Chapter 9

CAT IN VARIOUS CONDITIONS AND CONTEXTS

SUMMARY

CAT offers a general model of development and psychopathology which cuts across current, often unhelpful, diagnostic distinctions. A central feature of its practice is an emphasis on identifying and working with higher level self processes. The use of self-monitoring includes its use in investigating symptoms, as in CBT, but CAT focuses much more on the recognition of dysfunctional procedures and of state switches. The use of CAT for a variety of patient problems in various settings is reviewed along with theoretical developments associated with them. These include anxiety-related disorders, PTSD, depression, somatisation, deliberate self-harm, eating disorders, complications of medical conditions, substance abuse, gender-related issues, childhood sexual abuse, bereavement, primary care, old age, psychosis, learning difficulties, groups and organisations.

In this book so far we have presented CAT as a general psychotherapy model. In this and the next chapter we shall describe some particular applications of this model to different diagnostic groups and to work in various settings. Many of these are the focus of 'Special Interest Groups' and interested readers may find out more about these by consulting the ACAT website at www.acat.org.uk.

THE PROBLEM OF DIAGNOSIS

The word diagnosis comes from the Greek to discern or distinguish. It is a process well established in general medicine as the necessary basis for rational

treatment and research, but its application to psychiatry raises a number of problems (Kendell, 1993; American Psychiatric Association, 1994; World Health Organisation, 1992; Roth and Fonagy, 1996; McGuire and Troisi, 1998). While we use diagnostic terms it is important to recognise their limitations. The discriminations made between psychiatric conditions are more arbitrary and less reliable than those made in general medicine and, in the case of psychotherapy, the emphasis is upon treating disturbed or depressed people, not on treating 'personality disorder' or 'depression'.

Categorical diagnosis involves fitting cases into defined groups. Such labelling can be arbitrary and reductive, but for some patients it is a relief to know that they have a recognisable and potentially treatable condition. Whereas in general medicine such categories are often based on clear understandings of the causes of the disorder, in psychiatry they have to rely upon a combination of features such as the presence of particular clusters of symptoms, the course through time and the response to treatment. This reflects the fact that there is no general and agreed understanding of the underlying psychopathological processes.

Dimensional classifications seek to remedy the arbitrariness of categorisation by relying upon measures of the extent to which certain features are present; these could be symptoms, personality traits or behaviours and for some purposes are more satisfactory. However, in the absence of a shared model of pathology, the choice of which dimensions to measure is equally arbitrary. Such contributory causes as are identified are of variable and partial importance. Genetic causes in psychological disorders, except in rare conditions such as Huntington's disease which is due to the presence of a specific gene and is really a neurological disorder, do not account for psychological illness by themselves. In identical twins with schizophrenia or bipolar affective disorder, for example, about half of twins remain unaffected. Other factors play their part in psychiatric illness and interact with each other, including biological damage, developmental distortions and past and present patterns of relationships, traumatic events and the current social context.

Competing paradigms

Apart from the innate difficulties involved in psychiatric diagnosis, much confusion can stem from the fact that there are competing or contradictory paradigms applied to understanding disorder, and in many cases people committed to a particular perspective may over-extend its applications. A fully adequate understanding of an individual patient may need to take account of genetic and biological factors, including the areas described in evolutionary psychology (McGuire and Troisi, 1998; Stevens and Price, 1996) and of the effects of early experiences on development as described in Chapter 3, which may currently be explained within psychodynamic, attachment or cognitive theories. In addition, although this is often neglected, the current life circum-

stances and their impact on the individual's sense of self and his or her ability to act needs to be considered. A disorder resulting from all these factors may meet a particular categorical diagnosis, and such diagnoses may be of value in predicting response to treatment and in comparing different treatments and for these reasons are a necessary aspect of understanding, but in our view their utility to the psychotherapist is restricted. For psychotherapists, once diagnoses are made, the main task is to relate them to a fuller picture constructed in the form of a case formulation. As Kendell (1993) observes, diagnosis and case formulation have different, complementary functions.

Case formulation in CAT, as has been shown earlier, is a collaborative enterprise aiming to set patients' problems and distresses in the context of an understanding of their lives. This may include acknowledging both biological and social realities which have to be dealt with but the emphasis will be on life experience and the conclusions drawn from it—conclusions which have seldom been fully reflected on and which are manifest in the values and procedures guiding behaviour and shaping experience. Whatever the diagnosis, case formulation will aim to provide a new perspective on, and a heightened awareness of, the problems which therapy will seek to remedy. It also cuts across the misleading notion that patients may suffer from several 'separate' conditions simultaneously. These are frequently and unhelpfully described as being 'co-morbid'. In reality, different levels of damage affecting different aspects of development and self structure are found. We suggest that a comprehensive, individualised, biopsychosocial formulation, such as that offered by a CAT reformulation, should be a minimum prerequisite for working with any patient or client within mental health services. Unfortunately patients are very often treated or simply managed on the basis of much lesser understandings. Before considering and illustrating how this process may vary according to diagnoses and contexts, it is necessary to consider how symptomatic disturbances may be understood and treated.

THE SCOPE OF CAT

The scope of psychotherapy is broad; feelings of unfulfilment in life, general unhappiness, disabling emotional distress, disorders of bodily functioning, damaging and unsatisfying social and personal relationships, negative self-attitudes and poor self-organisation may all fall within its scope. It may also have a part to play in the treatment of physical disorders which are complicated by psychological factors or which require careful self-management. These different problems often co-exist. Cultural beliefs and the theoretical model of the psychotherapy offered will determine which level of disturbance is considered to indicate a need for intervention.

The model of CAT presented in the previous chapters is a general one; CAT is not a diagnosis-specific intervention, it is a general model of psychological

disorder and its treatment. In practice, it is primarily concerned with problems at the level of interpersonal and self processes and these are, of course, the central issues in treating patients with personality disorders. Leaving those aside, the problems which bring patients to therapy are commonly accompanied by physical symptoms and negative moods which can be understood at a number of levels from the biological to the sociological. At the present time they tend to be classified in ways parallel to the systems used in medicine and to be seen by both patients and clinicians as equivalent to organically determined illness. The pharmaceutical industry's eagerness to find a biologically focused treatment for every newly defined syndrome further reinforces such definitions. Behavioural and cognitive therapies could be said to address intermediate levels of disturbance. Thus the psychological understandings and interventions offered by behaviourists are largely based on simple animal models of nervous system functioning and learning and in cognitive therapy the main focus has been on associations between beliefs and moods and behaviours and on the extensive use of computer and cybernetic metaphors. Such treatments have their uses but also their dangers; to the extent that problems of living are defined as illness and to the extent that treatments are based on reductive versions of human activity and experience, and are delivered in didactic or authoritarian rather than collaborative ways, attention may be diverted from what are more fundamental, human and existential issues.

In CAT, the therapeutic aim is to understand symptoms in relation to the higher order processes derived from and continuously enacted in the relation between self and others. This emphasis does not deny the fact that these psychological issues may have important physiological determinants and expressions and that drug and psychological treatments addressing lower levels may have an important part to play. But the CAT therapist's concern is with anxious or depressed or somatising *people*, not with anxiety, depression and somatisation, and intervention will be concerned with how their symptoms are linked with their history, current context, sense of self and procedural repertoire as it affects their self-management and their interpersonal and social processes. Particular attention is paid to how the therapeutic relationship may reflect, reinforce or revise damaging patterns.

PRACTICAL METHODS—SYMPTOM MONITORING

The distressing mood changes, symptoms and unwanted behaviours for which patients consult are usually experienced by them as happening to them, that is to say as occurring without, or despite, their wishes or understanding. To understand how they relate to life issues, both CBT and CAT therapists seek to obtain an account of what internal and external processes and events precede and accompany their occurrence or variations in their intensity. These associations may be evident from careful history taking but in most cases instructing the

patient in self-monitoring provides more detailed evidence and has the added advantage that this activity frequently leads to a rapid reduction in the symptom.

Patients keeping self-monitoring diaries of problems in the form of moods, symptoms or unwanted behaviours should be asked to note in detail the events, situations, thoughts and feelings preceding and accompanying the problem. These recorded sequences may be interpreted in two ways. Cognitive therapists will concentrate on identifying and challenging the associated 'faulty' beliefs about, and irrational interpretations of, the events and situations identified. In CAT, these cognitive methods may be employed but particular attention will be paid to three additional questions:

1. With what perceived, enacted or anticipated reciprocal role procedure is the symptom associated? For example, in response to feeling abandoned an individual might feel anxious and empty and binge on food.
2. How far might the symptom be understood as an alternative to feared or forbidden feelings or acts? (This represents the 'primary gain' described in psychoanalysis.) For example, in a depressed patient, being guiltily angry in relation to perceived criticism and domination might have been replaced by depressed, relatively guilt-free, resentful compliance.
3. How far does this symptom serve to maintain control in interpersonal relationships or represent self-punishment serving to alleviate guilt. ('secondary gain')? For example, illness, or playing the 'sick role', may elicit a reciprocal caring relationship (*controlling dependency* in *relation to submissive care-giving*) or guilt at failure to achieve perfectionist goals may be followed (relieved or punished) by a severe headache, the pattern *inexorably demanding in relation to desperate striving* being replaced by *caretaking in relation to needy sufferer.*

PROCEDURAL MONITORING

Thus, as well as linking symptoms with immediately accessible beliefs and cognitions, the CAT therapist will aim to locate them in the procedural system identified and described during the reformulation sessions. Once these associations are understood, attention can be diverted from the symptom to the revision of the relevant role procedures. This calls for a new form of self-monitoring; rather than noting the appearances of symptoms and what provokes them patients will now learn to recognise their newly described procedures as they are manifest in their impulses, behaviour or interpretations of events. Recognition is usually achieved over a relatively brief period of time; thereafter very little direct attention needs to be paid to the symptoms, except that they may serve as signals indicating that a negative procedure is being followed. If symptoms persist or cannot be clearly linked to the procedural system and if the possible cost (snag) of losing the symptom has been explored without effect, more direct treatments aimed at the symptom may be needed.

In this way the CAT approach extends the CBT method of monitoring. It also introduces, in a revised language, psychoanalytic understandings of the relation of symptoms to (conflicted) relationships with self and other. But rather than relying on speculative interpretations of unconscious determinants of these links it is based on locating symptoms in terms of the jointly-created descriptive reformulation.

STRATEGIC ISSUES: WHEN TO ADDRESS SYMPTOMS DIRECTLY

Most psychotherapy patients score high on general symptom inventories, recording their experience of a mixture of anxiety, depression and physical symptoms. As stated above, such general symptoms nearly always fade in the course of CAT without direct attention being paid to them. However, notwithstanding what has been said above, some symptoms appear to have little association with deeper issues. Some may resolve with simple direct interventions and some may need direct treatment on account of their severity (which may undermine an individual's ability to work psychologically) or because of their persistence, despite therapy addressed to higher level procedures. Other symptoms seem to have become self-perpetuating, and may only respond to medication or to symptom-focused approaches.

From a CAT perspective it can be seen that focusing on symptoms, as in standard CBT, or on transference interpretations of presumed, related, underlying unconscious intrapsychic conflict, as in analytic therapy, may actually enact and reinforce a particular patient reciprocal role procedure (RRP). These could include, for example, *helpless, needy symptomatic patient* in relation to *powerful, knowledgeable therapeutic other*. Reinforcing this or other maladaptive RRPs may in turn perpetuate or exacerbate the entrenched symptoms, such as panic attacks or bowel dysfunction, with which the patient may have presented and which may represent maladaptive attempts to communicate to or control others. For this reason, approaches such as standard CBT which simply attempt to work with overt symptoms would be predicted to fail because there is no incentive for the patient to abandon them unless the underlying RRPs are addressed. These various issues will now be considered in relation to a range of diagnostic groups.

PANIC AND PHOBIA

Phobic avoidance of situations or panic evoked by cues such as spiders or feathers and more general avoidance behaviours such as agoraphobia can often be understood in terms of conditioning and can be treated by supported graded exposure or by other basic behavioural techniques (see Marks, 1987). It has been

suggested that our liability to simple phobias is due to predispositions to be afraid of certain stereotyped dangerous stimuli which have been highly conserved in evolution (McGuire and Troisi, 1998) and which would explain their relative independence of developmental and interpersonal issues. Symptom monitoring can identify the antecedent and accompanying thoughts, and cognitive rehearsal of alternatives may offer some control. Secondary worries about the accompanying symptoms, notably rapid beating of the heart or the fear of losing control, can usually be relieved by explanation. Instruction in symptom monitoring may be accompanied by the paradoxical injunction to have the symptom as thoroughly as possible as this often abolishes the symptom, presumably because you cannot deliberately lose control. In these self-reinforcing conditions it is appropriate to use CBT methods first but where such direct methods fail the wider issues of context and procedural systems must be addressed, in particular by attending to the interpersonal (usually controlling) role of the symptom. The use of medication to control symptoms may be effective and a satisfactory short-term response but its use should not leave unexamined the wider issues.

GENERALISED ANXIETY DISORDER

Generalised anxiety disorder (GAD) is described as a syndrome marked by excessive and widespread worry. Because of its poor response to conventional cognitive therapy Wells (1999) proposes a cognitive model in which the therapist, having identified the situational and cognitive antecedents of worry, explores the 'metacognitions' which serve to maintain 'negative feedback loops'. This metacognitive therapy model seeks to address higher order beliefs but, whilst this clearly represents an important advance on a focus confined to symptoms themselves, it shares with basic CBT a focus largely confined to individual mental processes, paying little attention to the formation and maintenance of self-managing procedures in interaction with others. Moreover, as is also true of psychiatric models of anxiety, it shows surprisingly little interest in the content and meaning of the worry or in the life circumstances with which the patient is coping. Whether or not these circumstances are objectively threatening, the fact is that they are beyond the patient's ability to evaluate and manage using their current procedures. The connection between threatening life events and circumstances and a vulnerability to anxiety disorders has been clearly demonstrated by many workers (Finlay-Jones and Brown, 1981).

In the CAT view, understanding generalised anxiety on the basis of enumerating faulty cognitions and metacognitions and deficient coping skills remains essentially impersonal and superficial. CAT would see it as being fundamentally important to seek to understand, acknowledge and work with the person's experience that their sense of self and their grasp of, and ability to influence, reality are inadequate and, in severe cases, that the whole of existence rests on

shaky foundations. In such cases the individual will usually feel essentially isolated and without social support and will thus be effectively 'out of dialogue', which has destabilising consequences. Therapy based on the exploration of both historical meaning and current circumstances recorded in the narrative and structural reformulation of CAT can offer such patients new ways of describing and controlling their life in the world. It can also provide a new basis for reflecting on their own processes and as such offers a more fundamental intervention than CBT. We would anticipate that the majority of patients in whom symptoms represent the outcome of complex developmental and interpersonal reciprocal role enactments would be amenable to treatment with CAT whilst frequently remaining refractory to CBT-based approaches. It is increasingly recognised that trials reporting efficacy of CBT for circumscribed symptoms in highly selected populations do not generalise well, probably for the reasons we have outlined. Clearly this hypothesis requires formal evaluation in the context of comparative, controlled trials.

OBSESSIVE-COMPULSIVE DISORDERS

Most people (and many animals) show some tendency towards ritualisation and social life relies heavily on symbolic rituals, notably in the areas of religious authority and the assertions of military and political power. In this way they induce the sense of a shared meaning and also provide a means of coping with the pervasive anxiety inherent in the human condition, arguably especially in the contemporary 'post-modern' one. The underlying procedural patterns found in people suffering from obsessive-compulsive symptoms can be seen as pathological exaggerations of these general tendencies, often expressed in the dilemma 'as if *either* absolute order *or* dangerous chaos', or in the perfectionist dilemma where, in reciprocating critical conditional acceptance, the choices are seen to be *either* shameful failure *or* absolute success. Pseudo-moral preoccupations with questions of sin and dirt are often part of the story. Issues of control originating in everyday activities and relationships may generate apparently forbidden or frightening intentions or affects and the perceived dangers of these may be managed by repetitive 'magical' rituals involving completing arbitrary or symbolically related acts (as hand washing was for Lady Macbeth) or the use of mental exercises such as counting. In full-blown obsessive-compulsive disorders these magical ritualised attempts to control feared feelings become largely controlling of the patient's life and often of those involved with the patient. Assessment must take account of the full procedural repertoire and of how the obsessive-compulsive symptoms operate in current relationships; in some cases partners or families reinforce the rituals and may need to be involved in treatment.

Genetic factors may also play a part in predisposing to severe anxiety or obsessionality and contribute to obsessive-compulsive disorder and by

implication determine what therapy can aim at or achieve. There is evidence from neuro-imaging studies of abnormalities of brain function, although it is not yet clear whether this is cause or consequence of the condition. It is of interest that these changes resolve following treatment whether with drugs or cognitive-behavioural therapy (Baxter et al., 1992).

In individual CAT, where the interference of the symptoms with life is moderate, self-monitoring can indicate how their frequency and intensity vary in relation to the context or the current procedures. Revising these procedures and challenging irrational guilt often allows the obsessiveness to recede. Where the pattern is established more thoroughly and where the reinforcement of the rituals by the short-term relief experienced when they are repeated has become dominant, behavioural methods, notably response prevention, may be helpful whereby, in a way analogous to graded exposure in phobic avoidance, patients are supported to resist repetitions for increasing periods of time. In severe cases medication may also have a part to play.

Case example: Susan (Therapist IK)

Susan was a young woman in her early thirties who had been referred by the local department of child psychiatry where the family had been seen because of the emotional and behavioural difficulties of her seven-year-old son. The team had been concerned about her and had referred her for an assessment for psychotherapy. Her difficulties centred largely around chronic feelings of panic and anxiety which related partly to her irritable bowel syndrome and her worry about whether she might lose control whilst far away from a toilet. She also suffered a continual worry that she might vomit although this had not happened since one episode 15 years previously. These anxieties were severely disabling and prevented her going far from home, for example to pick up her child from school or to eat in a restaurant. In addition, she had marked obsessive-compulsive symptoms, needing for example to rearrange clothes in her wardrobe before leaving her bedroom in the morning, a process which could easily take up to 20 minutes. She was also so anxious about untidiness in the kitchen that she could not go in to cook, leaving this to her husband instead. Interestingly, she found the Psychotherapy File disturbing to take home because there was no 'place' for it there, which caused her to bring it back very promptly! Because of her chronic panicky feelings she sometimes 'had' to call her husband back from work where he was a freelance IT consultant, as well as sometimes needing her mother to stay to help out. These anxieties had been clearly having a detrimental effect on her children (aged seven and three years) with whom she found it hard to engage. Frequently she would enlist her mother or husband to help out. She felt the need all the time to have a system around her which made her feel safe.

Susan had been the youngest of several children and she had always been, she thought, shy and anxious. She mentioned a photo of her bedroom taken when she was about seven which was meticulously tidy and ordered. Her father was 'lovely but absent'. Her mother suffered herself from severe anxiety and obsessional difficulties and had had eating problems, which had clearly got in the way of being a good mother. Susan had always kept her worries to herself and had always felt a pressure to do 'wonderfully well'. She had, in fact, done well academically at school and had been expected to go to university. However, she failed her A levels unexpectedly. Just prior to taking these exams she had suffered an episode of vomiting after an allegedly suspect meal and this had left her with her resultant fear.

She had done various administrative jobs and at the time of referral was working temporarily as manager in a clothes shop although she gave this up shortly afterwards because of her symptoms. The only serious boyfriend she had had was her husband whom she had met as a teenager. She described him as devoted and loving and a 'great support' although the sexual side of her relationship was described as 'fine' but 'not important'. He continued to worry about her and was anxious for her to receive treatment and would have been prepared to come along as well.

Susan had previously had experience of brief counselling through her GP, of an anxiety-management group and of a trial of cognitive-behaviour therapy with a psychologist. She had dropped out of all of these. During her work on anxiety, for example, she related that the more they tried to help her to let go and relax the more grimly she had 'held on'. At assessment it was felt that she was not a good candidate for analytic psychotherapy and was referred for a trial with CAT.

During her first few sessions of therapy her explicit agenda was focused around her 'symptoms' as she described them and she was very anxious to know if and how this therapy could help deal with them. It proved extremely difficult to divert her towards any reflection on their meaning or origins or indeed about her early life. It was clear that she was very distressed by the symptoms and the difficult feelings associated with them, which she was able to acknowledge explicitly. Apart from her obvious distress, however, she was recurrently obviously irritated by the lack of progress in sorting out and curing her symptoms. The therapist felt throughout the first few sessions that she was determinedly attending as if going through the motions to make a point of how difficult things were and to prove that things could never really change. This hopeless feeling was also induced in the therapist, as was a recurrent irritation that she would not act as a cooperative patient who would be willing to work. It seemed that this might have been a partial replay of what had happened during her previous failed 'attempts' at therapy and might be illustrating some of the roles which were enacted at home.

The reformulation phase

When going through the Psychotherapy File (see Appendix 2) the procedures she had identified strongly as applying to her were the trap of 'trying to please others and being anxious not to upset them, as a result of which we end up being taken advantage of which makes us angry, depressed or guilty' and the dilemma of '*either* trying to be perfect and feeling depressed and guilty, *or* not trying and feeling guilty, angry and dissatisfied'. She also identified the typical obsessional dilemma of '*either* keeping things in perfect order *or* fearing a terrible mess'. She also identified the dilemma of '*either* being sustained by the admiration of others *or* feeling exposed and contemptible'. She recognised the snag, of feeling limited in life by something inside herself, and of 'having to sabotage things as if she didn't deserve them'. She noted, interestingly, that she had tended to do this at school also. Finally, she noted most of the difficult states of mind as applying to herself to some extent at various times and also some of the different states. These included 'feeling bad but soldiering on and coping', 'being in control of self and other people', 'provoking and winding up others' (which she would do with her son), 'feeling agitated, confused and anxious', 'vulnerable and needy', 'resentfully submitting to demands' and 'intensely critical of self and others'.

The first intimation that something might change came during the drafting of the initial sequential diagrammatic reformation (SDR) (Figure 9.1) when, having jointly sketched a rough core 'subjective' self which seemed acceptable to her, the subsequent implications of her role enactments, both outside and in sessions, were persistently explored by the therapist. At this point she became for the first time overtly very angry and tearful, saying that she did not want to open up her 'messy' side and that it was 'none of his business'.

The initial, rough SDR centred around a 'core subjective self' is shown in Figure 9.1 and the subsequent simplified version showing one key reciprocal role procedure in Figure 9.2. What emerged powerfully from the work around the initial version was her intense and desperate inner feelings and the consequences of her attempts to cope with them by enacting various role procedures. These appeared to have in common the attempt to keep things under control (either her own emotions or other people's behaviour). It seemed important to acknowledge what a struggle this was and also her frustration and irritation when people would, for example at church, 'jolly her on' without understanding just how bad things were. She was also able, with reluctance, to describe bursting out angrily at times when she could no longer contain her feelings, mostly with her husband who could, as she put it, 'cop it'. She also described a 'keeping busy' coping mechanism which, however, never seemed to help for long. The therapist noted on the SDR those procedures which she might be enacting with the therapist in the room (shown as '*? in here*' or '*? with me*'; Figure 9.1). With persistence, this focus of the work was reluctantly accepted. It continued to be difficult for her, however, to own the '*controlling–controlled*' role

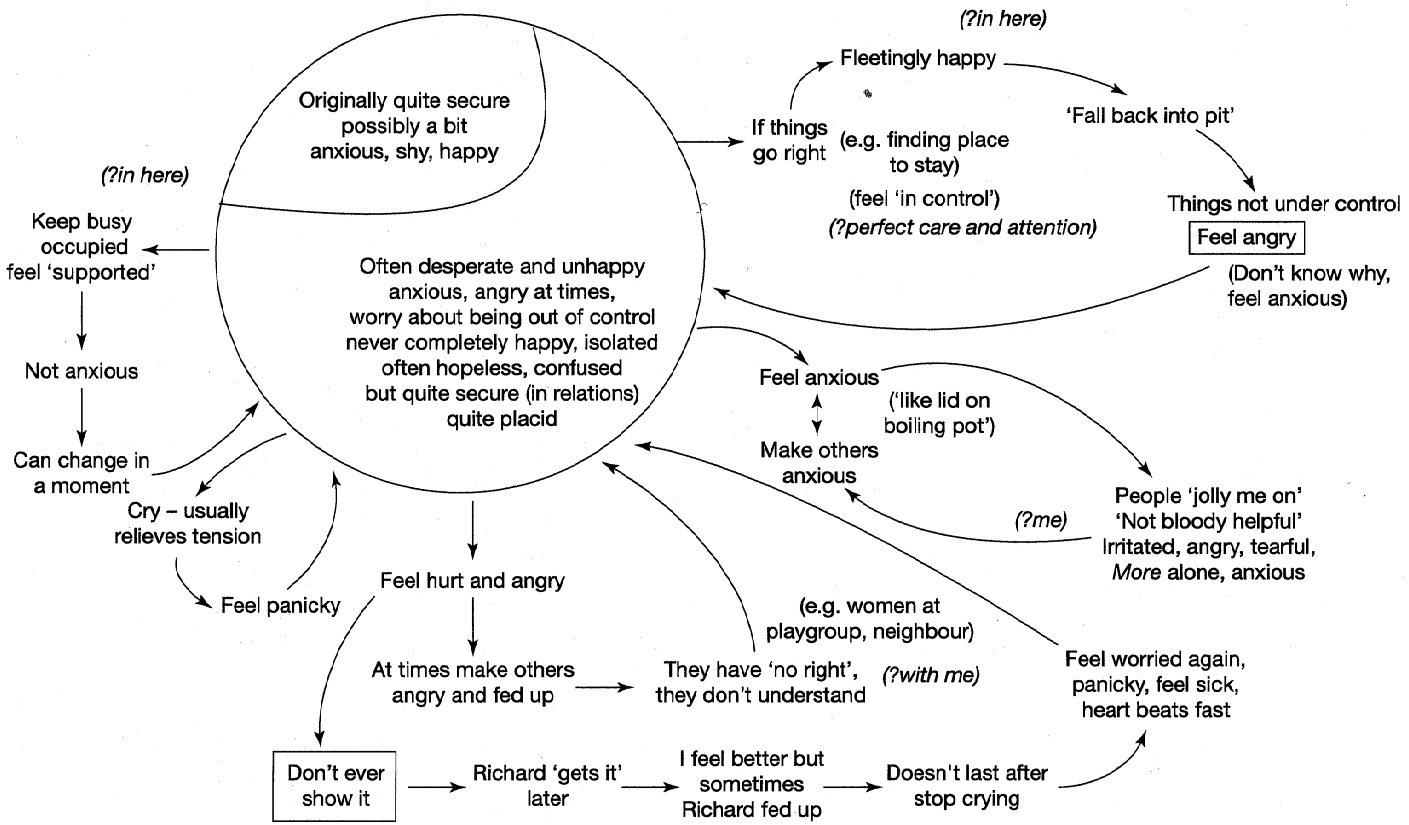

Figure 9.1 Initial version of SDR for Susan constructed around a core 'subjective self' showing mainly childhood-derived role enactments. The therapist's challenges on the enactment of these in session are in italics

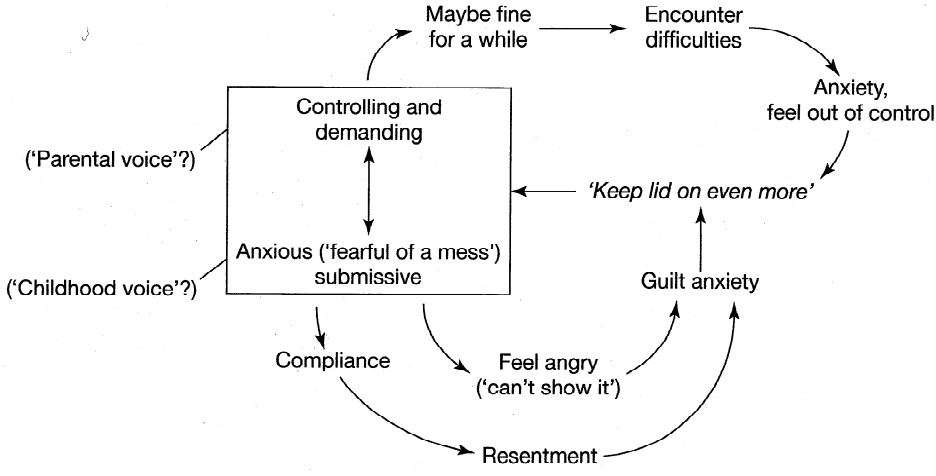

Figure 9.2 Simplified SDR for Susan showing the enactments of her key RRP

pattern which was subsequently highlighted on the simplified diagram (Figure 9.2).

Target problem procedures (TPPs) were described as follows:

1. Trying to keep to yourself worries about your imagined inadequacies, your anxieties and your angry feelings for fear of terrible consequences if they came out, but as a result feeling isolated, exhausted and desperate about how you can carry on. *Aim 1*: Try gradually to express some of your worries and emotions to people in all settings, and see what the consequences really are.
2. Dealing with your worries and your 'messy' side by keeping busy and keeping in control of things and of people (like me in therapy), which has the result that no-one gets 'let in' and that nothing ever changes. *Aim 2*: Try to consider that keeping in control of everything all the time may actually make things worse and try out the effect of letting people (like me) in.

Rating progress

For TPP 1 there was little recorded change on her rating sheet during therapy for either recognition or revision. Interestingly she wrote on her rating sheet for TPP 2 that *'I like being in control!'*. For this procedure her ratings showed increasingly good recognition but little apparent change. In therapy she continued intermittently to be angry at the therapist for apparently ignoring her symptoms and not curing them and for focusing on her feelings and role enactments. Similarly, she continued to insist until the end of therapy, despite seeming at times more relaxed and able to discuss her feelings and the consequences of her

role enactments, that this would never really help. She insisted that she was only going through with it in case she ever needed further help so that it would not be held against her that she had yet again dropped out. She repeatedly accused her therapist of being unempathic and not really understanding her difficulties or helping with them and this was very much the tone of her farewell letter, although she did say that she had found therapy 'challenging'.

Nonetheless, her therapist did feel that by the end of therapy Susan was noticeably more open about discussing her feelings and difficulties and more able to be 'in dialogue' and that she was possibly also surprised that this could happen. Parallel to this she reported that her irritable bowel symptoms had curiously diminished. In addition to clinical impressions that her symptoms had diminished, her scores on routine psychometric measures ('CORE' (see Barkham et al., 1998) and a standard anxiety questionnaire) also reduced considerably. The 'CORE' reduced from 76 at the start of therapy to 46 at the end with subscale ratings related to anxiety showing a parallel decrease from 36 to 23. At six-month follow-up these scores had diminished even further ('CORE' overall reducing to 34, with the anxiety-related subscale ratings reducing to 14, with parallel shifts in standard anxiety measures). She wrote a letter six months post therapy saying that things had improved considerably in her life and stated that:

> *I originally came to you with one set of anxieties and insecurities; these seem to no longer play a large part in my life and, although lonely and isolated at present, I feel there is hope for the future.*

It seems clear that for this patient the symptoms with which she presented were aspects of one key reciprocal role pattern around a *controlling–controlled* axis. What is of particular interest is that the enactment of this key RRP had undoubtedly prevented her from simply and cooperatively working on her symptoms as had been previously attempted by symptom-focused approaches. Indeed, such approaches could have been seen to be examples of colluding with this RRP, hence intensifying her 'resistance'. This case illustrates the point that, unless these role enactments in the therapy relationship are identified and worked on as a principal focus, the work will be sabotaged and the patient will acquire the epithet of being 'difficult' and elicit all the unhelpful reactions which go with it.

Formal research evaluation of CAT with 'difficult' patients with anxiety-related symptoms clearly needs to be undertaken. This could be either in the form of a controlled trial against CBT-based approaches or, alternatively, in treating those who, as in the case of this patient, have 'failed' to engage with previous treatments.

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD) usually develops weeks or longer after experiencing or witnessing very threatening events. Individual susceptibility clearly plays a part; according to a recent review by Adshead (2000) between 20% and 30% of individuals exposed to major disasters go on to develop PTSD. In theory this vulnerability could reflect both biological and psychological factors. As regards the latter, an individual's reaction to fear and helplessness or proneness to shame are likely to reflect procedures developed earlier, perhaps in analogous circumstances, which it will be helpful to identify. The symptoms include anxious re-living of the trauma, intrusive memories or images associated with it, vivid nightmares, avoidance of thoughts or places associated with the trauma and alternations or combinations of emotional numbness, hypervigilance, chronic anxiety and depression. Where the trauma has been a single, brief and unpredicted devastating event, hyperarousal, intrusive memories and avoidance are marked. Sustained or repeated stress, such as may be experienced in warfare and in abusive relationships, where helplessness and irrational guilt are commonly experienced, leads to similar initial symptoms but these are likely to be dealt with, with incomplete success, by dissociation which in turn may damage relationships and self-management and may lead to prolonged depression, anxiety and substance abuse. The symptoms of PTSD may last for decades and in chronic cases are associated with neurological and neuroendocrine changes (Van der Kolk et al., 1996; reviewed in Freeman, 1998).

Although the recent 'rediscovery' of the neuropsychological consequences of trauma was prompted by work with Vietnam war veterans, it has become increasingly accepted that a repeated experience of childhood trauma and deprivation has a comparable but more pervasive, damaging effect on the personality. This has come to be conceptualised as 'complex' PTSD (Hermann, 1992), or as a 'disorder of extreme stress not otherwise specified' (DESNOS) as categorised in DSM IV (Van der Kolk, 2000). The concept of 'complex' PTSD is seen as virtually synonymous with borderline personality disorder by these writers given the almost invariably traumatic origins of the latter. This emerging and powerful body of evidence adds weight to the views of those who have historically advocated deficit/trauma theories of psychopathology.

Brewin et al. (1996) suggest that the features of PTSD can be explained in terms of two forms of memory, one automatically accessed in response to contextual cues and one verbally accessible, the former having the quality of re-experiencing the traumatic event and the latter being open to successive editing. In the view of these authors, incomplete emotional processing is manifest in mood disorders and distortions of attention and memory whereas premature inhibition of processing leads to memory impairment, dissociation, phobic states and somatisation. Psychological treatments for PTSD were found to be more effective than medication in a meta-analytic study (van Etten and Taylor, 1998) but medication also has a place and the two may be combined.

Systematic desensitisation to cues or memories which have been avoided and cognitive restructuring methods are the common approaches to fear-based PTSD, with the recent addition of EMDR (eye-movement desensitisation and reprocessing; see MacCulloch, 1999). Where shame as well as fear is an important factor and where long-term symptoms have become associated with pervasive personal and interpersonal problems, a more general therapeutic approach is called for and it is here that CAT may have a part to play. At present there have been no systematic studies although work with PTSD has been undertaken by several practitioners (Evans, Kenny, Haupt and Wilton, personal communication).

Efforts to prevent the development of PTSD by early counselling of those exposed to trauma are common but are of uncertain effectiveness and may be harmful. Thus two studies involving burn victims (Bisson et al., 1997) and road traffic accident victims (Mayou et al., 2000) reported increased symptoms in those receiving debriefing. In many cases it may be more important to mobilise existing personal and social support. On the international scale it can certainly be argued that counselling has been oversold. Summerfield (1999) is particularly critical of the sending of Western-trained counsellors to devastated areas on the grounds that only local communities can offer culturally relevant ways of supporting their members. He suggests that practical and economic aid would be psychologically more supportive.

In the case of 'complex' PTSD, as with severe personality disorder, it may be that early psychological interventions could play a role in minimising or repairing some of the developmental damage inflicted by traumatic early life experiences (Chanen, 2000).

The following brief summaries of two case histories demonstrate the potential value of CAT in this area.

Case example: Richard (Therapist Ceri Evans)

Richard was a man in his early thirties who had been referred by his GP to a traumatic stress clinic. He had been experiencing considerable problems in living since an episode five years previously when he had been threatened with a gun during a robbery in a pub where he had been manager. He was clearly suffering from PTSD as assessed clinically and by standard questionnaires. His symptoms included long 1–2 minute 'video-like', highly distressing, intrusive re-experiencing of the episode when the gun had been held to his head and when he had feared he would be killed. In addition, he suffered from what were described as 'mind rages' (precipitous and explosive outbursts), he had developed a serious drink problem and had become cut off socially and depressed.

He reported symptoms of morbid arousal including insomnia, irritability and hypervigilance. These difficulties had resulted in the break-up of a previously stable relationship and in his losing his job. Richard himself was also able to link

these difficulties with a history of childhood victimisation and sexual abuse which he had previously 'coped with'.

His background also included childhood experience of a difficult and abusive relationship with an alcoholic father and an 'absent' mother who was remembered as passive and powerless. In addition, he had had a bad experience of school where he felt lonely and isolated. The sexual abuse he had suffered had been at the hands of a male neighbour from the ages of about 8 to 13.

Given the presence of complicating, pre-morbid personality factors Richard was offered a 14-session course of CAT by the traumatic stress clinic. He engaged well and committed regularly to therapy. Early assessment sessions elucidated childhood coping strategies of cutting off and withdrawal as well as indulging in risk-taking behaviour. He also expressed a sense of shame and guilt about the sexual abuse. Notable procedures which he identified in the Psychotherapy File included the 'trying to please' trap, the dilemma of 'keeping feelings bottled up or risking making a mess' and 'if I must then I won't', as well as most of the dilemmas around behaviours with others (see Appendix 2). He also identified most of the unstable and difficult states of mind. These procedures and role enactments were rehearsed in the written and diagrammatic reformulations where a *need to be in control, threatening and cut-off role* relative to a *feeling victimised or threatened* reciprocal role was noted. It was this precarious control which had apparently been shattered by the more recent traumatic episode. This was also a role which was experienced by the therapist in session and required much attention. The work of therapy subsequently centred to a considerable extent around experiencing and communicating painful emotions, especially his childhood memories, without resorting to these defensive role enactments. Some work was also done on identifying triggers for his intrusive memories. However, most of the work focused on his earlier experiences and their consequences, which had the interesting effect of enabling him to work on later experiences and difficulties himself. He reported a rapid improvement on both his social relations, alcohol consumption and PTSD symptoms although, interestingly, little of the work had focused on these explicitly. The therapist's goodbye letter emphasised that future stress might cause him to revert to old role enactments and that this was something which, with the help of the tools of therapy, he would need to continue to work on. At follow-up after three months he reported considerable improvement in his general well-being as well as in the specific symptoms he had presented with. In addition, he had a new partner and job and overall felt that he had made a 'full recovery'. This clinical impression was confirmed by psychometric testing which showed remarkable improvements on all measures used. These included shifts on the Revised Impact of Events from 65 to 1, the Penn Inventory from 51 to 17 and the General Health Questionnaire from 7 to 1.

Case example: Hannah (Therapist Ceri Evans)

Hannah was a young woman in her early thirties who had been referred to the traumatic stress clinic by her GP because of depression and unmanageable mood states including anger, guilt and shame. These followed an incident when she had been attacked on the street and subjected to an attempted rape. Significantly she had not initially reported this attempted rape to the police, only reporting the theft of her purse. Her father had developed cancer shortly after this event and she had been involved in looking after him at considerable cost to herself.

Other difficulties which she reported were a long-standing lack of assertiveness, a tendency to comfort eat and, more recently, 'rushes of fear' triggered by memories of the attack. These difficulties were also stressful, straining her relationship with her partner. However, she was still managing to work as a junior manager and put on an appearance of coping to the outside world. Her GP had initially refused to offer her counselling on the grounds that she seemed 'too well'. This had resulted in her being quite angry at presentation about how hard it had been to get help. She described how she still overloaded herself at work by agreeing to work overtime and consequently had virtually no time for herself.

Given the predominance of historical psychological issues in her history she was offered a 12-session CAT by the clinic. This included four sessions of 'nested' eye movement desensitision and reprocessing (EMDR—see review by MacCulloch, 1999) which would not have been possible without the prior CAT owing to the existence of complicating personality difficulties (see below).

She described a difficult upbringing with an unhappy and very critical mother who appeared to demand care from her but not to offer it in return. She had been frequently called sullen and miserable by her mother who also criticised the father which resulted in Hannah feeling alienated from him. It was only in later years that she had come to think that perhaps he had been quite a decent man. His illness and death consequently left her feeling cheated of a relationship she might have had with him. She had a younger brother who had often been ill and had, she felt, been very much the favourite with her mother. She had done well academically at school and subsequently at college where she got a good degree in business studies.

During the early sessions it became apparent that the reciprocal role repertoire Hannah had acquired had played an important role in her response to recent events as well as to therapy. These RRPs included, notably, a *striving to please and placate* relative to a *conditionally accepting and loving* role as well as an *idealising/care seeking role* relative to an *actively caring for but denying own needs* role. These had been enacted around the traumatic attack as well as with her therapist. Key procedures which were identified through the Psychotherapy File (see Appendix 2) included notably the placation trap, the dilemmas of '*either* keeping things in perfect order *or* fearing a terrible mess', '*either* 'being

sustained by the admiration of others *or* feeling exposed', '*either* sticking up for oneself *or* giving in and getting put upon by others and feeling cross and hurt', and, very significantly, the snag of feeling limited because of a sense of inadequacy, which sabotages progress.

These procedures were spelled out in her reformulations and worked on in therapy, where her tendency to idealise and placate were prominent. Despite her anxiety about the brevity of therapy she was able to use the insights and understandings she gained to work on her target problem procedures. The therapy also included some role-play on her difficulty with assertiveness, which appeared productive. Despite her initial reluctance to acknowledge the impact of the assault, after work on her RRPs, she eventually decided to have EMDR. This produced a major abreaction dominated by considerable anger and rage. Despite anticipating that she might slip back into re-enacting of old RRPs, she 'chose' not to write a goodbye letter, wishing not to make a fuss and because she 'happened' to be very busy. It was, however, possible to note this enactment helpfully with her. At follow-up she appeared to have done well and reported being less depressed, more confident and assertive, which had been noted at work, and she was able to talk openly about the assault. These impressions were confirmed by reductions in her psychometric measures. These reduced on the Impact of Events Scale from 49 to 14, on the Penn Inventory from 26 to 19 and on the General Health Questionnaire from 6 to 5.

DEPRESSION

The reported massively rising incidence of depression over the past decades (see *Economist*, 1998), if true, almost certainly reflects general social changes. Clinically, patients who are depressed commonly report a sense of exhaustion, existential isolation, hopelessness, the loss or lack of acknowledgement, care and love and the experience or anticipation of criticism, control or abuse from others and from themselves, the latter experienced in the form of irrational guilt. The experience of self-critical and hostile voices by depressed patients can be accounted for as the enactment of early internalised RRPs. Although one consequence of these RRPs may have been 'silencing' of any expression of anger, we see little validity in the traditional psychoanalytic formulation of depression as representing anger turned inwards upon the self. We rather note, certainly in severe cases, exhaustion and the *absence* of affect in conjunction with the other features noted above. Such factors are not necessarily operating in the present, for we do not live only in relation to our current social world, we have internalised the values and rules of that world. Physiological and psychological responses may therefore be initiated by events in the social context by remembered, anticipated or imagined events or by actions or intentions which provoke internal judgements derived historically from the social world.

Experiences which would be distressing to anyone, such as bereavement or loss of employment or status, may provoke more profound and persistent changes in those genetically predisposed to abnormalities of mood control. More severe symptoms such as poor sleep with early waking, low mood in the morning improving through the day, poor concentration, altered appetite, lack of interest in sex and the presence of suicidal preoccupations and irrational self-blame point to physiological changes which make it very difficult for the patient to make any use of therapy. In such cases medication is needed before or in parallel with therapy. Patients keen to avoid medication may be given a few trial therapy sessions, medication being started if there is no response within three or four weeks.

In treating depression, CAT will focus on procedures which maintain negative attitudes to self and submissive tendencies to others. Some of these are discussed in terms of 'self-esteem' and are considered in Chapter 4. There is now extensive, naturalistic evidence for the effectiveness of CAT for depression, both as a presenting problem and as an associated issue in other disorders in settings as various as general practice, student counselling services and health service outpatient departments (Dunn et al., 1997).

SOMATISATION

Depression is frequently accompanied by somatic symptoms but these may also occur independently as manifestations of procedural problems, notably internalised prohibitions on the expression of anger or assertion and associated submissive role procedures. One feature of the complex of procedures enacted in somatisation is very commonly an inability to communicate anxious feelings, often in relation to an internalised role of feeling one 'ought' to cope alone. It has been suggested that this inability may be partly constitutional and represent the complex of temperamental factors referred to as 'alexithymia' or literally, inability to put feelings into words (see Taylor et al. 1991). However, this inability may also reflect the difficulties in self-reflection and self-expression which individuals who have been subjected to childhood trauma or adversity are known to experience. Such internal processes, often acting in concert with ongoing social or interpersonal situations, may produce chronic physiological changes and may cause or exacerbate psychosomatic 'diseases'. These may in turn play a part in controlling interpersonal procedures, as when a depressed, submissive individual develops somatic disturbances which elicit care from others. In persistent or recurrent depression and somatisation, a full procedural analysis of the patient in relation to his or her current relationships is therefore necessary (see also the case example of Susan, in this chapter). The successful trials of brief psychodynamic–interpersonal therapy in 'functional' gut disorders (Guthrie et al., 1991; Hamilton et al., 2000) in our view address and modify these role enactments by means of a therapy which, as has been noted (Margison, 2000), has much in common with CAT.

DELIBERATE SELF-HARM

Deliberate self-harm is a major clinical problem, accounting for 140,000 visits to Accident and Emergency units each year (Hawton et al., 1997) and being the third most common cause of admission to general medical beds in one region of the UK (Gunnell et al., 1996). People who have self-harmed have a risk of suicide far in excess of the general population. Only a small proportion of self-harmers have a formal psychiatric illness but a considerable proportion have borderline traits or meet the full BPD diagnostic criteria and the great majority are experiencing interpersonal difficulties; in these the harm can be seen as a form of angry or help-seeking communication.

Repeated self-harmers are at a greatly increased risk but, even more than first timers, they frequently provoke hostile or indifferent responses from clinical staff, and they seldom receive more than a basic psychiatric screening designed to identify the few cases of severe mental disorder. The generally poor care received by these patients reflects the lack of an adequate psychological understanding among many medical and nursing staff and the power with which collusive responses—usually of rejection, sometimes of inappropriate concern—are elicited. In this respect they constitute a classic type of 'difficult' patient. Moreover, few A&E departments can offer any continuity of care to these patients (in whose lives themes of abandonment are often dominant), with the result that few return to follow-up appointments when these are arranged, thus reinforcing rejecting or helpless reactions among staff.

Cowmeadow (1994) reported the use of an eight-session CAT in self-harmers and also (1995) reported cases in which assessment was combined with a single session intervention which included the construction of a sequential diagram. Because the scale of the problem is such that the majority of patients will never be seen by trained psychotherapists, Sheard and Evans built on this work and on the CAT model of borderline personality disorder to devise a model of a structured one- to three-session intervention which could be taught to and delivered by staff without any therapy training. They report how they developed a manualised approach which pays particular attention to the feelings evoked in the assessing clinician during the interview with the aim of (1) guarding against reactions based on countertransference elicited by the patient and (2) using the recognised elicited feelings as an indication of the appropriate focus for a very brief intervention. The successful delivery of the approach by trainee psychiatrists was also reported (Sheard et al., 2000).

This work is an important example of the introduction of CAT ideas into psychiatric and medical contexts, using the basic reciprocal role model and structural understandings to provide accessible and comprehensible models of the clinician–patient interaction. It provides a further example of the value of 'using' the CAT model as opposed to 'doing' it as formal therapy.

EATING DISORDERS

Eating disorders represent the expression of inter- and intrapersonal problems through an abnormal preoccupation with weight and food. They are always associated with, but may serve to obscure, problems at the level of self processes, predominantly expressed around issues of control, submission, placation and perfectionism. In a proportion of cases there are associated problems, notably depression and substance abuse, and severe cases may meet criteria for personality disorders. Almost inevitably difficulties in communication are involved (usually within the family of origin), with the disorder representing a covert means of communicating or of coping with feelings of not being heard or being pressurised to 'perform'. In many cases these patients cause considerable systemic difficulty with splitting of teams and consequent frustration and burn-out, or alternatively over-involvement on the part of some staff. These are just the sorts of difficulties classically described by Main in the 'The Ailment' (Main, 1957); see also discussion in Kerr (1999). It may be helpful and necessary to work with the whole team and/or family, using individual and contextual reformulations, to create a common understanding of the patient's procedures and to avoid enacting collusive role reciprocations which may 'split' those involved.

Most cases of bulimia nervosa can be treated with the basic CAT approach of achieving a reformulation of the procedural repertoire, using patient self-monitoring to identify the role procedures accompanied by, or replaced by, vomiting or purging and then focusing on these procedures. Common antecedent cues leading to bingeing are fear of abandonment and unexpressed anger or disappointment. Commonsense advice about eating habits may be followed better once the procedural issues are understood. In some long-established cases controlled, anorectic phases alternate with sequences of angry bingeing, purging and vomiting. These cycles can seem self-perpetuating and require symptom-directed CBT methods within the context of the procedural model.

Anorexia nervosa is notoriously difficult to treat; many patients prove hard to engage in the therapeutic work and in severe cases the threat of further starvation puts intense pressures on therapists and other clinical staff. Apart from ensuring that a minimum weight is maintained, psychological treatments should focus on the procedural repertoire and not on the symptom. Both the traditional psychiatric force-feeding approach and cognitive therapy techniques are liable to provoke pseudo-compliance and covert or overt resistance. CAT reformulation is a powerful means of engaging with these patients; by being genuinely collaborative it avoids struggles about control and sets up a reciprocal role pattern which is 'off the patient's map'. All those involved in the treatment programme need to base their interventions on an understanding of the patient's diagram in order to recognise and resist pressures to collude. Such pressures commonly reflect patient-to-therapist roles involving (1) intense (controlling) *neediness* evoking *desperately caring*, (2) (controlling) *passive resis-*

tance evoking *angry control,* (3) (controlling) *emotional unavailability* evoking a *mirroring withdrawal,* (4) *perfectionist striving* leading *to exhaustion.* This is a frequent pattern in the patient's self-management which is often also induced in clinical staff. Patients often evoke different reciprocations from different staff members and without a shared diagram this can be a potent source of staff conflict. This can necessitate the use of 'contextual' approaches as noted above.

The spectrum of role procedures found in 30 eating-disordered patients was reported by Bell (1999). This author proposes a 'stepped care' approach whereby subjects with minimal associated psychopathology receive CBT-based self-help packages or treatments. Beyond that she recommends CAT as the most comprehensive time-limited approach but notes it is also the most complex to learn. As regards effectiveness, Treasure et al. (1995), from the Maudsley eating disorder unit, reported a pilot study in which CAT was compared to educational behaviour therapy; weight gain was similar in the two groups but CAT patients reported greater improvements in global functioning. Treasure and Ward (1997) further reviewed the use of CAT in anorexia nervosa and provide a case study of a severe case. Further research is being carried out in the Maudsley unit.

CAT AND THE MANAGEMENT OF MEDICAL CONDITIONS

A considerable proportion of patients with medical conditions do not adhere to their treatment regimes, even if they are given full explanations and support. Two conditions in which such failure has serious consequences and where the use of CAT has been evaluated are diabetes and asthma, in both of which there is some research support for the value of CAT in improving self-management

Management of insulin-dependent diabetes

Insulin-dependent diabetes is a condition where modern techniques using regular monitoring of blood sugar levels and carefully spaced and adjusted injections of insulin, combined with keeping to a strict diet, can allow the majority of patients to avoid the serious complications of damage to eyes and kidneys, arterial disease and peripheral neuritis. However, a sizeable proportion of patients develop these complications despite being fully educated and supported by diabetic nurses. Proper self-care in insulin-dependent diabetes is a tedious business and the effects of poor control are not immediately obvious, so it is not surprising that many patients take risks.

Work by Fosbury et al. (1997) with CAT has demonstrated that the reasons for failing to adhere to diets, do blood tests, take appropriate doses of insulin and so on are various and in no way specific to the condition. They are often manifestations of more general patterns of self-management and are related to

procedural patterns of which the patient is often largely unaware. The CAT approach is therefore particularly appropriate, reformulation allowing the 'symptom' of poor self-care to be set in the general procedural repertoire. CAT does not require the patient to submit to instructions—an important point in that a passive resistance in relation to authority in general and the clinic staff in particular is one common pattern. Other procedures underlying poor management include depressive self-neglect (which can extend to what amounts to slow suicide), eating disorders where, in the pursuit of weight control, omitting insulin can replace or supplement purging and vomiting, and resentment at having the disease expressed in denial or defiance.

Fosbury et al. (1997) demonstrated benefits from CAT compared to nurse education in the reduction of HbA1 blood levels (an indication of the average blood sugar level over past weeks). There were no significant biochemical differences at the end of the 16-week interventions but nine months later the HbA1 levels in the CAT group were significantly lower. It should be noted that these were long-standing patients few of whom had expressed an interest in counselling or therapy. This study suggests that early recognition of damaging self-care and preventive CAT would be humanly and cost effective.

Management of asthma

A broadly similar study relating to asthmatic patients' failure to use suppressive inhalant medication as recommended has been completed by Cluley et al. (2000). In a study of non-compliance with inhaled steroid medication, in which a concealed microchip recorded the actual use of the inhaler, a group of patients with severe asthma was identified and those showing poor compliance were randomised between usual care and CAT. Fourteen of the 17 patients allocated to CAT completed a 16-session therapy. Identified reciprocal role patterns were similar to those found in the diabetic study, notably, patterns of *critical control* to either *crushed or rebellious, neglecting–neglected* and *ideal care* fantasies. At six-month follow-up there were significantly better measures of treatment compliance ($P < 0.05$) and quality of life in the treated group. As with diabetes there would seem to be a case for early identification and treatment of poor self-managing cases. Walsh et al. (2000) report a study of asthma sufferers with poor self-management of their medication, arguing strongly for the value of a CAT-based understanding of the emotional and interpersonal factors responsible.

The studies of diabetes and asthma demonstrate the failure of both authoritarian and 'rational' attempts to achieve good self-management in many sufferers from these chronic diseases. The work reported lends support to the argument made in many parts of this book in favour of CAT as providing a whole person, high level understanding as opposed to the CBT focus on symptoms, behaviours and illness beliefs. The findings suggest that a broadly based understanding of the individual's specific damaging behaviours, locating them

within a model of the general reciprocal role repertoire, offers the best chance of avoiding what to the patient is often a slow suicide and what to the Health Service is liable to be a costly palliative exercise. Compared to the resources put into refining the medical treatment of diabetes and asthma (which patients so often undermine) and involved in treating the consequences of poor management, the instituting of preventative and early psychological intervention as a part of specialist medical services would require trivial sums.

It is clear that these approaches could be very usefully applied to a variety of disorders, such as those which present to the consultation and liaison psychiatrist in the form of psychological complications of medical disorder or as physical symptoms arising in relation to psychological problems. CAT may well have an important role to play as a consultation tool in these settings, beyond its immediate use as an individual therapy, as a general model for understanding patients and helping staff treat them. (See also the case example (Brenda) of a 'difficult' patient on an oncology palliative care unit discussed in Chapter 11.)

SUBSTANCE ABUSE

The place of CAT in treating substance-abusing patients is fully reviewed by Leighton (1997) and its relation to the Minnesota 'twelve step' approach is discussed by the same author (Leighton, 1995). As a general statement it can be said that patients continually abusing alcohol or drugs are unlikely to benefit from psychotherapy unless undergoing prior withdrawal. Where abuse is combined with borderline personality disorder (BPD), as it is in a small but possibly increasing percentage of cases, management of withdrawal in inpatient or group settings will be helped by CAT reformulation. A randomised controlled trial of the role of CAT in the treatment of adolescents at risk for developing BPD, the majority of whom are substance abusing, is currently in progress (Chanen, 2000). In this group it may be necessary to offer psychotherapy before withdrawal can be realistically achieved, the sole condition being that patients must come substance-free to their sessions. In older patients therapy is of most need after withdrawal has been accomplished, particularly in those patients for whom alcohol or drugs have served to keep at bay memories and feelings from disturbed early experiences. Many of the borderline patients treated by outpatient CAT have come following succesful treatment for substance abuse which has left them facing the sense of emptiness and unmanageable feelings which the substance had served to suppress. Such patients may not be able to use the supportive group offered by Alcoholics Anonymous and similar organisations and are liable to discharge themselves from most available treatments. Assessment of patients completing withdrawal programmes should routinely seek to identify such patients. The role of drugs and alcohol in general may combine elements of 'perfect care'—states of blissful fusion with the absence of conflict and need—with the enactment in self-management of an

abusing–abused pattern. It should also be noted that there is also some evidence of a genetic predisposition to addictions with the implication that some of the work of therapy may need to focus on living with such a vulnerability.

CAT IN OLD AGE AND EARLY DEMENTIA

The use of a CAT framework in work with elderly people facing early dementia, and those who have suffered past traumas and are now facing early dementia, has been pioneered by Sutton (Sutton, 1997 and in press; Sutton and Ryder, in press; Hepple and Sutton, in preparation) and CAT in the elderly is now a developing special interest group within ACAT. Sutton (personal communication) has written the following account of how she came to work with the elderly using CAT; it both illuminates what the work implies and has resonances for others who move from other theoretical backgrounds.

> I had been working in old age for a few years after qualifying as a clinical psychologist. I was largely schooled in CBT and was using this framework for my work with older people. While it was good for phobias, anxiety and the like, I didn't know what to do with clients telling me about the long lives they'd lived. I was aware of work elsewhere in reminiscence and life review in ageing. I felt that CBT failed to capture the qualitative perspective of age and, while personal construct theory was better, I was still frustrated by the split between cognitions/constructs and life review/reminiscences. When I first heard about CAT and attended a 2-day meeting I was working in a nursing home and I was astonished to find a model that described my client and her state shifts so well. The SDR we worked out made sense to my client's daughter and to the staff as well as to me and was the foundation for a year's work—the narrative part—in which her behaviour could be understood in terms of her past abuses (see Sutton, 1997).
>
> Narrative therapy was being introduced into dementia care, based on the stories that people with dementia tell. I began to find these approaches insufficiently critical; although they talked as if they addressed society they were essentially constructivist, not socioconstructivist; what I wanted to emphasise was restorying (Sutton and Cheston, 1997). Here too CAT appealed through its understanding of how a large part of the human suffering we encounter represents the internalisation of external relations; through its staying at the level of meaning, CAT avoids reifying and biologising human experience, countering the profound biological reduction of ageing. That, I feel, makes CAT, with its base in the historical formation of mind, a suitable framework for attending to the long histories of ageing people, while its dialogical understanding can ensure that the fact that we exist and are conscious and think in and through our relations with others is not forgotten. These points will be central to the book which Jason Hepple and I are preparing (Hepple and Sutton, in preparation) in which we will present the theoretical understandings and practice of CAT in old age, covering trauma, personality disorders, dementia, carers and systems and the need for developing a lifespan psychopathology.

In applying the CAT model to later life this work has drawn on and extended the basic Vygotskian and Bakhtinian elements in CAT theory. Human minds, to the end, are sustained by a continuing narrative and dialogue with others.

GENDER ISSUES

The aim of therapy in CAT is the revision and integration of the damaging procedures identified during the collaborative reformulation. Many role procedures may be expressed in sexual relationships and through sexual practices but, in a way consistent throughout CAT, these will be understood in terms of the basic procedures governing self-management and self–other relationships. These are concerned with giving and receiving acknowledgement and care and with issues of control and submission. It is of course the case that committed sexual relationships are likely to mobilise intense feelings and to generate conflicts between the wish for autonomy and the wish for care. In terms of psychoanalytic theories the CAT emphasis is more on two-person relationships than on three-person 'oedipal' ones, but issues of rivalry, jealousy and sex role identification are also of importance and need to be attended to.

Certain procedural patterns remain tied to gender stereotypes which have a long history and are still instilled and sustained by cultural and economic pressures. They are also to some degree rooted in, although in humans certainly not completely determined by, complex evolutionary predispositions which could be described as archetypal. In our culture, patterns of placation and submissive dependency are much more commonly found in women, helping to maintain continuing social inequalities, while the avoidance of emotional expression and denial of emotional needs remains a largely male characteristic. Procedural change in these respects is a common aim in CAT and fortunately receives more social validation than was the case in the past. Changes in the law and the slow diminution of prejudice have also eased the problems faced by homosexual persons. There are, however, additional problems faced by gay individuals, many of whom have had difficulties in being accepted by their families and all of whom are liable to encounter discrimination. Both of these features may contribute to self-blaming procedures the modification of which would be an appropriate aim in CAT. The problematic relationship procedures found in gay partners differ little from those found in heterosexual couples. Denman and de Vries (1998) provide an interesting case history illustrating many of the above issues.

THE EFFECTS OF CHILDHOOD SEXUAL ABUSE

The incidence of sexual abuse in childhood is higher in most psychiatric diagnostic groups than in the general population. It is particularly high in

borderline personality disorder where, in those genetically predisposed, it may be the common initial trigger for dissociation (see Paris, 2000). It is only in recent decades that the high rate of abuse has been acknowledged; discussions in the media served to make it something that could be talked about publicly and this seems to have enabled many people to recall and report experiences which had not been thought or talked about for many years.

CAT is not primarily concerned with the (impossible) task of autobiographical reconstruction but patients who recover or, as is more common, extend their recollections of childhood abuse during therapy need to be helped to make sense of and assimilate these memories. A major focus needs to be on disputing the almost universal irrational guilt suffered by victims of sexual abuse. The common forms of abuse are those involving family members, most often siblings and stepfathers, and those occurring in institutional settings. Within the family there is often associated violence towards the child and between the parents, often combined with evidence of personality disorder and substance abuse, all of which have damaging effects on the development of children. As Zanarini (2000) comments, sexual abuse may be 'the childhood event most horrific to clinicians ... it may not be so to patients. Rather, it may be emblematic of the ongoing chaos and insensitivity that they faced on a daily basis'. The effects of the abuse itself are more damaging where it involves penetrative sex, is repeated and is accompanied by threats of, or actual, violence, but sexualisation of an affectionate parent–child relationship and the blurring of generational and gender boundaries can also be a source of confusion and guilt.

The psychotherapy of adult abuse survivors will usually be concerned with the overall distortions of their self-management and relationship procedures. These are likely to take the form of the re-enactment of abusive procedures towards self and others, sometimes but not always including repetitions in the form of perverse sexual practices, or to involve restrictive and avoidant procedures. The narrative reformulation of CAT can help the integration of the many survivors with partially dissociated self states and the diagrams are of particular value in preserving therapeutic relationships in the face of distrust. Pollock (2001) has written and edited a book in which the use of individual and group CAT to treat abuse survivors is described in detail, sometimes in combination with other methods such as 'power mapping' (Hagan and Smail, 1997). The book includes some encouraging case histories and naturalistic studies of the effectiveness of CAT.

True or false recollections of abuse

After many decades in which memories of abuse were routinely interpreted as fantasy by psychoanalysts, the acknowledgement during the past 20 years that it was a common and real event led to a reversal of attitudes and to a general tendency for therapists to accept such memories as being at least based on

actual experience. More recently, however, there has been a growing realisation that this is not always so and, more importantly, that therapists can easily suggest, or can seem to offer validation of, false memories.

To have an experience of abuse denied can be abusive, especially where threats and lies had accompanied the abuse, and in the past many patients suffered in this way. But it is also abusive for a parent to be falsely accused of having committed abuse. The fact that recovered memories are liable to surface during therapy and that some therapists had actively sought for (and indirectly suggested the presence of) such memories generated a passionate reaction and divided people, including professionals, into believers and non-believers in the possible truth of recovered memories. The debate about the 'false memory syndrome' was therefore fuelled and obscured by much pain and anger on both sides. It is now generally accepted that most but not all memories of abuse, even those recovered after periods of amnesia, are based on real experience, but that, in line with all the research on memory, what is recalled is a mental construction with a variable and often slight resemblance to what occurred (Brandon et al., 1998; Offer et al., 2000). However, in the absence of corroboration, there is no way of distinguishing between true and false memories; in particular, the latter can be as detailed and vivid as the former. Where adults recall memories after decades of complete amnesia, where the memory refers to very early childhood and where elaborations such as accounts of satanic rituals are reported, the likelihood that the memory is a false construction is greater.

The practical implications of this for therapists have been spelled out by the Royal College of Psychiatrists (Brandon et al., 1998) and the British Psychological Society (1995). Techniques involving hypnosis or powerful suggestion should be avoided, and the suggestive potential of detailed questioning should be borne in mind. It should be made clear to patients that all memory involves selection and construction and that the truth or otherwise of uncorroborated memories cannot be established. Because false memories may be held with great conviction and because their effects on current family relationships can be devastating, responsible therapists will be careful to remain uncommitted about the truth of uncorroborated memories of childhood abuse.

Elaborations of fantasy of the kind emphasised by Freud, distorted interpretations of innocent events, retrospective revisions based on later experiences, sociological changes influencing gender roles, unresolved psychological tensions in the family and other factors may all be the source of partially or totally false recovered memories of abuse and their relative weights and frequencies have not been established.

UNRESOLVED MOURNING

The loss of others whom one needs or values, the loss of one's own health and capacities, the loss of one's beliefs or illusions and the losses imposed by time in

the receding past and diminishing future are all unavoidable aspects of life. These issues constitute an important and implicit focus of work in all forms of psychodynamic therapy, and a central and explicit focus in some, notably attachment-theory based approaches (Murray-Parkes et al., 1996; Marrone, 1998). Coping requires acceptance of the fact of loss followed by the assimilation of its meaning. The focus here will be on bereavement but other losses involve similar processes.

The period of early mourning following the death of a loved person is normally marked by emotional instability, with shifts between states of acute distress, of protest or anger at the deceased, of intrusive memories or hallucinations and of denial or disbelief. These fade with time as acceptance is gradually accomplished. In modern industrial societies the social rituals and conventions surrounding illness and death are generally impoverished and we have generated no replacement for the role played by religions in the past of supplying support and giving meaning to the experience. Failures to complete mourning are common and only a few people make their way to the available resources of self-help groups and counsellors. Maybe for these reasons, and also because of the more general loneliness of many people in our individualistic societies, incomplete mourning is frequently an aspect of the difficulties which bring people to psychotherapists. It commonly presents as depression and restriction which serve to avoid or suppress the more powerful affects of grief and rage associated with loss. Sadness may have been intolerable at the time of the loss due to the absence of support or the need to cope and care for others, or there may be anger or resentment reflecting the sense of abandonment which, because irrational and not respectable, has not been expressed. This anger may be redirected at professional carers who are seen to have failed to look after and save the dead person. Whatever coping mode was adopted at the time, the most common ones which involve suppressing feeling and getting on with the practical tasks can become habitual. In some cases the particular relationship with the dead person and the role procedures active in it may further complicate the mourning process, most notably where the subject feels guilt as if the death occurred as a result of his or her hostile feelings or actions.

One experience of loss and mourning requiring assimilation is a product of therapy itself. The reformulation commonly confronts patients with how their own past procedures have restricted and damaged their life so far. The appropriate recognition of this lost possibility is an important step on the road to change. More generally, therapy can reach beyond the defensive dulling of incomplete mourning. The termination of an emotionally powerful therapy relationship can be an emotional recapitulation of past losses which can be supported in ways allowing the revision of the previous restrictive modes. Here, the time limit of CAT, its intensity and the direct focus on loss at termination which is recorded in the 'goodbye letter' are all features which make it a suitable intervention for patients with problems in this area. On the other hand, the reformulation of the patient's role procedures allows the recognition of

specific relationship issues and general strategies which may have contributed to the incomplete assimilation of the loss. Issues surrounding the negotiation of death, dying and mourning are explored further from a CAT and Bakhtinian perspective in Kerr (1998a).

CAT IN PRIMARY CARE

CAT is being increasingly used in primary care settings by therapists and counsellors for the range of neurotic and less severe personality disorders encountered there. A further, demanding part of the workload in general practice centres around a number of 'frequent attender' patients (often referred to vividly if rather pejoratively as 'heart sink'). Such patients are estimated to represent about 5% of a typical practice workload. While less disturbed patients tend to recover with many different interventions by GPs or practice counsellors, for this 'difficult', frequent attender group the evidence suggests that CAT is an effective treatment in this setting. In a pilot study reporting on a series of patients ($n = 29$) with a range of disorders, many of whom fell into the frequent attender category (customarily defined as 11 or more attendances per annum), impressive results were obtained both in terms of psychological difficulties as assessed clinically and also by frequency of attendance. The latter reduced from a mean of 11 to 4 per annum across the whole group (Barker, Johnstone, Reidy and Williams, personal communication). Comparable results are also being obtained in a further extended series documented by these workers. Interestingly, however, in the few patients evaluated in the pilot study who received a mean of only six sessions a reduction of frequency of attendance was not seen. This suggests that a full course of CAT may be necessary to achieve clinically significant and lasting results in many patients, although these numbers are of course too small to be significant. This incidental finding raises important questions, however, about the widespread practice in primary care of restricting therapists or counsellors to delivering such a limited number of sessions only and is an issue which requires further, formal evaluation.

Given the sorts of difficulties generated by such patients in primary care, the support of staff through, for example, CAT-based discussion groups, could be a further, useful contribution of the model.

PSYCHOSIS

In recent years there has been a growing interest in the psychological treatment of psychotic illness and a CAT special interest group has been undertaking some work in this field. Out of this, some interesting findings and a preliminary CAT-based model of psychotic disorder has emerged (Kerr et al., 2000; for a fuller account see Kerr and Crowley, 2001). Given that this will be an unfamiliar

area to many psychotherapists, a brief overview of the background to this work will be given, noting in particular psychosocial aspects of these disorders. Detailed accounts of recent research into psychotic disorders can be found in recent volumes edited by Wykes et al. (1998) and Martindale et al. (2000) and a consideration of psychosocial issues is offered in a review by Hemsley and Murray (2000).

Current models of psychotic disorder

The dominant paradigm in addressing psychotic disorder has come to be that of a stress-vulnerability model as originally proposed by Zubin and Spring (1977). This paradigm views the occurrence of such disorders as the culmination of factors representing a vulnerability to the disorder (genetic and/or biological) acted upon by psychosocial stressors both during development and in the present. Exactly how vulnerability and, in particular, psychosocial stress is conceived of varies in different models and is still accounted for in only varying degrees of adequacy. In particular, the extent to which higher mental function is understood to be socially formed and subsequently expressed, both in normal and psychotic states, we would see as a neglected area in most current models.

Neurobiological and cognitive abnormalities in schizophrenia

Evidence from studies of heritability (e.g identical twins adopted and brought up apart and studies of incidence in first degree relatives) suggests that approximately 50% of the vulnerability to disorders such as schizophrenia and bipolar affective disorder is inherited. However, this leaves open the important question of what constitutes the remainder of the vulnerability. It is increasingly accepted that psychosocial factors affect both the development and the course of psychotic illness over and above the influence of genetic or biological vulnerability. Various neurobiological abnormalities have been shown in the schizophrenias, many of which implicate some neurodevelopmental abnormality. These abnormalities include pervasive and long-standing subtle neurological defects in most individuals who develop schizophrenia. The general consensus is that there exist systemic impairments of 'functional connectivity' or a widespread 'cognitive dysmmetria' (Andreason et al., 1998). Various complex but overlapping theories have been proposed to account for both overt symptoms and underlying neurocognitive deficits. A few studies in this area have paid attention to the social and interpersonal origins of the personal meaning of higher mental activities. Thus Bentall and his group (Bentall and Kindermann, 1998) hypothesise, for example, that persecutory delusions arise in response to perceptions that appear to represent personal threat and are associated with underlying attributional cognitive biases. Their study of the ways in which paranoid and delusional thinking is generated is rooted in a more social

constructivist viewpoint than are the monadic and purely 'information processing' perspectives implicit in most cognitive accounts.

Neurobiological and cognitive abnormalities in bipolar affective disorder

In bipolar affective disorder the overt symptoms appear to be rooted in a constitutional predisposition to lability of mood and disinhibition, with consequent grandiose and deluded thinking and behaviour in the acute phase. Much remains to be discovered about this disorder. It is known that psychosocial stressors are important in the course of the disorder although less is known about their role in its initial development. By analogy with the schizophrenias it seems likely that they play some role.

Secondary effects of psychotic illness

One important consequence of these abnormalities is not only the catastrophic disruption in the sense of self central to the experience of these disorders (Hemsley, 1998) and important in recovery from them (Davidson and Strauss, 1992), but also the profound damage done to the individual often attempting a delicate and difficult life stage and developmental transition from late adolescence to, and subsequently through, adulthood. The experience of psychosis may leave an individual with a frank post-traumatic stress disorder, which may require additional therapeutic consideration (McGorry et al., 1991).

Current psychological treatments for psychotic disorders

Psychosocial interventions

The idea that psychosocial stressors are of importance in the course of psychotic disorder has been recognised for several decades since the pioneering work of Brown et al. (1972) on the role of family environment in the outcome of schizophrenia. This work demonstrated the importance of high levels of 'expressed emotion' (i.e. overt criticism and hostility by family members) in determining subsequent relapse rates. Current treatments for this include family and systemic therapy focusing on both psycho-education for the family as well as on high expressed emotion.

Psychological treatments

More recent CBT-based treatments of major psychotic disorders, notably schizophrenia, have tended to focus either on the presumed underlying neurocognitive deficits in, broadly speaking, the areas of information processing or, as in the UK in particular, on particular symptoms or difficulties such as

delusions or hallucinations. Trials of CBT have now been reported by several groups demonstrating clear effectiveness in the major areas of psychotic symptomatology as well as, to varying extents, in associated problems such as depression, social function, and overall relapse rates. There are encouraging, reports of more psychodynamically informed treatments, notably from various groups in Scandinavia, from the well-known 'need-adapted' psychosocial interventions developed by Alanen in Finland and from the carefully formulated psychodynamic approach developed by Hogarty in the US. Several cognitively based theorists have also developed approaches aimed at normalising and working with experiences of hearing voices, based on an understanding that these are not fundamentally abnormal experiences (Chadwick et al., 1996; Leudar and Thomas, 2000). Significantly, early experience of trauma may adversely affect the way in which voices are internalised, integrated and subsequently experienced. Romme and Escher (Romme et al., 1992) in Holland have pioneered voice hearers' groups which have had apparently powerful therapeutic effects. It can be seen that these approaches represent a form of dialogical understanding and treatment.

Aims of psychotherapy for psychotic disorders

It is clear that treatment may need to be offered at a variety of levels ranging from increasingly specific pharmacological, to cognitive remediation work, individual psychotherapy through to more general social and family support of both a practical and psychoeducational nature. Garety et al. (2000) summarise the threefold aims of therapy as reducing the distress and disability caused by psychotic symptoms, reducing emotional disturbance and helping the person to arrive at an understanding of psychosis in order to promote active participation in the regulation of risk of relapse and social disability. Most authors in the field stress the importance of a detailed and individual formulation of the patient's problems, ideally in conjunction with the patient.

A CAT-based model of psychotic disorder

What CAT may have in particular to offer to the understanding and treatment of psychotic disorders is an account of how development (including its social and cultural dimensions) may, or may not, be stressful both historically and in the present, through the 'internalisation' of role procedures and their associated dialogic voices. Such a Vygotskian and dialogic model would predict that both vulnerability to and also expression of psychotic symptoms and experiences would be determined by an individual's repertoire of internalised reciprocal role procedures, constituting as they do fundamental components of higher mental function. Thus the form of psychotic phenomena such as auditory hallucinations or disturbed or self-harming behaviour, delusions (whether paranoid

or grandiose) or extreme self-critical depressed states could be largely accounted for in terms of internalized RRPs and their associated dialogic 'voices'. These would be evident in both internal self–self and self–other enactments, as is the case normally, but in psychotic states, whatever the cause, in a highly distorted, amplified and muddled form due to 'information processing' abnormalities in a vulnerable individual, particularly if stressed. It can be seen that distortion of these self–self procedures or inner dialogue could, for example, result in misattribution of 'voices' to external agencies such as the devil in the case of extremely self-critical or self-harming procedures, or the development of paranoid delusions (see parallel argument by Bentall and Kindermann, 1998).

A further consequence of psychotic states is the damage, as noted by Hemsley (1998), to the sense of self and its continuity. This can be seen as damage at levels 2 and, especially, 3 as described in the CAT developmental model (see also Figures 4.1 and 4.2). One implication of this model is that psychosis may be due to a failure of integration of RRPs and dissociation of self states for whatever reason. Such 'pockets' of refractory psychosis (paranoid beliefs and reciprocal role enactments) have been noted, for example, in BPD (Heather Wood, personal communication).

A CAT-based developmental model of vulnerability to psychosis

Developmentally it can also be seen that vulnerability, for example due to subtle neurological abnormalities, may result in social difficulties and abnormal interpersonal interactions, as well as in a tendency to mis- or over-interpret perceptual phenomena. This could in turn be compounded and exacerbated by difficult experiences *which may have been partly elicited or generated by that vulnerability* in a dialectical process. Thus we would suggest that the psychological internalisation of abnormal interpersonal experience in the form of RRPs could in itself be a 'self-stressful' dynamic which could have serious long-term psychological, and possibly neurobiological, consequences. It has, for example, been suggested that stress hormones could be in part responsible for mediating such pathways at a biological level (Walker et al., 1996). It is also known that neurodevelopmental processes are not complete until early adulthood and these processes may well be affected by such stress and determine the time of onset and severity of an illness. This RRP repertoire we would see as constituting a core aspect of these disorders and its expression, as well as determining how it is responded to by others, both during development and also in terms of current interpersonal difficulty. An important implication of this model is that stress may be generated internally through the prior internalisation of self-critical or restrictive reciprocal role procedures through early interpersonal experiences, informed also by their cultural values and meanings. This stress could be seen as 'internal' expressed emotion, by analogy with the overt expressed emotion addressed by family therapists.

A further implication of this dialogic model is that psychotic states may be viewed as a being 'out of' or 'impermeable to' dialogue, both internally, in terms of disrupted and disordered inner self–self dialogue, as well as in terms of dialogue with others. Interestingly, key risk factors for psychotic states in old age (formerly described as paraphrenia) include social isolation and deafness. Such consideration of the origins of psychotic phenomena appears to provide additional evidence for the validity of a dialogic approach to understanding and working with higher mental functions, whether in psychotic states or not.

Therapeutic implications of a CAT-based model of psychosis

This model implies that working with RRPs and their dialogic voices can inform and assist attempts to make sense of psychotic experiences with the patient. The CAT emphasis on active participation and agency on the part of the patient in generating a joint, meaningful, narrative of their story and experiences would also be expected to have important therapeutic effects given the core disruption of sense of the self. Therapeutic work would, as in CBT, focus on the origins and meaning of psychotic symptoms such as hallucinations or delusions but would pay particular attention to their interpersonal origins. Even with neurotic patients it can be helpful and surprising to consider what the nature of a 'voice of conscience', for example, might be. The CAT model would imply that it would be important for a patient to understand and revise highly 'self-stressful' RRPs to reduce risk of relapse. A key part of such work would be an attempt to get a patient back into dialogue both internally and externally with others as well as to understand the circular nature of maladaptive role enactments. It is clear that isolation of a damaged and disturbed person will exacerbate their problems and stress them and this will have often occurred historically. In part, a CAT-based approach would be explicitly psychoeducational, based on an understanding of the nature of vulnerability to psychotic states. Importantly, any therapist working with such patients would need to become a trusted and reliable other with whom it is possible to have a confiding relationship and develop a dialogue. A further important aspect of any psychotherapy with such disorders would be the talking through and mourning of a life that might have been led but for the illness, an undertaking which will be greatly assisted by the explicitly narrative-based approach of CAT.

CAT would also aim to address the self-sabotaging or 'resistant' RRP enactments which may occur in psychotic disorders. As in the case of various medical disorders, these may lead to the patient being seen as 'difficult' and eliciting unhelpful role reactions from staff and family, particularly if the behaviour is seen as directly due to the illness, rather than as maladaptive coping strategies which may be compounded or amplified by the illness. Mapping out these role enactments, whether individual or contextual, would be expected to be helpful in these instances. What such approaches would effec-

tively achieve would be the diminution of a generalised form of high 'expressed emotion' surrounding such patients in a way that will make sense to the patient and those around.

Two case histories will be described in order to illustrate these points in more detail. The first case describes work with a patient with a long-standing illness in a relatively stable condition, following recent discharge from hospital. The second case, which has been described at length elsewhere (Kerr, 2001) and will only be briefly summarised here, was a patient in a post-acute psychotic state in a locked ward who had become a 'difficult' patient with attendant, characteristic, unhelpful staff team role enactments.

Case example: Sarah (Therapist IK)

Sarah was a young woman in her early thirties, a graduate in fine art from a prestigious university, who was finally referred to a psychotherapy department with considerable reluctance by her community mental health team. She had been asking for psychotherapy for years and saw it as somehow a possible solution to her problems. She had a ten-year history of what was eventually diagnosed as a schizo-affective disorder and had been told by her doctor that she was 'born' with this and would always have it. There was no formal family history of psychotic disorder but her father was said to have been difficult, moody and incapable of intimacy and may have suffered from mood swings. Mother was quiet, rather timid and placatory towards her husband. Although she was described as supportive of Sarah they have never had an intimate or confiding relationship. As a child Sarah related that she kept herself to herself and was often lonely and cried alone in her room upstairs. She was also afraid of the dark. She said that she always *felt* criticised and teased by her father although on closer exploration she appears to have been seldom actually overtly criticised or punished. Her younger sister suffered from severe depression but has also managed to graduate from university.

Sarah had had multiple admissions to hospital, often under a 'section' of the Mental Health Act which involved admission to a locked ward. She described these as frightening and traumatic experiences and she did not feel treated seriously on large ward rounds. Some symptoms during these admissions were described in lurid terms in her case notes as 'very psychotic'. She described hearing the voice of God and of the Devil who urged her to attack people with knives or telling her she was worthless. She took a serious overdose one year prior to referral; she could not remember exactly why she did this. However, she remembered lying on the floor and it not seeming that she had herself done it. She 'coped' in the past with difficult feelings by cutting herself off and drinking heavily. She had an eating problem (bingeing and vomiting) at one point but had become overweight due to medication. She was taking lithium and neuroleptic medication although she was no longer on antidepressants, which

she was pleased about. She felt that medication muffles real feelings and 'jollies you up' and would ideally like to have come off it, despite advice from her doctors. She was living in a hostel where she had no intimate friends and was doing some voluntary work in an old people's home. She found this rewarding but would like to do more with her life. She was attending church regularly and seeing some people from there. By her own account she found difficulty in social relationships and had never had a long-term, serious relationship. When she presented for therapy she did so with an intense enthusiasm but with also an obvious wariness and sadness.

She was offered a 40-session CAT-informed psychodynamic therapy as an outpatient which she eagerly if warily took up. She attended regularly and punctually and respected boundaries although was clearly often curious to know a lot more and be involved with her therapist. She joked in fact in her goodbye letter about still not knowing whether he was interested in art although she was sure he was. Her initial concerns appeared to centre around what the therapist's agenda was and what his connection with the community team was. She was also, it transpired, initially very wary about the therapist trying to recover repressed memories and also worried that psychotherapy might be 'dangerous'. She also expressed worries about what she called the 'trip wire' for her 'crashes' and about not really understanding what her illness was. She felt that she had suffered an 'emotional illness' related to the stress of her past. One of her major initial stated aims was to try to find her real self which she felt she had lost. She expressed considerable confusion and lack of confidence about her identity, especially as a woman and in relation to men. She noted that it felt difficult somehow to say 'I' and felt as if somehow she had been adopted. It gradually became clear that she also felt fearful about expressing any intense or angry feelings because in the past she felt that it had led to people thinking she was ill and to her being locked up. She thought there was a lot of 'frozen anger' inside which might be causing a depression. When depressed she felt that she 'ought' to punish herself and felt she had no concept of being comforted and that she had never been 'allowed' to feel despondent or sad. She also slowly discussed her angry but also, it appeared, idealised view of God although she was very reluctant to do so because talking about God too had led to her being locked up. Gradually too she discussed what she adamantly described as 'not schizophrenic' but recurrent 'critical voices'. On exploration it seemed that most of these could be related historically to her father but also to some teachers and a female family friend who continually ticked her off, as well as the culture around the school she attended. She had been frequently told, she said, that she was stupid and worthless and, in an interesting 'Vygotskian' comment, noted that somehow '*you* can't do that' had become '*I* can't do that' in her head.

Therapy for the first few months consisted very largely of her exploring and testing out the space and relationship offered to her about which, understandably, she remained very wary, appearing apprehensive of rebukes or rejection.

This period culminated before one Christmas in her attending obviously a little tipsy from a party and slightly disinhibited and, it seemed, testing out the therapist's reaction. She agreed subsequently that she had been really very surprised and relieved that she had not been criticised or rejected and that this had constituted an important point in the therapy. Gradually too it became possible for there to be some longer thoughtful silences and occasional tearfulness in reflecting on her life and what had become of it. Given the apparent need for this longer initial phase of building trust, the work of reformulation was not undertaken until about halfway through this therapy. In this respect the written reformulation in particular took the form more of a review letter reflecting on what had gone on in therapy up to then as well as on her story. It was nonetheless, as so often, a very moving and tearful moment. This letter (not shown) focused also in her case on the tentative discussion of her illness and eventual agreement with her therapist to refer to it as a 'vulnerability'. This is referred to in the list of TPPs, or 'key issues':

1. Feeling that you must somehow cope heroically on your own with difficulties, which seems, however, to leave you often feeling isolated, depressed and sometimes full of angry feelings, and so feeling even more that something is wrong with you and that you should keep things to yourself.
   Aim: Think about the costs we have discussed of trying to cope 'heroically' and check out the consequence of trying gradually to share some of your worries and anxieties with other people.
2. Believing your self-critical 'voices' as if they were really true 'reflections' of you, which leads you often to put yourself down and to feel that you don't deserve care and attention, which in consequence leaves you feeling that the 'voices' must be right.
   Aim: Consider where those internalised 'voices' might have come from as we have discussed and check out the evidence especially with other people as to whether you really believe them.
3. Because of being sensitive and having a psychological vulnerability to stress, feeling that life can never work out perfectly and that it is not worth trying, which in turn seems to confirm your worst fears when you don't try things.
   Aim: Consider that anyone with any vulnerability or disability has a right to a fulfilling life despite them and that it might be possible to live well without things having to be 'perfect', which might in any case be an illusory ideal.

Much of this list was concerned with coming to an agreed, joint understanding of her vulnerability and what might lie behind it and on how she might in the future cope with it. She also constructed with the therapist a detailed 'messy' SDR sketching role enactments around a 'core subjective' and 'original' self which was also a moving moment for her. Interestingly, Sarah insisted on writing at the top of the diagram that 'I have a personality', which she then

amended to 'I *am* a personality'. Incorporated within the 'core subjective self' was also some description and agreement about what amounted to her psychotic vulnerability. These included a tendency to be 'up and down', to 'turn' and be 'scared of snapping a trip wire' along with a more general description of being 'sensitive' and tending to 'pick things up'. A refined version focusing on what emerged as key reciprocal role enactments and their consequences is shown in Figure 9.3. This also notes those enactments (either self–self or self–other) which might cause, broadly speaking, 'stress'. The key RRP of *criticised* relative to *criticising* (mostly of self, but potentially of others, which she could relate to since she felt her father did just this) proved to be a fundamental discussion point in terms of thinking about where this voice came from and whether she was prepared to 'own' it. It seemed clear that this self-critical voice constituted a major source of 'stress' for her and could be considered, as noted above, a form of internal 'expressed emotion'. In her goodbye letter, Sarah identified her understanding and modifying of this 'voice' as a major achievement in her therapy.

During this period of therapy Sarah remained stable and had no further admissions although these had hitherto occurred on at least an annual basis. She had also managed to move on and out of her hostel. Her team reported that she appeared markedly more communicative, cooperative and less depressed. She remained well at three-month routine follow-up and said that she wanted to get on with her life meantime and did not want any more therapy. Most interestingly, she said that she was for the first time in years now able to 'cry with God', which she felt was an important change. This does seem to indicate how she had moved on to be able to be more in dialogue, not only with staff but also, arguably, internally with some greater aspect of herself.

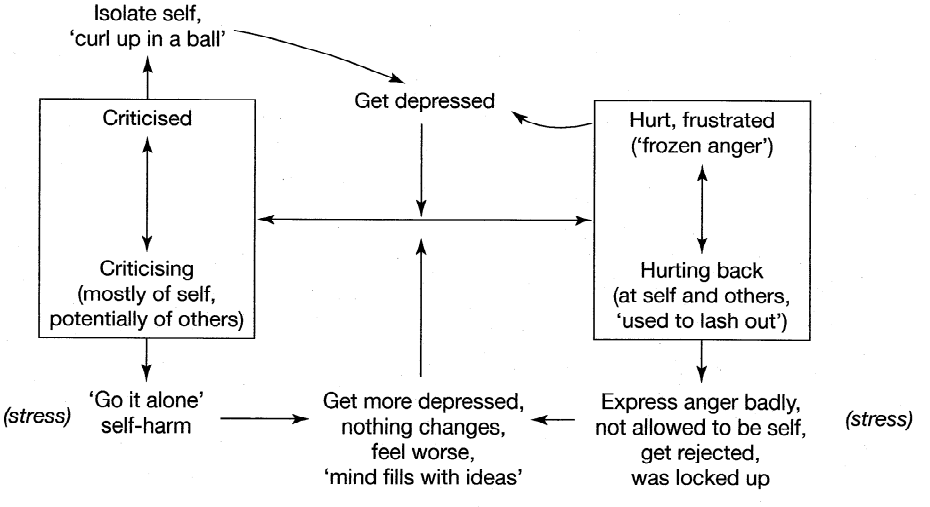

Figure 9.3 Simplified SDR for Sarah showing enactments of key RRPs

Sarah was also enthusiastic about being used as a case example for an article when asked, since she felt very strongly that other people with serious mental illnesses should also have the chance to have psychotherapy and that this might help towards that. This seemed in itself a significant, hopeful and 'dialogic' utterance.

Case example: Andrew

Andrew was a young man in his early twenties who had suffered from a bipolar affective disorder (manic depression) for three years. This had interrupted his studies and his ambitions to be a writer. He had had repeated relapses and compulsory readmissions to hospital due to non-compliance with medication. At the time of his brief CAT he had been admitted to the locked ward and was in 'seclusion' due to his highly disturbed and aggressive behaviour. His behaviour had elicited very different reactions from the staff team who, for the most part, enacted very angry and punitive roles towards him, although a few felt sympathy and had some understanding of how difficult things might be for him. Immediately prior to being offered brief CAT, he had been locked in the seclusion room and had stripped himself naked, torn the mattress apart and was smearing faeces over the walls. Eventually, following medication, he agreed he had 'made a point' and agreed that he might consider meeting to 'talk things through'. This resulted in six sessions of variable length of therapy and the joint construction of diagrammatic and written reformulations. He filled in the Psychotherapy File identifying particularly the dilemma, which he ticked, underlined and added three plus signs to, which states *'if I must not then I will; it is as if the only proof of my existence is by resistance. Other people's rules, or even my own feel too restricting, so I break rules and do things which are harmful to me'.* Key problem procedures described in reformulation included sabotaging of treatment (and so becoming a 'difficult' patient) if he could not be 'perfectly' well, and developing and enacting 'unrealistic' fantasies or dreams about the future to compensate for his illness experience. What emerged from this work was that much of what had been regarded as psychotic behaviour was essentially the enactment of comprehensible if maladaptive attempts at coping with the damaging effects of his illness. These enactments had, however, been compounded and exacerbated by the illness. This was also worsened by the attempts of family and staff to force treatment on him and then reacting in a hostile fashion when he did not 'comply'.

It seemed that a very important aspect of this very brief intervention had been the explicit demonstration that the team were prepared to listen and acknowledge his traumatic story. Interestingly, he too had insisted on writing across the top of his diagram that 'I am more than just my illness'. The reactions of the staff were also mapped onto his diagram as a rudimentary 'contextual reformulation' and this, by their account, not only contributed to a better

understanding and working relationship with Andrew but also reduced the stress they themselves had been experiencing. The result was an immediate de-escalation of his disturbed and 'difficult' behaviour and made possible his return a few days later to an open ward. Andrew himself used his reformulation document to negotiate with his community team about his care and in particular his medication regime. This enabled him to return to university and remain stable without further readmission for the year up to follow-up.

What these two case studies illustrate, consistent with the clinical experience of the interest group so far, is that a CAT-based psychotherapeutic approach can be successfully employed with varying sorts of patient difficulties in different settings. In these cases the difficulties were associated with firstly a long-term experience of a severe mental illness and secondly an acute crisis in hospital which resulted in the generation of some of the typical dynamics around a 'difficult' patient. Particular features of the CAT approach which appear to have been important include, notably, a proactive and collaborative stance and the attempt to make, from a coherent theoretical framework, explicit sense (as articulated through reformulation documents) of the patients' distress and difficulties, both present and past. It also appeared that the direct work with these patients had helpful, indirect effects in educating and supporting the teams attempting to treat them, as illustrated in particular by the second case.

It appears that CAT may provide a useful conceptual framework from which to approach the understanding and treatment of psychotic disorders. The abnormal experiences and interpersonal therapeutic difficulties characteristic of these disorders may be understood partly in terms of the internalisation of reciprocal role procedures and their enactments. As such, CAT may usefully extend and amplify some of the more recent, valuable CBT-based work in this field. It may prove especially helpful in engaging patients at an early stage of their illness and so contribute to the prevention of 'secondary' damage. Such a CAT-based model may have an additional, important role to play in team education and support and could serve, as discussed by McGorry (2000), as an integrative platform from which to base treatment for this neglected group of disorders. Clearly formal, controlled evaluation of its efficacy will need to be undertaken on the basis of these encouraging, initial studies and this preliminary model.

LEARNING DISABILITIES

It is well recognised that those with learning disabilities (LD) very commonly suffer from emotional and psychological problems (Szivos and Griffiths, 1990) but treatment for them has been generally neglected. These individuals suffer from a range of problems including depression, anxiety, difficulties with anger and with relationships, personality disorder, experience of abuse and some

have forensic histories for offences such as fire setting or inappropriate sexual behaviour. It has been shown that the majority of individuals with learning disabilities do not suffer severe disability but rather mild to moderate forms of it. It is only recently that attempts have been made to provide psychotherapy to this group using cognitive (Dagnan and Chadwick, 1997) and dynamic (Sinason, 1992) models.

It is clear from this work that people with learning disabilities can make use of the simple concepts of cognitive therapy. Experience with CAT (Crowley et al., personal communication) demonstrates that, for individuals with mild to moderate LD who cannot usually read or write, the tools of CAT, with modifications, can be used successfully. Thus the Psychotherapy File has been simplified verbally and symbolisations of traps and dilemmas developed. It has proved possible to represent RRPs symbolically and an SDR can be presented using colours and pictorially in collaboration with the client. The reformulation letter can be audiotaped so that the client can listen to it repeatedly to understand it fully.

Typically, those with learning disabilities have been disabled from an early age, have suffered major losses and have been marginalised and stigmatised by society all their lives, factors which determine their repertoire of RRPs. These commonly include *abused or victim* to *abusing or bully, not hearing or understanding* to *not being heard or understood, rejecting* to *rejected* and *abandoning* to *abandoned*. Common 'fantasies' are for someone who will perfectly love them, the wish to be perfect and normal and a wish for a powerful or magical care-giver or rescuer. Common procedures enacted include the trying to please trap, the bottling up dilemma, feeling one has to say yes and the snag of sabotaging success or anything good. Frequently such individuals may actually try to appear more disabled than they are. This enactment has previously been described as 'secondary handicap' (Sinason, 1992). However, clients with LD also have similar wishes and needs to those termed 'normal'.

The experience with CAT has been that its descriptive, collaborative, structured and time-limited approach is of great benefit to both clients and therapists. The process of engagement and active participation for the client in creating shared signs and language, in problem solving and in the generation of choices has an empowering effect on a client group that feels usually unheard, powerless and 'stupid'. CAT has appeared particularly helpful in restraining the tendency of therapists to enact the powerful care-giver or magical rescuer, roles which have unhelpful consequences for the client. More generally, CAT has proved to be again useful in this context as a consultative tool in working with staff themselves in both residential and community settings to help them in avoiding collusion with clients' maladaptive RRPs.

The concept of the zone of proximal development (ZPD) is particularly important in working with this client group. Interestingly, much of Vygotksy's own interest in this concept stemmed from his own work in the field of what was then called 'defectology'. Such clients often present with a poor emotional

vocabulary, find it difficult to form a narrative and lack the skill of self-reflection. It is interesting to consider that part of these difficulties may have arisen as 'secondary handicap' consequent to inadequate or depriving experiences of care during development. Therapy, to some extent, can aid the development of these skills through the assistance of an enabling other. Not surprisingly these clients require a rather longer experience of therapy, usually around 24 sessions, or up to 32 for those with additional features of personality disorder.

This fascinating work is currently being undertaken by a few practitioners but has clearly important implications for a neglected client group. The CAT approach appears to have much to offer, once the apparent impediment of lack of literacy is overcome by the creative techniques described. This work also confirms and illuminates the relevance of Vygotskian theory whatever the ability of the individual being worked with. It also confirms the importance of helping to create through therapy a meaningful narrative and dialogue whatever the age or ability of the individual concerned. There is now an ACAT special interest group in this area and an extended description of some of this work will be published shortly (Crowley et al., in preparation).

CAT IN GROUPS AND ORGANISATIONS

It would be anticipated that CAT, with its radically social understanding of the formation of mind and its subsequent enactments, could contribute useful insights and understandings into the function and dysfunction of groups and organisations. There is already some experience of running CAT-based therapeutic small groups. In these, patients had individual sessions leading to reformulation before meeting in a group, with diagrams then being shared in the group (Duignan and Mitzman, 1994). In a review of the field, Maple and Simpson (1995) suggest that it is possible to shorten the length of groups, with 24 sessions being found to be effective for many patients. It has also been found in several psychotherapy departments that standard 16-session individual CAT followed by group therapy is effective for patients who may need more therapy and for whom the opportunity to put into practice the lessons of their individual therapy in a group setting is valuable.

The extent to which CAT theory and practice as used in this setting has been genuinely integrated with the theoretical framework of group psychotherapy, of whatever theoretical orientation, has, however, been much more limited. There are clearly conceptual overlaps between these approaches, notably the interest in and therapeutic focus on the individual as a social being. Nonetheless, as is well recognised, complex transpersonal processes are enacted within groups to which the understandings of the CAT model have not yet been rigorously applied and this remains an area of potential exploration. The overlapping and complementary paradigms of CAT and group

psychotherapy could certainly both benefit from such work. An attempt to apply Vygotskian insights to the large group processes of a therapeutic community has, more recently, been made (Kerr, 2000).

It would also be anticipated that the CAT model could contribute useful insights to the function and dysfunction of organisations. An account of the usefulness of an innovative CAT-based approach to a dysfunctional organisation (a hospital surgical unit) has been given by Walsh (1996). There are a small number of CAT practitioners with active interest in the area of organisational consultancy who constitute an ACAT special interest group. These workers have found that the CAT focus on the social formation of mind, and on how organisational processes may be conceptualized as reciprocal role procedures, are of some interest and assistance in describing dysfunctional organisational processes (Bristow, Encombe and Walsh, personal communication). They also note many commonalities with existing organisational literature which stresses, for example, systemic thinking, narrative methods, a collaborative, enquiring stance of the part of intervener, and a stress on a capacity for self-reflection (see Senge, 1994). Some writers also emphasise the existence of universal patterns of relating noted by anthropologists such as Bateson (2000).

Clearly, there are major differences in interventions aimed at organisations as opposed to individual patients. The applicability of existing CAT methods of analysis such as diagrammatic reformulation, useful as they appear to be in this context, will require further exploration and integration with existing organisational theory if CAT is to contribute fully to this fascinating area. It should be noted that one implication of such work is to stress the importance of the function and psychological well-being of the individuals comprising an organisation as well as the healthy functioning of the organisation. The original CAT focus on individual psychotherapy may paradoxically re-emerge from such studies of organisational pathology.

FURTHER READING

General problems relating to diagnosis and classification are reviewed in Kendell (1993). A range of psychological treatments of physical illness and of somatisation is described in Hodes and Moorey (1993).