are best left on the table between the patient and therapist during sessions and during supervision so that both events occurring during the session and the reports of the previous week can be located and placed in the context of the whole picture.

RECAPITULATING AND REVIEWING THE SESSION

It is a good idea, especially in the first half of therapy as a common understanding is being established, to set time aside at the end of each session to go over the main themes and feelings and to repeat (or now notice for the first time) their meanings. Often, the content may have dominated the discussion and the mood and important aspects of the process with transference implications may not have been noted. At this recapitulation, both reports and transference enactments need to be located in the procedural system by reference to the diagram, a process which establishes the diagram as part of the shared language and understanding. This review leads on naturally to the rating of

change; this should be done by the patient but commented on by the therapist, especially where there are discrepancies between the rating and what has been reported in the session. This review also serves as the basis for the negotiation of homework. Where audiotaping of sessions is carried out by trainees this recapitulation provides a useful focus for supervision.

HOMEWORK

The term homework, taken over from cognitive-behavioural practice, has echoes of schooldays which are liable to induce delinquency. But the idea of doing work between sessions must be established in any brief therapy. The crucial thing is to devise with the patient an activity related to the themes and current preoccupations of the therapy. Learning to recognise problem procedures as they are mobilised is the essential task, as discussed above, but apart from this a variety of detailed homework tasks linked to the reformulation may be useful. Common examples would be:

1. Clarifying past history by constructing a life chart, completing family trees or writing brief self-descriptions.
2. Writing assertive 'no send' letters to hated past or present, dead or alive, people.
3. Writing to, or carrying out some ritual acts on behalf of, incompletely mourned loved others.
4. Following simple behavioural programmes such as graded exposure to feared situations or practising alternatives to identified procedures, for example practising assertion in place of placation or passive anger.
5. Rehearsing ways of managing difficult emotional states. This may involve identifying misinterpretations of external events or getting their scale wrong through 'catastrophising' and overpersonalising.
6. Rehearsing alternative thoughts and forms of self-talk.
7. Practising physical relaxation or forms of meditation.
8. Identifying and amplifying whatever forms of control the patient may have developed.

This last may be particularly valuable where episodes of self-harm have occurred. Making a list of ways of coping, such as writing a letter to the therapist, contacting friends or telephone counselling services or following some form of distraction, provides a readily available repertoire of active alternatives to self-harm.

All these activities should be linked to the diagram so that when the patient recognises a negative procedure beginning to operate, an immediate rehearsed alternative is available. If homework is negotiated and agreed, then failure to carry it out is an example of a negative procedure in action which needs to be

discussed and linked to the reformulation. Equally, therapists are responsible for following up and discussing what homework was done.

ACCESSING PAINFUL MEMORIES AND FEELINGS

In a therapy which is going well it will be a matter of only a few weeks before patients can locate themselves reliably on the map and at this point they usually report less anxiety and more control. But this stage may also be marked by the emergence of painful feelings and memories which will amplify, but do not usually contradict, the understandings summarised in the diagram. The pace at which these are contacted and their assimilation depends upon the safety offered by the therapy relationship; it should not be imposed by the therapist. Procedural changes are initially dependent on deliberate conscious control; the automatic mobilisation of positive or at least less harmful procedures may take a long time to become established. Once the use of the reformulation is reliably established, the need to refer to the reformulation tools diminishes but patients are advised to keep them to consult if the need arises. A common comment at post-therapy follow-up is that 'well of course I still get the old impulses and may even begin to go down the old road. But now I can stop and think'.

NOT RECOGNISING PROCEDURES AS THEY OCCUR

Not all patients get off to a flying start, however, and some who do go on to stagnate after a few sessions. Where clearly recognised procedures are responsible, such as the one summarised in the Psychotherapy File as 'If I must then I won't', they will need to be repeatedly identified and challenged. Stagnation in mid-therapy is often the result of therapists being drawn into unrecognised collusive reciprocal role patterns. Experience with audiotape supervising suggests that such unrecognised collusions may originate in inadequate diagrams in which the therapist and patient seem to have agreed to omit an important procedure. This points to the need to take careful note whenever an event occurs which cannot be located on the current diagram. It also indicates one of the limitations of normal modes of supervision and the value of audiotaping; therapists cannot report and may not convey phenomena, or the absence of phenomena, which they have not identified.

With or without audiotape supervision, if a therapy seems to be drifting into stagnation it may be helpful for the therapist to write a 'midway letter' to the patient reviewing what has and has not been discussed and suggesting what may be happening in the therapy relationship to account for the absence of movement. The most common explanation is that the patient's unexpressed but indirectly communicated anger has elicited in the therapist a placatory, avoidant, passively resistant or emotionally cut-off response. If such stalemates

are not challenged the patient may go on to miss sessions and may drop out, whereas, if they are, the experience of having negative feelings acknowledged and allowed and understood in this context has a major therapeutic impact. As part of the challenge therapists should 'shake the transference–countertransference tree', that is to say they should identify and name what they are feeling and consider how far it is a reciprocation to what the patient is conveying and how far an empathic echoing of what the patient cannot express. Discussing these issues in supervision is helpful; not infrequently the stalemate and emotional flatness is reflected in the way the session is reported, which creates an inert, non-productive therapist–supervisor relationship and a bored, yawning supervision group. This is less a case of 'parallel process' than of serial role induction.

If the patient consents intellectually to the new understandings but remains unengaged emotionally in therapy and in daily life, more active methods may be called for, such as empty chair conversations, role play exercises with the therapist, directly confronting the patient with descriptions of countertransference feelings or the use of drawing, painting or writing. Work through parallel therapeutic modalities, such as music therapy or psychodrama if available, may also be very productive at this level. All of these should be planned and carried out with reference to the reformulation descriptions of the key procedures involved in maintaining emotional disengagement.

THE CAT MODEL OF RESISTANCE

In many models of therapy the failure of patients to engage constructively in the work of therapy is labelled resistance. This term implies an (unconsciously) motivated refusal to get better which overrides the consciously expressed wish for change. The word smacks a little of blaming the victim and it seems better to define the phenomenon as a manifestation of, and the therapist's failure to achieve change in, one of the patient's negative procedures. In CAT the likelihood of problem procedures operating within the therapy relationship will have been noted in the reformulation letter. As the therapy-blocking procedure will almost certainly have been manifest in other aspects of life it will have been described in the reformulation, so the phenomenon of non-cooperation can be made use of to illustrate and challenge a procedure of general importance. The work of therapy may need to be focused entirely on the manifestation of this procedure in the therapy relationship until it has been modified. A more general source of resistance is derived from the fact that the sense of identity is sustained by the enactments of individual procedures and is undermined by relinquishing any of these, even if they are harmful, an idea close to Fairbairn's concept of 'adhesion to the bad object' (Fairbairn, 1952).

DROPPING OUT OF THERAPY

One group of patients who drop out of therapy are those acting on particular role procedures concerned with resisting demands; the fact that CAT requires activity from the patient may mean that it is particularly prone to mobilise this reaction. In such patients all demands from others—but also their own plans and intentions—are experienced as oppressive; it is as if the only freedom lies in refusal. The underlying reciprocal role procedure is something like *exigent demand* in relation to either *surrender* or *passive refusal*. Such patients can be very difficult to move, despite the hollowness of their victories. Excellent fictional portraits of this are provided in Herman Melville's 'Bartleby the scrivener' and in 'Oblomov' by Goncharev. A similar but more tragic pattern is found where childhood has imposed a universal sense of guilt and non-entitlement (a pervasive snag) so that any dawn of pleasure or achievement is sabotaged.

Another group of patients with a high drop-out rate are patients with borderline characteristics. There are many reasons for this. Most have had seriously abused childhoods and have little basic trust in others and many have sought unrealistic ideal care only to be disillusioned. The response to these patients must be based on an early, accurate reformulation, often involving successive provisional diagrams, of their range of self states and of switches between them, with an acknowledgement of their past pain and with a particular focus on the procedures which threaten the therapy relationship. Without the self states sequential diagram to guide them therapists are almost bound to end up confused and 'back on the patient's map' in a collusive role. This may be based on accepting idealisation and then not managing the ensuing disillusion or may result from being provoked into some form of counterhostility. A more subtle collusion can take the form of focusing on only one self state by working hard on one of the more innocuous roles such as coping or placation or being emotionally cut off while leaving the other, more threatening aspects of the patient out of the room and off the map. Where patients are in the care of several individuals or agencies, maladaptive role relationships may be set up with different workers with negative effects on staff relations and on the patient. Containment under these circumstances requires a shared conceptualisation, which may be achievable through contextual reformulation as described in Chapter 11 (see also Dunn and Parry, 1997, and Kerr, 1999).

Borderline patients easily experience the therapist as intrusive and critical on the one hand and as unconcerned on the other and a therapist consigned to this knife edge should discuss it explicitly with the patient and try to work jointly on keeping the precarious balance. As far as possible, ways in which the patient can retain control of the pace of the therapy should be devised as otherwise, and often anyway, patients will do it by missing sessions.

In many borderline patients this 'knife edge' phenomenon reflects the fact that the safety and understanding offered by the early sessions, perhaps combined with the requirement to reduce substance abuse, leads to more direct

access to memories of the original trauma and this can be a source of increasing distress. Therapists need to be concerned and supportive as the patients experience what they have spent their lives avoiding, and no pressure should be applied to pursue memories or to go faster or further than is manageable. It is as important to be able to control feelings as it is to access them. And it is important to recognise that some memories and feelings are too disruptive to face and are best left unaccessed.

RECOGNISING PROCEDURES AT TERMINATION; GOODBYE LETTERS

During the last phase of therapy the formal use of reformulation tools and rating of progress may become less important as the more turbulent relationship is lived through and understood, using the shared language established in the earlier sessions. In this phase, as termination is approached, the absence of anxiety and disappointment would suggest that the reality of the end is not yet felt by the patient, even if sessions have been carefully counted and the likely feelings around ending explored. Some therapists may be drawn into collusive responses which serve to avoid painful feelings and maybe sustain a degree of idealisation while others find it difficult to accept how important they have become to the patient. As termination approaches, indirect expressions of fear and anger often take the form of a recurrence of the initial symptoms; these need to be accepted calmly and further fluctuations predicted; even quite distressed patients will nearly always be able to regain the ground in the period before the follow-up meeting. Termination of therapy can also be seen as an opportunity, albeit usually a very anxiety-provoking one, particularly for very damaged patients, to enact a new role, namely that of *ending well*. This involves owning and communicating painful feelings of loss and uncertainty about the future and such a role enactment will be difficult but may also be highly therapeutic, especially when mourning for past losses has been incomplete. Discussing this final piece of work in these terms can be helpful in itself, since it will not be clear to the patient why ending is so difficult for them or why it may be important to attempt to do it well.

In CAT these issues are recorded in a 'goodbye letter' from the therapist which is read and discussed in the last or next to last session. The therapist will briefly rehearse the original list of problems and problem procedures and will consider with the patient how far these have been resolved, indicating where further work needs to be done. Both disappointment and gratitude need to be acknowledged but the main emphasis will be on assessing realistically what the patient has managed to go through and achieve, including noting how the patient has been able to be open and accept help and how what has been of value can be retained. Patients are also invited to write letters if they wish, and are encouraged to make these as realistic and frank as possible.

THE COURSE OF THERAPY

The last two chapters have provided an overview of the work of therapy, in which a sequence of activities occurs, namely:

1. The therapist listens actively to the patient's story and acknowledges the meanings of the experiences described in it, initially verbally in the sessions and then in the reformulation letter.
2. The therapist works with the patient to detect links and patterns in the experiences described in the story and evident in the developing working alliance and a summary reformulation describing these is agreed.
3. Further memories or reports of daily life and enactments of the patterns in the therapy relationship are linked with these general descriptions. This may include the patient contacting hitherto avoided memories and affects.
4. Once the patient's recognition of problem procedures is secure, alternatives are explored.

This sequence is paralleled by the individual exchanges around each new report or episode; this detailed model of good therapeutic practice will be presented in the next chapter. Meanwhile, the following excerpts from the therapy of a patient with a diagnosis of BPD illustrates many of the issues discussed above.

CASE HISTORY: RITA (Therapist Kim Sutherby)

Rita was aged 26 when referred for CAT. She had been brought up as the eldest in a large family but she herself had been largely cared for by her aunt. She gave an appalling history of early and persistent, childhood sexual abuse from her uncle and others and at the age of 13 had become pregnant. She was taken into care and the pregnancy was terminated (against her wishes). For the next four years she was intermittently in care or in hospital and was involved in heavy alcohol and drug abuse. At 16 she became pregnant again and since then had lived independently and cared for her daughter, now aged 10, while working part-time and continuing her education, obtaining 3 A-levels. Throughout that time she had used cannabis every day. She was currently living with a partner who had been with her for two years; he had been intermittently violent but she said he was currently making a big effort to control his temper and it seemed he was able to offer some support. Her daughter had recently been excluded from school on a number of occasions for disruptive behaviour.

During her first three sessions Rita gave a detailed history, showing little emotion and saying explicitly that she was not ready to discuss some of her memories. The therapist was impressed by her evident capacity in rearing a child and pursuing education and by the fact that she had been economically

independent through various forms of part-time work. Rita marked ++ for all the descriptions of unstable states of mind in the Psychotherapy File. She did not complete the agreed homework task of monitoring her mood changes but went on to work cooperatively on the construction of her diagram, identifying three main reciprocal role patterns from her childhood. These were labelled as follows: *unsupported* (B) in relation to *neglect* (A) (derived from self in relation to parents); *scared and guilty* (D) in relation to *abusive* (C) (derived from self in relation to both parents and aunt); *submissive and placatory* (F) in relation to *cruel criticism* (E) (derived from self to aunt). She was distressed to describe how she often saw herself being cruelly critical (E) to her daughter just as her aunt had been to her; this often led to a guilty switch into placatory expiation (F).

These three patterns were clearly differentiated. They are described as three self states in the diagram (Figure 7.1). When Rita experienced others as repeating the patterns of rejection, abuse or criticism she could be overcome with unmanageable feelings of loss and rage; these acted as a trigger (marked as X on the diagram) which led either to a state of rage (G) or to an emotionally cut off, zombie state (H). She had managed her life for the past ten years by maintaining this emotionally cut-off state through regular cannabis use. This trigger point probably represents the point at which dissociation was initiated in childhood.

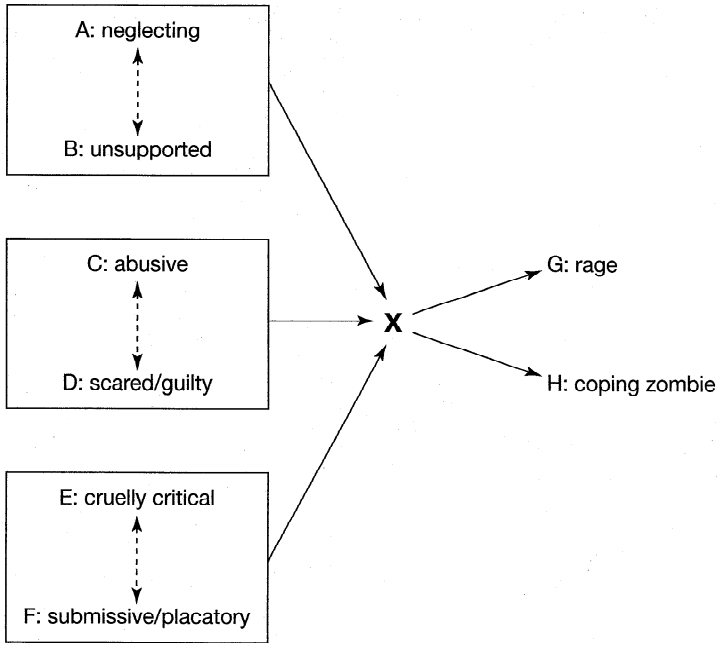

Figure 7.1 Self states sequential diagram for Rita showing reciprocal roles. B, D and F respresent childhood-derived roles which, when activated by experiences, perceptions or memories of A, C or E, lead to flashpoint X followed by either rage or the dissociated alternative coping zombie state

Rita missed two out of her first six appointments but cooperated actively in the construction of her diagram. During these sessions she was increasingly emotionally upset and her missed sessions were probably because of this. They were not deducted from her planned 24 sessions; to have done so before a collaborative relationship had been established would undoubtedly have been experienced as punitive. The therapist was moved by Rita's courage and pained by her story and by the continuing events in her life.

Nearly all the interactions with other people which Rita reported during her therapy were examples of her interpreting others' behaviour or her own behaviour in terms of the reciprocal role patterns identified on the diagram. Thus, over the 12 sessions following the completion of the diagram, 14 events or memories were linked to the A–B self state, seven to C–D, six to E–F, and five each to G and H.

The following is an excerpt from the sixth session. Rita had described being hit by her partner Derek (Derek C to Rita D) and she herself had hit her daughter Alice (Rita C to Alice D), following which her aunt had been very critical of her (Aunt E to Rita F). The following is verbatim:

Rita: She says to Derek that she is 'so concerned that I hit my daughter' ... well she's never shown an ounce of concern before. If she was, why did it never occur to her that I was strung out and needed a break occasionally .... (*Rita B to Aunt A*). Anyway one thing about Derek—he doesn't hurt my daughter; I'm the horrible one (*Rita E to self F*).

Therapist: Can we just slow down a minute. You're furious today about a whole lot of things. Can we look more carefully at some of them. What it seems to me is that you are more aware of what you need from other people and that means you're more aware of what you don't get ...

Rita: So what did I do? I took drugs. (*Rita C to self D or H*) I'm fucking out of my head and I just cannot cope all the time.

Therapist: I wonder how that switch from things seeming OK to suddenly becoming overwhelming happened?

Rita: I've not been sleeping and my eating is all over the place ... everything is going wrong ...

Therapist: I was wondering if this is to do with being angry with me? Coming here has made you open up so many painful feelings. (Therapist suggests *Rita D to therapist C*)

Rita: I thought about that and I thought I can't take it out on you because it's not your fault. I know I don't want to come here but that's not you it's me. I don't want to look at things that are painful and loads of things are getting stirred up. No, I'm not angry with you at all ... (? *Rita F to therapist E*).

Therapist: You know it can be OK to be angry.

Rita: (shouts) I don't often get angry ... because if I do I can't control it (G) and the next moment I've hurt Alice ... I never meant that to happen.

At the next session Rita described her increasingly clear memories of her aunt sexually abusing her when she was aged three (*Aunt C to Rita D*). (Involving the insertion of plastic toys into her vagina.)

Rita: She is totally off her head. She and my mum had terrible childhoods and they have just shoved all that shit into me ... I hate her. I think I should go home now.
Therapist: It's really hard to think about these things that make you so angry.
Rita: Not angry, sick.

Later in the session Rita spoke movingly about her sense of not having ever been cared for (*Rita B to others A*):

Rita: When you sit down and think about your life you realise that there's been thousands of people—social workers, care workers in children's homes—you know there's always been somebody, but there hasn't, if you know what I mean, been anybody. (*Rita B to everyone A*)

Some sessions later, at the therapist's suggestion, Rita wrote a 'no send' letter to her aunt. It was at once bitter and forgiving and ended by expressing the wish never to see her again. Reading the letter provoked a fit of weeping and then the following:

Rita: I hate that woman so much but I don't hate her as well you know. I haven't cried like that for ages.
Therapist: You managed to keep it all inside didn't you ... Do you want me to keep the letter?
Rita: I don't want it. It's said now. I mean, I hate that woman; she'll never regret what she's done—she'll just never know ...
Therapist: It doesn't really come across as a hateful letter.
Rita: Because I don't hate her ... I don't ... I forgive her ... I forgive her for everything ...
Therapist: It all comes across as very, very sad what you've been through, what you've had to face up to ...
Rita: It is sad ... the saddest thing is she'll never know, she'll never read it, she'll never get her head around it to see what she has done. She could read the letter and it would have no impact on her at all, not until she can admit to herself, you know ... what she did.

Rita broke all contact with her aunt at this point, having meanwhile discovered that one of her siblings had also been abused by her.

With Rita's history it was inevitable that termination would be a very painful time. Two sessions before the end the therapist raised the coming end (not for the first time, of course).

Therapist: I don't want you to miss out on the chance of saying a goodbye that is not a rejection.

Rita, after listing her most painful losses, commented:

Rita: That's the only goodbyes I've had in my life ... well, not goodbyes but byes ... there was nothing good about them ...

Rita wrote a goodbye letter which included the following:

> *It takes so long to trust someone and they have to go through the mill to prove their love and loyalty and sometimes it goes terribly wrong. I feel like I have betrayed you and never really given you a chance—well not in the beginning anyway ... I do feel sad but not abandoned' ...*

In the event, Rita did not attend her final (six-month) follow-up and did not reply to subsequent letters. This was likely to be a sign of her anger at the pain she had experienced or of her choice of the abandoning role (A) rather than of the sadness of once more being left (B). It is unlikely that she would have committed herself initially to open-ended therapy (from which BPD patients have a very high drop-out rate) had it been available, but it is possible that a continuing supportive contact based on what was learned in this therapy would have been acceptable; unfortunately it could not be offered.

FURTHER READING

The CAT understanding of transference and countertransference is described in Ryle (1997c). An introduction to psychoanalytic models of therapeutic change is provided by Bateman et al. (2000) and by Bateman and Holmes (1995). Beck (1976) and Davidson (2000) give clear introductions to cognitive therapy and recent advances are reviewed in the volume edited by Salkovskis (1996).