REFORMULATION AS A MINIMAL INTERVENTION:
A PRELIMINARY PATIENT SERIES OUTCOME EVALUATION OF
4-SESSION COGNITIVE ANALYTIC THERAPY

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ABSTRACT

This study represents an early-phase outcome evaluation exploring the potential value and feasibility of two versions of 4-session reformulatory CAT preliminary to implementation of a large-scale controlled or naturalistic study. A consecutive series of thirty-two GP-referred patients were sequentially allocated to one of two 4-session interventions: Prose plus Sequential Diagrammatic Reformulation (PSDR) or Sequential Diagrammatic Reformulation (SDR). In a time series design, patients completed the Beck Depression Inventory (BDI), Symptom Checklist 90R, and Inventory of Interpersonal Problems at Pre-Screening, Screening, Post-Termination and Follow-Up; an idiographic measure, the Target Problem Rating Scale (TPRS) was completed at Post-Termination and Follow-Up. In addition, patients' subjective evaluations of the helpful and hindering aspects of either intervention were assessed at Post-Termination using an adaptation of the Session Impact Scale.

Statistical analyses indicated highly significant mean change overall from Screening to Post-Termination and Follow-Up, with no significant interaction effects between treatment variation and time-point. Effect sizes across standardised measures emerged as large (0.8 to 1.2) in the case of the PSDR cohort and, in the main, small (0.1 to 0.4) for the SDR cohort. With respect to the TPRS, effect sizes were large (0.7 and 1.0) for both treatment variations, with a size advantage for the PSDR cohort. Depending on the outcome instrument selected, within-group analyses of individual change confirmed that between 37.5% and 50% of patients in the PSDR cohort and between 10% and 11.7% of patients in the SDR cohort achieved clinically significant and reliable improvement at Post-Termination. At Follow-Up, between 25% and 56% of PSDR patients and between 0 and 48% of SDR patients had made clinically significant and reliable gains. The findings in relation to clinically significant and reliable deterioration indicated that one SDR patient disimproved on the SCL 90R by Post-Termination and one patient each disimproved on the IIP at Post-Termination and Follow-Up. Two patients in the SDR cohort made a clinically significant disimprovement on the TPRS at Follow-Up. Overall, severity had a moderate negative association with outcome, although in the case of the PSDR cohort the correlation was high.

The SIS results indicated that both the PSDR and SDR intervention variations were evaluated somewhat positively by patients, although the PSDR condition emerged with a non-significant arithmetic rating advantage over the SDR condition. Patients evaluated their intervention as not at all hindering, regardless of cohort. Overall, subjective impact and psychotherapeutic outcome were only weakly correlated.

The findings are discussed in the context of the limitations inherent in a small uncontrolled patient series study and suggested directions for future research. However, the data provide initial evidence of psychotherapeutic outcomes with a proportion of NHS-referred patients following either of two credible 4-session reformulatory CAT interventions. In addition, the findings also offer preliminary indirect case series support for claims of a specific impact of Prose Reformulation on outcome.
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I dedicate this work to Mum and Dad, Monica and Edward Wilde
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CHAPTER 1

LITERATURE REVIEW

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1.1 HISTORICAL PREAMBLE

1.1.1 The Domain of Psychotherapy Research

The last four decades have witnessed a considerable channeling of research interest into psychotherapy as a systematic medium for human change, an applied field which has proved fertile territory for many clinical psychologists (Bergin and Garfield, 1994). Across this period the specific goals of psychotherapy research have been to advance conceptualisations of psychological intervention, understand the mechanisms and processes through which interventions exert their effects, and evaluate their impact on patient functioning. The complexity of that research task is inherent in the sheer scope of psychological treatments, the range of mental health problems to which they can be applied, and the vast array of methods for evaluating their impact. A further dimension to that complexity concerns the dynamic interaction between psychotherapy practice and research and, while many commentators have often lamented the degree of cross-fertilisation (Roth and Fonagy, 1996; Barkham, 1990; Barlow, Hayes and Nelson, 1984), the impact of the two related enterprises on each other historically has been an undoubted source of creativity and innovation.

1.1.2 Early Generations of Outcome Research

In a useful historical overview of methodological issues and substantive findings, Barkham (1996) presents psychotherapy outcome research since the 1950s as comprising a series of successive but overlapping generations. Research spanning the period 1950s to 1970s addressed the effectiveness of psychotherapy. In 1952 Eysenck’s touchstone critique claimed that ‘there is no evidence for the effectiveness of psychotherapy’, an assertion he continued to maintain as recently as 1992 (Eysenck, 1992). This publication stimulated a phenomenal generation of rejoinders,
controlled outcome research and meta-analytic studies through to the late seventies in which the overarching theme became ‘justification’ for the practice of psychotherapy (Bergin, 1971; Luborsky, Singer and Luborsky, 1975; Sloane, Staples, Cristol, Yorkston and Whipple, 1975; Smith and Glass, 1977; Smith, Glass and Miller, 1980). The effectiveness of psychotherapy was clearly established by this generation of research output.

The key theme throughout psychotherapy research in the 1960s to 1980s was specificity. Outcome researchers logically directed their efforts beyond the established consensus on the overall general effectiveness of psychotherapy towards questions of comparative effectiveness among different psychotherapies. In response to the ‘uniformity myth’ implicit in the assumptions of earlier research, and also with the rapid development of newer therapies such as behaviour therapy, this era sought to address the differential issues epitomised in Paul’s (1967) litany: “What treatment, by whom, is most effective for this individual with that specific problem, and under what set of circumstances?”.

The overriding consensus view among researchers and commentators reviewing this generation of outcome research has reflected psychotherapies as consistently evidencing broadly equivalent effectiveness (Bergin and Garfield, 1994; Stiles, Shapiro and Elliott, 1986; Barkham, 1996, Elkin, 1994; Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Liber, Docherty, Fiester and Parloff, 1989; Shapiro, Barkham, Rees, Hardy, Reynolds and Startup, 1994). Some of the more stringent, sophisticated and well-funded studies have compared cognitive-behavioural therapy
with psychodynamic/interpersonal therapy and/or placebo conditions (Elkin, 1994; Elkin et al., 1989; Shapiro et al., 1994). Findings have tended to conform to the ‘equivalence paradox’ (Stiles et al., 1986) whereby outcome advantages for a particular method of therapy (invariably cognitive-behavioural) have emerged more as arithmetically than statistically significant.

1.1.3 Psychotherapy Research in the 1990s

Psychotherapy research in the 1990s has sought to extend the agenda and concerns of forerunning research generations. As with previous research generations, the 1990s have been unsurprisingly dominated by major trends and issues which have evolved, in turn, with the changing developments, emphases, and controversies characterising the history of psychotherapy practice itself. A selection of some of the more noteworthy themes to have emerged might therefore include: an openness to empirical integrationism (Norcross and Goldfried, 1992; Jensen, Bergin and Greaves, 1990); an atheoretical shift towards the formulation of more pragmatic micro-level research questions (Emmelkamp, 1994; Henry, Strupp, Schacht and Gaston, 1994); increasing endorsement of methodological pluralism (Kazdin, 1994; Alexander, Holtzworth-Munroe and Brooke-Jameson, 1994); a continuing preoccupation with the ‘equal outcomes’ phenomenon (Elkin, 1994; Lambert and Bergin, 1994); a search for commonality and specificity in therapeutic effects (Elkin, 1994; Lambert and Bergin, 1994); an increasing emphasis on process research (Lambert and Hill, 1994; Orlinsky, Grawe and Parks, 1994; Henry et al., 1994; Greenberg, Elliott and Lietaer, 1994); dramatic changes in conceptualisation and redefinition of the major therapeutic orientations (Henry et al., 1994; Greenberg et al., 1994); the contribution of therapist and patient differences, and their interaction, to outcome (Garfield, 1994; Beutler,
Machado and Allstetter Neufeldt, 1994); a renewed emphasis on clinically as opposed to statistically significant change (Kazdin, 1994; Lambert and Clara, 1994; Lambert and Bergin, 1994); recognition of the potential for harm of psychotherapy (Lambert and Bergin, 1994); and continuing, albeit insufficient, innovation in the measurement of clinical phenomena (Lambert and Clara, 1994; Lambert and Bergin, 1994). The majority of the above have also featured in shortlists of related research achievements for the century by several leading cognoscenti in the field (Garfield, 1992; Lambert and Bergin, 1992; Bergin and Garfield, 1994).

While a pervasive emphasis on the mechanisms and pathways for therapeutic change has become a research hallmark of the current decade, a return to the outcome effectiveness issues of the 1950s to 1970s has also been notable. Recent NHS 'market force' reorganisations in the structure and delivery of psychotherapy services have fuelled demands to justify its clinical impact and demonstrate cost-effectiveness. To this end, Roth and Fonagy (1996) have provided an extensive review of evidence for the efficacy of specific psychotherapeutic interventions in relation to specific mental health conditions. Whilst drawing attention to the complex relationship between efficacy as reported in research trials and clinical effectiveness in services as delivered, these authors attempt to integrate research findings so that they can be constructively applied in service settings. Perhaps Roth and Fonagy's most seminal contribution in this area will prove to be their presentation of a model for the development of evidence-based practice in psychotherapy services. In essence, their model locates the differing contributions of the researcher and clinician by conceptualising clinical
practice as informed both by research-derived guidelines and by professional consensus arising from audit of service delivery.

1.1.4 The Growth and Prominence of Brief Psychotherapy

Among the most discernible trends to emerge from contemporary psychotherapy is a continuing emphasis on the practice of brief forms of psychological treatment, the upper boundary for which is consistently delineated by the literature as twenty-five sessions (Koss and Shiang, 1994; Budman and Gurman, 1988; Garfield, 1989). Whether by design or default most psychotherapy is brief, with the median duration of psychotherapeutic contact, as reported in the USA at least, at six to eight sessions (Garfield, 1986). Although for many years effective psychotherapy was considered to be an essentially long-term process, and brief therapy was viewed as a superficial, expedient treatment to be used only in 'emergency' situations until long-term therapy could begin, the prevailing consensus view has changed and now acknowledges brief psychotherapy to be the intervention of choice for many selected patients (Wells and Phelps, 1990; Roth and Fonagy, 1996). Brief therapy in the 1990s has developed as an entity in its own right and empirical research into brief treatments has made significant contributions to understanding process and outcome in psychotherapy generally (Stiles, Shapiro and Elliott, 1986; Beutler and Crago, 1991).

A number of historical antecedents have given impetus to the growth of brief psychotherapy practice. As early as the 1920s, concerns that neurotic maladjustment had become more widespread a population problem than could be treated by traditional protracted psychoanalysis led to attempts at developing more brief, active and directive psychodynamic approaches (Ferenczi, 1960; Alexander and French,
1946). During World War II the proliferation of 'shell-shock' in soldiers on the front line triggered the design of short-term crisis interventions for trauma (Grinker and Speigel, 1944; Kardiner, 1941). The rise of the community mental health movement as a response to health disadvantage in the under-privileged and the historic arrival of cognitive-behavioural techniques for behaviour modification have also stimulated innovation in brief therapy (Garfield, 1989).

Outcome research and socioeconomic factors have combined to account for the contemporary prominence of brief approaches to psychotherapy. Patients typically enter psychological treatment with specific, focal mental health difficulties and the expectation that their service needs will be addressed within the short term (Garfield, 1978). Moreover, it now seems clear that specific patient populations with a range of circumscribed, mild to moderate mental health problems and no comorbidity potentially benefit from short-term, structured treatments (Roth and Fonagy, 1996). Such problems include less severe presentations of depression, anxiety, phobias, panic, post-traumatic stress, obsessive-compulsive difficulties and interpersonal distress. Notably, comparative studies of brief and time-unlimited therapies have generally reported similar success rates, despite an acknowledgment that the extent and stability of improvement can vary within populations (Koss and Shiang, 1994). As a consequence, brief therapy has increasingly been recognised as an acceptable, cost-effective means to reach a greater proportion of selected population need in a climate of accountability and finite healthcare resources.
The following sections of this chapter provide an overview of brief psychotherapy practice and research in general before proceeding to review one time-limited approach, Cognitive Analytic Therapy (CAT), and evidence for its effectiveness, in some detail. Sections 1.2 and 1.3 identify the range of approaches to brief psychotherapy and distill the common core principles underlying their practice. Section 1.4 reviews empirical research specifically relating to outcome in brief psychotherapy.

1.2 MODELS OF BRIEF PSYCHOTHERAPY

Major orientations to brief psychotherapy can be classified as (i) psychodynamic; (ii) behavioural and cognitive-behavioural; (iii) interpersonal; and (iv) eclectic. This short section identifies the range of brief therapeutic approaches designed for the individual psychotherapy of adults. Excluded from discussion is consideration of group treatment, family therapy, and crisis-oriented interventions.

1.2.1 Psychodynamic Approaches

Psychodynamic approaches to brief psychotherapy abound. It is an irony that the tradition most immediately associated with long-term therapy, psychoanalysis, has also pioneered numerous focal dynamic approaches: Alexander and French’s (1946) psychoanalytic psychotherapy, Sifneos’ (1972) anxiety-provoking psychotherapy, Malan’s (1976) brief psychotherapy, Davanloo’s (1979) short-term dynamic psychotherapy, Luborsky’s (1984) supportive-expressive therapy, and Strupp and Binder’s (1984) time-limited dynamic psychotherapy. Most brief dynamic psychotherapy has a duration of between 12 and 25 sessions. Such focal systems adopt as the goals of therapy the resolution of unconscious conflict and understanding
of circumscribed focal recurring problems, rather than pervasive personality transformation. As with long-term psychodynamic therapy, interpretation is the mainstay technique but it is usually modified to be integrative and focused on present circumstances, rather than regressive and centred on childhood experiences.

A number of approaches target the first contact with the patient and advocate focused single-session psychotherapy (Bloom, 1981; Talmon, 1990). The Two-Plus-One model, developed by Barkham and Shapiro primarily to address NHS waiting lists, advocates once-per-week exploratory (psychodynamic-interpersonal) or prescriptive (cognitive-behavioural) therapy for two weeks followed by a single session three months later (Barkham, 1989; Shapiro, Barkham, Hardy and Morrison, 1990). Aveline (1995) has also suggested that in the NHS context a Four-Plus-Two model of dynamic psychotherapy might be advantageous. In all these abbreviated therapy designs, an immediate or key issue for the patient is addressed and effort is directed at enabling the patient to experience themselves effecting change in their lives.

1.2.2 Behavioural and Cognitive-Behavioural Therapies

While not primarily brief by design, most behavioural and cognitive-behavioural approaches conform to the time-limits of brief psychotherapy. Since the mid-eighties there has been an notable upsurge of clinical and research interest in the behavioural and cognitive-behavioural therapies (Koss and Shiang, 1994). This class of approaches focuses on how maladaptive aspects of behavioural and cognitive functioning are maintained by the individual’s environment and through properties inherent to their belief systems. The goal of these orientations is to change definable,
verifiable maladaptive behaviours and/or beliefs using a wide range of prescriptive clinical techniques, such as self-monitoring, identifying and challenging underlying thoughts and assumptions, activity scheduling, etc.


**1.2.3 Interpersonal Psychotherapy**

Interpersonal psychotherapy (IPT) is an active and supportive brief treatment that focuses on current interpersonal problems as they relate to the onset and maintenance of psychological distress (Sullivan, 1953). Initially formulated for delivery in the acute phase of depression, IPT highlights the causal role of social relationships and expectations, and specifically relates depressive symptoms to one of four interpersonal areas: grief, interpersonal role disputes, role transitions, or interpersonal deficits. Following a diagnostic, educational phase the IPT therapist pursues a repertoire of strategies specific to one of these problem areas (e.g., facilitating mourning and helping the patient to find new relationships and activities to compensate for the loss) before finally going on to a relapse prevention phase where the focus becomes early recognition and management of depressive symptoms, as they arise.
1.2.4. Eclectic Therapies

The fourth and last typology of brief therapy to be considered in the present outline concerns eclectic approaches. A process of rapprochement and integration among several of the leading therapeutic approaches has led to the development of a number of eclectic hybrids. A core assumption underlying eclectism is that the complexities of the human mind in distress require a variety of approaches and techniques (de Shazer, 1988; Garfield, 1989; Lazarus and Fay, 1990). Eclecticism has been characterised as a loosely-defined movement of therapists who combine concepts, methods and strategies for human change predicated more on demonstrable effectiveness, rather than any single unifying theory (Norcross, 1986). One notable exception to this atheoretical integrationism, and the subject of the current study, is Ryle’s cognitive-analytic therapy (CAT) which deliberately combines cognitive-behavioural and psychodynamic approaches within a coherent, overarching procedural sequence object relations model (PSORM).

Eclectic approaches to brief therapy can include behavioural techniques, cognitive techniques, problem-solving methods and family techniques. Eclectic therapies that are either specifically brief, or naturally lend themselves to a time limitation, are further exemplified by multi-modal therapy (Lazarus, 1981), the transtheoretical approach (Prochaska and DiClemente, 1984), and the interpersonal-developmental-existential (IDE) approach (Budman and Gurman, 1988).
1.3 COMMON CORE PRINCIPLES

A survey of brief approaches to psychotherapy suggests clearly discernible philosophical and technical characteristics common to many forms of practice. Koss and Shiang (1994) identify a core set of three broad principles underlying the practice of brief psychotherapy:

1.3.1 Human Capacity for Change is Lifelong

Therapeutic goals in brief psychotherapy are set on the assumption that patients continue to change and grow across their lifespan. Based on the environmental context, practitioners of brief therapy orientations essentially intervene to facilitate growth and adaptive functioning with an emphasis on the here-and-now. This root principle guides therapists to take an active role in facilitating patients toward self-defined goals. In contrast to the 'therapeutic perfectionism' (Malan, 1963) and 'prejudices of depth' (Wolberg, 1965) inherent in more traditional time-unlimited psychotherapies, most brief therapists agree a number of more circumscribed therapeutic goals with patients, such as rapid improvement in disabling symptomatology; a return to a previous level of emotional equilibrium; or the development of patient understanding in relation to current problems and improving coping in the future.

1.3.2 Change is Achievable within a Limited Time

Whether viewed as the overall duration of contact between patient and therapist or the duration of each therapy session, brief therapy is time-focused in contrast to the assumption of timelessness inherent in long-term psychoanalytically-oriented therapy. Most brief therapists contract for a limit to the number of therapeutic sessions to be offered and make pivotal clinical use of the meaning and effect of the time limit. Brief
contracting is viewed by its practitioners as structuring therapy with a definite beginning, middle and end, in addition to having the inherent advantages of confronting the patient with the reality of work; encouraging optimism through the therapist's confidence that improvement is possible in a relatively short time; providing a set of shared goals that define the benefits and limitations of therapy.

While 25 sessions is commonly agreed as the upper limit for 'brief' therapy, considerable variation exists in the number of sessions offered by brief therapists. Contracts can range from single-session therapy (e.g., Talmon, 1990); to the Two-Plus-One model advocated by Shapiro, Barkham, Hardy, and Morrison (1990); and the 10-40 session average offered by focal psychotherapists such as Malan (1963). Similarly, while most brief therapy practitioners adhere to the standard 45-to-60-minute hour at 1-week intervals, there is variability in both length and spacing of sessions. Close spacing of initial sessions with gradually increasing inter-session intervals and a planned follow-up or booster session have been advocated by some clinicians (e.g., Budman and Gurman, 1983), as also has the practice of multiple courses of intermittent brief therapy over many years as required.

1.3.3 Time-Limited Change Requires a Patient-Therapist Alliance

The development of a working alliance is now acknowledged as a primary therapeutic change principle across most psychotherapy orientations (Goldfried, 1980). Over the last decade, cognitive-behavioural approaches have placed increasing emphasis on the role of the therapeutic alliance (Moretti, Feldman, and Shaw, 1990). In a study of patients treated for depression with cognitive-behavioural therapy, Burns and Nolen-Hoeksema (1992) found a robust moderate-to-large association between clinical
improvement and therapeutic empathy, which was not related to the facilitation of homework compliance. In contrast to long-term therapy, strong feelings of warmth, liking for the therapist, trust, admiration, and confidence tend to be considered necessary for successful outcomes in brief psychotherapy (Koss and Shiang, 1994). Most brief therapists believe that the development of a confident therapist attitude and the communication of optimistic expectations of change to the patient are critical to outcome (Malan, 1963).

1.4 OUTCOME RESEARCH RELATING TO BRIEF PSYCHOTHERAPY

There is now a considerable corpus of research attesting to the effectiveness of brief psychotherapies, particularly with patient populations whose mental health problems are specific rather than multiple or diffuse. For example, the different approaches to brief therapy have been shown to be effective in the treatment of job-related distress (Barkham and Shapiro, 1990), maladaptive patterns of interpersonal functioning (Strupp and Binder, 1984), anxiety disorders (Butler, Cullington, Hibbert, Klimes, and Gelder, 1987), depression (Dobson, 1989), panic disorders (Beck, Sokol, Clark, Berohick and Wright, 1992) and post-traumatic stress disorder (Foa, Rothbaum, Riggs and Murdock, 1991). The outcome research in this area centres on comparative studies of brief psychotherapy and the relative effectiveness of brief psychotherapy approaches.

1.4.1 Comparative Studies of Brief Psychotherapy

A number of issues related to duration of treatment are relevant to the comparative outcome research on brief psychotherapy. Comparative studies have focused on two
related themes: the relation between length of therapy and positive outcome; and interactions between duration of therapy and type of therapy.

1.4.1.1 Duration of Brief Psychotherapy and Positive Outcome

Many clinicians believe that the therapeutic process is accelerated by the time constraints inherent in brief psychotherapy (Frank, 1959; Eckert, 1993, Reynolds, Stiles, Barkham, Shapiro, Hardy and Rees, 1996). The major findings relating to the dose-effect literature derives from a study conducted by Howard, Kopta, Krause and Orlinsky (1986). These researchers produced a meta-analysis of 15 outcome studies covering a period of 30 years and reported on the percentage of patients that could be expected to show measurable improvement as a function of the number of weekly therapy sessions they received. Howard et al. found that the percentage of patients showing measurable improvement following specified numbers of sessions was as follows: 24 per cent after a single session, 30 per cent after two sessions, 41 per cent after four sessions, 53 per cent after 8 sessions, 62 per cent after 13 sessions, 74 per cent after 26 sessions, 83 per cent after 52 sessions and 90 per cent after 104 sessions. This dose-response relationship was graphically represented as a negatively accelerating curve in which the greatest improvement occurs early in therapy (by the eighth session), with diminishing returns thereafter such that successively smaller gains are made in response to increasing sessions. Such a cornerstone outcome study, while not based on therapies of planned duration, has provided much incentive for practitioners committed to briefer forms of psychotherapy (Barkham, 1990).

1.4.1.2 Interaction between Duration and Type of Therapy

Piper, Debbane, Bienvenu and Garrant (1984) reported interaction effects for duration (short and long) with modality (individual versus group) of therapy. In a study of 106
outpatients with mild neurotic and personality problems, brief treatments and long
treatments lasted 22 sessions and 76 sessions respectively. While minimal evidence
was found for main effects based on either duration or modality of therapy,
considerable outcome and process evidence was found for an interaction whereby the
impact of time limitation was modified by the modality of therapy. The time limitation
and problem focus of brief individual therapy was perceived as facilitative of change
by patients and therapists alike. Satisfaction was also expressed with long-term
individual therapy by patients, but not by therapists who perceived extensive sessions
as implicitly fostering increased resistance against affective involvement, excessive
regression and restricted enactment of transference. With regard to satisfaction with
group therapy, however, a consistent consensus emerged across both patients and
therapists. Time limitation was perceived as depriving, while long-term group therapy
was felt to facilitate a high degree of involvement and attentiveness.

1.4.2 Relative Effectiveness of Alternative Brief Psychotherapy Approaches

Reviews of comparative outcome studies of the different psychotherapies have
generally yielded the conclusion that approaches are broadly equivalent in
effectiveness (Shapiro and Shapiro, 1982; Smith, Glass and Miller, 1980; Stiles,
Shapiro and Elliott, 1986). However, many researchers believe that the 'Dodo
verdict' (Luborsky, Singer and Luborsky, 1975) reflects limitations in the design (e.g.,
inadequate sample size, weak power, use of inappropriate outcome measures) and
implementation of studies (e.g., poor treatment adherence) which render them
insensitive to true differences in treatments' effectiveness (Stiles et al., 1986). Such
reservations about the validity of much 'equivalent outcome' research has therefore failed to curb the tide of continuing investigation in this area.

1.4.2.1 Large Scale Comparative Outcome Trials

A range of studies have examined the comparative outcome of different approaches to psychotherapy, including behaviour therapy, cognitive therapy, dynamic psychotherapy, and Gestalt therapy (e.g., Cross, Sheehan and Khan, 1982; Sloane, Staples, Cristol, Yorkston and Whipple, 1976; Strupp and Hadley, 1979). One major US comparative outcome study, the National Institute for Mental Health (NIMH) collaborative study of depression (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, and Parloff, 1989; Elkin, 1994) compared four treatment modalities: (i) interpersonal psychotherapy (IPT), (ii) cognitive-behavioural therapy (CBT), (iii) imipramine hydrochloride plus clinical management (IMI-CM), and (iv) placebo plus clinical management (PLA-CM). The stringent design comprised three research sites in which 250 patients were randomly assigned to the four treatment conditions for a 16-week intervention. Despite some concern over an underlying assumption of patient homogeneity (Koss and Shiang, 1994), the study involved a number of methodological improvements over most comparative studies, including the use of separate trained therapists in the two differing psychotherapies, manualisation of treatments, the incorporation of checks on therapists' adherence to treatment protocols, and repeated measures of symptomatology and functioning.

Over the 16-week period, patients in all the treatment conditions showed significant reduction in their depressive symptoms and general improvement in their functioning.
In general, there was consistent ordering of the effectiveness of treatments at termination: patients in the IMI-CM condition were most improved, patients in the PLA-CM condition least improved, and patients in the two psychotherapy conditions in between but closer to the IMI-CM condition. However, differences were not large. Indeed, there were no differences between the two psychotherapies or between either of them and the IMI-CM condition. Differences between the psychotherapies and the placebo condition showed only one instance of a trend towards lower scores for patients in the IPT condition as compared with the PLA-CM and no significant or trend difference for CBT.

In the UK, a series of studies have researched the outcomes of contrasting brief psychotherapy formats while at the same time examining the impact of the scheduling of sessions (Shapiro, Barkham, Hardy and Morrison, 1990; Barkham and Shapiro, 1990; Shapiro, Barkham, Rees, Hardy, Reynolds and Startup, 1994; Shapiro, Rees, Barkham, Hardy, Reynolds and Startup, 1995; Barkham, Rees, Shapiro, Stiles, Agnew, Halstead, Culverwell and Harrington, 1996). Shapiro et al. (1994) investigated the effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioural (CB) and psychodynamic-interpersonal (PI) psychotherapy. A total of 117 depressed patients, stratified for severity, completed 8 or 16 sessions of either manualised treatment. Each of 5 clinician-investigators treated patients in all four treatment conditions. On most measures, CB and PI were equally effective, irrespective of the severity of depression or the duration of treatment, with evidence of a small advantage to CB on one measure, the Beck Depression Inventory (Beck, Ward, Mendelson, Mock and Erbaugh, 1961). However, there was a
significant severity by duration interaction which showed that patients with high
severity depression did significantly better in 16 than in 8 sessions. Findings at one-
year follow-up showed that patients in the 8-session PI condition did less well than
patients in the the other three conditions (Shapiro et al., 1995). Moreover, a
collaborative multi-site NHS psychotherapy project replicating Shapiro et al.'s (1994,
1995) studies reported similar broad equivalence outcomes (Barkham et al., 1996).
Collectively, these comparative studies would appear to support the 'equivalence
paradox' (Stiles et al., 1986) conclusion, despite the often reported arithmetic, but
non-significant, advantage for one particular approach to therapy (invariably
cognitive-behavioural).

1.4.2.2 Super-Brief Models of Psychotherapy

Barkham and his colleagues have also published extensively on the development and
implementation of a model of very brief psychotherapeutic intervention, namely the
Two-Plus-One model of therapy (Barkham, 1989; Barkham and Shapiro, 1989;
Barkham and Hobson, 1989; Barkham and Shapiro, 1990). Within this model,
patients are seen for two one-hour sessions one week apart, followed by a third
session three months later. Theoretically, the Two-Plus-One model proposes that
positive change occurs through patients making successful resolutions of specific
problematic experiences through highly focused work carried out during the initial
two sessions. This work is subsequently developed and built upon by the patient in the
time span between the second and third session.

Within the Two-Plus-One model, Barkham and Shapiro investigated outcomes
following presentation of a brief cognitive-behavioural package, called 'Prescriptive
Therapy’, and a brief relationship-oriented package, called ‘Exploratory Therapy’. Initial outcome data were presented from a pilot study comprising 12 consecutive patients suffering from mild job-related depression, of whom half received one therapy mode and half the other within a psychological clinic. Twenty per cent of the patients showed improvement after two sessions; and 55-73 per cent showed improvement after the third session.

Similarly encouraging findings for the utility of very brief psychotherapeutic interventions have been reported by Aveline (1995). Aveline describes the rationale, feasibility, and findings at the mid-point of a randomised controlled trial of the value of a very brief intervention at the time of assessment for dynamic psychotherapy. Brief intervention and follow-up (BRF), a Three-Plus-One model, was compared with a single-session standard assessment (SA) in 136 consecutive referrals for dynamic psychotherapy. According to Aveline et al., results at the mid-point of the project showed that fewer BRF patients were being put on the waiting list than those in the SA. Moreover, BRF patients showed a significant reduction in symptomatology as measured by the Brief Symptom Inventory (Derogatis, L.R., 1993).

1.5 COGNITIVE ANALYTIC THERAPY: BACKGROUND AND ORIGINS

The present research focuses on a preliminary evaluation of two versions of a minimal reformulatory intervention dismantled from Ryle’s (1990, 1995) model of brief therapy, Cognitive Analytic Therapy (CAT), and delivered in an NHS primary care setting. CAT is a brief, focal, integrative and active psychotherapy which has increasingly been adapted by a wide range of mental health professionals, particularly
over the last five years. It was originally devised by Anthony Ryle in the late 1970s (Ryle, 1982) and has been described as “the application of psychoanalytic understanding and of some psychoanalytic techniques within a framework, and with additional treatment methods, derived from cognitive psychology and psychotherapy” (Ryle, 1990). A combination of reflective practice and research in CAT and cognate fields has contributed to the evaluation of CAT’s theoretical foundations while at the same time continues to manifest the range of its applicability in treating mental health problems as diverse as eating disorders, Borderline Personality Disorder, and repetitive self-harm. Indeed Ryle (1990) claims that the approach constitutes a beneficial intervention for the majority of mental health referrals from primary care sources, in addition to being a safe and useful first treatment for more disturbed clients.

In terms of its evolution, the history of CAT spans over four decades. It developed from the convergence of three of Ryle’s personal concerns: a commitment to developing modes of psychotherapy that could be delivered effectively and faithfully in NHS settings; an involvement in psychotherapy research; and a conviction that an integrative psychotherapy theory was needed (Ryle, 1994; Leiman, 1994). Ryle was first alerted to the high prevalence of emotional distress and common psychiatric disorders as a London-based G.P. in the 1950s. His first epidemiological research confirming that pervasive distress in a practice population was to shape a determined commitment to innovate brief therapies that could be available to all.
On moving to the University of Sussex in the mid 1960s as Director of the University health Service Ryle obtained formal training and supervision in psychoanalytic individual and group therapy although he remained at odds with many aspects of the theoretical structure of psychoanalysis itself. It was during this period that Ryle also developed a research interest in the neuroses and in psychotherapy outcome research, an interest fuelled as much by the need for political justification in a polemical field as by clinical curiosity about the nature of change brought about by therapy (Ryle, 1975).

Kelly’s (1955) Personal Construct Theory and repertory grid technique were increasingly to provide the tools for Ryle’s research. Initially, Ryle employed the grid technique to generate parallel descriptions to those derived from clinical data formulated in psychoanalytic terms (Ryle, 1975). In time, this approach was extended. The research requirement to define and clarify the goals of psychotherapy in advance found Ryle increasingly consulting his patients and discovering that descriptions of patients’ problems in terms derived from repertory grid testing were often the ones most accessible and useful to patients (Ryle and Lunghi, 1970). In this way the specificity inherent in the research process was beginning to transform Ryle’s clinical practice.

These parallel experiences, his exposure to personal construct theory and developments in the behavioural and cognitive literature led Ryle to attempt a restatement in a common cognitive language of the theories of the different psychotherapies (Ryle, 1978). The result of this clinical and conceptual convergence
was Ryle's emergent conviction in the central role of the act of reformulation whereby
the description of the patient's problematic procedures in a transformed form evolved
per se into a crucial therapeutic act. The continuing use of grid techniques to measure
change and the full participation of the patient in the course of administering and
feeding back grid tests, combined in most cases with a time-limited format, generated
Ryle's trust in this tool of self-reflection. These sources also contributed to the
development of new ways of describing core neurotic problems in terms of three
patterns (labelled Traps, Dilemmas and Snags) which, in turn, opened a new way to
measure individual therapeutic change (Ryle, 1979). It was from these developments
that the "cognitive" concerns and collaborative style of CAT emerged.

In the remainder of the literature review which follows, examination of the theoretical
evolution of CAT precedes an outline of its main features and practice. A review of
the existing body of research and evaluation relating to CAT is contained in a further
subsection before proceeding to some conclusions concerning methodological
limitations.

1.6 THEORETICAL EVOLUTION OF CAT

In elaborating an integrative model of psychotherapy, Ryle has sought to avoid the
hidden pitfalls associated with, on the one hand, the reductionism and "heady
generalisation" of cognitive and behavioural approaches, and, on the other, the infinite
metapsychological "hypothetical contemplation" of psychoanalysis (Ryle, 1990).
Moreover, to the extent that both behaviourism and psychoanalysis, albeit for
different reasons, have stood morally condemned of what Laing (1967) has called
“natural scientism’ or the ‘error of turning persons into things’ the theoretical basis of CAT has striven to minimise such dangers. The CAT model is offered as a means of describing intentional, aim-directed action without implying that an individual’s aims and intentions are fully known to them, or correspond necessarily to their account of them. The model itself is ‘cognitive’ in the broad sense of the higher functioning and organisation of thought, feeling, and action but by no means excluding consideration of unconscious mental processes. Behavioural and cognitive theories are incorporated as subsets of the general theory. Psychoanalytic concepts are also incorporated as central to the model but they are radically restated in terms which are more accessible to therapy and more compatible with mainstream general psychology. The major developments and influences underlying CAT theory as it continues to evolve are considered below.

1.6.1 Early Conceptual Integration in CAT

The origins of CAT can be traced back over two decades prior to its actual birth in the 1980’s. During this period, Ryle made extensive use of repertory grid techniques in order to study the characteristics of psychotherapy patients and to investigate the outcome of long-term psychodynamic psychotherapies (Ryle, 1975). Ryle’s contact with personal construct theory and increasing application of cognitive assessment devices to psychodynamic psychotherapy was to generate a search for a ‘common language’ for the traditionally opposed therapeutic traditions (Ryle, 1978). In particular, the use of grid techniques both to measure change and to mobilise patients’ reflective capacities resulted in the development of new ways of conceptualising core neurotic problems.
Examination of the therapy records from a patient series adverted Ryle to the recurrence in every case of a circumscribed number of focal themes in the work of therapy. Moreover, close attention to the patient’s narrative as well as sensitivity to transference and countertransference issues led Ryle to the view that focal themes could be identified within the early sessions of therapy, often as early as the first session. A study of these themes, seeking to identify what had prevented the revision of target problems, highlighted three main patterns whereby change was blocked. These patterns were labelled by Ryle (1979) as *Traps, Dilemmas and Snags*, defined as follows:

- In *Traps* negative assumptions or beliefs generate actions or roles which produce consequences seemingly reinforcing the assumptions.

- In *Dilemmas* the individual acts as if the options for relating to self or others were limited to polarised alternatives, usually without being aware that this is the case.

- In *Snags* appropriate goals or roles are abandoned or undone (a) on the (true or false) assumption that others would oppose them, or (b) independently of the view of others, as if they were forbidden or dangerous. The individual may be more or less conscious that they act in this way and may or may not relate this to feelings such as guilt.

Taken together Traps, Dilemmas, and Snags represent the earliest mode of reformulation in CAT and encapsulate the first phase of conceptual integration of four contemporary traditions in psychotherapy (Leiman, 1994). Traps with their characteristic self-maintaining circular pattern of thinking and acting had been used in behaviour modification and family therapy. Dilemmas may be identified from
repertory grid data on the basis of construct correlations and represent perhaps the clearest example of the integration of Kellian constructivism with psychoanalytic understanding. Internalised snags represented a graphic way of conceptualising unconscious guilt and fear of envy, both so often the preoccupations of the psychoanalytic tradition. However Ryle’s reformulations of neurotic suffering imply a structural as well as a phenomenological property. A neurotic patient repeats self-limiting and harmful patterns of thought and action, while seemingly unable to learn from experience. It is the patterned sequential character inherent in patients’ distress, and the apparently reinforced assumptions involved, that Ryle attributes to patients’ inability to revise their suffering.

1.6.2 The Procedural Sequence Model

Within the theoretical base of CAT, Traps, Dilemmas and Snags are particular examples of the kinds of procedure involved in the general organisation of intentional, aim-directed action. In the early 1980’s Ryle went on to link these patterns through the formulation of an explicit general model of intentionality, the Procedural Sequence Model (PSM; Ryle, 1982). This theoretical model incorporated or restated current cognitive, behavioural and psychoanalytical ideas using the language of information processing theory, and gave a general account of the psychological processes involved in the carrying out of aim-directed activity or the enactment of roles in relationships.

According to the PSM, the unit of description is the Procedure, which combines in sequence: (i) mental processes (perception, appraisal, intention, prediction, selection of means), (ii) action, including role playing, and (iii) the evaluation of the consequences, leading to (iv) the confirmation or revision of the aim or means.
Procedures are seen to be formed, enacted and ultimately understood in relation to both the individual’s past history and current context. In flow-chart format, Ryle (1982, 1990, 1991) elaborated the constituent stages of a procedural sequence, a full account of which will include the following:

1. A description of the individual’s active involvement with their surroundings.
2. Their appraisal of this involvement.
3. The formation and pursuit of goals in this context
4. Their anticipation of their capacity to attain these goals and likely consequences.
5. Their consideration and selection of available means.
6. Their enactment of selected means.
7. Their evaluation of the efficacy and consequences of their action, and
8. Their confirmation, revision or abandonment of their aims or means.

Within the PSM, neurosis was understood in terms of processes that perpetuate an individual’s reliance on ineffective procedures or that lead to the inappropriate abandonment of aims. Procedural sequences are normally revised in the light of feedback and experience. However neurotic or maladaptive procedures in the form of Traps, Dilemmas and Snags are characteristically ineffective, self-perpetuating and resistant to revision. As such, the aims of therapy came to be defined by Ryle as the recognition and ultimate revision of the individual’s Traps, Dilemmas and Snags.

Within the context of theory development, Leiman (1994) evaluates the contribution of the PSM in the early eighties as two-fold. At the time of its introduction the model
reflected a considerably more inclusive conceptualisation of neurotic suffering than contemporary cognitive theories with their reliance on reductionistic notions of the interactions between cognition, behaviour and affect. Moreover the location of the Traps, Dilemmas and Snags within a sequential model of intentionality integrating both internal and external aspects represented a cornerstone in the subsequent development of CAT theory. However Ryle (1997, 1985) himself was to subsequently acknowledge the limitations of the PSM and now regards it as a useful analytical tool rather than as a general model of human learning. Although the PSM was capable of integrating psychoanalytic concepts, Ryle recognised that some key contributions from the object relations literature were missing, notably the attempt to explain how early experience shaped both personality and patterns of relating to others. In procedural terms Ryle came to identify interpersonal and intrapersonal procedures as being acquired in interaction and influenced by the caretaker’s procedural patterns rather than being formed and modified through rational learning. His later restatement of developmental and structural concepts from object relations theories in cognitive language sought to remedy deficiencies in the PSM.

1.6.3 Object Relations Theory and Reciprocal Role Procedures

In the mid-1980s, Ryle (1985) began to systematically incorporate concepts from object relations theories into the PSM. His aim was to clarify and restate in the language of modern cognitive psychology the cluttered ideas on the early origin of object relations described by Klein and developed by Fairbairn, Winnicott, and Guntrip (Ogden, 1983). For Ryle, the clinically valuable insights of object relations theory lay in the understanding of unconscious processes as internal interactive patterns or dialogues and the concept of early learning as a sequence of introjection,
projection and reintrojection. Indeed its particular relevance for the PSM and the theoretical evolution of CAT generally has been an emphasis on a common origin for interpersonal and intrapsychological phenomena, namely early infantile experience.

This stage in the development of CAT centred on Ryle's extension of the notion of the procedure. *Reciprocal Role Procedures* (or RRP’s) emphasised how procedures concerned with maintaining relationships incorporate a capacity to predict or adapt to the response of the other. RRP’s are seen to operate largely unconsciously and to be learnt from early family experiences and the prevailing culture in which the individual grows up. Each relationship is the basis on which two role procedures are learnt in interaction, for the individual must learn the essential rules governing both their own and the other’s roles. The repertoire of reciprocal roles so acquired stabilises to become a form of perceptual set or template for the evaluation of interactions with others generally and will also lead to behaviours intended to elicit reciprocations apparently confirming the repertoire. Furthermore this same core repertoire becomes internalised to form the basis of personality and also of self management in the sense of procedures to care for and control the self.

1.6.4 The Procedural Sequence Object Relations Model

An extended conceptualisation of the PSM embracing this object relations based revision became known as the *Procedural Sequence Object Relations Model* or the PSORM (Ryle, 1992; 1994). An explicit developmental model of interpersonal and intrapsychological phenomena and their organisation was brought into the heart of CAT theory and derived from the description of RRP’s as key concepts.
According to the detail of Ryle's developmental account, the biological predisposition for attachment involves the new-born infant in elaborating RRP's for relating to its mother (or other primary caretaker) from birth (Ryle, 1991). In each interaction the child learns two role procedures (one self- and one other-derived) although early role procedures are concerned with only parts or aspects of the mother and their development precedes the infant's ability to discriminate self from other. In time the child's understanding of the roles of self and other progresses to becoming able to enact either role and to reverse these, for example playing the maternal role to the mother or to dolls. At a later date, the child comes to enact the maternal or parental role towards himself/herself and with this internalisation comes the capacity for self-care, self management, self consciousness and, of course, internal conflict. Personality is thus uniquely shaped in each child and is the product of temperament or biological endowment in interaction with a specific internalised reciprocal role dialogue, cultural context and experience.

A major task of early childhood is seen as the integration of formative reciprocal roles concerned with only parts or aspects of the mother into complex, whole-person procedures. This integration is fostered by the creation of a safely predictable environment appropriate to the child's temperament and developmental level. Separations, neglect and more severe disturbances of parenting may damage the child's capacity to integrate contrasting, polarised part procedures. It is this failure in integration which Ryle (1991) considers to be at the heart of adult personality disorders in particular.
While retaining the unquestionable clinical value of key concepts in object relations theory the PSORM is offered by Ryle as a more accessible developmental account which dispenses with the persistent reification of intrapsychological processes so characteristic of psychoanalytic thought generally. In contrast with the Kleinian view, early life experience, rather than the clash of innate instinctual forces in quasi-autonomous "objects' and "part-objects' relating to an "ego' or "part-egos', is seen to determine the range, quality and integration of an individual's reciprocal role repertoire. The phenomenon of splitting is understood within the PSORM to represent the absence of integration and a self-observing capacity manifest in persistent contrasting polarised judgements, rather than a defence of the good object by separation from the bad. Splitting is understood to be maintained or reinforced through the repeated elicitation of apparently confirmatory reciprocal roles in interaction with others. Similarly, projective identification, the other major defence mechanism posited by object relations theory, is viewed by Ryle (1985) as the elicitation of responses from others which represent the feared or disavowed pole of a dissociated RRP, rather than as a defensive strategy for dealing with persecutory internal objects animated by the death instinct.

On the basis of the PSORM, neurosis is conceptualised in relation to the restrictions or distortions inherent in the individual's procedural repertoire. Some procedures may represent deficits in reflective capacity or an inability to remember, perceive and acknowledge certain situations or wishes. Personality disorders, in addition to a self-limiting procedural repertoire, entail the added complexity of the operation of a number of more-or-less dissociated self-states (see Ryle, 1997).
1.6.5 Vygotsky and Sign-Mediated Activity Theory

The fourth and last strand in the present review of major developments and influences underlying CAT theory concerns the impact of Vygotsky and others’ sign-mediated Activity Theory (Vygotsky, 1962, 1978; Wertsch, 1985). Vygotsky’s Activity Theory was born of the intellectual fervour that characterised post-revolutionary Russia and represented an attempt to develop a non-dogmatic Marxist psychology of the individual in terms of his historical and cultural origins. The Vygotskian emphasis on the socio-cultural context of psychological development and on the role of internalised sign-mediated activity began to influence CAT in the early 1990s. Its overarching contribution has been to provide a basis for integration in the conceptual evolution of CAT, particularly in relation to the articulation of a developmental process theory (Ryle, 1990; 1991; Leiman, 1992; 1994).

The main corpus of Vygotsky’s research (1962, 1978) focused on pre-verbal sign mediation and the development of de-contextualised thought - the transformation of interpersonal activity, involving tools and/or language, into intrapersonal cognitive activity. According to the Vygotskian understanding of early development, a child’s first learning occurs in the context of interaction with a primary caregiver and others. A process of internalisation by way of mediating signs potentiates early social interaction as the basis of that internal dialogue which constitutes thought. To the extent that mediated thought concerning concepts of self and other is learned in early social interaction means that significant others provide not just our first interpersonal experiences but also the more or less adequate means we have of making sense of them. The subjective experience of the child, in combination with the intersubjective
account of it offered by others, shapes the functionality of the individual’s construction of social reality and capacity for self-reflection. To rephrase Vygotsky’s oft quoted statement: ‘what the adult can or cannot let the child do or know today, the child can or cannot let herself do or know tomorrow’.

Two important and related ideas to emerge from the Vygotskian tradition were to have a notable impact on the development of CAT. The concept of the zone of proximal development in developmental psychology, defined as the gap between a child’s actual observed performance and potential competence with the help of an educator, was seen to have analogous relevance for the task of therapy (Ryle, 1991; 1995; 1997). This concept pointed to the notion that the task of an educator (or therapist) must be to provide a ‘scaffolding’ role ahead of development, leading the learner (or patient) into his/her zone of proximal development and generating the necessary conditions for internalisation (Bruner, 1966; Wood, Bruner and Ross, 1976). In practice, later research on Activity Theory was to clarify those necessary conditions for internalisation as including the learner’s (or patient’s) active participation in appropriate tasks with the help of an educator (or therapist) who provides an accurate verbal commentary and who transfers responsibility to the learner (or therapist) at an appropriate rate (Wertsch, 1985).

Recent developments in CAT theory and practice have further elaborated the concept of sign mediation as it applies directly to the therapy situation (Leiman, 1992; 1994, 1995; Ryle, 1991). The emphasis on jointly elaborating descriptions and diagrams of damaging procedures, as well as the handing over of the descriptive ‘mediating tools’
of the reformulation, embodies the essence of Activity Theory. The joint activity which is at the heart of CAT reformulation represents the interpersonal context for what Ryle views as a particular form of education applied to the domain of self-knowledge (Ryle, 1991). It is in this sense that reformulation is viewed as a mediating tool to develop the patient’s capacity to reflect on self.

1.7 THE MAIN FEATURES AND PRACTICE OF CAT

The CAT model represents an integration and extension of concepts and techniques employed in different, often diametrically opposed approaches. Ryle (1990, 1995) claims that it is not, however, an eclectic pot pourri with neither logic nor structure. Instead, it is offered as a coherent framework in which a variety of specific techniques can be accommodated according to a unifying model of therapeutic change. The cornerstone of CAT is the emphasis placed on the formulation and sharing with the patient of high-level descriptions of harmful procedures that cause or maintain problems. Within the context of a humanly safe and constructive relationship which is the central basis of all therapy, the joint activity of reformulation is seen as fully mobilising and extending the patient’s own skills and capacities for self-understanding and control, while at the same time guiding the therapist in ensuring that the relationship serves its therapeutic purpose.

CAT involves an explicit treatment contract with clients based on a specific brief number of sessions. In practice, 16 sessions plus a follow-up session usually 3 months after termination has evolved as the optimum treatment length. The technical framework underlying CAT has been fully elaborated in two books by Ryle (1990;

1.7.1 Sessions 1-3: The Reformulatory Phase

In CAT, the object of the initial sessions is to establish a working relationship, to maximise the allegedly powerful and non-specific effects of therapy on morale, and to convert passive suffering to active engagement in problem-solving. The first three sessions with the patient will consist largely of semi-structured and unstructured interviewing aimed at history-gathering and the joint task of reformulation. During this phase, a full life-history and detailed account of the presenting problems will be explored while at the same time the patient’s interactional approach, attitude to assigned tasks and reactions to any provisionally offered reframing will be noted. The patient history will be particularly explored for transitional life events and how these were negotiated and responded to. In particular the CAT approach requires the therapist to draw inferences concerning what the patient might have concluded from his early formative experiences about himself as an individual and in terms of his values, assumptions and strategies. Above all, emphasises Ryle (1990), the CAT therapist will be concerned:

“to identify and describe the repetitively used harmful or restrictive procedures for self-care and control and for relating to others operating in the patient’s life, and often manifest in the ‘here and now’ of the session. The particular flavour of the CAT reformulation derives from this emphasis on achieving such descriptions at this early stage, aiming to make the highest-level, most generally applicable descriptions possible”. (p.16)

At the end of the first therapy session the patient is given the Psychotherapy File to read, an inventory describing common patterns of problem procedure. Discussion and exploration of the File is aimed at enabling the patient to accurately identify which of
the labelled traps, dilemmas or snags apply to them. Contained within the File are also instructions for the self-monitoring of recurrent moods or symptoms in which particular emphasis is placed on interpersonal context and on issues of self-care and control. Both use of the File and self-monitoring contribute to the formal focusing of the fourth session.

1.7.2 Session 4: Prose Reformulation

Within the CAT approach, reformulation is considered a crucial element. In the fourth session the reformulation process is formally brought to fruition when the therapist offers the patient a written draft reformulation for modification where necessary following joint discussion. This prose reformulation will contain a descriptive section accounting for the patient's key past experiences as well as a description of how these were coped with and how present problems are maintained by the maladaptive survival strategies developed in response to the past. The aim in this culminating stage in the reformulation process is to validate and deepen the patient's sense of his own history or "chronically endured pain" (Mann and Goldman, 1982).

The remaining section of the Reformulation letter consists of a list of TPs and TPPs similarly agreed with the patient and the suggested aims for each of these may also be discussed and recorded. This TP/TPP list serves to emphasise that the work of therapy is concerned with the revision of current repetitively used, harmful procedures and all subsequent therapy will relate to these as the focus. In its final form, highlights Ryle (1990), "each TPP should be a clear, succinct, accurate, generally applicable and
specifically adequate description" of a patient's maladaptive survival strategy. The ultimate listing will also provide the basis for a rating of change at the end of all subsequent sessions using a simple visual analogue scale.

1.7.3 Sequential Diagrammatic Reformulation

For some patients, particularly those with poorly integrated personalities, the Prose Reformulation is supplemented with a Sequential Diagrammatic Reformulation (SDR) in which procedures are depicted and interlinked in flow-chart format. The aim of such diagrams is to amplify understanding of often complex procedural sequences and their inter-relationships in a way that words alone cannot. SDR's, which are often elaborated by around the sixth or seventh session, usually contain a core state of negative feelings or attitudes from which different modes of escape are tried (eg interpersonal, coping, symptomatic etc). Interlinking of these states sequentially demonstrates how they serve only to maintain the negative core state. These diagrams also inform the delivery of effective counter-transference interventions as well as provide a stabilising basis for self-monitoring by the patient.

1.7.4 Sessions 5 - 16: Active Therapy Phase

From the fifth session onwards the focus of therapy is the agreed Reformulation and the therapist's activity is directed at helping the patient to recognise the operation of focal procedural sequences in his life, with a view towards revision by more adaptive models of thinking, feeling and acting. With Reformulation laying down the framework for active therapy, the range of therapeutic techniques which may be employed is limitless. Whether derived from cognitive, psychoanalytic or any other approach CAT places an emphasis on the integration of therapeutic methods in that all
are related to the TP/TPP formulations and can be applied in concert towards the achievement of therapeutic change.

In all cases, however, the patient is actively involved by the therapist in learning to recognise how he slips into repeating the maladaptive sequences made explicit in Reformulation. Such recognition is facilitated by diary-keeping which initially records repetition but soon leads to early enough recognition to permit the enactment of alternatives. The other formal task of the active therapy phase will be the rating after each session of self-reported progress on recognition and revision of TPPs. These ratings are aimed at rewarding progress and maintaining the focus of the therapeutic task for both patient and therapist.

1.7.5 Termination and Follow-up

Within the CAT model, discussion of termination is considered essential. The fact of termination is kept in awareness throughout therapy by naming the number of each session. Moreover, as termination approaches more time during each session is devoted to issues of separation, relating these to TPs and TPPs where relevant. In the last few sessions this is combined with a review of the process of therapy and the progress made. The work of therapy and the issues raised by termination are also summarised in the form of a “Good-bye” letter written by the therapist and, often, by the patient.

The Good-bye Letter from the therapist offers a realistic appraisal of the successes achieved and indicates where vigilance or further work is called for. The patient’s Good-bye Letter is similarly an experience of self-evaluation. In both cases the aim of
this evaluation procedure is to keep the person of the therapist and the tools of therapy active in the patient’s mind through the follow-up period and beyond.

The period between termination and follow-up is an important one in which it becomes clear how far the tasks of therapy have been assimilated and internalised. Ryle (1995) ordinarily recommends a follow-up appointment at about three months following the completion of therapy, primarily to review the degree to which gains have been maintained or extended. A semi-structured post-therapy interview is recommended in which each of the TPs, together with examples of related change, is discussed. A primary focus of the review will concern a detailed assessment of the degree to which the reformulation has been exploited in relation to both recognition and revision of focal TPPs. Where appropriate to need, a further follow-up or a series of “top-up” booster sessions may be arranged.

1.8 OUTCOME RESEARCH RELATING TO CAT

The explicitly focused, time-limited form of CAT makes this therapy amenable to research evaluation and audit. The use of measurement and monitoring underlies the structure and philosophy of the therapy, making compliance with research activity by both patient and therapist more likely. In addition to the clear statement of treatment goals, the explicit theory upon which CAT is based has generated a range of specific tools and instruments all of which will have testable impact.

Notwithstanding these features and the very research origins in the historical derivation of the model, Ryle (1995) has lamented the slow accumulation of CAT-
based research activity in the last decade. While the clinical practice of CAT over this period has increased enormously the combined obstacles of large caseloads, long-waiting lists and limited resources are all likely to have militated against the potential development of CAT's evidence base. Within the context of this thwarted climate the existing outcome and process research into CAT will now be reviewed.

Outcome research relating to CAT may largely be grouped into three distinct yet overlapping areas: variations of patients series evaluation; evaluations of CAT as applied to specific clinical populations; and controlled outcome trials.

1.8.1 Patient Series Evaluations
Several studies have reported uncontrolled outcome evaluations or audits of CAT. In one of the first papers to establish many of the defining features of what was to evolve as CAT, Ryle (1979) describes a pilot outcome study of brief interpretive psychotherapy. The study involved six patients who all presented with DSM III Axis I disorders. During a treatment length averaging ten sessions (range 4 - 14) spread over 4 - 12 months, patients completed serial ratings on Target Problems and Target Problem Procedures in addition to an initial and a repeat dyad repertory grid. In essence, the dyad grid technique offers patients a way of describing their relationships with others (Ryle and Lunghi, 1970). The analysis of such grids generates mathematical or graphic representations of associations between the elements (people or relationships) and constructs (terms of comparison and contrast), and between elements and constructs. The dyad grid used in this study contained 10 supplied constructs, and the elements were the relationships between the parents, between self...
and each parent, between self and three other important people and between self and
self.

The results of the six cases were in general evaluated as satisfactory by Ryle (1979).
All patients rated themselves as changed, both in respect of the problems which were
their presenting complaints, and in respect of the maladaptive procedures identified
early on in treatment. Moreover, in 27 out of 36 instances, the grid measures showed
changes in accord with prediction, and in most instances in line with the TPP ratings.

One year later, Ryle (1980) published a further seminal paper detailing
an outcome study of “focused integrated active psychotherapy” (subsequently to be
labelled CAT). In this uncontrolled study, measures of change were reported on a
series of fifteen patients treated with between five and thirty (mean= 11)
psychotherapy sessions. The diagnostic profile of this cohort consisted of 10 patients
meeting DSM criteria for Axis I disorders of recent onset and 5 patients with Axis 2
disorders. Treatment goals were defined in terms of TPs and TPPs and outcome was
evaluated through administration of the 60-item General Health Questionnaire
(G.H.Q.; Goldberg, 1972) and the standard dyad grid before and after therapy. As in
the earlier outcome study, patients in this series generally recorded improvements in
respect of both TPs and TPPs. The resolution of TPPs was accompanied in nearly
every instance by appropriate predicted changes in construct correlation values as
rated on the grid. While the extent of cognitive revision in the intended direction did
vary, the accompanying symptom reduction as evidenced by TP changes and shifts in
GHQ scores did suggest a satisfactory degree of change given the brief treatment length and the long-term nature of the problems rated as TPPs.

Ryle, Sharon and Savorin (1992) report an uncontrolled outcome trial of CAT conducted at Guy's Psychotherapy Department. Thirty-eight patients who completed 16 sessions of CAT were administered a battery of nomothetic and idiographic measures that included the 90-item Symptom Checklist (Derogatis, Lipman and Covi, 1973), the Beck Depression Inventory (Beck, Ward, Mandelson, Mock and Erbaugh; 1961), the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno and Villasenor; 1988) as well as the Dyad Repertory Grid. No information as to diagnostic classification or problem types is supplied. Average pre-post score differences indicated improvement on all measures of psychological functioning and, with the exception of the IIP, those pre-post score differences reached statistical significance (Wilcoxon P<0.05) in all cases.

Pre-therapy scores on the SCL, BDI and IIP were all positively correlated, as were the change scores on these measures (P<0.05). Change scores on both the SCL and the IIP correlated negatively with respective pre-therapy scores, suggesting that patients with higher pre-therapy scores change less. The effect was reversed in the case of the BDI.

In terms of the relationship between dyad grid-derived scores and the nomothetic measures, only two significant associations were found between the pre-post- and change scores: the post-therapy BDI and the post-therapy Negative Self Attitude
(NSA) score were moderately correlated, as were the NSA change and BDI change scores. Ryle et al. (1992) speculate that this association may have reflected the preponderance of negative self-attitude statements contained within the BDI while the more global independence of the grid measures from the inventory scores suggests that appropriately diverse aspects of functioning are sampled by the different nomothetic and idiographic measures.

No significant associations were reported between the various grid-derived scores with the exception that the Self-Other and Other-Self grid prediction scores associated moderately.

Based in Thessalonika in Greece, Garyfallos, Adampoulou, Saitis, Sotiriou, Zlatanas and Alektoridis (1993) report an audit of a patient series receiving CAT at a community health centre. The aim of this study was to measure change using a standard post-therapy interview in addition to pre- and post-therapy testing with the Minnesota Multiphasic Personality Inventory (MMPI). A preponderance of patients met DSM-III(R) criteria for anxiety and depressive disorders and a high proportion received Axis 2 diagnoses. Of 56 cases in whom Axis 2 disorders were reported, 17 met borderline personality disorder criteria. Patients were evaluated at two and twelve months follow-up. Of 85 patients recruited, 10 dropped out of therapy and 11 remained in therapy at time of writing. Of 64 completers, 56 attended the 2-month follow-up, and 33 of the 39 eligible attended at 12 months. Six patients at two months and none at 12 months requested further therapy. The MMPI repeated at two
months showed significant mean changes on nearly all subscales, a finding which further maintained at 12 months.

In a paper emphasising how routine audit of psychotherapy practice can be clinically informative, easily administered and economic timewise, Nicholson (1994) presents an account of a series of patients treated with CAT in psychiatric outpatient departments. In the course of a 12-month period during which the author was a trainee psychiatrist, sixteen people were offered 45-minute sessions of CAT weekly for 16 weeks. Four patients withdrew prior to completion of the assessment phase. Two others had contact prematurely terminated due to unavoidable circumstances and had also not completed assessment. Of the ten completing assessment and receiving some therapy, six were primarily suffering from depression, one had a fear of public places, one suffered from an eating disorder, one was obsessed with the risk of food poisoning and one had interpersonal difficulties. Three of these then terminated after seven sessions.

Measurement of change was based on elicitation of TPs and TPPs as well as administration of a repertory grid and the BDI at assessment, termination and follow-up. At termination, eight patients demonstrated some improvement in all their TPs and the BDI simultaneously. The mean BDI score at completion of assessment was 20.7 compared to 9.3 following termination (Wilcoxon P<0.01). Evidence of beneficial underlying change was less pronounced but still favourable, with five individuals showing some improvement in all of their TPPs and 50 percent or more of their grid-derived target correlations simultaneously.
Seven patients attended for follow-up and the overwhelming tendency was for no change between this and termination. Of the 39 measurements made at follow-up, three indicated deterioration, ten indicated an improvement, and the others remained the same.

Based on the Structure-Process-Outcome service evaluation model of Donabedian (1988), Denman (1995) provides a detailed description of the evolution of a computerised audit system for CAT (CATsys) at the Psychotherapy Departments of Guy’s and St Thomas’ Hospitals in London. In addition to other output data such as drop-out rate, data on outcome were routinely collected at Guy’s in the form of assessment, termination and follow-up scores on measures identical to those in the Ryle (1992) study, namely the BDI, SCL-90 and IIP. A fourth questionnaire on social circumstances and adjustment (the SAS) was also employed (Weissman).

The outcome data available for analysis related to 32 patients who had completed a full CAT therapy. There was good evidence for measurable improvement in this group and outcomes were comparable to those in Ryle (1992). The mean “pre” (x=1.61; S.D. =.62) and “post” (x= 1.31; S.D. =78) scores on the IIP were significantly different (p= 0.02), as were the mean “pre” (x= 1.4; S.D. =.72) and “post” (x =1.04; S.D. =.78) scores on the SCL-90 (p= 0.008). The scores on the BDI were also significantly reduced (pre-therapy mean = 19, S.D. =10; post-therapy mean = 14, S.D. = 10; p= 0.006). However, average outcome scores on the measure of social adjustment, the SAS, were not significantly changed (pre-therapy mean= 19, S.D.=19; post-therapy mean =18; S.D. = 10; p = 0.415).
In the context of an uncontrolled evaluation, Denman was less impressed by the outcomes on the more transient measures of symptomatology, namely the BDI and SCL-90, than she was in the case of the IIP which detects more long-term deficits in interpersonal functioning. According to Denman, outcomes relating to symptomatology might be expected to reduce over time regardless of psychotherapeutic intervention whereas an IIP shift in distress arising from interpersonal sources may be a more faithful measure of the impact of therapy. The Social Adjustment Scale measured factors such as housing conditions which would have been likely to have changed in the timescale of the study.

Interestingly, no audited feature was found to predict or associate with drop out from therapy. One fifth of patients who had been assessed and referred for CAT failed to attend their final session and a further third attended the first session but failed to complete therapy.

1.8.2 Specific Clinical Populations and CAT Outcome

A number of uncontrolled descriptive studies report outcome measures following the application of CAT to defined clinical populations or therapeutic modalities. Duignan and Mitzman (1994) and Mitzman and Duignan (1993) describe and assess the use of CAT techniques in group therapy. A 12-session therapy group was led by the two authors following a total of four individual pre-group preparatory sessions during which each of the 8 patient members met both therapists. During these preparatory sessions a psychiatric assessment as well as psychometric and repertory grid testing was conducted. Written and sequential diagrammatic reformulations were also agreed
at this stage. Duignan and Mitzman report that three of the eight patients met borderline personality disorder criteria and one narcissistic personality disorder.

Seven of the eight patients completed the 12 group sessions, of whom only two requested further therapy. Psychometric scores on the Beck Depression Inventory (BDI, Beck et al. 1961), Crown-Crisp Experimental Index (CCIE; Crown and Crisp, 1979) and General Health Questionnaire (GHQ; Goldberg, 1972) fell significantly (Wilcoxon p<0.026) and improvements in measured grid outcomes were comparable to those reported for individual therapy by Brockman, Poynton, Ryle and Watson (1987) reported below. The innovative application of CAT methods in the work of Duignan and Mitzman would appear to provide strong evidence for the relevance and impact of sequential diagrammatic reformulation in particular.

The treatment of seven female survivors of childhood sexual abuse with 8-16 sessions of CAT is the subject of one descriptive study reporting measures of change by Clarke and Llewelyn (1994). Single element and dyad repertory grids were completed before and after therapy as were a battery of psychometric measures which included the BDI, the SCL-90R (Derogatis et al., 1973), the Rosenberg Self-Esteem Scale (Rosenberg, 1965), and the Jehu Belief Inventory (Jehu, 1988). The latter battery was also readministered at three-month follow-up. Six of the seven females completed therapy.

Results of the repertory grids administered before and after therapy were consistent with the exploratory hypothesis of the authors that abuse forms a central component
of the women's relationships, hence making re-victimisation a real possibility. The outcome of therapy using CAT was positive, although considerable and significant symptomatic change observed on the psychometric measures were accompanied by significant change in only a relatively small number of the women's constructs, suggesting the persistence of the centrality of abuse despite therapy. While two of the women revised how they construed the relations of men to them, the view of how women related to men (as victims) was little altered.

The adoption of multiple outcome measures in this study was thus particularly instructive in that the limited evidence of dynamic change from the repertory grid prevented over-estimation of the effects of therapy. Clarke and Llewlyn suggest that some of the patients in their study might have benefited from longer therapies, and that transference work with a male therapist might have been of benefit.

In an interesting study extending some of the issues raised by Clark and Llewelyn, Pollock and Kear-Colwell (1994) report a role construct repertory grid analysis and CAT-based treatment of two women with a history of very significant sexual abuse who had stabbed their male partners. Treated in a forensic setting, both patients completed grids with supplied role titles which included a number of versions of the self. The most significant dimension that emerged was in general terms that of "abuser-victim". It was evident that there was considerable confusion about their self-perceptions with regard to these roles. These patients perceived themselves as abusers despite their histories of victimisation. There was a high level of guilt associated with the victim role in each woman and in previous therapy simply dealing
with their victim role was considered to have given rise to very disturbed self-destructive behaviour and even more guilt.

Therapy along CAT lines focused on the "abusing-abused" reciprocal role procedure and on related procedures. The use made of Sequential Diagrammatic Reformulation was claimed to have been effective in both cases. Readministration of the original repertory grids at 11 months or more into therapy confirmed significant and consistent changes in self-perception. Marked improvement was also evident at a behavioural level, with one patient ceasing self-mutilation and being made an informal patient, and the other discharged into the community. Both entered into relationships with men, evidently on different terms. Pollock and Kear-Colwell's study represents a model application of repertory grids both in the reformulation process and as a measure of change.

1.8.3 Controlled Outcome Trials

A literature search on research relating to CAT produced five studies reporting controlled outcome trials. Brockman, Poynton, Ryle and Watson (1987) reported a comparative outcome study in which 48 outpatients were randomly assigned to 12 sessions of either CAT or a focused brief interpretive therapy carried out on the lines described by Mann (Mann and Goldman, 1982). In effect this study represented a dismantling design in which the active homework and written tasks so integral to CAT were eliminated in the otherwise comparable Mann approach. The therapists, trainees from various professional backgrounds with no brief therapy experience, treated patients in both conditions under common supervision.
Therapy outcomes were measured using validated instruments (Beck Depression Inventory, General health Questionnaire, and Crown Crisp Inventory) and repertory grids. Patients in both groups showed significant reductions in their symptom scores and in ratings carried out on Target Problem and Target Problem Procedure scales, formulated before therapy commenced by the researcher. Mean predicted changes in selected construct correlations in the dyad repertory grid were significantly larger in the CAT sample, averaging 33 degrees. The effect size of CAT over interpretive therapy on this measure was 0.5. Grid derived measures of changes in positive and negative self-attitudes were also larger in the CAT sample, with effect sizes, after matching for initial scores, of 0.53 and 0.38 respectively. While this study suggests that CAT effects greater cognitive restructuring than a purely dynamic approach its design would have been strengthened had the two therapy conditions been separately supervised by supervisors committed to their therapy model, a limitation acknowledged by Ryle (1995).

Whilst great advances have been made in the treatment of the eating disorder bulimia nervosa (eg Fairburn, Jones, Peveler, Carr, Solomon, O'Connor, Burton and Hope, 1991) the development and evaluation of psychological treatments for anorexia nervosa is still in its infancy (Fairburn, 1990). In an interesting pilot study, Treasure, Todd, Brolly, Tiller and Denman (1994) describe a comparative outcome trial of two forms of individual outpatient therapy for anorexia nervosa sufferers. Thirty anorexia patients aged over 18 were randomly assigned to outpatient treatment with either educational behaviour therapy (EBT) or CAT for 20 weekly sessions. Therapists
were experienced in the former but had only a brief introduction and ongoing supervision in CAT.

Clinical outcome ratings were made using the Morgan and Russell (1975) scales which comprise five subscales measuring nutritional, menstrual, mental state, psychosexual and social functioning. In addition, general outcome was based on measures of body weight and menstrual function. Three categories were defined: (i) Good outcome: body weight maintained within 15 per cent of the average body weight (ABW) according to actuarial tables and regular menstrual cycles; (ii) Intermediate outcome: body weight has risen to within 15 per cent of ABW with persistent amenorrhoea; (iii) Poor outcome: greater than 15 per cent below the ABW. Follow-up assessments performed by a psychiatrist who had not been involved in the treatment programmes occurred at the end of treatment and at 3-monthly intervals up to a year.

A total of 10 cases from each group (i.e. two thirds of the entire sample) completed the course of 20 sessions. Outcome at one year was similar for the two groups on the objective measures. The only difference in outcome between the two groups was in terms of a self-progress scale, the patient's subjective reported improvement. The CAT group rated themselves as improved significantly more than the EBT group. There was also a trend for fewer of the patients in the CAT group to remain in the poor outcome category but this did not reach significance. Overall the results suggest that CAT is at least as safe and effective as a more educational intervention for this patient group. Methodological shortcomings acknowledged by the authors in the
form of small sample size and the relative inexperience in CAT of the therapists are moreover likely to have reduced the chance of demonstrating larger differences.

Poor self-management and treatment compliance is a common and serious problem in a number of medical conditions and can be associated with higher rates of morbidity and mortality. In the case of insulin-dependent diabetes, poor self-care regarding blood tests, diet and insulin injection can leave sufferers at greatly increased risk for serious medical complications. The psychological causation of poor self-care is little understood although it seems likely that depressive self-neglect may be one contributory factor (Ryle, 1995). Evaluated attempts at educational or behavioural interventions for this patient group have consistently met with poor outcome (Surwit, Scovern and Feinglos, 1982; Leventhal and Cameron, 1987; Bloomgarten, Karmally and Metzger, 1987).

In one unpublished comparative outcome study, Milton (1989) randomly assigned 32 diabetic patients between CAT, intensive nurse education, neither or both. Patients were selected on the basis of HbAI levels of over 11%, a measure giving a reliable indication of mean short-term blood sugar level in addition to identifying patients at risk and the outcome of intervention. Milton demonstrated that CAT, with or without education, was associated with a significantly greater fall in the HbAI levels at 9-month follow-up. A subsequent comparative trial of nurse education and CAT interventions for poorly controlled insulin-dependent diabetes by Fosbury (1994) demonstrated that, while education is associated with a drop in HbAI levels at the end
of the intervention, only CAT was associated with a sustained and significantly greater drop at 9-months follow-up (p<0.02). In this latter study, the incorporation of SDRs was a central feature so that the sequences of various non-compliance behaviours were located procedurally and hence connected with other aspects of intrapersonal and interpersonal patterns.

Psychological research into interventions for other medical conditions also reinforces the suggestion that educational and therapeutic approaches can be effectively combined. Bosley, Fosbury, Parry and Higgins (1992) conducted an evaluation of the impact of CAT on treatment compliance in asthmatic subjects. Non-compliance data generated by Turbohaler inhalation technology, and measured blind to the study's subjects, revealed that fifty percent of subjects omitted one-quarter or more of their prescribed dosage. Non-compliant subjects were offered counselling education, without the fact that their non-compliance was known being declared. The intervention was focused on general issues of self-care, but including asthma management, and was linked to the appropriate procedures described in the SDRs. Compliance, as a function of Turbohaler inhalation measures, was significantly improved at 12-week follow-up.

1.9 PROCESS RESEARCH RELATING TO CAT

Process studies into CAT have focused almost exclusively on psychotherapy with patients of borderline personality organisation (Ryle and Marlowe, 1995; Ryle, 1995; Evans and Parry, 1996; Bennett and Parry, 1998). Much of the process research relates to a cumulative, quasi-naturalistic and prospective study of CAT with
borderline patients at Guy's Hospital London, in which the overall impact of the approach is being evaluated in conjunction with process measures (Ryle, 1997). Such research into this patient group has tended to focus on the process of reformulation and may be reviewed as three distinct but interrelated strands: self-state conceptualisations and the self-state sequential diagram; the impact and accuracy of reformulation in CAT; and the relationship of SDR self-states to transference and counter-transference enactments.

1.9.1 Self-States Conceptualisations and the Self-State Sequential Diagram

Conceptualising Borderline Personality Disorder (BPD) as essentially the alternate presentation of a small number of discrete 'self-states', Ryle and Marlowe (1995) report on the identification of multiple self-states with five borderline patients as articulated through the collaborative production of both a Self-State Grid (SSG) and a Self-State Sequential Diagram (SSSD). Comparisons between the defining constructs associated with each self-state in the repertory grid and the descriptive features of each state within the SSSD suggested high consistency and were seen to support the validity of both self-state/state-shift conceptualisations of borderline patients and the reformulation process itself. The study purported to show that patients and therapists alike can apply the concept of multiple self-states to the patient's experience and behaviour in terms of mood, access to emotion, sense of self, and sense of other.

1.9.2 The Impact and Accuracy of Reformulation in CAT

Evans and Parry (1996) employed a multiple baseline research design to evaluate the short-term impact of reformulation on the therapies of 4 patients with treatment-resistant mental health problems. Contrary to prediction, results showed that reformulation did not have a systematic short-term impact upon measures of the
patient's perceived helpfulness of the sessions, the therapeutic alliance or individual problems. However, in semi-structured interviews patients reported that the reformulation had considerable impact upon them. In accounting for this discrepancy the authors consider how far this finding reflects the focus of the measures used. They also speculate on the possibility that the focus of the study, namely the sessions immediately following reformulation, may have been too narrow to measure the impact of reformulation. According to this hypothesis, while exchange of the written reformulation in the fourth session is a culmination of the process, the impact clearly begins from the first session with the joint reformulatory work of therapy and patient. In terms of its impact, reformulation may be more meaningfully viewed as a continuous process across the first four sessions rather than specific only to the fourth session.

Bennett and Parry (1998) report a single-case validation study on the accuracy of SSSD reformulation using two established systematic research-based methodologies, namely the Core Conflictual Relationship Theme Method (CCRT; Luborsky and Crits-Christoph, 1990) and the Structural Analysis of Social Behaviour-Cyclic Maladaptive Pattern (SASB-CMP; Benjamin, 1974, 1987; Benjamin, Foster, Roberto and Estroff, 1986; Schacht and Henry, 1994). Comparison of the themes identified by these methods with those recorded in the SSSD showed high levels of consistency and lent support to the view that a collaboratively produced descriptive diagram can validly represent core recurrent relationship patterns.
1.9.3 Self-State Sequential Diagrams and Transference/Countertransference

Further evidence for the accuracy and clinical utility of self-state SDRs is contained in single-case process data further reported by Ryle and Marlowe (1995). Two borderline patients rated their post-session attitude to their therapist across treatment on the Therapy Experience Questionnaire (TEQ; Brockman et al., 1987), whilst therapists completed the Sessional Grid (Ryle, 1995). The self-states and procedures described in the SSSD for each patient were found to predict and explain the patterns implied by the score variation on each process instrument.

1.10 SUMMARY AND CONCLUSIONS

1.10.1 CAT in Context

An examination of the literature relating to CAT has been set in the context of a generic overview of brief psychotherapy outcome research, specifically in terms of the major historical trends, themes and findings which have accompanied the rise of brief psychotherapy to its current prominence.

CAT is one such brief, focal, integrative, active and not least evolving time-limited psychotherapy which has found currency with an increasing range of mental health professionals. The form and structure of CAT makes research evaluation of its effectiveness highly practicable and, over the last decade in particular, a slowly accumulating body of research has documented the beneficial impacts of this time-limited approach. It seems likely that a key to the success of CAT in helping patients lies in its quintessentially collaborative approach and use of early written and
diagrammatic reformulations of patient problems, although such a speculation awaits further research validation.

A combination of reflective practice and research enterprise in CAT and cognate fields has contributed to the evaluation of a theoretical foundation which, far from an eclectic *pot pourri*, offers a coherent underlying model of therapeutic change. At the same time, CAT is continually manifesting the range of its applicability in helping adults with mental health problems across the transient to enduring continuum. Indeed, there exists a growing, again albeit small, number of studies, including controlled trials, which lend collective support to Ryle’s claim that the approach constitutes a beneficial intervention for a large proportion of primary care mental health referrals, in addition to being a safe and useful first treatment for more disturbed patients with borderline problems. Interestingly, the gradual emergence of CAT treatment innovations in the medical field and with people of forensic, substance misuse and learning disability backgrounds also shows early promise.

1.10.2 Limitations in CAT-Based Research

Research relating to CAT has comprised patient series evaluations, studies targeting specific clinical populations, and some controlled trials. However, despite its roots in a research-driven ethos and the generation of specific tools and instruments, all of which have a testable impact, the overall empirical base for the claimed effectiveness of CAT has been accumulating only slowly. Whilst the clinical practice of this time-limited approach has increased enormously over the last decade, the ever-spiralling pressures of large caseloads, long-standing waiting lists, and limited resources are all likely to have mitigated against the potential development of CAT’s evidence base.
The relative scarcity of research skills and orientation amongst many practitioners of CAT is also an undoubted factor.

A range of threats to the validity of existing CAT-based research by way of limitations in methodology, design and evaluation can be discerned from the literature reviewed. In terms of the quality of many CAT studies, and their contribution and integration in the body of psychotherapy research, salient issues relating to sample characteristics, design, procedures, therapists, treatment, assessment and statistical evaluation are all worthy of consideration.

One criticism, often quoted in appraisals of psychotherapy research generally, concerns the descriptive incompleteness with which sample characteristics are specified in some CAT studies. In general, the quality of CAT-based research could be improved by greater delineation and operationalisation of core inclusion and exclusion criteria, particularly the clinical dysfunction which served as the basis for sample selection. Greater consistency in the use of a specific diagnostic system (such as DSM-IV) combined with core psychometric dimensional measures (such as the Symptom Checklist 90R and the Inventory of Interpersonal Problems) to describe or to select patients would also be constructive. Similarly, a proportion of CAT studies omit basic yet defining subject and demographic descriptors, such as socioeconomic status, intelligence, achievement, race, and ethnicity. Such sample characteristics are often related to clinical dysfunction and adaptive functioning in ways that may impact treatment outcome (Kazdin, 1994).
Perhaps one of the more serious limitations embedded in many CAT-based studies concerns a lack of sophistication in research design. The pre-post design predominates and there persists a notable dearth of clinically relevant, randomised controlled research evaluating CAT’s comparative impact with other psychotherapies. Given the unusually rich and, nowadays, context-sensitive array of designs and evaluative strategies that can be drawn from psychotherapy research, there is a lamentably low output of CAT-based process-outcome studies employing the range of group contrast, correlational, naturalistic and single-case designs. At a general level in CAT research, methods for obtaining participants, the allocation of participants to conditions and the selection of conditions, treatments or groups in relation to the hypotheses of interest need to be made more explicit. Similarly, the manner in which related threats to validity are affected by choice of research design is often unacknowledged in CAT research literature.

A third area of concern in relation to the CAT research literature reflects on the implementation, verification and reporting of study procedures. Careful description of procedures relating to participants, therapists and treatment delivery, as well as checks to ensure that the procedures are executed as intended, are often lacking. Variation in the administration of conditions emerging over the course of a study can go under-specified or unmentioned. Such attention to procedure is all the more important in service-based research where the sources of variability within studies are likely to be considerable.
Therapist factors have increasingly been acknowledged as a major source of variation in psychotherapy outcome and as such merit specification in a similar way to patients (Beutler, Machado and Allstetter-Neufeld, 1994). No published CAT study, to the knowledge of the author, has sought to evaluate the influence of therapists on treatment outcome. Moreover, the CAT research literature is erratic in the extent to which therapist dimensions such as experience, level of training, age, sex, race, ethnicity and the specific rationale for the selection of therapists are reported. Fuller specification in these domains would undoubtedly facilitate the replication of studies.

A fifth area of salience in the quality of psychotherapy research centres on treatment factors per se. Some CAT studies are ambiguous concerning the characteristics of specific clinical problems which make CAT a reasonable treatment approach. Frequently, research reports provide insufficient information to determine whether the specific version of CAT treatment under investigation is representative of the approach as it is usually carried out, and therefore constitutes a strong treatment test. Again, greater specificity in this area would aid meaningful replication by others. Methods to ensure treatment integrity and evaluation of the extent to which the CAT approach is faithfully rendered are, however, currently being developed (e.g., Bennett, 1998).

The CAT research literature can be criticised on the grounds of a number of assessment issues. Many CAT studies fail to sufficiently reflect the psychotherapy research consensus that multiple domains of functioning need to be selected that directly address the basis for clinical referral. In addition to reductions in distress
related to specific areas of symptomatology, it is also important for CAT research to examine interpersonal and prosocial functioning. Where outcomes are assessed in CAT research they are often sampled at an insufficient number of time points. Pretreatment data collected across a wider baseline interval of time would enable more accurate identification of the initial level and scope of presenting dysfunction. Also, such data would increase the power of statistical analyses to evaluate treatment differences. Whilst immediate posttreatment assessments of the evaluation of change are commonplace in CAT research, follow-up assessment data on the extent to which effects are stable or changeable across the medium to long-term (six months and beyond) are regrettably less in evidence.

The last threat to the validity of existing CAT studies to be considered here concerns limitations in the statistical evaluation of its outcomes. Studies are frequently vague about the primary measures and data upon which their predictions depend. Specification of the assumptions underlying data analysis and the relation between selected statistical analyses and the original hypotheses and purposes of the study can be similarly ambiguous. As in the case of psychotherapy outcome research generally, studies comparing CAT with other approaches typically suffer from small sample size and resultingly weak statistical power to detect group differences. Moreover, the evaluation of meaningful, in addition to statistically significant, patient change using clinical significance and reliability criteria is evident in only a minority of CAT studies.

In conclusion, the limited scale and design of much existing CAT-based research highlights the many unanswered questions
concerning both the extent of its (comparative) effectiveness and the variables mediating its benefits to patients. Considerably more carefully designed and clinically relevant process-outcome studies are required, both within formal research settings and services as delivered. Presumably, such developments may only be achieved with the emergence of explicit public health funding for psychotherapy research linked to evidence-based practice generally. A greater alliance between practitioners and researchers will also be an undoubted sine qua non for the development of CAT. Notwithstanding, CAT has already been shown to be of beneficial impact, with relative time economy to therapist and patient, and therefore at the very least shows promise as a good entry-level treatment for a proportion of patients with mental health problems across the transient to enduring range.

1.11 INTRODUCTION TO THE STUDY

The purpose of this study is an initial exploratory outcome evaluation of two four-session CAT interventions. At the level of an early phase investigation, the explicit intent is to examine the value and feasibility of two very brief CAT interventions, as a preliminary to the organisation of a randomised controlled trial or large-scale naturalistic study. Interest in the present research was initially fuelled by publications on the development, implementation and evaluation of models of brief psychotherapeutic interventions, such as the Two-Plus-One model (Barkham, 1989; Barkham and Shapiro, 1989) and the Three-Plus-One model (Aveline, 1995). However, the rationale for the four-session model under investigation in this study arises from the traditional overall structure of CAT contracts between therapist and patient. In the CAT approach, a four-session reformulation phase is typically followed
by an 8 - 12 session phase of ‘active’ therapy. Ryle (1990) argues that the process of reformulation, and especially the sharing of the reformulation with the patient, has a number of functions, including: (1) cementing the therapeutic alliance; (2) defining accurately the process which therapy will seek to modify; and (3) providing a new understanding, enabling the patient to initiate new acts and discover new experiences.

Bell (1995), in examining the key strengths and limitations of the CAT approach, suggests that the reformulation emphasis so individual to this model may render its effects more powerful than the more superficial formulations of other brief intervention models. In particular she calls for more ‘minimal intervention’ research with respect to CAT and long-term change. Further research in this area, she claims, would be valuable in developing the most economic interventions for different patient groups, in particular: evaluation of a three-to-four session protocol of a CAT reformulation in comparison with other brief intervention models; trials to establish which patients can make significant changes without further therapy if given a CAT reformulation; and the relative benefits and disadvantages of a break post-reformulation.

In order to initiate research evaluation in this area, the present study represents an early-phase exploration of psychotherapeutic outcomes following 4-session reformulatory CAT in respect of two intervention variations and related patient series. The generalisation and maintenance of psychotherapeutic outcomes over time are also considered in relation to a post-reformulation break and follow-up interval. In addition to patient perceptions of the helpful and hindering impacts of very brief
reformulatory CAT, the relationship between such perceptions and psychotherapeutic outcomes is also assessed. Lastly, the study explores any association between the severity of patients' presenting problems and psychotherapeutic outcome following either CAT reformulatory intervention.

Regarding its distinctive methodological features, the present study has attempted to address some of the limitations summarised in the preceding review of the CAT literature. Sample characteristics, particularly regarding the clinical dysfunction of presenting patients, major demographic descriptors and inclusion/exclusion criteria, are clearly and fully specified, as are all patient procedures and the treatment protocol. In relation to the selection of measures, multiple domains of patient dysfunction (nomothetic and idiographic) were assessed using a core battery of validated psychometric instruments. Pre-treatment data collection was staggered over a baseline interval and outcome data was collected both following treatment and at follow-up. Lastly, the study sought to address a frequent statistical evaluation weakness in the CAT literature through the use of clinical significance and reliable change concepts in assessing the meaningfulness of patient outcomes. In sum, the present research represents an initial testbed for exploring the psychotherapeutic outcomes and subjective impact of two 4-session reformulatory CAT interventions in a naturalistic service delivery setting.
CHAPTER 2

METHODOLOGY
2.1 RESEARCH QUESTIONS AND HYPOTHESES

In essence, this study involved an exploratory evaluation of two CAT reformulatory interventions, similar in all but one treatment procedure, delivered to two consecutive cohorts of GP-referred patients. One cohort received both a Prose Reformulation and a Sequential Diagrammatic Reformulation (PSDR), while the second cohort received a Sequential Diagrammatic Reformulation (SDR) alone. In addition to a screening appointment, each patient attended four 45-minute sessions and an additional follow-up assessment appointment three months later. The major research questions and associated hypotheses relating to the central purpose of the study, namely a preliminary outcome evaluation of 4-session reformulatory CAT, were as follows:

**Research Question 1:**

The first research question concerns core psychotherapeutic outcomes in symptomatology and interpersonal problems following four-session reformulatory CAT. It was hypothesised that indices of psychological distress would show measurable improvement on selected psychometric instruments when assessed in the weeks immediately after the fourth session.

**Research Question 2:**

The second research question centres on the maintenance and extension of any psychotherapeutic outcome gains over time following 4-session reformulatory CAT. It was hypothesised that measurable improvements in psychotherapeutic outcome on selected psychometric instruments in the weeks immediately after the fourth session would be maintained or extended at 3-month follow-up.
Research Question 3:
A third research question concerns an investigation of patients' subjective evaluation of helpful and hindering impacts following 4-session reformulatory CAT. It was hypothesised that patients would evaluate their intervention as helpful on a selected psychometric measure in the weeks immediately after the fourth session.

Research Question 4:
Research Question 4 consisted of an exploration of the relation between patients' subjective evaluation of the helpful and hindering impacts of four-session reformulatory CAT and psychotherapeutic outcomes. It was hypothesised that the perceived helpfulness of their intervention would be positively associated with psychotherapeutic outcomes in the weeks immediately after the fourth session and at three-month follow-up.

Research Question 5:
The fifth and last is a subsidiary research question and concerns the differential impact of severity of presenting psychological distress on psychotherapeutic outcome following 4-session reformulatory CAT. It was hypothesised that the severity of patients' presenting psychological distress as measured on selected psychometric instruments would be negatively associated with psychotherapeutic outcome in the weeks after the fourth session and at 3-month follow-up.

2.2 ETHICAL APPROVAL
The study was ethically approved by Barnsley Community and Priority Services NHS Trust.
2.3 PATIENT SCREENING AND SELECTION

This study explored the clinical impact on outcome of two approaches to brief treatment delivery. In effect, two preliminary outcome evaluations were conducted whereby one consecutive sample of patients received both a Prose Reformulation and Sequential Diagrammatic Reformulation (PSDR treatment condition) and a second consecutive sample received a Sequential Diagrammatic Reformulation alone (SDR treatment condition). These samples will be referred to as the PSDR and SDR cohorts respectively, where the distinction becomes relevant.

The outcome study that emerged, however, did deviate from the initial research project as planned and proposed such that some comment is appropriate here. At inception, the intent was to conduct a service-as-delivered evaluation of reformulatory CAT using the combination of prose and diagrammatic methods traditional to the approach. The initial study was therefore predicated on the basis of an estimated feasible consecutive cohort of over thirty patients each receiving a PSDR treatment condition. In the event, several months into the life of the project the clinical and administrative demands of the original research proposal started to exceed the day-to-day service resources of time and support available to the author and, after some difficult deliberations regarding feasibility, the scope of the study had to be curtailed accordingly. In effect, adjustments to the nature of the proposed study led to the conduct of two small-scale preliminary patient series evaluations, with a smaller PSDR patient cohort receiving one more dismantled treatment component than a larger SDR patient cohort.
Patients in the present pilot evaluation were all referred by GPs at three practices in which the author conducted once-weekly sessional psychological clinics. In conjunction, counsellor colleagues employed within the same service provider as the author also conduct sessional counselling clinics at these GP practices and in the several years of operation of these clinics mutual expectations and a working consensus as to appropriate referral practices have evolved between all three professional groups. Within these primary care settings, brief models of intervention predominate as the treatment-of-choice for both psychologist and counsellors alike.

Across a fourteen-month period, thirty-two consecutive referrals to the author for psychological assessment and therapy were mailed a standard Patient Information Leaflet describing the nature and operation of the clinics as well as three self-report measures for psychological evaluation (See Section 2.7). All thirty-two patients had, up to this point, been on the clinic waiting list for anywhere between two and six months. Within the leaflet the clinical use of questionnaires was elaborated as a routine feature of the assessment of patients’ problems and evaluation of their progress. Patients were asked to complete and return the three measures if they wished to ‘opt-in’ to the service following which an initial (screening) assessment appointment would be forwarded within four weeks. Patients were informed in the standard leaflet that failure to make contact with the service within two weeks would result in discharge on the assumption that the service was no longer required.
On this basis, all thirty-two patients opted in to the service and were forwarded screening appointments together with a repeat batch of measures which they were requested to fill in on the day of their appointment. Within the appointment letter, it was explained that this repeat administration would aid evaluation of the pattern of their symptoms and problems across time. Following a screening appointment all were assessed as suitable for and allocated to 4-session reformulatory CAT as a first treatment, preliminary to any subsequent therapy needs. Limitations of time and resource alluded to above led to the allocation of the first ten consecutive patients to the PSDR condition and a remaining twenty-two consecutive patients to the SDR condition. In essence a flexible, albeit time-limited, treatment contract was made explicit with each patient whereby four weekly 45-minute sessions would precede a 12-week follow-up for the purpose of evaluating progress and any requirement for further therapy.

The objectives of the screening appointment were to elicit a full description of the parameters and impact of Target Problems (TPs), initiate a therapeutic alliance, establish mutual expectations concerning the nature of the treatment being offered, and exclude patients for whom psychological treatment might be inappropriate. The only exclusion criteria adopted were wholly founded on clinical judgement and followed on Ryle’s (1990) recommended contraindications including transient adjustment reaction to normal life events, psychotic symptoms, severe substance abuse, and active suicidal intent.
2.4 PATIENT PROFILE

2.4.1 PSDR Cohort

The sample of patients in the PSDR cohort comprised ten consecutive referrals to the psychological clinic, five of whom were women. The mean age was 33.4 years (S.D. = 9.29) with a range from 23 to 48 years. All ten patients completed the PSDR intervention.

Table 2.4.1.1 details the frequencies with which patients reached primary diagnostic criteria for psychiatric disorders based on retrospective application of DSM-IV classifications from casenotes.

Table 2.4.1.1: Primary DSM-IV Classifications and Frequencies for the PSDR Cohort (N= 10)

<table>
<thead>
<tr>
<th>Primary Diagnostic Classification</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Panic Disorder with Agoraphobia</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>

No patient had any previous history of psychiatric disorder or psychological problem, nor had any patient had previous contact with mental health services. All patients were in receipt of psychotropic medication during the course of therapy but none had begun or substantially changed psychotropic medication in the three months prior to assessment.
With regard to marital status, 5 patients were married; 3 single; and 2 divorced. The occupational profile of patients reflected full-time employment in the case of 5; 2 patients were full-time housewives; 1 patient was in full-time education and 2 were unemployed.

2.4.2 SDR Cohort

The second and larger SDR cohort comprised twenty-two consecutive referrals to the psychological clinic: 8 men and 14 women. The mean age of patients in this sample was 41.8 years (S.D. = 13.88) with a range from 20 to 70 years. All twenty-two patients completed the SDR intervention.

Psychiatric classification on the basis of retrospective application of DSM-IV diagnostic criteria confirmed a primary disorder profile as detailed in Table 2.4.2.1

Table 2.4.2.1: Primary DSM-IV Classifications and Frequencies for the SDR Cohort (N= 22)

<table>
<thead>
<tr>
<th>Primary Diagnostic Classification</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder</td>
<td>5</td>
<td>22.7%</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>6</td>
<td>27.3%</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>3</td>
<td>13.6%</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>3</td>
<td>13.6%</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Panic Disorder without Agoraphobia</td>
<td>1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Panic Disorder with Agoraphobia</td>
<td>2</td>
<td>9.1%</td>
</tr>
<tr>
<td>Bulimia</td>
<td>1</td>
<td>4.5%</td>
</tr>
</tbody>
</table>
Of the 22 patients, none had a previous history of psychological or psychiatric complaint and no patient had ever received any form of psychological treatment previously. As in the case of the PSDR cohort all patients had been placed on some form of psychotropic medication prior to assessment but none had commenced or substantially changed medication in the previous three months.

With respect to marital status, 17 of this patient sample were married, 1 divorced, 3 single and 1 cohabiting. In terms of occupation, eleven patients were in full-time employment; six were retired; four were full-time housewives, and one was unemployed.

2.5 THERAPIST PROFILE

All thirty-two patients within the two cohorts were assessed and treated by the author. At the initiation of the study the author possessed three year’s post-qualification experience as a clinical psychologist and had half-completed basic accreditation training for practitioner status in CAT. Pre-qualification training in clinical psychology had been predominantly cognitive-behavioural in orientation.

2.6 RESEARCH DESIGN

The randomised controlled trial (RCT) has long been hailed as the ‘gold standard’ and *sine qua non* of clinical research. Because of its unrivalled power to sustain strong causal inference, the RCT is generally considered the most persuasive form of evidence concerning the effectiveness of a clinical intervention. However, Aveline, Shapiro, Parry and Freeman (1995) have highlighted countervailing arguments
suggesting that the RCT on its own may be an insufficient or misleading basis for evaluating psychotherapy in practice and within service delivery systems. These arguments hinge on the prohibitive resource costs and technical difficulties of running an RCT, the ungeneralisability of RCT findings to clinical practice, and their lack of informativeness concerning the mechanisms of therapeutic change.

A number of leading researchers have advocated a psychotherapy research strategy combining RCTs with other modes of investigation (Aveline et al., 1995; Parry and Roth, 1997; Salkovskis, 1995). In the ‘hourglass’ metaphor advanced by Salkovskis (1995), novel forms of service delivery or experimental clinical techniques are likely to be tested through initial small-scale clinical studies or case series evaluations, represented by the top wider portion of the hourglass, in which rigorous control and strong causal inference are relaxed. The intermediate, narrow stem of the hourglass involves RCTs whose objective is to confirm or disconfirm the promise of initial clinical studies in a more rigorous and definitive fashion and establish whether or not a treatment is efficacious. The final broader portion of the hourglass tests the generalisability of RCT findings to everyday clinical practice in service settings through larger-scale field trials of clinical effectiveness.

The present research represents one such initial small-scale study exploring two versions of an as yet unevaluated clinical approach, namely four-session reformulatory CAT. This early-phase exploratory study by its very nature lacks the statistical power and level of randomisation necessary to make strong causal inferences concerning treatment effects. By design, the study is, however, equipped to contribute towards an
examination of the potential value and feasibility of using the approach as a preliminary to further research developments, such as an RCT and larger-scale naturalistic field trial.

The present research represents a ‘naturally-occurring’ descriptive study conducted and constrained in the context of routine N.H.S. service conditions with limited time, resource and administrative assistance. Moreover the study is based on minimal deviation both from the succession of G.P. referrals to psychological clinics operated by the author, and from the author’s traditional brief therapy orientation as practised in primary care settings. In essence the study constitutes a patient series with repeated measures design in which the psychotherapeutic outcomes and impact of two variations of 4-session reformulatory CAT dismantled from the full therapeutic protocol are evaluated.

A feature of the present design lies in its ecological fit with and utilisation of the audit and service evaluation framework in operation across the Clinical Psychology Department at which the author is employed. The obvious advantages of ‘piggy-backing’ a naturalistic outcome study onto an existing routine clinical audit and evaluation framework are that the means of collecting change data become highly cost-efficient while at the same time enabling direct comparison with service norms and the generation of clinically meaningful studies of treatments-as-delivered. The adoption of existing service outcome measures in the present study was rendered all the more attractive for future comparability by the employment of those same
measures in a number of previous reported evaluations of CAT (e.g., Ryle, Sharon and Savorin, 1992; Denman, 1995).

As can be determined from Figure 2.7.1 below, in common with all referrals to the host Psychology Department, the thirty-two patients in the present study completed a core battery of nomothetic evaluation and outcome measures. The schedule of time-points according to which mental health status was measured spanned a period of twenty weeks: firstly, on opting in to the service; four weeks later on the day of the screening appointment; two weeks after session four; and on the day of the follow-up session twelve weeks later. The time interval between opt-in and screening in effect constituted a waiting list condition in the study. With the exception of the opt-in (i.e. waiting list) evaluation, this schedule mirrored the evaluation framework employed at the author’s Department in relation to administration of the core battery at assessment, termination and three-month follow-up. In addition to the above, an individualised Personal Questionnaire, rating improvement in Target Problems, was completed by each patient at the beginning and end of the follow-up interval whilst a process measure of the impact of sessions was also completed two weeks after Session four.

For reasons concerned with the scope and resource limitations of the study, no attempt was made to introduce no-treatment or comparison-treatment conditions and the results of the study will therefore be explicitly evaluated in the light of such methodological constraints.
2.7 DEPENDENT MEASURES

The outcome measures selected for inclusion in the study are amongst the most valid and reliable in the field. The three standardised measures described below have reflected an increasing consensus on the desiderata of a core outcome battery for adoption nationwide (eg Parry 1992; Firth-Cozens, 1993). Moreover, of equal importance to the principal aim of this study, they will in the future allow a level of comparability both in general terms with local servicewide norms and more specifically in relation to previously reported CAT evaluation studies. A fourth outcome measure in the form of a Personal Questionnaire relating to identified individual Taret Problems was incorporated in order to achieve some idiographic balance in the domains of outcome evaluated. Lastly, although the primary purpose of this pilot study was an outcome evaluation, a sessional process measure was also included to enable some determination of its helpful or hindering impacts.

2.7.1 Symptom Checklist-90R

The Symptom Checklist-90R (SCL-90R; Derogatis, Lipman and Covi, 1973), the utility of which has been repeatedly recommended in the psychotherapy outcome research literature (Beutler and Crago, 1983), was employed as an overall measure of patient symptomatology. This measure comprises 90 self-report items covering nine domains: somatisation (perceptions of bodily dysfunction), Obsessive-Compulsive (thoughts, impulses and actions which are unremitting and unwanted), Interpersonal Sensitivity (perceptions of personal inadequacy and inferiority), Depression (manifestations of clinical depression), Anxiety (signs and symptomatology of manifest clinical anxiety), Hostility (thoughts, feelings and actions of the state of anger), Phobic Anxiety (feelings of fear in response to a specific person, place or
situation), Paranoid Ideation (disordered thinking and delusions), and Psychoticism (first rank symptomatology of schizophrenia). Each item on the SCL-90R is rated on a 5-point scale of distress (0 - 4), ranging from 'not at all' to 'extremely'. In addition to the nine primary symptom dimensions the measure is also scored and interpreted in terms of three indices of global distress: the Global Severity Index (GSI), combining the number of symptoms and the intensity of disturbance; the Positive Symptoms Distress Index (PSDI), which is a pure intensity measure functioning as a measure of response style; and the Positive Symptom Total (PST) which is simply a count of the symptoms endorsed.

Reliability studies of the SCL (Derogatis, Rickels and Rock, 1976) have shown a high degree of internal consistency in that all item scores correlate well with scales (ranging from .77 to .90). Test-retest reliability measures were obtained from a sample of ninety-four heterogeneous psychiatric outpatients who were assessed during an initial evaluation visit and reassessed one week later, prior to their first therapeutic hour. The majority of test-retest coefficients hovered between .80 and .90 evidencing appropriate levels for measures of symptom constructs.

A range of empirical studies attest to the validity of the SCL-90R (e.g., Derogatis, Rickels and Rock, 1976; Boleloucky and Horvath, 1974). Derogatis et al. (1976) contrasted the SCL-90R with a range of other established multidimensional measures of psychopathology such as the MMPI clinical, content and cluster scales, and the Middlesex Hospital Questionnaire. Results of these studies reflected a high degree of convergent validity for the SCL-90R.
## Figure 2.7.1: Schedule of Psychometric Evaluations

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### Notes:
- **SCL-90R** = Symptoms Checklist-90R
- **IIP** = Inventory of Interpersonal Problems
- **BDI** = Beck Depression Inventory
- **TPRS** = Target Problem Rating Scale
- **SIS** = Sessions Impact Scale
The sensitivity to change of the measure has been established in a variety of clinical and medical contexts (Weissman, Pottenger, Kleber, Williams and Thompson, 1977; Horowitz, Wilner, Kaltreides and Alvarez, 1980; Horowitz, Krupnick, Kaltreider, Wilner, Leong and Marmar, 1981). For example, Wissman, Slobets, Prusoff, Mezritz and Howard (1976) reported on clinical depression among methadone addicts and found the SCL-90R to be highly sensitive to clinical manifestations.

In a more general evaluative review of the clinical and psychometric characteristics of the SCL-90R, Edwards, Yarvis, Mueller, Zingale and Vagman (1978) had very positive conclusions regarding its properties and provided a favourable assessment of its use in community mental health settings. The American Group Psychotherapy Association found the SCL-90R sufficiently sensitive and reliable to include it in their core battery recommendations (Dies and Mackenzie, 1983) and Beutler and Crago (1983) independently evaluated the SCL-90R favourably as a psychotherapy outcome measure. A copy of the SCL-90R is included in Appendix 2.7.1.1.

2.7.2 Inventory of Interpersonal Problems

The Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Urenio and Villasenor, 1988) consists of 127 self-report items measuring patient difficulties in interpersonal functioning. Such difficulties can be experienced as things patients find 'too hard' to do (eg join in on groups) or things that they do 'too much' (eg getting irritated in the company of others). Based on a 5-point response scale from 'not at all' (0) to 'extremely' (4), the IIP comprises 78 question items with the stem 'It is hard for me to .....' and 49 items with the stem 'These are things I do too much'. The
measure is scored and interpreted as a total score and in terms of a range of dimensions of interpersonal distress.

Like the SCL-90R, the IIP has been increasingly recommended as a measure of outcome in psychotherapy research (e.g., Mohr, Beutler, Engle, Shoham-Solomon, Bergan, Koszniak and Yost, 1990; Muran, Segal, Wallner, Samstag and Crawford 1994). The centrality of interpersonal issues in psychodynamic, interpersonal and, increasingly, cognitive-behavioural therapies too (e.g., Safran and Segal, 1990) lends strong support for the adequate measurement of this domain. The first studies reporting the development of the IIP by Horowitz and has collaborators extracted six subscales from factor analyses of a sample of patient responses at an initial and second baseline: Hard to be Assertive, Hard to be Sociable, Too Responsible, Too Controlling, Hard to be submissive, and Hard to be Intimate. Test-retest reliability ranged between 0.82 and 0.90 on the 6 subscales, based on a sample of 103 psychiatric outpatients. Reported validations of the measure by Horowitz et al. (1988) included repeated assessments of 28 patients completing 20 sessions of brief dynamic psychotherapy in which statistically significant score reductions were obtained and concurrent validation in relation to the SCL-90R.

However these initial studies were criticised by Barkham, Hardy and Startup (1994) on the grounds of three methodological shortcomings. First the sample (N=103) used by Horowitz et al. was smaller than the number of items comprising the IIP. Second, they used an eigenvalue >3 for selecting factors in the absence of any rationale,
leading to the possibility of selecting too few factors. And third, the sample itself contained a strong gender bias with 86 per cent being women.

In a UK study addressing these shortcomings, Barkham et al. (1994) found a somewhat different factor structure for the IIP using a larger sample, a non-arbitrary cut-off for eliciting factors, and equal proportions of men and women. The eight factors extracted and their subscale derivatives were therefore employed in the present study and comprise: Too Responsible (perceptions of caring for others at the expense of self), Too Aggressive (perceptions of losing temper, fighting and irritation with others), Too Open (sharing self with others in a damaging way), Too Dependent (feelings of not being an autonomous person), Hard to be Supportive (difficulties with attending to other people’s needs), Hard to be Physically Close (difficulties with showing affection to appropriate people), Hard to be Assertive (experiencing difficulties with saying no to people), and Hard to be Sociable (difficulties with making friends and joining in on groups. A copy of the IIP is included in Appendix 2.7.2.1

2.7.3 Beck Depression Inventory

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock and Erbaugh, 1961) was employed in the present study as a measure of depressive symptomatology. The BDI has been recommended as the appropriate single-target dimensional measure for depression in psychotherapy outcome research (Beutler and Crago, 1983). The measure is a 21-item self-report instrument and its items cover mood, pessimism, sense of failure, lack of satisfaction, guilt, sense of punishment, self-hate, self-accusation, self-punitive wishes, crying spells, irritability, social withdrawal,
indecisiveness, body image, work inhibition, sleep disturbance, fatigue, appetite, weight, somatic preoccupation and libido. Each item has four or five verbally anchored response options with scores ranging from 0 to 3 for each option. The score for the BDI is the sum of all individual item scores.

A comprehensive review of the literature on the BDI indicating moderate to good levels of reliability and validity has been published by Beck, Steer and Gorbin (1988). Reliability studies have shown a high degree of internal consistency, in that all scores correlate highly with total score, and high split-half reliability has invariably been found. Test-retest reliability has been studied indirectly (Beck et al., 1961) and directly, test-retest correlations having ranged from 0.48 to 0.90 with intervals varying from a few hours to four months (Beck et al., 1988).

Validation studies have indicated that the BDI correlates well with clinicians' ratings of severity of depression and with other depression scales. Beck et al. (1961), on the basis of 226 hospital outpatients and admission, and 183 patients in a replication group, tested the BDI against independent psychiatric diagnoses made by four psychiatrists. Their agreement with the scale was 56 per cent; and agreement within one degree of specificity was achieved in 97 per cent of cases. The authors reported that the scale was able to discriminate between depth-of-depression categories based on clinical ratings for both original and replication groups, the correlations ranging from 0.59 to 0.68. The BDI correlates moderately to highly with the Hamilton Rating Scale and a correlation of 0.75 has been obtained in respect of the Minnesota Multiphasic Personality Inventory (MMPI) (Beck et al., 1988).
A review of the literature from 1961 to 1986 by Beck et al. (1988) reported that the concurrent validates of the BDI with respect to comparisons with clinical ratings and the Hamilton Scale for Depression were high. The mean correlations with the Hamilton Scale and clinical ratings for psychiatric patients were over 0.70. The respective mean correlations for non-psychiatric patients were 0.74 and 0.60. Validation studies have also suggested that the BDI represents one underlying general syndrome of depression, comprising three highly intercorrelated factors: negative attitudes to self, performance impairment and somatic disturbance (Beck et al, 1988). A copy of the BDI is included in Appendix 2.7.3.1.

2.7.4 Target Problem Rating Scale

In addition to the above three standardised measures, one idiographic measure of outcome was incorporated into the study. The Target Problem Rating Scales (TPRS), completed at the beginning and end of the follow-up interval, measures self-reported distress arising from the initial presenting complaints elicited from patients at the screening appointment. It is essentially an adapted variation of Shapiro’s Personal Questionnaire method. Each of the Target Problems was recapitulated by the author in the form of a brief descriptive phrase and patients were asked to rate the extent to which each Target Problem had troubled them during the previous week on a five-point scale, ranging from 0 (not at all) to 4 (extremely). A copy of the Target Problem Rating Scale is included in Appendix 2.7.4.1.
In addition to measures of outcome, this study employed one process measure, the Sessions Impact Scale, (SIS; Elliott and Wexler, 1994) in order to assess the short-term subjective effects on patients of the CAT interventions under investigation. The SIS, a self-report measure, includes 16 items that characterise impacts. Each item includes a label and a short paragraph description which patients are asked to rate on a 5-point scale, anchored as follows: 1 = not at all; 2 = slightly; 3 = somewhat; 4 = pretty much; and 5 = very much. The labels are: 1. realised something new about myself; 2. realised something new about someone else; 3. more aware of or clearer about feelings and experiences; 4. definitions of problems for me to work on; 5. progress toward knowing what to do about problems; 6. feel my therapist understands me; 7. feel supported or encouraged; 8. feel relieved, more comfortable; 9. feel more involved in therapy or inclined to work harder; 10. feel closer to my therapist; 11. more bothered by unpleasant thoughts or more likely to push them away; 12. too much pressure or not enough directions from therapist; 13. feel my therapist doesn’t understand me; 14. feel attacked or that my therapist doesn’t care; 15. confused or distracted, and 16. impatient or doubting value of therapy. The text that accompanies these labels is presented in Appendix 2.7.5.1.

For practical reasons patients were asked to complete the measure once following Session Four in the study and not following every session as intended in the original purpose of the SIS. Item 9 and a further open-ended item 17 were omitted from the study on similar grounds.
Elliott and Wexler (1994) derived the SIS from earlier cluster- and content-analytic studies of patients’ open-ended descriptions of significant therapy events (Elliott, 1985; Elliott, James, Reinschuessal, Cislo, and Sack, 1985). In these studies, therapeutic impacts were found to fall into two broad groups: helpful and hindering. In addition, two kinds of helpful impacts were found: (a) task impacts, in which patients experienced progress on their presenting problems (eg insight into self or problem solution) and (b) relationship impacts, in which patients reported some form of positive interpersonal contact with the therapist or counsellor (eg feeling supported or closer to the therapist). In contrast to these two varieties of helpful impacts, hindering impacts involve the patients’ negative experiences, such as feeling misunderstood or impatience with the lack of progress.

Elliott and Wexler (1994) report psychometric data on the SIS based on a study of 48 depressed patients seen for an average of 16 sessions of process-experiential therapy. Factor analyses of patient data in this study were consistent with the expected hierarchical structure of the measure suggested by the original cluster-analytic research (Helpful Impacts and Hindering Impacts, with Helpful Impacts divided into Task Impacts and Relationship Impacts subscales). Interim reliability was an adequate .67 for the Hindering Impacts factor and a high .84 and .91 for the Task Impacts and Relationship Impacts respectively.

Support for the validity of the SIS was presented on convergent, discriminant and construct grounds. In comparison with Stiles’ (1980) Session Evaluation Questionnaire (SEQ) (a widely used semantic differential measure geared toward
measuring the evaluative meanings of session impact) the SIS converged strongly with client Depth and Positivity while at the same time discriminating equally discerningly with respect to client post-session Arousal on the SEQ. The hypothesised factor structures were supported by the data in keeping with the original cluster-analytic work (Elliott, 1985) as well as with the model of helpful impacts as divided into task and relationship types. Moreover the pattern of SIS patient ratings obtained was consistent with the process-experiential treatment model.

In a study designed to replicate and extend previous findings, Stiles Reynolds, Hardy, Rees, Barkham and Shapiro (1994) investigated the structure of the SIS and the SEQ in a large British sample of (N=218 clients) and assessed the concurrent validity of scales derived from each measure by examining the scales’ relations with each other and with single-item global measures of session goodness and helpfulness. In contrast to Elliott and Wexler (1994), assessment of the dimensional structure of the SIS produced five SIS dimensions: three helpful impacts factors, which Stiles et al. (1994) called Understanding, Problem Solving, and Relationship, and two negatively tinged factors, which were called Unwanted Thoughts and Hindering Impacts. Indexes of the five impact dimensions were based on these factor-analytic results and calculated as the means of the items designated under each. The more differentiated dimensional structure and scoring of Stile’s et al. (1994) was adopted in the present research study.

Regarding psychometric status, internal consistency was adequate to good for all multiple item indexes (coefficient alpha = .78 to .90). High intercorrelations among
most of the SIS and SEQ indexes suggested that these impact measures are heavily slanted toward measuring clients' evaluations of their sessions rather than toward other, more descriptive attributes. The SIS's positive impacts indexes (Understanding, Problem Solving, and Relationships) were moderately to strongly correlated with the SEQ Depth index (.44 to .72) which suggested that the SIS evaluative items concern the potency-value as part of session evaluation. Moderate to strong correlations were also found between the SIS's positive indexes and two single-item global evaluation indexes, Good-Bad and Helpful-Hindering (.45 to .70). The SIS single-item Unwanted Thoughts index showed only modest correlations with the other indexes and appeared to be primarily descriptive rather than evaluative. The last of the SIS indexes, Hindering Impacts, was endorsed only infrequently suggesting that its utility might be less as a continuous scale and more as a flag for distinctively difficult sessions or problematic therapeutic relationships.

2.8 PROCEDURE

The present study represents an initial evaluation of the potential value of four 45-minute sessions of essentially reformulatory assessment within the CAT framework. Sessions were conducted at weekly frequency with the exception of occasions on which illness or unforeseen circumstance required deviation. The first four sessions were devoted to the gathering of history and to the joint task of reformulation. Within each of the two outcome trials (PSDR and SDR treatment conditions) the author sought to deliver sessions with broad consistency for all patients in accordance with the semi-structured and unstructured interviewing style advocated in Ryle (1980,
An account of the delivery of sessions is described below while a full case study is contained in Chapter 4.

### 2.8.1 Session 1

Typically Session One and the first half of Session Two were devoted to eliciting a full life history and detailed account of the patient's problems while at the same time noting interactional style and their ability to explore any comments or provisional reformulations offered. Most of the initiative and selection of topics was left to the patient while the personal meanings accorded to reported experience were prompted and elucidated. Remembered and elicited or apparently avoided emotional responses were also noted. As the history unfolded the author internally scanned for events likely to have made particular adjustments difficult or particular solutions necessary for survival and an attempt was made to explore what conclusions that patient may have drawn from his experience about himself and in terms of his values, assumptions and strategies.

After clarifying a full family tree, the nature and significance of earliest recollections of life were explored. The patient was asked for an adjectival pen-picture of parents or significant care-givers and the impact of important relationships and events within and outwith the family context were elicited in a sequence that loosely approached the typical developmental life cycle: birth and the pre-school years (including family anecdotes and the patient's own mental snap-shots); the school years (including starting school, school work, relationships with teacher and peers, changes, moves, losses, and pets); puberty and adolescence (including the beginnings of sexual awareness, first sexual experiences, misuse of drugs or food, and any criminal
activity); and adulthood (including jobs, partners, children, deaths, moves, unemployment and food or substance misuse etc).

Additionally, the nature and impact on the patient’s life of any medical history (in terms of illnesses, accidents, disabilities, operations etc) was ascertained, as was the significance of any other important facets to the patient’s life, such as religion or political beliefs etc. Above all the objective of the author was to generate sufficient historical and ‘in-session’ information from which to identify and describe the repetitively used harmful or restrictive procedures for self-care and control and for relating to others operative in the patient’s life.

Towards the end of the first session the main themes emerging were recapitulated by the author to allow for confirmation. At this point the relevance of self-monitoring was introduced and diary-keeping homework negotiated in respect of intermittent or variable moods or psychologically provoked symptoms. It was emphasised to the patient that self-monitoring needed to note (i) the occurrence of a symptom or mood change, (ii) the context in which it occurs and (iii) the preceding and accompanying thoughts or images.

Lastly, the Psychotherapy File was produced and patients were asked to read it at the level of an aid to discussion in preparation for Session Two while marking any descriptions in it that they recognised as applying to themselves. A copy of the Psychotherapy File is included in Appendix 2.8.1
2.8.2 Sessions 2 and 3

The first half of Session 2 focused on completion of the exploratory history-taking initiated in Session One and a review of the outcome of the negotiated self-monitoring exercise. Earlier perusal of baseline questionnaires returned at the previous session enabled noting and exploration of symptoms not already discussed. As much clinical interest was paid to any identifiable patterns of thought, action and feelings which emerged as to the way in which the patient carried out or failed to carry out the task. Response to the task assignment was often seen to elucidate aspects of patient’s interpersonal procedures which in itself became another source of understanding for the purpose of reformulation.

However the greater part of Session 2 and all of Session 3 were devoted to exploration of the patient’s responses to the Psychotherapy File with the aim of identifying procedural sequences and their evolution. The aim was not to use the Psychotherapy File mechanically but to make up a Target Problem Procedure list with the patient in as individual a way as possible, drawing upon the patient’s own language and metaphors. Patients were asked to illustrate why they felt a particular description applied to them and to recruit several recollections of the procedures, particularly in relation to the earliest recalled source. In cases where patients found themselves reflected in many descriptions, they were encouraged to consider degrees of importance and to prioritise a shortlist of four or five. In all cases the co-operation of the patient was enlisted in sketching out provisional sequential diagrams of identified procedures using pen and paper as they unfolded in discussion.
2.8.3 Session 4

Based upon clinical interviewing, patients’ self-monitoring, transference and counter-transference enactments in the consulting room, baseline psychometric data, and the patient’s use of the Psychotherapy File, Prose Reformulations and Sequential Diagrammatic Reformulations were prepared and then duly presented, read out, and discussed with patients in Session Four. As noted earlier, the first 10 consecutive patients received both a Prose Reformulation and a Sequential Diagrammatic Reformulation while a subsequent 22 consecutive patients received the Sequential Diagrammatic Reformulation alone.

The Prose Reformulation contained two parts: the letter or description and the listing of Target Problems and Target Problem Procedures. The letter sought to give an account of the patient’s key past experiences, describe how these were coped with and demonstrate how present problems were maintained by the procedures developed during the patient’s past. The account described both the patient’s sense of his relationship with himself and his way of relating to others. The emotional significance of events was clearly and directly named and the individual’s inability in the past to acknowledge fully such feelings was also indicated, where appropriate.

The prose account was followed by the list of Target Problems and Target Problem Procedures which had been agreed with the patient, together with suggested exits or aims for each of these. This list served to underline the fact that therapy is concerned with the modification of recurrent, repetitively used, harmful procedures, and that all subsequent effort at change, including during the follow-up period, should be directed
at learning to recognise and revise these. Where Target Problem Procedures had been
in operation during the therapy relationship already this was described or alluded to.
All 10 Prose Reformulations are reproduced in Appendix 2.8.3.1.

All thirty-two patients in the series were presented with a Sequential Diagrammatic
Reformulation representing the manner whereby procedures were generated,
connected and maintained. The construction of the SDR was based on elicited
history, on the identification and description of manifest procedures and on the
elaboration of a core state object relations model. Much of the diagram had already
been drafted with the collaboration of the patient during Sessions 2 and 3. The core
of the SDR listed the patient’s repertoire of reciprocal roles which both generated and
were maintained by a range of maladaptive survival procedures. Reflecting the
unresolved residue of early experience the core often included elements of unmet
needs, sadness, and destructive feelings which related to deprivations or adversities
experienced at childhood when the individual was unable to control or emotionally
process the situation, and also parentally derived critical or abusive elements. The
core rules and expectations about relationships as represented in the SDR derived
from those originally developed by the immature child and included often quite
distorted or exaggerated patterns of both negative and positive roles. The selection of
procedural loops emanating from the core object relations model was then based on
the most economical version possible of the patient’s dominant self management,
reciprocal role, defensive and symptomatic procedures. Thirty-one SDRs are
reproduced in Appendix 2.8.3.2. One SDR was lost from the study.
In all cases patient reaction to both the presentation and content of the reformulation devices was explored. Potential aims of exits were discussed in relation to each TPP and patients were encouraged to view their TPP listing as the focus for the subsequent 12-week follow-up interval, in anticipation of the fifth appointment. Self-monitoring using a diary, in combination with regular recourse to the reformulation devices, was specifically advocated as an aid to learning to recognise and revise TPPs.

2.8.4 Follow-Up Session

The follow-up session continued with a semi-structured format. Each of the TPs were discussed in turn with detailed examples of any changes elicited. Moreover the details of the TPPs and reformulation devices were enquired after both to see how far they were accurately remembered and/or still being consulted, and also to seek evidence as to whether they had been revised. Any new important life event arising since Session 4 was also discussed. On the basis of this interview the author rated patient change and also asked the patient to evaluate overall change in relation to both the TPs and TPPs. General comments on the intervention were invited, and patients were asked if they felt they needed further treatment. In accord with the consensus between author and patient, patients were then discharged, followed-up at a subsequent interview, or treated with a further contract of therapy sessions, as appropriate.
CHAPTER 3

RESULTS
3.1 INTRODUCTION

3.1.1 Levels of Statistical Analysis

Within the context of a service-based treatment research project, the body of data generated in the present study proved to be substantial. Repeated measure data on some thirty nine dependent variables were collated, processed and analysed for all thirty two patients using the Statistical Package for Social Sciences (SPSS) for Windows Version 6.1. In all, responses from 448 self-report inventories were entered into the study (A full raw data listing is reproduced in Appendix 3.1.1).

The strategy for analysis of the data with regard to the central aim of the study was informed by a number of related considerations. The conduct and evaluation of the interventions under conditions of routine on-going service provision meant that the sophistication of the research design was limited to a patient series, albeit with a repeated measures control feature. Moreover, restrictions in time and resource resulted in selection of small sample sizes despite the obvious negative implications for statistical power. Whilst such a naturalistic patient series design has clear ecological fit with the audit and evaluation of a therapy service as delivered, it allows only limited determination of cause-and-effect relationships between variables of interest. The first level of analysis, therefore, addresses the levels of psychological distress and change at each observation interval in the self-reports of patients, without regard to the statistical significance of differences in levels at each interval. Descriptive statistics in the form of measures of central tendency and dispersion were derived for all outcome variables.
The second major consideration involved the type of inferential statistics to be used on the data. Small sample sizes might traditionally have limited the selection of parametric statistics which could be employed in a reliable manner, particularly in relation to multivariate modelling procedures. However, the balance of the decision in favour of using parametric analyses in this study was weighted by three factors: Firstly, the robustness of multivariate methods against violations of normal distribution has been demonstrated and highlighted in recent years (e.g., Hand and Crowther, 1996); secondly, the design of the study is premised on the use of multiple and repeated measures of outcome; and thirdly, all the outcomes evaluated in the study are measured as continuous dependent variables.

In order to compare means, an analysis of variance (ANOVA) model was applied, with the reformulatory intervention as the independent factor and the various outcome scales as dependent variables. In the case of the entire unsplit 32 patient cohort a series of three repeated measures ANOVAs were carried out on the global scales of the major self-report inventories used in the study. A further repeated measures ANOVA was performed in respect of the two differentiated patient cohorts at the four time points, namely the PSDR and SDR treatment condition groups. A full account of the use of these analyses is contained within the relevant sections of this chapter.

A further level of analysis focused on estimates of association between variables of interest. Parametric Pearson correlation calculations were applied mainly to the relationship between the subjective impact of the reformulatory interventions on
patients and measures of outcome. Correlational analyses were also performed to measure the extent of association between baseline severity and change.

3.1.2 Reliable and Clinically Significant Change

A final consideration concerned the related measurement issues of reliable and clinically significant change. Jacobson et al. (Jacobson and Revenstorf, 1988; Jacobson and Truax, 1991) have achieved considerable prominence in this area and the statistical procedures which they have advocated for evaluating clinically meaningful change were adopted in the present study. Jacobson and Truax (1991) advocate that clinical significance be operationalised as a post-intervention level of functioning which falls outside the range of the dysfunctional population and within the range of the functional or normal reference group. In relation to comparisons with untreated dysfunctional norms, Jacobson and Truax (1991) suggest a somewhat stringent minimum change criterion of two standard deviations in the direction of functionality. Given the untested outcome effectiveness of the abbreviated CAT interventions in the present study it was considered not unreasonable to adopt a less ambitious one standard deviation of functional change on each of the measures of interest as representing clinically meaningful improvement. Estimates of clinically meaningful change on measures were thus calculated for each patient.

In order to enable comparison among the multiple outcome measures used in the study, Post-Termination and Follow-Up means were converted to a common metric in the form of between-subjects effect sizes based on the standard deviation of pre-intervention scores. Cohen (1977) suggests that in the context of psychological
treatment research an effect size of around 0.2 is indicative of a small effect, a value of around 0.5 of a medium effect and a value of around 0.8 of a large effect.

For change to be statistically reliable, a patient’s change must exceed measurement error. Jacobson, Follette and Revenstorf (1984) proposed that the magnitude of change post-intervention should be sufficient to render it improbable at the 95% confidence level that such change is attributable to measurement error. They developed a Reliable Change Index, or RCI (calculated by dividing the absolute magnitude of change by the standard error of measurement), in order to determine whether observed change is greater than the change which would be expected on the basis of the error in the measure. The RCI is essentially a $z$ score from a normal distribution. When the RCI exceeds 1.96 it is unlikely that the magnitude of change could be attributable to an unreliable measuring instrument. In the present study Jacobson et al.’s RCI was calculated for all patients in both cohorts on the basis of the global scale scores for each outcome measure.

Largely on the grounds of manageability, the results from this research are now presented and organised into four sections corresponding to the principal research questions and associated hypotheses underlying the study. Results are presented separately for patients in the respective PSDR and SDR treatment condition cohorts with respect to the Beck Depression Inventory (BDI), Symptom Checklist 90R (SCL 90R), Inventory of Interpersonal Problems (IIP) and the Target Problem Rating Scale (TPRS). The first three measures were completed on four occasions: at Pre-Screening, one month later on the day of Screening, two weeks
Post-Termination, and three months later on the day of Follow-Up. The TPRS was completed at Post-Termination and Follow-Up. Section 3.2 contains full descriptive data on initial baseline clinical dysfunction as measured on the four instruments. The outcome results from these measures are presented in Section 3.3 and, as appropriate to the scheduling of administrations, are broadly formatted into two sub-sections of analyses: statistical change at Post-Termination and Follow-Up; and clinically significant and reliable change at Post-Termination and Follow-Up. Section 3.4 presents results on the relation between severity and psychotherapeutic outcome from the study. The fourth and final results section of the chapter treats the results from the Sessions Impact Scale (SIS), a process measure of the subjective impact of the intervention. The SIS was completed once by patients at Post-Termination.

3.2 SEVERITY OF DISTRESS AND SYMPTOMATOLOGY

3.2.1 Beck Depression Inventory

A total of ten consecutive patients constituted the Prose plus Sequential Diagrammatic Reformulation (PSDR) condition cohort. The mean BDI scores for the PSDR cohort at Pre-Screening and Screening (intake) were 18.20 (S.D. = 8.51; range 8-34) and 17.90 (S.D. = 8.94; range 6-36) respectively. The remaining consecutive twenty two patients formed the SDR condition cohort, with mean BDI scores at Pre-Screening and Screening (intake) reaching 20.77 (S.D. = 12.52; range 2-46) and 17.47 (S.D. = 13.01; range 1-47), respectively.

Tables 3.2.1.1 and 3.2.1.2 below present frequencies and percentages on the BDI at intake for the PSDR and SDR cohorts respectively.
Table 3.2.1.1: Beck Depression Inventory (BDI) Score Frequencies and Percentages for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort at Screening (n= 10)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>1</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>10-18</td>
<td>5</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>19-29</td>
<td>3</td>
<td>30</td>
<td>90</td>
</tr>
<tr>
<td>30-36</td>
<td>1</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3.2.1.2: Beck Depression Inventory (BDI) Score Frequencies and Percentages for the Sequential Diagrammatic Reformulation (SDR) Cohort at Screening (n= 17).

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>5</td>
<td>29.4</td>
<td>29.4</td>
</tr>
<tr>
<td>10-18</td>
<td>6</td>
<td>35.3</td>
<td>64.7</td>
</tr>
<tr>
<td>19-29</td>
<td>3</td>
<td>17.6</td>
<td>82.3</td>
</tr>
<tr>
<td>30-47</td>
<td>3</td>
<td>17.6</td>
<td>100</td>
</tr>
</tbody>
</table>

Based on Beck’s (1987) cut-score classifications the range of BDI scores across the 32 patients overall spanned all four levels: minimal (6 or 22.2%), mild (11 or 40.7%), moderate (6 or 22.2%) and severe (4 or 14.8%). Within the PSDR cohort, the number of patients whose intake BDI scores fell within each of these classifications was 1 (10%), 5 (50%), 3 (30%) and 1 (10%) respectively. The distribution of BDI scores in the SDR cohort was also weighted towards the mild classification (6 or 35.3%) whilst minimal, moderate and
severe scores were obtained in respect of 5 (29.4%), 3 (17.6%) and 3 (17.6%) patients respectively.

3.2.2 Symptom Checklist 90R

All 32 patients in the study completed the revised 90-item Symptom Checklist (SCL 90R) as a postal Pre-Screening opt-in to a Screening (intake) appointment four weeks later. The SCL 90R requires patients to rate the extent to which specific symptoms distress them on an ascending 5-point scale, as follows: 0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; and 4 = extremely. In terms of the best single summary measure within the SCL 90R (Derogatis, 1983), the mean Global Severity Index (GSI) scores for the PSDR cohort at Pre-Screening and Screening were 1.44 (S.D.= 0.66; range 0.61 - 2.59) and 1.41 (S.D.= 0.72; range 0.41 - 3.21), respectively. Mean GSI Pre-Screening and Screening scores for patients in the SDR cohort were 1.29 (S.D.= 0.80, range 0.14 - 3.18) and 1.24 (S.D.= 0.86; range 0.14 - 3.03), respectively.

Tables 3.2.2.1 and 3.2.2.2 below present frequencies and percentages on the GSI at intake for each of the respective cohorts. Based on the above rating scale, GSI scores across the 32 patients overall spanned the range of minimal to severe distress: minimal distress rated from 0 to 0.99 (10 patients or 33.3%); mild distress rated from 1 to 1.99 (14 patients or 46.7%); moderate distress rated from 2 to 2.99 (4 patients or 13.3%); and severe distress rated from 3 to 4 (2 patients or 6.75%). Within the PSDR cohort, the numbers of patients whose GSI scores fell within each of the ascending distress categories were as follows: 1 (10%) in the minimally distressed range; 8 (80%)
Table 3.2.2.1: Symptom Checklist 90R (SCL 90R) Global Severity Index (GSI) Frequencies and Percentages for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort at Screening (N= 10)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0- 0.99</td>
<td>1</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>1.0- 1.99</td>
<td>8</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>2.0- 2.99</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3.0- 4.0</td>
<td>1</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>

in the mildly distressed range; and 1 (10%) in the severely distressed range. No patient in the PSDR cohort scored within the moderately distressed range. The distribution of GSI scores for the SDR cohort was weighted in the minimal (9 patients or 45%) to mild (6 patients or 30%) range, with moderate and severe GSI scores obtaining in the case of 4 patients (or 20%) and 1 patient (or 5%) each, respectively.
3.2.3 Inventory of Interpersonal Problems

All 32 patients completed the 127-item version of the Inventory of Interpersonal Problems (IIP) as a postal Pre-Screening opt-in to a Screening (intake) appointment four weeks later. The IIP requires patients to rate the extent to which specific interpersonal problems distress them on an ascending 5-point scale, as follows: 0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; and 4 = extremely. The mean IIP scores for the PSDR cohort at Pre-Screening and Screening were 1.53 (S.D. = 0.66; range 0.44 - 2.43) and 1.45 (S.D. = 0.76; range 0.33 - 2.32) respectively. Mean full-scale IIP Pre-Screening and Screening scores for patients in the SDR cohort were 1.36 (S.D. = 0.73; range 0.15 - 2.5) and 1.30 (S.D. = 0.83; range 0.14 - 2.7) respectively.

Tables 3.2.3.1 and 3.2.3.2 below present frequencies and percentages on the IIP at intake for each of the respective cohorts. Based on the above rating scale, mean full-scale IIP ratings across the 32 patients overall spanned the range of minimal to moderate self-reported interpersonal distress: minimal distress rated from 0 to 0.99 (11 patients or 39%); mild distress rated from 1 to 1.99 (8 patients or 28.6%); and moderate distress rated from 2 to 2.99 (9 patients or 32%). No patient rated a mean IIP score in the severely interpersonally distressed range at intake.

As regards the PSDR cohort at intake, the numbers of patients whose mean IIP scores fell within each of the ascending distress categories were as follows: 3 (37.5%) in the minimally distressed range; 2 (25%) in the mildly distressed range; and 3 (37.5%) in the moderately distressed range. The distribution of mean IIP scores for the SDR
Table 3.2.3.1: Inventory of Interpersonal Problems (IIP) Full-Scale Score Frequencies and Percentages for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort at Screening (n=8)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-0.99</td>
<td>3</td>
<td>37.5</td>
<td>37.5</td>
</tr>
<tr>
<td>1.0-1.99</td>
<td>2</td>
<td>25.0</td>
<td>62.5</td>
</tr>
<tr>
<td>2.0-2.99</td>
<td>3</td>
<td>37.5</td>
<td>100</td>
</tr>
<tr>
<td>3.0-4.0</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 3.2.3.2: Inventory of Interpersonal Problems (IIP) Full-Scale Score Frequencies and Percentages for the Sequential Diagrammatic Reformulation (SDR) Cohort at Screening (n=20)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-0.99</td>
<td>8</td>
<td>40.0</td>
<td>40.0</td>
</tr>
<tr>
<td>1.0-1.99</td>
<td>6</td>
<td>30.0</td>
<td>70.0</td>
</tr>
<tr>
<td>2.0-2.99</td>
<td>6</td>
<td>30.0</td>
<td>100</td>
</tr>
<tr>
<td>3.0-4.00</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

cohort was weighted in the minimally distressed range (8 patients or 40%), whilst respective mild and moderate IIP mean scores obtained in the case of 6 patients each.

3.2.4 Target Problem Rating Scale

One idiographic outcome measure in the form of the Target Problem Rating Scale (TPRS) was completed by all patients in both the PSDR and SDR treatment cohorts at Post-Termination (two weeks after Session 4) and at Follow-Up (twelve weeks after Session 4). The TPRS required patients to estimate the extent to which each of a
maximum of four identified Target Problems had troubled them during the previous week on an ascending 5-point scale, calibrated as follows: 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit), and 4 (extremely). The mean TPRS ratings for the PSDR and SDR cohorts at Post-Termination were 1.76 (S.D. = 1.11; range 0-3.5) and 2.33 (S.D. = .76; range 1.0-3.5), respectively.

Tables 3.2.4.1 and 3.2.4.2 below present frequencies and percentages on mean TPRS ratings at Post-Termination for the PSDR and SDR cohorts respectively. Based on the above calibration, mean TPRS ratings across the entire 32-patient sample overall at Post-Termination spanned the range of self-reported distress: minimal distress rated from 0 to 0.99 (2 patients or 6.7%); mild distress rated from 1 to 1.99 (9 patients or 30%); moderate distress rated from 2 to 2.99 (12 patients or 40%); and severe distress rated from 3 to 4 (7 patients or 23.3%). Within the PSDR cohort at Post-Termination, the number of patients whose TPRS ratings fell within each of these ascending severity categories was as follows: 2 (22.2%) in the minimally distressed range; 3 (33.3%) in the mildly distressed range; 3 (33.3%) in the moderately distressed range; and 1 (11.1%) in the severely distressed range. The distribution of mean problem ratings for the SDR cohort was weighted in the moderate range (9 patients or 43%) whilst respective mild and severe problem ratings were both reported by 6 patients each. No patient in the SDR cohort reported a mean target problem rating in the minimal range.
Table 3.2.4.1: Target Problem Rating Scale (TPRS) Mean Frequencies and Percentages for the PSDR Cohort at Post-Termination (n= 9)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-0.99</td>
<td>2</td>
<td>22.2</td>
<td>22.2</td>
</tr>
<tr>
<td>1.0-1.99</td>
<td>3</td>
<td>33.3</td>
<td>55.5</td>
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<td>2.0-2.99</td>
<td>3</td>
<td>33.3</td>
<td>88.8</td>
</tr>
<tr>
<td>3.0-3.99</td>
<td>1</td>
<td>11.1</td>
<td>100</td>
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Table 3.2.4.2: Target Problem Rating Scale (TPRS) Mean Frequencies and Percentages for the SDR Cohort at Post-Termination (n= 21)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-0.99</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1.0-1.99</td>
<td>6</td>
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<td>28.57</td>
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<tr>
<td>2.0-2.99</td>
<td>9</td>
<td>42.86</td>
<td>71.73</td>
</tr>
<tr>
<td>3.0-3.99</td>
<td>6</td>
<td>28.57</td>
<td>100</td>
</tr>
</tbody>
</table>

3.3 HYPOTHESES RELATING TO PSYCHOTHERAPEUTIC OUTCOME

Two of the research questions and associated hypotheses underlying this study related directly to psychotherapeutic outcome:

Hypothesis 1:

Psychotherapeutic outcomes on the Beck Depression Inventory (BDI), Symptom Checklist 90R, Inventory of Interpersonal Problems (IIP) and Target Problem Rating Scale (TPRS) will show measurable improvement when assessed two weeks after the fourth session (i.e. Post-Termination)
Hypothesis 2:

Measurable improvements in psychotherapeutic outcome at Post-Termination on the above instruments will be maintained or extended at 3-month re-assessment (i.e. Follow-Up)

In order to test these two hypotheses, analyses of patient distress were conducted at two levels: statistical change and clinically significant outcome.

3.3.1 Statistical Change

Tables 3.3.1.1 to 3.3.1.3 present mean and standard deviation scores at Screening, Post-Termination and Follow-Up on the BDI, SCL-90R and IIP for PSDR, SDR and Overall patients. Calculations are based on the summary or global indexes for the

| Table 3.3.1.1: Beck Depression Inventory (BDI) Means and Standard Deviations for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Screening, Post-Termination and Follow-Up |
|-----------------|-----------------|-----------------|-----------------|
|                 | Screening       |                 |                 |
|                 | M   | SD  | n   | M   | SD  | n   | M   | SD  | n   |
| **PSDR Cohort** | 17.90 | 8.94 | 10  | 6.88 | 4.67 | 8   | 7.3  | 6.36 | 10  |
| **SDR Cohort**  | 17.47 | 13.01 | 17  | 16.18 | 12.87 | 22  | 16.5 | 12.76 | 20  |
| **Overall**     | 17.63 | 11.49 | 27  | 13.70 | 11.95 | 30  | 13.43 | 11.78 | 30  |

three measures. As Screening measures were not obtained on the TPRS, Table 3.3.1.4 presents mean and standard deviation scores in relation to Post-Termination and Follow-Up only.
Table 3.3.1.2: Symptom Checklist 90R (SCL 90R) Global Severity Index (GSI), Positive Symptom Distress Index (PSDI) and Positive Symptom Total (PST) Means and Standard Deviations for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Screening, Post-Termination and Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>Screening</th>
<th>Post-Termination</th>
<th>Follow-Up</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td><strong>PSDR Cohort</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>1.4</td>
<td>0.72</td>
<td>10</td>
</tr>
<tr>
<td>PSDI</td>
<td>2.0</td>
<td>0.74</td>
<td>10</td>
</tr>
<tr>
<td>PST</td>
<td>60.3</td>
<td>14.7</td>
<td>10</td>
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<td><strong>SDR Cohort</strong></td>
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<tr>
<td>GSI</td>
<td>1.2</td>
<td>0.86</td>
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<td>PSDI</td>
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<td><strong>Overall</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>1.2</td>
<td>0.81</td>
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</tr>
<tr>
<td>PSDI</td>
<td>2.0</td>
<td>0.63</td>
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<tr>
<td>PST</td>
<td>52.9</td>
<td>21.5</td>
<td>30</td>
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Table 3.3.1.3: Inventory of Interpersonal Problems (IIP) Means and Standard Deviations for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Screening, Post-Termination and Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>Screening</th>
<th>Post-Termination</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td><strong>PSDR Cohort</strong></td>
<td></td>
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</tr>
<tr>
<td>Overall</td>
<td>1.45</td>
<td>.75</td>
<td>8</td>
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<tr>
<td><strong>SDR Cohort</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>1.3</td>
<td>.83</td>
<td>20</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
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</tr>
<tr>
<td>Overall</td>
<td>1.3</td>
<td>.79</td>
<td>28</td>
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</tbody>
</table>
Table 3.3.1.4: Target Problem Rating Scale (TPRS) Means and Standard Deviations for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Post-Termination and Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>Post-Termination</th>
<th>Follow-Up</th>
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<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
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<tr>
<td><strong>PSDR Cohort</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1.76</td>
<td>1.11</td>
</tr>
<tr>
<td><strong>SDR Cohort</strong></td>
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<td>2.33</td>
<td>.76</td>
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<tr>
<td><strong>Overall</strong></td>
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</tr>
<tr>
<td></td>
<td>2.16</td>
<td>.91</td>
</tr>
</tbody>
</table>

In addition, Figures 3.3.1.1 to 3.3.1.3 display graphically all four timeplots on the summary score or global index of the BDI, SCL 90R and IIP for both the PSDR

Figure 3.3.1.1: Timeplot Graph of Beck Depression Inventory (BDI) Mean Scores at Pre-Screening, Screening, Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Cohorts

![BDI Timeplot Graph](image)
Figure 3.3.1.2: Time-plot Graph of Symptom Checklist 90R (SCL 90R) Mean Global Severity Index (GSI) Scores at Pre-Screening, Screening, Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Patients

![GSI Time-plot Graph](image)

PSDR= ---  SDR= -----

Figure 3.3.1.3: Timeplot Graph of Inventory of Interpersonal Problems (IIP) Mean Scores at Pre-Screening, Screening, Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Patients

![IIP Timeplot Graph](image)

PSDR= ---  SDR= ----
(continuous curve line) and SDR (broken curve line) cohort means. No timeplot graph is presented for the TPRS means as the study did not include a Screening administration of this measure.

To enable more robust statistical conclusions to be drawn in relation to overall changes across time-points, an analysis of variance (ANOVA) model based on Hotellings' multivariate hypothesis test (Norusis, 1992) was applied to BDI, GSI/SCL 90R and IIP scores (Insufficient repeated measures made this level of analysis inappropriate for the TPRS). Repeated measures analyses of variance were performed on scores at the four time-points under both treatment-undifferentiated and treatment-specific conditions and the results of these analyses are displayed in Tables 3.3.1.5 and 3.3.1.6., respectively.

Based on all 32 patients, a series of one-factor ANOVAs confirmed a highly significant main effect of the treatment-undifferentiated condition on the BDI, the GSI/SCL 90R and the IIP. A series of repeated measures ANOVAs with the treatment-specific conditions entered as dependent variables confirmed significant main effects for the treatment conditions but no significant interaction between treatment condition and time-point. In short, multivariate testing confirmed a parallel response profile across the two cohorts for all three psychometric measures.

3.3.2 Clinically Significant and Reliable Change

3.3.2.1 Effect Size Outcomes

As an aid to further exploratory evaluation of overall psychotherapeutic outcome following each CAT reformulatory intervention, Post-Termination and Follow-Up
Table 3.3.1.5: One-Factor ANOVA to Test for Independent Effects of the Undifferentiated 4-Session Reformulatory CAT Intervention on the Beck Depression Inventory (BDI), the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) and the Inventory of Interpersonal Problems (IIP)

<table>
<thead>
<tr>
<th>Measure</th>
<th>F value</th>
<th>d.f</th>
<th>p level</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>7.73</td>
<td>3</td>
<td>0.001</td>
</tr>
<tr>
<td>GSI/SCL 90R</td>
<td>5.64</td>
<td>3</td>
<td>0.005</td>
</tr>
<tr>
<td>IIP</td>
<td>5.84</td>
<td>3</td>
<td>0.004</td>
</tr>
</tbody>
</table>

Table 3.3.1.6: Repeated Measures ANOVA to Test for Independent Effects and Interactions Between the Prose plus Sequential Diagrammatic Reformulation (PSDR) Treatment Condition, the Sequential Diagrammatic Reformulation (SDR) Treatment Condition and Time-Point on the Beck Depression Inventory (BDI), the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) and the Inventory of Interpersonal Problems (IIP)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Treatment Condition Effect</th>
<th>Interaction Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F value p level (d.f.= 3)</td>
<td>F value p level (d.f.= 3)</td>
</tr>
<tr>
<td>BDI</td>
<td>9.14 0.001</td>
<td>1.74 0.193</td>
</tr>
<tr>
<td>GSI/SCL 90R</td>
<td>6.34 0.003</td>
<td>1.73 0.189</td>
</tr>
<tr>
<td>IP</td>
<td>7.64 0.001</td>
<td>1.98 0.147</td>
</tr>
</tbody>
</table>

means were converted to between-subjects effect sizes (ES) for all summary scores, global indexes and, where appropriate, subscale scores on the four instruments employed. Effect sizes were calculated as Post-Termination or Follow-Up means respectively minus the Screening mean, divided by the standard deviation of Screening
scores. Tables 3.3.2.1.1 to 3.3.2.1.4 display both Screening/Post-Termination and Screening/Follow-Up effect sizes for PSDR, SDR and Overall patients on the BDI, SCL-90R, IIP and TPRS.

Considered together, the 32-patient sample evidenced a small improvement in mean BDI score at Post-Termination. In terms of the PSDR and SDR cohorts, however, patients in the former showed substantial improvement on the BDI at Post-

Table 3.3.2.1.1: Beck Depression Inventory (BDI) Effect Sizes at Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients

<table>
<thead>
<tr>
<th>Screening/Post-Termination Effect Size</th>
<th>Screening/Follow-Up Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSDR Cohort</strong></td>
<td></td>
</tr>
<tr>
<td>1.23</td>
<td>1.19</td>
</tr>
<tr>
<td><strong>SDR Cohort</strong></td>
<td></td>
</tr>
<tr>
<td>.10</td>
<td>.07</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td></td>
</tr>
<tr>
<td>.38</td>
<td>.37</td>
</tr>
</tbody>
</table>

Termination whilst patients in the latter showed little change at all. It is also notable that these respective trends in BDI outcome were maintained at three-month follow-up.

In the case of the SCL 90R, when considered as one, 4-session reformulatory CAT showed an overall small to medium effect size by Post-Termination, which largely maintained by Follow-Up. As in the case of the BDI, however, the separate profiles of effect sizes for the PSDR and SDR cohorts differed markedly, with the former showing substantial improvement on the global indexes and primary symptom dimensions, and the latter only small change for the most part.
With the exception of a medium effect size on the *Obsessive-Compulsive* (thoughts, impulses and actions which are unremitting and unwanted) and *Hostility* (thoughts, feelings and actions indicative of the state of anger) dimensions, all remaining SCL 90R global indexes and primary symptom dimension means for the PSDR cohort at

Table 3.3.2.1.2: Screening/Post-Termination and Screening/Follow-Up Effect Sizes (ES) for the Symptom Checklist 90R (SCL 90R) Global Indexes and Primary Symptom Dimensions Scores of Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients

<table>
<thead>
<tr>
<th>Indexes/Dimensions</th>
<th>PSDR Cohort</th>
<th></th>
<th>SDR Cohort</th>
<th></th>
<th>Overall</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI</td>
<td>1.05</td>
<td>1.07</td>
<td>0.29</td>
<td>0.42</td>
<td>0.5</td>
<td>0.63</td>
</tr>
<tr>
<td>PSDI</td>
<td>0.78</td>
<td>0.66</td>
<td>0.53</td>
<td>0.55</td>
<td>0.63</td>
<td>0.62</td>
</tr>
<tr>
<td>PST</td>
<td>1.86</td>
<td>1.63</td>
<td>0.21</td>
<td>0.34</td>
<td>0.54</td>
<td>0.62</td>
</tr>
<tr>
<td>Somatisation</td>
<td>0.79</td>
<td>0.42</td>
<td>0.20</td>
<td>0.28</td>
<td>0.33</td>
<td>0.31</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>0.49</td>
<td>0.71</td>
<td>0.22</td>
<td>0.29</td>
<td>0.32</td>
<td>0.45</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>1.36</td>
<td>1.21</td>
<td>0.11</td>
<td>0.5</td>
<td>0.39</td>
<td>0.72</td>
</tr>
<tr>
<td>Depression</td>
<td>1.14</td>
<td>1.15</td>
<td>0.35</td>
<td>0.43</td>
<td>0.54</td>
<td>0.63</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.09</td>
<td>0.94</td>
<td>0.39</td>
<td>0.42</td>
<td>0.56</td>
<td>0.57</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.62</td>
<td>0.87</td>
<td>0.27</td>
<td>0.27</td>
<td>0.40</td>
<td>0.47</td>
</tr>
<tr>
<td>Phobic Anxiety</td>
<td>0.81</td>
<td>0.74</td>
<td>0.36</td>
<td>0.59</td>
<td>0.5</td>
<td>0.65</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>1.09</td>
<td>1.39</td>
<td>0.14</td>
<td>0.16</td>
<td>0.31</td>
<td>0.38</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>0.81</td>
<td>0.81</td>
<td>0.25</td>
<td>0.31</td>
<td>0.42</td>
<td>0.48</td>
</tr>
</tbody>
</table>
Post-Termination emerged with large effect sizes: the GSI; the Positive Symptom Distress Index (PSDI); the Positive Symptom Total (PST); Somatisation (perceptions of bodily dysfunction); Interpersonal Sensitivity (perceptions of personal inadequacy and inferiority); Depression (manifestations of clinical depression); Anxiety (signs and symptomatology of manifest clinical anxiety); Phobic Anxiety (feelings of fear in response to a specific person, place or situation); Paranoid Ideation (disordered thinking and delusions); and Psychoticism (first-rank symptomatology of schizophrenia). By Follow-Up, that pattern of large effect sizes for the PSDR cohort was maintained and further extended to the Obsessive-Compulsive and Hostility
symptom dimensions. The only exception at Follow-Up was the Somatisation dimension effect size which reduced from large to medium.

In respect of the SDR cohort, both the GSI and PSI showed only small effect sizes by Post-Termination, whilst the PSDI showed a medium effect size. All primary symptom dimension means for the SDR cohort showed no more than a small to medium effect size at Post-Termination. By Follow-Up, the trend towards small to medium effect sizes on the SCL 90R for this cohort was maintained, albeit with evidence of slight increases.

With respect to the IIP, on aggregate 4-session reformulatory CAT, evidenced an overall small effect size by Post-Termination, which maintained and increased to a medium effect size by Follow-Up. Again, the profile of effect sizes for the PSDR and SDR cohorts differed markedly, however, with the former cohort showing substantial improvement on the majority of IIP scales and the latter only small and, in the case of two subscales, negative change.

With the exception of a small effect size on the Too Open (Sharing self with others in a damaging way) subscale, medium and greater effect sizes on all remaining IIP subscales at Post-Termination emerged in the case of the PSDR cohort. Three of the eight subscales emerged with large effect sizes at Post-Termination: Hard To Be Assertive (experiencing difficulties with saying no to people); Hard To Be Sociable (difficulties with making friends and joining in on groups); and Hard To Be Supportive (difficulties with attending to other peoples’ needs). By Follow-Up, that
pattern of large effect sizes was maintained and further extended to all five remaining IIP subscales: Too Responsible (Perceptions of caring for others at the expense of self); Too Aggressive (Perceptions of losing temper, fighting and irritation with others); Too Open (Sharing oneself with others in a damaging way); Too Dependent (Feelings of not being an autonomous person); Hard To Be Physically Close (Difficulties with showing affection to appropriate others).

In respect of the SDR cohort, five subscales emerged with small effect sizes at Post-Termination and maintained or slightly increased their effect size at Follow-Up: Hard To Be Assertive; Hard To Be Sociable; Hard To Be Supportive; Too Open; and Too Dependent. Amongst the remaining subscales, one emerged with a small positive effect size at Post-Termination which deteriorated to a small negative effect size by Follow-Up (Hard To Be Physically Close); and a second subscale evidenced precisely the reverse pattern (Too Responsible). The eighth and last IIP subscale, Too Aggressive, emerged with a small effect size at Post-Termination which diminished still further by Follow-Up.

Table 3.3.2.1.4: Target Problem Rating Scale (TPRS) Effect Sizes for Prose plus Sequential Diagrammatic Reformulation, Sequential Diagrammatic Reformulation (SDR) and Overall Patients

<table>
<thead>
<tr>
<th>Post-Termination/Follow-Up Effect Size</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PSDR Cohort</td>
<td>.95</td>
</tr>
<tr>
<td>SDR Cohort</td>
<td>.72</td>
</tr>
<tr>
<td>Overall</td>
<td>.78</td>
</tr>
</tbody>
</table>
In relation to the TPRS, the undifferentiated 32-patient sample evidenced an overall large improvement in mean TPRS rating at Follow-Up, the only time comparison for the measure employed in this study. In terms of the differentiated PSDR and SDR treatment conditions, both cohorts of patients showed substantial improvement, although a larger effect size obtained in the case of the former.

3.3.2.2: Within-Group Analyses of Clinical Change

Within-group analyses drawing on criteria for reliable and clinically meaningful change reflected a more discriminating outcome picture. In line with measurement procedures for significant improvement as advocated by Jacobson and Revenstorf (1988), patients' outcome scores on the BDI, GSI/SCL 90R and IIP were required to (i) meet the 'end-state' of at least one standard deviation below the Screening mean, and (ii) exceed a Reliable Change Index (RCI) score. On the basis of a critical significance value >1.96, the RCI for each patient was calculated as the difference between the Screening mean on each measure and respective Post-Termination and Follow-Up means divided by the standard error of the difference score (i.e. the square root of twice the standard error of measurement squared). In calculating the standard error of measurement for each RCI, the reported test-retest reliabilities for the three instruments were assumed: 0.75 in the case of the BDI (Beck et al., 1961), 0.84 for the GSI/SCL 90R (Derogatis, 1983) and 0.98 for the IIP (Horowitz et al., 1988).

Table 3.3.2.2.1 displays the calculated criteria for significant improvement in the two cohorts on each measure, in addition to respective reliable change indexes. The one idiographic measure employed in the study, the TPRS, was excluded from analyses of reliable change.
Tables 3.3.2.2.2 to 3.3.2.2.5 report the crosstabulated frequencies of patients in each treatment condition and overall showing clinically significant improvement, no clinically significant change and clinically significant deterioration on each measure, based on the standard deviation criterion. Also shown in brackets are the frequencies of patients meeting reliable change criteria for clinically significant improvement, no clinically significant change and clinically significant deterioration. RCI scores for

Table 3.3.2.2.1: Clinical Significance and Reliable Change Cut-Scores on the Beck Depression Inventory (BDI), Symptom Checklist 90R (SCL 90R), Inventory of Interpersonal Problems (IIP) and Target Problem Rating Scale (TPRS) Based on Jacobsonian Criteria for the Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Cohorts

<table>
<thead>
<tr>
<th>Measure/Cohort</th>
<th>-1 Standard Deviation</th>
<th>Reliable Change Index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>End State</td>
<td></td>
</tr>
<tr>
<td><strong>BDI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSDR</td>
<td>8.96</td>
<td>7.87</td>
</tr>
<tr>
<td>SDR</td>
<td>4.46</td>
<td></td>
</tr>
<tr>
<td><strong>GSI/SCL 90R</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSDR</td>
<td>0.68</td>
<td>0.42</td>
</tr>
<tr>
<td>SDR</td>
<td>0.37</td>
<td></td>
</tr>
<tr>
<td><strong>IIP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSDR</td>
<td>0.7</td>
<td>0.13</td>
</tr>
<tr>
<td>SDR</td>
<td>0.47</td>
<td></td>
</tr>
<tr>
<td><strong>TPRS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSDR</td>
<td>0.65</td>
<td>NA</td>
</tr>
<tr>
<td>SDR</td>
<td>1.57</td>
<td></td>
</tr>
</tbody>
</table>

each patient on the BDI, GSI/SCL 90R and IIP at Post-Termination and Follow-Up are contained in Appendices 3.3.2.2.1 to 3.3.2.2.3.
Overall, just under one third of patients in the study for whom full data were obtainable evidenced clinically significant improvement on the BDI at Post-Termination, a proportion which reduced to one quarter of patients after adjustment for reliable change criteria. The overall rate for clinically significant improvement lowered to 25% by Follow-Up, with all but one case meeting reliable change criteria. In terms of the two treatment conditions, 75% of patients in the PSDR cohort made clinically significant improvement by Post-Termination, half of whose scores met reliable change criteria. Two patients (11.8%) in the SDR cohort made a clinically significant and reliable improvement by Post-Termination. At Follow-Up, 60% of patients in the PSDR and no patients in the SDR cohort showed clinically significant improvement, a percentage which, in the case of the former, adjusted to 50% following reliable change calculations.

In relation to non-significant outcome, a quarter and 40% of PSDR patients showed evidence of no clinically significant change on the BDI by Post-Termination and Follow-Up respectively, although reliability adjustments were negative for all but two patient scores at Follow-Up. Non-significant outcome on the BDI was considerably greater for the SDR cohort at both time-points, with 88-100% of patients showing evidence of no clinically significant change, although again reliability calculations were positive in only a minority of cases. No patient in either cohort made a clinically significant disimprovement on the BDI by Post-Termination or Follow-Up.

In relation to the SCL 90R, more than one third of patients in the study overall showed evidence of clinically significant improvement on the GSI at Post-Termination, a proportion which reduced to 21% after allowance for reliable change
Table 3.3.2.2.2: Crosstabulated Frequencies of Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients Showing Reliable Clinically Significant Improvement, No Clinically Significant Change and Reliable Clinically Significant Deterioration on the Beck Depression Inventory (BDI) at Post-Termination and Follow-Up.

<table>
<thead>
<tr>
<th></th>
<th>PSDR Cohort</th>
<th>SDR Cohort</th>
<th>Overall Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PT</td>
<td>FU</td>
<td>PT</td>
</tr>
<tr>
<td></td>
<td>(RCI&gt;1.96)</td>
<td></td>
<td>(RCI&gt;1.96)</td>
</tr>
<tr>
<td>n</td>
<td>n=8</td>
<td>n=10</td>
<td>n=17</td>
</tr>
<tr>
<td>Clinically Significant Improvement</td>
<td>6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(5)</td>
<td>(2)</td>
</tr>
<tr>
<td>No Clinically Significant Change</td>
<td>2</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(2)</td>
<td>(7)</td>
</tr>
<tr>
<td>Clinically Significant Deterioration</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3.3.2.2.3: Crosstabulated Frequencies of Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients Showing Reliable Clinically Significant Improvement, No Clinically Significant Change and Reliable Clinically Significant Deterioration on the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) at Post-Termination and Follow-Up.

<table>
<thead>
<tr>
<th></th>
<th>PSDR Cohort</th>
<th>SDR Cohort</th>
<th>Overall Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PT</td>
<td>FU</td>
<td>PT</td>
</tr>
<tr>
<td></td>
<td>(RCI&gt;1.96)</td>
<td></td>
<td>(RCI&gt;1.96)</td>
</tr>
<tr>
<td>n</td>
<td>n=8</td>
<td>n=10</td>
<td>n=20</td>
</tr>
<tr>
<td>Clinically Significant Improvement</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>(4)</td>
<td>(5)</td>
<td>(2)</td>
</tr>
<tr>
<td>No Clinically Significant Change</td>
<td>3</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>(1)</td>
<td>(5)</td>
</tr>
<tr>
<td>Clinically Significant Deterioration</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>(0)</td>
<td>(0)</td>
</tr>
</tbody>
</table>
Table 3.3.2.2.4: Crosstabulated Frequencies of Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation and Overall Patients Showing Reliable Clinically Significant Improvement, No Clinically Significant Change and Reliable Clinically Significant Deterioration on the Inventory of Interpersonal Problems (IIP) Full-Scale at Post-Termination and Follow-Up.

<table>
<thead>
<tr>
<th></th>
<th>PSDR Cohort</th>
<th>SDR Cohort</th>
<th>Overall Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PT (RCI&gt;1.96)</td>
<td>FU</td>
<td>PT (RCI&gt;1.96)</td>
</tr>
<tr>
<td>Clinically Significant Improvement</td>
<td>n=7</td>
<td>n=8</td>
<td>n=20</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>No Clinically Significant Change</td>
<td>4</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(5)</td>
<td>(12)</td>
</tr>
<tr>
<td>Clinically Significant Deterioration</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
</tbody>
</table>

Table 3.3.2.2.5: Crosstabulated Frequencies of Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation and Overall Patients Showing Clinically Significant Improvement, No Clinically Significant Change and Clinically Significant Deterioration on the TPRS at Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>PSDR Cohort</th>
<th>SDR Cohort</th>
<th>Overall Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=9</td>
<td>n=21</td>
<td>n=30</td>
</tr>
<tr>
<td>Clinically Significant Improvement</td>
<td>5 (56%)</td>
<td>10 (48%)</td>
<td>15 (50%)</td>
</tr>
<tr>
<td>No Clinically Significant Change</td>
<td>4 (44%)</td>
<td>9 (43%)</td>
<td>13 (43%)</td>
</tr>
<tr>
<td>Clinically Significant Deterioration</td>
<td>0</td>
<td>2 (9%)</td>
<td>2 (7%)</td>
</tr>
</tbody>
</table>
criteria. The overall rate for clinically significant and reliable improvement increased to 24% by Follow-Up. In terms of the PSDR cohort, 50% of patients made clinically significant and reliable improvement by Post-Termination. By comparison, the same proportion of SDR patients showed evidence of clinically significant progress by Post-Termination, although only in two cases (10%) were change scores reliable. At Follow-Up, 50% of PSDR patients and, again, 10% of SDR patients showed clinically significant and reliable improvement.

In relation to non-significant outcome, 38% of PSDR patients and 70% of SDR patients made no clinically significant change, positive or negative, by Post-Termination, although confirmatory reliability statistics were obtained for only 25% of patients in each respective cohort. By comparison, the rate of non-significant change at Follow-Up emerged as 50% for the PSDR cohort and 58% for the SDR cohort, with 10% of the PSDR change scores and 42% of the SDR change scores meeting reliability criteria.

No patient in the PSDR cohort made a clinically significant and reliable disimprovement on the GSI by either time-point. In the SDR cohort, clinically significant deterioration was evident in one case (5%) at Post-Termination and two cases (10%) at Follow-Up, although reliable change calculations for the Follow-Up scores were confirmatory in neither case.

Turning to the IIP, one quarter of patients in the overall study for whom measures were obtainable showed evidence of clinically
significant improvement on mean scores at Post-Termination, a proportion which decreased to 15% after rectification for reliable change criteria. That overall rate for clinically significant and reliable improvement increased to one third of patients by Follow-Up. In terms of the two specific treatment conditions, 43% of patients in the PSDR cohort made clinically significant and reliable improvement by Post-Termination. By comparison, 20% of SDR cohort patients showed clinically significant improvement by Post-Termination, although only in one case (5%) were reliable change calculations confirmatory. At Follow-Up, 25% of PSDR patients and 37% of SDR patients showed improvement that was both clinically significant and reliable.

In relation to non-significant outcome, no clinically significant change on mean IIP was evident in the case of 57% of PSDR patients and 75% of SDR patients at Post-Termination, although reliable change criteria reduced the respective percentages to 43% and 60%. By comparison, non-significant change rates at Follow-Up were 75% for the PSDR cohort and 53% for the SDR cohort, with confirmatory reliable change calculations for all but one case each.

No patient in the PSDR cohort made a clinically significant and reliable disimprovement by either time-point. In the SDR cohort, clinically significant deterioration was evident in one case (5%) at Post-Termination and two cases (10.5%) at Follow-Up, although reliable change criteria for the Follow-Up scores were confirmatory in just one case.
In respect of the fourth and last of the outcome measures, approximately half the patients in each treatment condition evidenced clinically significant improvement on the TPRS by Follow-Up, with a slight proportionate advantage for the PSDR cohort. A similar proportion within each cohort achieved improvement albeit insufficient to meet the adopted criterion for clinical significance, again with a slight proportionate advantage for patients in the PSDR treatment condition. Two patients in the SDR cohort, and none in the PSDR cohort, manifested clinically significant deterioration on the TPRS by Follow-Up.

Figures 3.3.2.2.1 to 3.3.2.2.14 provide a graphic representation of individual outcome on each of the four measures in the form of a scatterplot of Screening scores against Post-Termination and Follow-Up scores for patients in each treatment condition cohort. The central diagonal line in each scatterplot delineates no change, whilst plot points below and above the diagonal represent clinical improvement and deterioration, respectively. The striped area represents the limits for reliable change, with plot points falling outside representing changes that are statistically reliable on the basis of RCI criteria (critical value > 1.96). The lower and upper horizontal lines respectively represent the cut-score for clinically significant improvement and deterioration adopted in this study (i.e. at least one standard deviation below or above the Screening mean). Score plots on or below the lower horizontal line and to the right of the striped area represent patients classed as clinically and reliably improved, whilst score plots on or above the
Figure 3.3.2.2.1: Scatterplot of Screening (Horizontal Axis) and Post-Termination Scores (Vertical Axis) on the Beck Depression Inventory (BDI2 and BDI3) for Patients in the Prose plus Sequential Diagrammatic Representation (PSDR) Cohort

Figure 3.3.2.2.2: Scatterplot of Screening (Horizontal Axis) and Follow-Up Scores (Vertical Axis) on the Beck Depression Inventory (BDI2 and BDI4) for Patients in the Prose plus Sequential Diagrammatic Representation (PSDR) Cohort
Figure 3.3.2.2.3: Scatterplot of Screening (Horizontal Axis) and Post-Termination Scores (Vertical Axis) on the Beck Depression Inventory (BDI2 and BDI3) for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort

Figure 3.3.2.2.4: Scatterplot of Screening (Horizontal Axis) and Follow-Up Scores (Vertical Axis) on the Beck Depression Inventory (BDI2 and BDI4) for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort
Figure 3.3.2.2.5: Scatterplot of Screening (Horizontal Axis) and Post-Termination Scores (Vertical Axis) on the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) for Patients in the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.3.2.2.6: Scatterplot of Screening (Horizontal Axis) and Follow-Up Scores (Vertical Axis) on the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) for Patients in the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort
Figure 3.3.2.7: Scatterplot of Screening (Horizontal Axis) and Post-Termination Scores (Vertical Axis) on the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort

Figure 3.3.2.8: Scatterplot of Screening (Horizontal Axis) and Follow-Up Scores (Vertical Axis) on the Global Severity Index of the Symptom Checklist 90R for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort
Figure 3.3.2.2.9: Scatterplot of Screening (Horizontal Axis) and Post-Termination Means (Vertical Axis) on the Inventory of Interpersonal Problems for Patients in the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.3.2.2.10: Scatterplot of Screening (Horizontal Axis) and Follow-Up Means (Vertical Axis) on the Inventory of Interpersonal Problems for Patients in the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort
Figure 3.3.2.2.11: Scatterplot of Screening (Horizontal Axis) and Post-Termination Means (Vertical Axis) on the Inventory of Interpersonal Problems for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort

Figure 3.3.2.2.12: Scatterplot of Screening (Horizontal Axis) and Follow-Up Means (Vertical Axis) on the Inventory of Interpersonal Problems for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort
Figure 3.3.2.2.13: Scatterplot of Mean Post-Termination (Horizontal Axis) and Follow-Up Scores (Vertical Axis) on the Target Problem Rating Scale (TPRS) for Patients in the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.3.2.2.14: Scatterplot of Mean Post-Termination (Horizontal Axis) and Follow-Up Scores (Vertical Axis) on the Target Problem Rating Scale (TPRS) for Patients in the Sequential Diagrammatic Reformulation (SDR) Cohort
upper horizontal line and to the left of the striped area indicate clinically reliable deterioration. All remaining score plots reflect clinically non-significant change.

**3.4 HYPOTHESIS RELATING SEVERITY TO OUTCOME**

A related research question within the study concerned any differential impact of severity of presenting psychological distress on psychotherapeutic outcome following 4-session reformulatory CAT:

**Hypothesis 6:**

It was hypothesised that the severity of patients’ presenting psychological distress as measured on the BDI, SCL 90R, and IIP would be negatively associated with psychotherapeutic outcome on these measures at Post-Termination and at Follow-Up.

In order to explore this hypothesis, a correlation analysis using Pearson’s product-moment coefficient was therefore performed on the basis of BDI, GSI/SCL 90R, and IIP Screening scores and change scores on these measures at Post-Termination and Follow-Up. Tables 3.4.1 to 3.4.3 present the obtained Pearson correlation coefficients on each measure with associated significance.

<table>
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<tr>
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<th>Screening/Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>p Value</td>
</tr>
<tr>
<td><strong>PSDR Cohort</strong></td>
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<td>.005</td>
</tr>
<tr>
<td><strong>SDR Cohort</strong></td>
<td>-.46</td>
<td>.05</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>-.48</td>
<td>.01</td>
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</table>
Table 3.4.2: Pearson Correlations between Symptom Checklist 90R (SCL 90R) Global Severity Index (GSI) Scores and Change Scores at Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients

<table>
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<th>Screening/Follow-Up</th>
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<tbody>
<tr>
<td></td>
<td>r</td>
<td>p value</td>
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<tr>
<td>PSDR Cohort</td>
<td>-0.91</td>
<td>.002</td>
</tr>
<tr>
<td>SDR Cohort</td>
<td>-0.27</td>
<td>.243</td>
</tr>
<tr>
<td>Overall</td>
<td>-0.46</td>
<td>.01</td>
</tr>
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</table>

Table 3.4.3: Pearson Correlations between Inventory of Interpersonal Problems (IIP) Screening Scores and Change Scores at Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients

<table>
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<tr>
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<th>Screening/Follow-Up</th>
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<tr>
<td></td>
<td>r</td>
<td>p Value</td>
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<tr>
<td>PSDR Cohort</td>
<td>-.81</td>
<td>.03</td>
</tr>
<tr>
<td>SDR Cohort</td>
<td>-.4</td>
<td>.12</td>
</tr>
<tr>
<td>Overall</td>
<td>-.5</td>
<td>.01</td>
</tr>
</tbody>
</table>

levels both for patients in the respective treatment condition cohorts and patients overall. The results presented in Tables 3.4.1 to 3.4.3 were in the predicted direction and suggested a significant negative association between intake severity on the three measures and post-intervention outcome such that greater distress is related to lower treatment gains. Although the negative associations obtained in the case of both PSDR and SDR cohorts the size of the coefficients were large for the former and
small to medium for the latter. With the exception of the SDR Screening/Post-Termination correlation coefficient, all correlations involving the GSI/SCL 90R were highly statistically significant. Moreover, in the case of the IIP only the coefficients relating to the PSDR cohort reached statistical significance.

3.5 HYPOTHESES RELATING TO TREATMENT IMPACT

Two of the research questions underlying this study concerned patients' subjective evaluations of the helpful and hindering impacts of 4-session reformulatory CAT:

**Hypothesis 3:**
It was hypothesised that patients would rate their intervention as helpful overall on the Sessions Impact Scale at Post-Termination.

**Hypothesis 5:**
It was hypothesised that patients' ratings of the helpfulness of their intervention would be positively associated with psychotherapeutic outcomes at Post-Termination and Follow-Up.

One process measure, an adopted version of the Session Impacts Scale (SIS; Elliott and Wexler, 1994), was employed in the study in order to assess the short-term subjective effects on patients of either intervention. For reasons of practical economy, patients were requested to complete the measure once two weeks Post-Termination, rather than after every session, as intended by Elliott and Wexler. Sixteen items containing a labeling phrase and a short paragraph description were rated by patients on a 5-point scale, anchored as follows: 1 = *not at all*, 2 = *slightly*, 3 = *somewhat*, 4 = *pretty much*; and 5 = *very much.*
The dimensional structure and scoring system advocated by Stiles, Reynolds, Hardy, Rees, Barkham and Shapiro (1994) formed the basis for the analysis of the results presented below. Patients' item responses were divided into five factor-based dimensions. These comprised two closely related task dimensions, *Understanding* and *Problem Solving*; a therapeutic relationship dimension, *Relationship*; an underrepresented (1 item) but theoretically important *Unwanted Thoughts* dimension; and a broad *Hindering Impacts* dimension. Table 3.5.1, presenting summary descriptive data on the SIS for the two treatment cohorts, precedes a closer inspection of the results for each factor-based dimension in relation to the above hypotheses. Ratings were unobtainable in the case of two patients in the PSDR cohort.

Table 3.5.1: Sessions Impact Scale (SIS) Means and Standard Deviations for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients

<table>
<thead>
<tr>
<th>SIS Index</th>
<th>PSDR Cohort M</th>
<th>PSDR Cohort SD</th>
<th>PSDR Cohort n</th>
<th>SDR Cohort M</th>
<th>SDR Cohort SD</th>
<th>SDR Cohort n</th>
<th>Overall M</th>
<th>Overall SD</th>
<th>Overall n</th>
</tr>
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<tbody>
<tr>
<td>Understanding</td>
<td>3.4 .84</td>
<td>8</td>
<td>3.3 .99</td>
<td>22</td>
<td>3.3 .94</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td>3.9 .74</td>
<td>8</td>
<td>3.5 1.05</td>
<td>22</td>
<td>3.6 .98</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>3.8 .75</td>
<td>8</td>
<td>3.3 .94</td>
<td>22</td>
<td>3.4 .91</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unwanted Thoughts</td>
<td>2.9 1.6</td>
<td>8</td>
<td>1.9 .99</td>
<td>22</td>
<td>2.1 1.2</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindering Impacts</td>
<td>1.2 .24</td>
<td>8</td>
<td>1.1 .31</td>
<td>22</td>
<td>1.1 .30</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.5.1 Helpful and Hindering Dimension Ratings

3.5.1.1 Understanding Index

The Understanding Index seeks to reflect the extent to which, as a result of all four sessions collectively, the patient experiences new insight or understanding about cognitive, affective or behavioural aspects of the self and of others. It also measures the extent to which the patient has acquired greater awareness or clarity about significant feelings, thoughts or memories.

On average, patients in the study reported somewhat greater understanding (M = 3.3, S.D. = .94, range 1.3 - 5.0) in these domains post-termination, regardless of treatment cohort. Within the PSDR cohort, 6 (75%) patients endorsed the Understanding dimension items in the somewhat (50%) to very much (25%) range. Two PSDR patients (25%) reported slightly improved Understanding post-termination and no patient endorsed the not at all rating. Similarly, the majority (63.6%) of patients in the SDR cohort reported somewhat (22.7%) or pretty much (40.9%) improved understanding following their intervention. Seven (31.8%) SDR patients reported slightly improved understanding whilst a not at all rating was obtained in the case of one SDR patient (4.5%). Figures 3.5.1.1.1 and 3.5.1.1.2 present frequency histograms on the SIS Understanding index for each cohort.

In order to further compare the sessions impact of either intervention, t-tests based on the PSDR and SDR cohorts were computed for SIS Understanding dimension. An independent samples t-test performed on the Understanding index revealed non-significant differences between the two cohorts (t = .353, d.f. = 15, p = .73).
Figure 3.5.1.1.1: Frequency Histogram of Sessions Impact Scale (SIS) Understanding Indexes for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.5.1.1.2: Frequency Histogram of Sessions Impact Scale (SIS) Understanding Indexes for the Sequential Diagrammatic Reformulation (SDR) Cohort
3.5.1.2 Problem Solving Index

The Problem Solving Index provides a measure of the extent to which, as a result of all four sessions collectively, the patient has become clearer concerning both appropriate goals for change in life and possible ways of progressing towards them.

At the aggregate level, patients across the study endorsed somewhat greater Problem Solving (M= 3.6, S.D.= .99, range 1.5 - 5.0), regardless of treatment cohort. Within the PSDR cohort, 6 patients (75 %) rated the Problem Solving dimension items in the pretty much range. One PSDR patient (12.5 %) each reported somewhat improved and slightly improved Problem Solving post-termination, respectively. Meanwhile, 11 patients (50 %) in the SDR cohort rated pretty much (40.1 %) to very much (9.1 %) improved Problem Solving following their intervention. Nine SDR patients (40.1 %) reported slightly (13.6 %) to somewhat (27.3 %) improved Problem Solving whilst a not at all rating was obtained in the case of two SDR patients (9.1 %). Figures 3.5.1.2.1 and 3.5.1.2.2 present frequency histograms on the SIS Problem Solving Index for each cohort.

In a further comparison of the sessions impact of either intervention, t-tests based on the PSDR and SDR cohorts were computed for the SIS Problem Solving index. An independent samples t-test performed on the Problem Solving index revealed non-significant differences between the two cohorts (t= 1.14, d.f.= 18, p=.27).

3.5.1.3 Relationship Index

The Relationship Index reflects the extent to which, as a result of all four sessions collectively, the patient feels more deeply understood, supported or encouraged towards coping by the therapist. It also measures the extent to which the patient has
Figure 3.5.1.2.1: Frequency Histogram of Sessions Impact Scale (SIS) Problem Solving Indexes for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.5.1.2.2: Frequency Histogram of Sessions Impact Scale (SIS) Problem Solving Indexes for the Sequential Diagrammatic Reformulation (SDR) Cohort
experienced relief from distressing feelings, and the degree to which a trusting collaborative relationship with the therapist has been perceived as having developed.

Overall, patients in the study averaged a rating of somewhat therapeutic (M= 3.4, S.D.= .91, range 1.25 - 5.0) for their relationship with the therapist, regardless of treatment. Figures 3.5.1.3.1 and 3.5.1.3.2 present frequency histograms on the SIS Relationship index for each cohort.

Within the PSDR cohort, 4 patients (50 %) endorsed the Relationship dimension items in the pretty much range. Three PSDR patients (37.5 %) reported their patient-therapist relationship as somewhat therapeutic and 1 patient endorsed it as slightly therapeutic.

At the same time, five patients (22.7 %) in the SDR cohort rated the patient-therapist relationship as either pretty much (18.2 %) or very much (4.5 %) therapeutic. However, the largest proportion of SDR patients (50 %) rated the dimension in the somewhat range, whilst 6 SDR patients (27.3 %) experienced the patient-therapist relationship as slightly therapeutic. Two (9 %) of the SDR patient cohort perceived the patient-therapist relationship as not at all therapeutic.

In a further comparison of the sessions impact of either intervention, t-tests based on the PSDR and SDR cohorts were computed for the SIS Relationship dimension. An independent samples t-test performed on the Relationship index revealed non-significant differences between the two cohorts (t= 1.54, d.f.= 15, p= .14).
Figure 3.5.1.3.1: Frequency Histogram of Sessions Impact Scale (SIS) Relationship Indexes for the Prose plus Diagrammatic Reformulation (PSDR) Cohort

Figure 3.5.1.3.2: Frequency Histogram of Sessions Impact Scale (SIS) Relationship Indexes for the Prose plus Diagrammatic Reformulation (SDR) Cohort
3.5.1.4 Unwanted Thoughts Index

The Unwanted Thoughts index is a single-item measure of the extent to which, as a result of all four sessions collectively, the patient has experienced uncomfortable or painful ideas, memories, or feelings that were perceived as unhelpful and to be avoided.

Overall, on average patients across cohorts reported experiencing unwanted thoughts slightly (M= 2.1, S.D.= 1.22, range 1.0 - 5.0). Figures 3.5.1.4.1 and 3.5.1.4.2 present frequency histograms on the SIS Unwanted Thoughts index for each cohort.

Within the PSDR cohort, 4 patients (50 %) endorsed the Unwanted Thoughts dimension items in the pretty much (37.5 %) to very much (12.5 %) range. Two patients (25 %) experienced unwanted thoughts slightly whilst the same number reported a not at all rating for the dimension.

In relation to the SDR cohort, 7 patients (31.8 %) rated the Unwanted Thoughts items in the somewhat (27.3 %) to pretty much (4.5 %) range, whilst 4 patients (18.2 %) experienced this dimensional item slightly. By far the largest proportion of patients (50 %) within the SDR cohort, however, endorsed the Unwanted Thoughts item within the not at all range.

In order to further compare the sessions impact of either intervention, t-tests based on the PSDR and SDR cohorts were computed for the SIS Unwanted Thoughts dimension. An independent samples t-test performed on the Unwanted Thoughts
Figure 3.5.1.4.1: Frequency Histogram of Session Impact Scale (SIS) Unwanted Thoughts Indexes for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.5.1.4.2: Frequency Histogram of Session Impact Scale (SIS) Unwanted Thoughts Indexes for the Sequential Diagrammatic Reformulation (SDR) Cohort
index revealed non-significant differences between the two cohorts (t= 1.72, d.f.= 9.16, p=.119).

3.5.1.5 Hindering Impacts Index

The Hindering Impacts Index provides a measure of the extent to which, as a result of all four sessions collectively, the patient feels misunderstood, attacked or confused by the therapist. The Index also reflects the extent to which the patient has experienced too much pressure or insufficient direction from the therapist, or has come to feel impatient and doubting of the value of therapy.

An average rating of not at all for items in the Hindering Impacts dimension was obtained for all patients in the PSDR (M= 1.16, S.D.= .24, range 1.0 - 1.6) and SDR (M= 1.08, S.D.= .31, range 0 - 1.6). Figures 3.5.1.5.1 and 3.5.1.5.2 present frequency histograms on the SIS Hindering Impacts index for each cohort.

In order to further compare the sessions impact of either intervention, t-tests based on the PSDR and SDR cohorts were computed for the SIS Hindering Impacts dimension. An independent samples t-test performed on the Hindering Impacts index revealed non-significant differences between the two cohorts (t=.698, d.f.= 16.6, p=.495).

3.5.2 Sessions Impact Ratings and Psychotherapeutic Outcome

An explicit aim within the study was to test for any association between sessions impact and outcome. For each cohort a series of correlation analyses based on Pearson’s product-moment coefficient were therefore performed on the basis of the SIS Understanding, Problem Solving, Relationship, Unwanted Thoughts and Hindering Impacts indexes and summary or global indexes from the four outcome
Figure 3.5.1.5.1: Frequency Histogram of Sessions Impact Scale (SIS) Hindering Impacts Indexes for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort

Figure 3.5.1.5.2: Frequency Histogram of Sessions Impact Scale (SIS) Hindering Impacts Indexes for the Sequential Diagrammatic Reformulation (SDR) Cohort
instruments employed. Tables 3.5.2.1 to 3.5.2.5 display the obtained Pearson correlation coefficients with associated significance levels for both cohorts and patients overall at Post-Termination and Follow-Up.

As can be discerned from Table 3.5.2.1, correlations between the SIS Understanding index and outcome indexes overall were low-negative and non-significant (p > .05). Within the PSDR cohort however, low- to high-negative correlations were obtained, although only in the case of one high negative correlation with the Global Severity Index (GSI) of the SCL-90R at Post-Termination did the obtained coefficient reach statistical significance. Correlations for the SDR cohort were consistently low-negative and non-significant.

As is evident from Table 3.5.2.2, correlations between the SIS Problem Solving index and outcome indexes overall were low-negative and in half-part non-significant (p > .05). Within the PSDR cohort, all correlations at Post-Termination and Follow-Up emerged as low-negative and no coefficient reached significance. Correlations for the SDR cohort were similarly low-negative and only in the case of two outcome indexes, the BDI and the IIP, did correlation coefficients reach significance, at Post-Termination for the former and at both Post-Termination and Follow-Up for the latter.

Table 3.5.2.3 reflects the finding that correlations between the SIS Relationship index and outcome indexes across cohorts were low- to medium-negative and in all cases statistically significant (p < .05). Within the PSDR cohort, medium- to high-negative correlations with Relationship indexes obtained for the BDI, GSI and IIP at both
Table 3.5.2.1: Pearson Correlations between the Sessions Impact Scale (SIS) Understanding Index and Global Indexes from the Beck Depression Inventory (BDI), Symptom Checklist 90R (SCL-90R), Inventory of Interpersonal Problems (IIP) and Target Problem Rating Scale (TPRS) for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Post-Termination and Follow-Up

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<th>Follow-Up</th>
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<td></td>
<td>r</td>
<td>p value</td>
<td>n</td>
<td>r</td>
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<td><strong>PSDR Cohort</strong></td>
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<td></td>
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<tr>
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</tr>
<tr>
<td>GSI (SCL-90R)</td>
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<td>8</td>
<td>-0.4</td>
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<tr>
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<td>.172</td>
<td>8</td>
<td>-0.6</td>
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<tr>
<td>TPRS</td>
<td>-0.2</td>
<td>.620</td>
<td>7</td>
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<td><strong>SDR Cohort</strong></td>
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<tr>
<td>BDI</td>
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<td>.54</td>
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<td>-0.2</td>
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<tr>
<td>GSI (SCL-90R)</td>
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<tr>
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<td>.366</td>
<td>22</td>
<td>-0.2</td>
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<tr>
<td>TPRS</td>
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<td>.436</td>
<td>21</td>
<td>-0.1</td>
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<td><strong>Overall</strong></td>
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</tr>
<tr>
<td>BDI</td>
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<td>.392</td>
<td>30</td>
<td>-0.2</td>
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<tr>
<td>GSI (SCL-90R)</td>
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<td>.328</td>
<td>30</td>
<td>-0.2</td>
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<tr>
<td>IIP</td>
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<td>.180</td>
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<tr>
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<td>.346</td>
<td>28</td>
<td>-0.2</td>
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Table 3.5.2.2: Pearson Correlations between the Sessions Impact Scale (SIS) Problem Solving Index and Global Indexes from the Beck Depression Inventory (BDI), Symptom Checklist 90R (SCL-90R), Inventory of Interpersonal Problems (IIP), and Target Problem Rating Scale (TPRS) for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Post-Termination and Follow-Up

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Table 3.5.2.4: Pearson Correlations between the Sessions Impact Scale (SIS) Unwanted Thoughts Index and Global Indexes from the Beck Depression Inventory (BDI), Symptom Checklist 90R (SCL 90R), Inventory of Interpersonal Problems (IIP) and Target Problem Rating Scale (TPRS) for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Post-Termination and Follow-Up

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Table 3.5.2.5: Pearson Correlations between the Sessions Impact Scale (SIS) Hindering Impacts Index and the Global Indexes from the Beck Depression Inventory (BDI), Symptom Checklist 90R (SCL 90R), Inventory of Interpersonal Problems (IIP) and Target Problem Rating Scale (TPRS) for Prose plus Sequential Diagrammatic Reformulation (PSDR), Sequential Diagrammatic Reformulation (SDR) and Overall Patients at Post-Termination and Follow-Up

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Post-Termination and Follow-Up, although only the IIP correlated significantly at both time-points. By contrast, correlations for the SDR cohort were consistently in the low- to medium-negative range and, with the exception of the IIP at Post-Termination and Follow-Up, none were statistically significant.

Overall correlations between the SIS Unwanted Thoughts index and outcome indexes across cohorts, as reflected in Table 3.5.2.4, were in the low-negative and low-positive range, with no coefficient reaching statistical significance ($p < .05$). Within the PSDR cohort, a trend towards low-negative correlations with outcome indexes at Post-Termination was proceeded by a similar, albeit slightly increased, low- to medium-negative correlation trend at Follow-Up, although no coefficient reached statistical significance. A comparable pattern emerged in relation to patients in the SDR cohort, with the important difference that all correlation coefficients for this cohort were positive.

As regards the last of the SIS indexes (see Table 3.5.2.5), overall correlations between the SIS Hindering Impacts index and outcome indexes across cohorts were in the low-positive range and non-significant ($p > .05$). Within the PSDR cohort, a trend towards non-significant medium-positive correlation coefficients at Post-Termination altered to a predominantly low-medium non-significant correlation profile by Follow-Up, with the exception of a TPRS coefficient which increased slightly. Correlation coefficients for patients in the SDR cohort, on the other hand, tended to be in the non-significant low-positive range, with the exception of a significant medium-positive IIP coefficient at Post-Termination.
3.6 SUMMARY OF RESULTS

Results relating to the research questions underlying the study can be summarised under six sub-headings:

3.6.1 Severity of Baseline Psychological Distress

The first level of analysis concerned the presenting or baseline severity of patients' psychological distress on each outcome measure. The greater proportion (63%) of patients across the study presented with a BDI classification in the mild to moderate severity range, whilst 15% scored as severely and 22% as minimally depressed. With respect to the SCL 90R, the largest proportion of patients (46.7%) across the study presented with a GSI score in the mild range, whilst minimal, moderate and severe distress ratings were obtained for 33.3%, 13.3% and 6.7% of patients, respectively. Overall close to a third each of patients presented with minimal, mild and moderate interpersonal distress as measured on the IIP, while no patient rated their overall interpersonal distress as severe. The greater proportion (70%) of patients entered the Follow-Up interval with average baseline TPRS ratings in the mild to moderate range, whilst minimal and severe target problem ratings were reported by 7% and 23% of patients respectively.

3.6.2 Aggregate Analyses of Statistical Change

Aggregate analyses of statistical change on the BDI, GSI/SCL 90R, IIP and TPRS following 4-session reformulatory CAT indicated highly significant mean change from Screening to Post-Termination and Follow-Up. Interaction effects between treatment condition cohort and time-point were non-significant.
3.6.3 Effect Size Outcomes

Effect sizes calculated for each treatment cohort on the BDI, SCL 90R and IIP emerged as substantial (between 0.8 and 1.2) in the case of PSDR patients and, in the main, small (between 0.07 and 0.4) in the case of SDR patients. With respect to the TPRS, effect sizes were large for both treatment conditions, with a size advantage for the PSDR cohort.

3.6.4 Within-Group Analyses of Clinically Significant and Reliable Change

Within-group analyses of clinically significant and reliable change discriminated a more revealing outcome picture. In the case of the BDI, three quarters of PSDR patients and 11.8% of SDR patients showed clinically significant improvement by Post-Termination, although in the case of the former reliable change criteria reduced that rate by half. At Follow-Up, 60% of patients in the PSDR cohort and no patients in the SDR cohort showed clinically significant improvement, although again adjustments for reliable change in the case of the former lowered the proportion to half the PSDR cohort. No patient in either cohort made a clinically significant deterioration by Post-Termination or Follow-Up.

On the GSI/SCL 90R, 50% of PSDR patients and 10% of SDR patients showed evidence of significant and reliable improvement at Post-Termination and Follow-Up. One patient in the SDR cohort made a clinically significant and reliable deterioration by Post-Termination.

Within-group analyses of change on the third measure, the IIP, confirmed that over 40% of PSDR patients and 5% of SDR patients met dual improvement criteria by
Post-Termination, whilst 25% and 37% of patients in the respective cohorts made clinically significant and reliable improvement by Follow-Up. Clinically significant and reliable deterioration was evident within the SDR cohort in one case at Post-Termination and one case at Follow-Up.

With regard to the fourth and last of the outcome measures, the TPRS, 56% of the PSDR cohort and 48% of the SDR cohort met the standard deviation criterion for significant improvement. Only two (SDR) patients made a clinically significant disimprovement on the TPRS by Follow-Up.

3.6.5 Severity and Differential Psychotherapeutic Outcome

Overall, greater severity of presenting symptomatology and distress on the BDI, GSI/SCL 90R and IIP emerged as moderately associated with lower post-intervention improvement. In the case of the PSDR cohort this negative relationship was highly correlated.

3.6.6 Helpful and Hindering Dimension Ratings

Average patient ratings on the Sessions Impact Scale across the two cohorts suggest that both the PSDR and SDR treatment conditions were evaluated somewhat positively in terms of the Understanding, Problem-Solving and Relationship dimensions. The PSDR treatment condition emerged with an average arithmetic rating advantage over the SDR treatment condition in these domains, although differences were not statistically significant. Endorsements of the single-item Unwanted Thoughts dimension suggest that, on average, PSDR patients experienced unwanted thoughts associated with their treatment to a greater degree than SDR patients, although again differences emerged as non-significant. In relation to the negative impacts of sessions,
the findings suggest that patients evaluated their treatment as *not at all* hindering, regardless of treatment cohort.

### 3.6.7 Sessions Impact and Psychotherapeutic Outcome

Correlational analyses between positive impact domains and the four outcome measures employed in the study indicated, with some exceptions, predominantly non-significant low- to medium associations across cohorts, although coefficients for the PSDR cohort tended to be slightly higher. Correlational analyses based on SIS negative impact domains indicated a largely comparable profile of association with outcome measures.
CHAPTER 4

4-SESSION REFORMULATORY CAT AND OUTCOME:
A CASE STUDY EVALUATION
4.1 INTRODUCTION

This case study explores one illustrative example of the thirty-two 4-session CAT reformulatory interventions delivered and evaluated by the author during the course of the present study. The patient, fictitiously alluded to as ‘Mary’, was referred by her GP and treated at a surgery-based Clinical Psychology clinic. The case is selected from a cohort of ten consecutive referrals all of whom received both a Prose and a Sequential Diagrammatic Reformulation within their treatment (PSDR cohort). In order to preserve confidentiality, obvious identifying details have been altered although the case illustration represents an otherwise faithful account.

‘Mary’, aged 32 and married with two young children (2 and 4 years old), complained of cancer phobia, hypochondriacal obsessions and Irritable Bowel Syndrome, most notably since the birth of her second child. Her presentation contained distinct obsessive-compulsive hallmarks which met primary diagnostic criteria for the DSM IV classification (American Psychiatric Association, 1994). A central feature of ‘Mary’s’ anxiety involved ritualised checking of faeces for evidence of bowel cancer as often as four times daily. All medical tests for organic disease proved negative and her excessive attendance and reassurance-seeking at her GP surgery despaired ‘Mary’ and health care staff alike. Mary felt consumed in her preoccupation with bodily dysfunction and read health books voraciously in a vain attempt to quell her ever-spiralling anxiety about cancer. She reflected some insight into the procedural character of her health anxiety when she remarked ‘I know that I’m in the middle of a vicious circle’.
'Mary' worried that she might be neglecting her husband and children as so much of her attention and daily existence were dominated by cancer anxieties. By the time of assessment she had been absent three months from a part-time job in a department store due to the over-arching nature of her problems. 'Mary' complained of related long-standing problems with closeness and intimacy in relationships and admitted occasional distrust of her husband's fidelity despite acknowledging an absence of evidence. Pervasive feelings of rejection, domination and neglect had been experienced since childhood and 'Mary' quickly linked much of her distress back to her formative years. A particular problem area concerned her relationship with her mother whom she found intrusive and controlling and described as 'another hypochondriac with a craze for housework'. 'Mary' never felt good enough and found herself forever trying to avoid disapproval by striving to please or giving in to her. The arrival and extra demands of 'Mary's' second child had intensified her sense of inadequacy and neglect in a way that left her feeling out of control and unable to cope.

4.2 REFORMULATION PHASE

4.2.1 Sessions 1 to 3

The reformulation phase (Sessions 1-3) focused on the elicitation of 'Mary's history and clarification of the recurrent maladaptive strategies in her Target Problem Procedures. 'Mary' was raised an only child. She described a strict and unsettled upbringing, largely dominated by the ongoing tensions and conflict in her parents' marriage. She experienced her mother as an intolerant, controlling and cold woman who gave her sufficient material, but little emotional, comfort. Her earliest abiding
memory was her mother’s daily abandonment of her to the play-pen ‘so that she could get on with the more important housework’. ‘Mary’ recalled that she had always been afraid of upsetting her mother and quickly learned to survive a critical rejecting tongue by doing exactly as was expected of her. By contrast, father was characterised as an open and loving, albeit ‘hen-pecked’, parent who had always made time for ‘Mary’ and encouraged her throughout her upbringing. She acknowledged that her father was the source of any belief she had in herself and his unequivocal affection had always made her feel close to him.

Throughout her early years, home life was marked by constant parental conflict and the threat of marital, and family, separation. First attendance at Junior School was difficult for ‘Mary’ as many of the children seemed so much more ‘streetwise and confident’ than she had been allowed to become. However, in subsequent years she went on to do well at school and made good friendships. School came to represent a welcome break from her mother’s stifling overbearance and the tense atmosphere at home. By the time ‘Mary’ had reached her teenage years her struggle to assert an identity for herself was more apparent. Adolescence became a time of passive rebellion as she increasingly provoked the wrath of her mother by staying out late at night and drinking.

After taking ‘A’ Levels ‘Mary’ left school and gravitated towards work that she in retrospect feels undershot her capabilities. The intervening adult years have seen her continue to struggle with issues of individuation as she remained excessively influenced by her mother. Her identity at work, in relationships and even in the rearing
of her two children have all taken second place to the implicit or explicit approval of her mother. The ambivalence between dependency and angry abandonment was nowhere more apparent than in 'Mary’s resentment at her mother’s criticism of her mothering role while at the same time refusing to offer any assistance with caring for her grandchildren.

Regarding clarification of Target Problems and Target Problem Procedures 'Mary’s main concerns centred around her hypochondria, the management of her relationship with her mother and fear of closeness in relationships generally. She identified quickly with the essence of the Procedural Sequence Object Relations Model (See Section 1.2.4) and could articulate much of the feeling and thought central to the triggering and maintenance of the restrictive patterns underlying her distress. In the first session collaborative checking was used to clarify one dilemma (Checking and Reassurance Dilemma) before locating a generic version of the Procedure in the Psychotherapy File (See Appendix 2.8.1) which 'Mary’ was given to take away. A rationale for intersession diary-monitoring of hypochondriacal symptoms on the basis of context and preceding/accompanying thoughts was also negotiated.

The predominant focus of the second and third sessions was exploration of 'Mary’s responses to the Psychotherapy File with the aim of identifying recurrent procedural sequences and their evolution. The overwhelming feelings of out-of-control health-related anxiety which were precipitating excessive GP consultations were understood in the context of the controlling and overly-ordered relationship she had with herself and expected of others. An event illustrating her Checking and Reassurance Dilemma
occurred during the course of initial sessions: for fear of being overwhelmed by out-of-control health anxiety and feelings of insecurity "Mary" consulted her GP seeking unequivocal certainty and reassurance that she had not contracted cancer. Following absolute reassurances from her GP "Mary" felt some relief only to discover within a further two days that her anxieties about cancer were escalating again. She then booked a further consultation with her GP in order to seek repeated reassurance that critical prodromal symptoms might not have been overlooked.

A diagram, later incorporated into the Sequential Diagrammatic Reformulation was collaboratively drawn in order to clarify the sequential character of thought, action and emotion. "Mary" immediately recognised a Reciprocal Role Procedure based on a Controlling to Out of Control self as triggering and maintaining the cycle. In addition, with some help she was able to suggest a possible exit from the dilemma in the form of gradually reducing her checking and reassurance-seeking behaviour while at the same time learning to perceive in less absolutistic terms. This example also facilitated exploration of the development of the pattern historically since she was a young child. The controlling, rejecting relationship she had experienced at the hands of her mother had resulted in a survival self that coped by seeking to control and order feelings in absolute terms. "Mary" acknowledged that this pattern was as true for the manner in which she managed health worries as it was for any other area of her emotional life. The circularity of her distress became clear to her in session and further self-monitoring of the pattern using a diary was agreed.
In the same manner, two further dilemmas reflecting Control and Rejection in ‘Mary’s object relational core were identified and jointly elaborated using diagrams: one procedure in which feelings could only be externalised and legitimised with the approval of others; and a second in which distance in relationships was perceived as the only means of avoiding engulfment and smothering.

By the end of Session 3, ‘Mary’ appeared to have achieved substantial understanding of the nature of her difficulties, actively collaborating in sessions and demonstrating commitment to therapy by engaging with self-monitoring tasks. She reported early symptomatic improvement, particularly in relation to the Checking and Reassurance procedure, and I was alerted to the likely influence of placation issues in the therapy relationship. It was also thought that the themes of control and abandonment would be central, particularly in the context of a very brief intervention. These issues were raised and linked with the emergent patterns in ‘Mary’s problems in a way that enabled her to tentatively acknowledge the feelings.

4.2.2 Session 4

During Session 4, the culminating stage in the reformulation process, ‘Mary’ was read out, and handed over, the following Prose Reformulation with the objective of further validating and deepening her sense of her own history:

Dear ‘Mary’

You came seeking help having long suffered disabling worry about your health. In addition, you find it difficult to express your true feelings to your mother and in relationships. More generally, both trust and closeness have been problematic for you.

During the first couple of sessions you managed to acknowledge and explore the roots of some deeply threatening feelings - roots which have had an impact on much of the course of your life. You recall your early life with a mixture of
sadness as well as fond memories. Life outside the home was happy and full so that you got on well at school and enjoyed good friendships. Nearer to base, however, the atmosphere of your family life was less secure and you lived in fear of the regular conflict between your parents as they struggled to deal with the problems in their own relationship. You remember well feeling emotionally neglected and unloved by your mother as she channelled all her energy into the housework. While your mother always made it plain that she would ‘do’ anything for you she has not found it easy to express that affection and as a result you have little sense of what it is like to show affection yourself. During those formative years you experienced your mother as critical and stifling as she exerted excessive control over your identity and freedom right down to your adolescent years when you started to rebel a little. By contrast your relationship with your father became a source of your belief in yourself as he made part of you feel accepted and encouraged in a way which has always made you feel close to him.

However the overwhelming experience of those formative years in your flowering as an individual left you feeling dominated, neglected and insecure. To try and cope you found yourself keeping feelings bottled in fear of risking further rejection. Endless checking and seeking reassurance as well as striving for certainty and order became your best response to feeling that control was being taken from you. Similarly, keeping some distance between yourself and others important in your life came to be your best response to avoiding further engulfment and smothering. As these coping patterns continued into your adult life the result has become a vicious circle of spiralling mistrust, guilt and perceived rejection regarding others, and an increasing inner confusion at the loss of a sense of safety and self-worth.

The problems you brought for help concern over-worrying about your health, your relationship with your mother and closeness in relationships generally. The key self-defeating patterns underlying your distress which you can learn to recognise and revise through practise can be summarised as follows:

1. Bottling Feelings Pattern

Fearing the disapproval or rejection of others you often try to control your feelings as if there were only two extreme options: Either bottled up, always having to give in to others, with resentment festering, and then feeling guilty for it; Or burst open, offending others in an uncontrollable flood, becoming the object of resentment, with you left feeling ostracised and guilty.

The aim is to become increasingly aware of the pattern and to learn to break the sequence by expressing your feelings in a way which involves neither extreme.

2. Checking and Reassurance Pattern

When faced with the inevitable uncertainties in life you try to control your anxieties as if there were only two extreme options: Either striving for perfect order, always searching for certainty, forever checking and seeking reassurance,
and then reassurance about the reassurance, leaving you feeling terrified and out of control; Or fearing total chaos and disorder, flooded with uncertainty, drowning and unable to cope.

The aim is to become conscious of the vicious circle and to break the pattern, for example by resisting the search for reassurance so that you allow yourself to come to realise that life is neither absolutely ordered nor absolutely uncertain and that you can cope.

3. Engulfed by Others Pattern

You seek happiness and fulfilment in your relationships with people but you act as if there were only two extreme ways to be in relation to others: Either close to somebody, feeling smothered, always having to give in, left feeling angry and resentful at the control of others, and then feeling guilty; Or distant from others emotionally, in total control, feeling ‘safe’ but somewhat removed and isolated.

The aim is to begin to notice the self-defeating pattern as it happens and to begin to break the cycle by realising that it is possible to find closeness and safety at one and the same time in relationships in a way that doesn’t involve the extremes of engulfment or isolation.

The above three self-defeating patterns are illustrated on the Diagram which has already been provided so that you can work at recognising and revising them between now and your fifth session.

Following the reading aloud of the Prose Reformulation, ‘Mary’ sat in silence for a couple of minutes and seemed emotionally taken aback by the content. She stated that she felt somewhat overpowered by the starkness and accuracy of the letter as a summary statement of her life problems. She also made it clear that she felt understood for the first time in her life. No amendments or revisions were therefore made to the initial version.

Further discussion of the Prose Reformulation was then augmented by presentation of a Sequential Diagrammatic Reformulation (SDR) (See Figure 4.1). This represented an amalgamation of several smaller procedural diagrams which had been collaboratively produced across the first three sessions and as such contained no
2. Checking and Reassurance Pattern

3. Engulfed by Others Pattern

1. Bottling Feelings Pattern

- Always giving in to others
- Checking and seeking reassurance
- Feeling angry
- Feeling out of control
- Sensing fear of disapproval or rejection
- Hurting others
- Left feeling isolated and guilty
- Controlling, critical, rejecting, neglecting
- Controlled, criticized, rejected, neglected, insecure
- Insecure, always searching for certainty
- Feeling out of control
- Feeling isolated
- Permanent checking and seeking reassurance
- Feeling out of control
- Perfectly ordered
- Feeling perfectly ordered
- Feeling perfect.

Core Dialogue

- Try to control feelings
- Flooded with uncertainty
- Feeling out of control
- But isolated
- And still more reassurance
- Feeling geographically close
- Feeling geographically distant
- "Safe"
- "Safe"
- Feeling smothered
- Feeling angry
- Always having to give in
- In control
- Or distant
major surprises. The diagram appeared to help ‘Mary’ in consolidating her understanding of the patterning and predictability of her distress. Most palpable was her new-found optimism that she could use that increased understanding to overcome her difficulties. Potential aims and exits in relation to each Target Problem Procedure were reiterated and ‘Mary’ was encouraged to view increasing recognition and revision in these areas as the focus for the subsequent 12-week interval before the follow-up session. Self-monitoring using a diary, in combination with regular recourse to both reformulation devices, was specifically advocated as a continuing aid to learned personal change.

4.3 POST-REFORMULATION FOLLOW-UP PHASE

At the 3-month follow-up session, ‘Mary’ acknowledged that anticipation of the appointment had helped her to stay focused on the work of therapy, which in turn allowed her to build and maintain confidence in her ability to cope through her own resources. During the follow-up interval she had successfully made a return to work. She reflected on how ‘these sessions have really sunk in; I often find myself thinking about what I have learned from them’. Her account of the follow-up interval made it clear that she had actively continued to work on all three procedural areas and she frequently referred to the written tools of the intervention, the SDR and self-monitoring in particular.

‘Mary’s capacity for self-reflection and interpersonal problem-solving had notably consolidated. In terms of her TPPs, self-reported assertiveness with respect to feelings and needs was clearly growing. Checking and reassurance-seeking behaviours were by
this time transient and minimal, whilst ‘Mary’ was also feeling much more at ease and much less engulfed in her relationships, the outward manifestation of which had reportedly been noted by her husband. Core unmanageable feelings of domination, rejection and neglect had become manageably infrequent and short-lived where they did occur. Overall ‘Mary’s self-assessment seemed appropriately positive and balanced while at the same time she had evidently found a new confidence and appetite for living.

4.4 IDIOGRAPHIC AND NOMOTHETIC OUTCOMES

A range of repeated measures were administered to ‘Mary’ in order to allow psychometric determination of psychotherapeutic outcomes. The primary aim was to evaluate reduction in psychological distress using well-validated instruments. However, a process measure was also incorporated so that some assessment of helpful and hindering impacts arising from the intervention could be made. Selected measures comprised a Target Problem Rating Scale, the Beck Depression Inventory, the Symptom Checklist-90R, the Inventory of Interpersonal Problems and an adopted version of the Session Impacts Scale. Respective outcome findings for each measure are now presented.

4.4.1 Target Problem Rating Scale

A Target Problem Rating Scale was administered two weeks after Session 4 and again at the 3-month Follow-Up Session. This took the form of a Personal Questionnaire intended to measure distress arising from the initial presenting complaints, or Target Problems, which had been elicited at a screening appointment. The measure was completed by ‘Mary’ who was asked to rate the extent to which each Target Problem
had troubled her during the previous week on an ascending five-point scale, ranging from 0 (not at all) to 4 (extremely). Table 4.4.1.1 presents the results.

Table 4.4.1.1: ‘Mary’s Target Problem Ratings at Post-Termination and Follow-Up

<table>
<thead>
<tr>
<th>Post-Termination</th>
<th>At Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>TP1: Dealing with Mother</td>
<td>4</td>
</tr>
<tr>
<td>TP2: Hypochondria</td>
<td>2</td>
</tr>
<tr>
<td>TP3: Closeness to Others</td>
<td>0</td>
</tr>
</tbody>
</table>

‘Mary’s Target Problem ratings reflected significant change between Post-Termination (Mean TP rating = 2.0) and Follow-Up (Mean TP rating = 0.33). In relation to the study norm for the PSDR cohort, ‘Mary’s mean TP rating moved from 0.2 standard deviations above the cohort mean at Post-Termination to 1.3 standard deviations below the same mean at Follow-Up. As would be expected, she reported experiencing an increased preoccupation and disillusionment with the mother-daughter relationship for several weeks after the intervention. However, she described with some satisfaction how this escalation led to her assertively confronting her mother with her feelings and needs for the first time in her life, an experience which she summed up as ‘very therapeutic’. This event had since enabled ‘Mary’ to bridge a healthy emotional distance from the excessive influence of her mother and she had noticed the beginnings of a more respectful and considerate attitude between the two.

‘Mary’ had already reported a reduction in health-related anxiety during earliest sessions. By the time of follow-up, distress arising from hypochondriacal
symptoms was minimal and 'Mary' had not consulted her GP once during the previous 3 months. Similarly, self-reported distress arising from her third Target Problem, fear of emotional closeness to others, had dramatically disappeared when rated at Post-Termination and that improvement had sustained itself twelve weeks later. Mary's greater sense of feeling at ease in the company of family had also been noted by her husband who also remarked on improvements in her well-being generally.

4.4.2 Beck Depression Inventory

The Beck Depression Inventory (Beck et al., 1961) or BDI, was employed as a measure of the severity of depressive symptomatology. It was administered on four occasions: at pre-screening, at screening, two weeks after Session 4 and at the follow-up session. Results are presented in Table 4.4.2.1 below.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Screening</th>
<th>Screening</th>
<th>Post-Termination</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Index Score</strong></td>
<td>34</td>
<td>36</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

On the BDI 'Mary's Pre-Screening score placed her as functioning in the severely depressed range. Four weeks later at her screening appointment her measured depression was at a virtually identical level. However, on administration two weeks after Session 4 she evidenced dramatic improvement and scored within the asymptomatic or minimal range. Three months later at follow-up that improvement had been maintained. In relation to the study norm for the PSDR cohort, 'Mary's BDI rating met reliable change (RC) criteria and moved from 2.0 standard deviations
above the cohort mean at Screening to 1.33 and 1.5 standard deviations below the same mean at Post-Termination and Follow-Up, respectively.

4.4.3 Symptom Checklist-90R

A second standardised measure, the Symptom Checklist-90R (Derogatis , 1983), or SCL-90R, was employed as an overall measure of patient symptomatology. The measure was administered at identical intervals to the BDI above. Table 4.4.3.1 presents the results of repeated measurement for global and symptom cluster domains across the four intervals.

'Mary’s overall profile on the SCL-90R suggested considerable change and benefit in relation to her presenting symptomatology, pre-intervention. In the context of available SCL-90R norms ‘Mary’s pre-intervention score of 3.21 on the Global Severity Index (GSI) was considerably greater than the 1.26 average for the psychiatric outpatient population, thus confirming high levels of overall psychological distress (Derogatis, 1983). At the symptom cluster level, her presenting sub-scale scores were significantly elevated for virtually all domains, most notably Obsessive-Compulsiveness, Depression, Anxiety, Hostility and Phobic Anxiety. By the time of the third administration of the SCL90R, two weeks after Session 4, her GSI score of 0.67 reflected substantial improvement and placed her near to the 0.31 norm for the non-clinical population (Derogatis, 1983). Moreover at 3-month follow-up ‘Mary’s gains had been maintained and, in the case of the majority of scales, further improved upon.

In relation to the norm for the PSDR cohort, ‘Mary’s GSI score met reliable change (RC) criteria and moved from 2.51 standard deviations above the cohort mean at
Table 4.4.3.1: ‘Mary’s Symptom Checklist-90R (SCL90-R) Scores at Pre-Screening, Screening, Post-Termination and Follow-Up

<table>
<thead>
<tr>
<th></th>
<th>Pre-screening</th>
<th>Screening</th>
<th>Post-Termination</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI</td>
<td>2.59</td>
<td>3.21</td>
<td>0.67</td>
<td>0.16</td>
</tr>
<tr>
<td>PSDI</td>
<td>3.33</td>
<td>3.66</td>
<td>1.50</td>
<td>1.56</td>
</tr>
<tr>
<td>PST</td>
<td>70</td>
<td>79</td>
<td>40</td>
<td>9</td>
</tr>
<tr>
<td>Somatization</td>
<td>1.42</td>
<td>2.67</td>
<td>0.42</td>
<td>0.08</td>
</tr>
<tr>
<td>Obsessive-Comp</td>
<td>3.00</td>
<td>4.00</td>
<td>1.20</td>
<td>0.10</td>
</tr>
<tr>
<td>Inter Sensitivity</td>
<td>1.89</td>
<td>2.33</td>
<td>0.22</td>
<td>0.00</td>
</tr>
<tr>
<td>Depression</td>
<td>3.23</td>
<td>3.46</td>
<td>0.85</td>
<td>0.08</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3.50</td>
<td>3.9</td>
<td>0.5</td>
<td>0.00</td>
</tr>
<tr>
<td>Hostility</td>
<td>3.00</td>
<td>3.33</td>
<td>1.17</td>
<td>1.17</td>
</tr>
<tr>
<td>Phobic Anxiety</td>
<td>3.43</td>
<td>3.71</td>
<td>0.57</td>
<td>0.00</td>
</tr>
<tr>
<td>Para Ideation</td>
<td>1.33</td>
<td>2.50</td>
<td>0.83</td>
<td>0.00</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>2.50</td>
<td>3.40</td>
<td>0.40</td>
<td>0.10</td>
</tr>
</tbody>
</table>

Screening to 1.0 and 1.7 standard deviations below the same mean by Post-Termination and Follow-Up, respectively.

4.4.4 Inventory of Interpersonal Problems

The Inventory of Interpersonal Problems (Horowitz et al., 1988), or IIP, was employed as a measure of distress arising from interpersonal sources. As in the case of the two previous measures, administration of the IIP was repeated at intervals: at pre-screening, screening, post-Session 4 and at follow-up. ‘Mary’s scores relating to global and sub-scale domains on the IIP are presented in Table 4.4.4.1 below.
Consistent with the trend in relation to previous outcome measures, 'Mary's score profile on the IIP evidenced significant overall change across administrations. Before intervention her scores indicated high levels of distress on most dimensions of interpersonal functioning, notably areas highlighted during the reformulation phase: difficulties with saying 'No' to others (Hard to be Assertive); difficulties with attending to the needs of others (Hard to be Supportive); sharing self with others in a damaging way (Too Open); feelings of not being an autonomous person (Too Dependent); perceptions of losing temper, fighting and irritation with others (Too Aggressive); and difficulties with showing affection to

<table>
<thead>
<tr>
<th></th>
<th>Pre-Screening</th>
<th>Screening</th>
<th>Post-Termination</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIP Mean</td>
<td>2.24</td>
<td>2.32</td>
<td>0.71</td>
<td>0.09</td>
</tr>
<tr>
<td>Hard TB Assert</td>
<td>2.17</td>
<td>2.0</td>
<td>0.44</td>
<td>0.11</td>
</tr>
<tr>
<td>Hard TB Sociable</td>
<td>1.33</td>
<td>2.0</td>
<td>0.33</td>
<td>0.00</td>
</tr>
<tr>
<td>Hard TB Support</td>
<td>4.0</td>
<td>2.14</td>
<td>0.14</td>
<td>0.00</td>
</tr>
<tr>
<td>Hard TB Close</td>
<td>4.0</td>
<td>4.0</td>
<td>0.67</td>
<td>0.00</td>
</tr>
<tr>
<td>Too Responsible</td>
<td>0.75</td>
<td>1.25</td>
<td>1.50</td>
<td>0.00</td>
</tr>
<tr>
<td>Too Open</td>
<td>3.0</td>
<td>3.0</td>
<td>2.25</td>
<td>0.50</td>
</tr>
<tr>
<td>Too Dependent</td>
<td>3.20</td>
<td>3.6</td>
<td>0.80</td>
<td>0.20</td>
</tr>
<tr>
<td>Too Aggress</td>
<td>3.33</td>
<td>3.17</td>
<td>1.83</td>
<td>0.33</td>
</tr>
</tbody>
</table>

others (Hard to be Close). Indeed 'Mary's overall global score of 2.32 on the IIP when screened considerably exceeded the available norm of 1.56 for an outpatient
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psychotherapy department as reported in the psychotherapy research literature (Shapiro, 1994).

As for the BDI and SCL-90R, ‘Mary’s global IIP score exhibited significant improvement at the Post-Termination administration. In relation to the norm for the PSDR cohort, ‘Mary’s global IIP score met reliable change (RC) criteria and moved from 1.2 standard deviations above the cohort mean at Screening to 1.0 and 1.8 standard deviations below the same mean by Post-Termination and Follow-Up, respectively. Albeit temporarily, one dimension, Too Responsible, showed a slight elevation on the screening score (from 1.25 to 1.50), a finding which may have reflected an equally transitory increase in guilty feelings as ‘Mary’ started for the first time to handle her relationship with her mother more assertively. However, by follow-up improvements had been maintained or further extended on all sub-scale dimensions, with dramatic reductions to zero ratings in the case of half. As might be expected, comparison of the IIP and SCL-90R profiles in relation to the acceleration of change suggests that improvements peaked more rapidly for symptomatic than for (underlying) interpersonal distress, the latter evidencing greater reduction at the end of the follow-up period.

4.4.5 Sessions Impact Scale

In addition to measures of outcome, one process measure, the Sessions Impact Scale or SIS (Elliott and Wexler, 1994), was administered two weeks after Session 4 to enable some evaluation of the short-term subjective effects of the CAT reformulation intervention. ‘Mary’ was asked to rate a total of 15 helpful and hindering items on an ascending 5-point scale ranging from 1 (not at all) to 5 (very much). The results,
grouped according to the measure's five major factor clusters, are presented in Table 4.4.5.1 below.

'Mary's index rating profile across the SIS confirmed that she evaluated the intervention positively overall. Her ratings indicated that as a result of the four sessions she had developed new insights and understandings concerning herself and her relationships with others. She had become more aware of her true feelings and felt less distressed by them. 'Mary' felt understood, supported, encouraged and closer to

Table 4.4.5.1: 'Mary's Sessions Impact Scale (SIS) Scores at Post-Termination

<table>
<thead>
<tr>
<th>Index</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding Index</td>
<td>3.33</td>
</tr>
<tr>
<td>Problem Solving Index</td>
<td>4.0</td>
</tr>
<tr>
<td>Relationship Index</td>
<td>4.0</td>
</tr>
<tr>
<td>Unwanted Thoughts Index</td>
<td>4.0</td>
</tr>
<tr>
<td>Hindering Impacts Index</td>
<td>1.6</td>
</tr>
</tbody>
</table>

the author as therapist following the intervention. She was also left with a clear definition of problems to work on and the perceived means to tackle them.

A total of two item areas from amongst 15 were rated negatively. One rating indicated that as a result of sessions 'Mary' felt that she had been made to think of uncomfortable or painful thoughts or feelings that were not helpful. Another rating suggested a 'slight' belief that too much pressure or not enough direction had been forthcoming from the author as therapist. Both ratings could speculatively reflect the recurring experience of neglect and emotional distancing in 'Mary's life that had
become core themes in reformulation. However, it must also be acknowledged that for many patients very brief, focused interventions such as that under consideration will inevitably be experienced as pressurised, ‘not good enough’ care, regardless of any overall beneficial outcome. It is noteworthy that despite indicating these two areas of reservation within a fortnight of Session 4 ‘Mary’ confirmed no need for further sessions when probed at 3-month follow-up. This would suggest that earlier post-intervention apprehensions diminished over the course of the follow-up interval as perceived self-efficacy concerning therapeutic learning and change continued to grow.

4.5 REVIEW AND CONCLUSIONS

In the case of ‘Mary’, a very brief 4-session reformulatory CAT intervention dismantled from the fuller 16 session protocol evidently was associated with positive psychotherapeutic outcomes in the form of significant intrapersonal and interpersonal change. The integration of core cognition, behaviour and affect facilitated by the template of the Procedural Sequence Object Relations Model appeared to enable ‘Mary’ to conceive of the possibility of change in her life and it was notable how readily she identified with the notion of cyclical distress. The written materials and tools of CAT appeared to be powerful agents of change as they seemed to enable assimilation of early life and experience as well as the maintenance of goal-directed focus throughout the intervention. For both patient and the author alike the reformulation process became a guiding light for the management of change both within and outwith the consulting room. In particular, the diagrammatic reformulations jointly produced across sessions, and culminating in the full version SDR, allowed for greater alerting and sensitivity to in-session transference and
countertransference. In view of the nature of 'Mary's relationship with her mother in particular this was an important therapeutic tool, not least because our relationship might easily have been one in which the author enacted the role of controlling, rejecting caregiver and she became dominated and dependent
CHAPTER 5

DISCUSSION
5.1 INTRODUCTION
The volume and variety of the results obtained in the study necessitate division of this concluding chapter into subsections in order to maintain clarity and brevity. In general terms, the Discussion will follow the organisation of the Results chapter as it relates to the principal research questions and associated hypotheses of the study. The Discussion will continue with a consideration of the limitations of the study and suggestions for the direction of future research, before closing with conclusions from its findings.

5.2 FINDINGS IN RELATION TO RESEARCH QUESTIONS
The research described in this thesis has been concerned with a first-phase exploratory evaluation of two variations of 4-session reformulatory CAT as delivered to two small patient series in an NHS setting. The research aims underlying the study were five-fold: (i) to assess psychotherapeutic outcomes after the termination of either 4-session reformulatory CAT intervention; (ii) to assess the extent to which psychotherapeutic outcomes maintained, improved or deteriorated at 3-month follow-up; (iii) to assess patients’ subjective evaluation of the intervention in terms of its helpful and hindering impacts; (iv) to assess the relation between patients’ subjective evaluation of the impact of the intervention and psychotherapeutic outcomes; and (v) to assess any differential impact of severity of presenting psychological distress on psychotherapeutic outcomes following 4-session reformulatory CAT. The findings in relation to each research hypothesis are now considered.
5.2.1 Did patients show measurable improvement after either 4-session reformulatory CAT intervention?

The principal research question in this study concerns psychotherapeutic outcomes following two variations of 4-session reformulatory CAT. The overall findings in relation to the 32-patient sample indicate highly significant mean change on outcome measures following 4-session reformulatory CAT. Findings confirm that at Post-Termination patients in the PSDR cohort as a group achieved substantial effect size improvement. Patients in the SDR cohort on average achieved small improvements. Within-group analyses of individual change suggested that a large proportion of patients in the PSDR cohort and a small proportion of SDR patients achieved clinically significant and reliable change at Post-Termination. A proportion of outcome scores in both cohorts did not meet dual criteria for significant change, positive or negative. The findings in relation to clinically significant and reliable deterioration indicated that at Post-Termination two SDR patients (9.1%) disimproved, each on one of two instruments.

Interpretation and comparison of the results in relation to each measure can at best be speculative, not only due to limiting factors in the size, design and scope of the study, but also on account of the dearth of evaluated planned 4-session interventions in the psychotherapy literature with which to make initial comparisons. However, as preliminary findings the results do suggest that a reformulatory CAT intervention influenced significant treatment outcomes for a proportion of patients in this study and as such the approach warrants further investigation. In the case of the BDI, the overall finding across cohorts of an 0.4 effect size for 4-session reformulatory CAT
suggests that this model of intervention was associated with a measurable improvement in depressive symptomatology. The large effect size discrepancy between the PSDR cohort (ES= 1.2) and SDR cohort (ES= 0.1) may have reflected an impact of Prose Reformulation on BDI outcome although the present study is clearly unequipped to confirm such differential issues. Similar speculation is attracted by the results relating to individual change, which indicate that more than a third (37.5%) of PSDR patients and 11.7% of SDR patients achieved clinically significant and reliable improvement on the BDI at Post-Termination. Notably, forty one per cent of the SDR cohort made no clinically significant change, positive or negative, although it is also noteworthy that no patient in either cohort made a clinically significant deterioration on the BDI at Post-Termination.

The findings in relation to the Global Severity Index (GSI) of the SCL 90R suggest that this instrument was associated with the largest improvement in psychotherapeutic outcomes across the two cohorts. An effect size of 0.5 for the 32-patient sample on the GSI suggests that on average patients achieved a demonstrable reduction in general symptomatology following 4-session reformulatory CAT. As with the BDI, a large effect size difference between the PSDR cohort (ES= 1.1) and SDR cohort (ES= 0.3) adds speculation to the possible specific impact of Prose Reformulation on outcome. Interestingly, among the primary symptom dimensions on the SCL 90R the Interpersonal Sensitivity sub-scale (perceptions of personal inadequacy and inferiority) emerged with the largest effect size (1.4) for the PSDR cohort, followed by the Depression sub-scale (1.2). One speculation on this finding might be that the integrative function of the Prose Reformulation claimed by Ryle (1990, 1995)
mediated an increase in perceived locus of control and self-esteem, with a consequential reduction in the extent and severity of symptoms.

The IIP, itself devised on the basis of psychotherapy research, is the standardised measure on which measurable change would have been most readily predicted to occur. Similar to the BDI and SCL 90R, 4-session reformulatory CAT was associated with a measurable improvement in distress arising from interpersonal sources for patients overall (ES= 0.3). Speculation on the specific effects of Prose Reformulation is also warranted by effect size findings on the IIP. The full-scale IIP score showed a large effect size (0.8) for the PSDR cohort and a small effect size (0.1) for the SDR cohort. Moreover, a consistent trend towards large effect sizes across all IIP sub-scales (with the exception a medium effect size for Too Open) in the PSDR cohort would suggest that as a group these patients may have experienced improvement in relation to all four of what Gilbert (1989) has termed the basic social competencies: competition, socialising, nurturance and independence.

One of the advantages of employing widely-used outcome instruments is that preliminary comparison with available service norms and data from several published research sources becomes possible. Table 5.2.1.1 presents PSDR and SDR effect sizes for the BDI, SCL 90R and IIP alongside effect size data (where calculable) for Barnsley Psychological Health Care (BPHC; Kellett, 1995), Denman (1995) and Barkham and Shapiro (1990). The BPHC effect size is calculated from an audit of three hundred consecutive patients referred to the host service for the present study and treated with a range of psychotherapeutic approaches (Mean treatment
dosage= 8 sessions), while effect sizes from Denman (1995) were calculated from an uncontrolled outcome evaluation of standard-duration (i.e. 16-session) CAT with thirty-two patients referred to a specialist psychotherapy service, as outlined earlier (See Section 1.8). Effect sizes from Barkham and Shapiro (1990) were calculated from their published data on twelve patients in a pilot evaluation of brief prescriptive and exploratory therapy within a Two-Plus-One model (See Section 1.4.2.2)

Table 5.2.1.1: Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Effect Size Comparisons with Barnsley Psychological Health Care (BPHC), Denman (1995) and Barkham and Shapiro (1990) on the Beck Depression Inventory (BDI), the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R) and the Inventory of Interpersonal Problems (IIP)

<table>
<thead>
<tr>
<th></th>
<th>BDI</th>
<th>SCL 90R</th>
<th>IIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSDR</strong></td>
<td>1.2</td>
<td>1.1</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>SDR</strong></td>
<td>0.1</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>BPHC</strong></td>
<td>1.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Denman (1995)</strong></td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Barkham and Shapiro (1990)</strong></td>
<td>1.5</td>
<td>1.0</td>
<td>-</td>
</tr>
</tbody>
</table>

It can be seen from Table 5.2.1.1 that on the basis of a preliminary comparison with psychotherapy service norms and findings from selected brief therapy research the BDI effect size for the PSDR intervention ranks favourably. Despite cross-study variability in sampling, clinical dysfunction and treatment factors, initial findings would suggest that the potential value of 4-session reformulatory CAT among the range of psychotherapeutic interventions offered in an NHS setting, either
as a stand-alone brief intervention or as a waiting-list treatment, merits further investigation.

One of the principal sources of practical interest in brief psychotherapy has been a concern for cost-effectiveness in the context of scarce health care resources. The model under consideration in the present study addresses this issue directly by employing a very brief psychotherapeutic intervention totalling four sessions. The finding that between 37.5 and 50% of patients in the PSDR cohort achieved clinically significant and reliable improvement by Post-Termination after only four sessions (depending on the outcome instrument selected) suggests that reformulatory CAT may constitute one brief treatment alternative warranting future cost-effectiveness research. Of course, it could be argued that change at Post-Termination was a function of cumulative change across time (spontaneous remission) rather than of the intervention. However, while the intervals between Pre-Screening, Screening and Post-termination were not uniform, the finding that no significant differences obtained between the two baseline assessments for each measure lends some support to the conclusion that extraneous change was not reliable pre-intervention.

5.2.2 Were measurable gains in psychotherapeutic outcome maintained at 3-month follow-up?

A related outcome question of central interest to the study concerns the maintenance and extension of psychotherapeutic gains across time following either 4-session reformulatory CAT intervention. Overall, the findings in relation to the 32- patient sample and 4-session reformulatory CAT indicate highly significant mean change on
outcome measures at 3-month follow-up. Effect size results on the three standardised outcome measures suggest that at Follow-Up patients in the PSDR cohort on average achieved large improvements and, with the exception of one instrument, patients in the SDR cohort on average achieved small improvements. Within-group analyses of individual change suggested that a sizeable proportion of patients in the PSDR cohort and, with the exception of one standardised measure, a small proportion of patients in the SDR cohort achieved clinically significant and reliable change at Post-Termination. In relation to idiographically measured change, the results suggest that a substantial proportion of patients in each cohort made significant improvements in relation to their individually targeted problems at Follow-Up. Clinically significant deterioration at Follow-Up occurred for one SDR patient on the IIP and two SDR patients on the TPRS.

As for the results at Post-Termination, interpretation of the findings in relation to each measure is limited by methodological and design factors. As preliminary findings, however, these results do suggest that a reformulatory CAT intervention was associated with psychotherapeutic benefits for a proportion of patients at Follow-Up, adding further weight to justifications for a controlled trial. In the case of the BDI, the overall finding across cohorts at both Post-Termination and Follow-Up of an 0.4 effect size for 4-session reformulatory CAT suggests that the measurable improvements in depressive symptomatology associated with this model of intervention were maintained, at least over a period of three months. Moreover, the large Follow-Up effect size discrepancy between the PSDR cohort (ES= 1.2) and SDR cohort (ES= 0.1) attracts further speculation concerning the possibility of a
differential role for Prose Reformulation with respect to outcome. The findings in relation to individual change are also interesting in this regard as they indicate that half of the PSDR cohort and no SDR patients achieved clinically significant and reliable improvement on the BDI at Follow-Up. This indicates an increase from Post-Termination to Follow-Up in the proportion of patients with measurable gains and suggests that for some patients in the present study improvements following 4-session reformulatory CAT only begin to emerge in the follow-up interval. It is also notable that no patient in either cohort made a clinically significant deterioration on the BDI at Follow-Up.

The findings in relation to the Global Severity Index (GSI) of the SCL 90R suggest that this instrument was associated with the largest improvement in psychotherapeutic outcomes across the two cohorts at Follow-Up. An effect size of 0.6 for the 32-patient sample on the GSI suggests that on average patient reductions in general symptomatology following 4-session reformulatory CAT were maintained at three-month follow-up. As with the BDI, the maintenance of a large effect size difference between the PSDR cohort (ES= 1.1) and SDR cohort (ES= 0.4) indirectly attracts speculation on Prose Reformulation and outcome. Interestingly, among the primary symptom dimensions for the PSDR cohort, the Paranoid Ideation subscale (disordered thinking and delusions) emerged as having extended its already large Post-Termination effect size (1.1) the most at Follow-Up (1.4). Once again, the Interpersonal Sensitivity and Depression sub-scales also emerged among the primary symptom dimensions with large effect sizes in the PSDR cohort at Follow-Up (1.2 and 1.1, respectively). A recurrent theme concerning negative self-evaluation could be
seen to add weight to a previous speculation that the Prose Reformulation may mediate an increase in perceived locus of control and self-esteem, with a consequential reduction in the extent and severity of symptoms.

Follow-Up results relating to individual change on the SCL 90R also indicated stability of measured gains, with PSDR and SDR cohorts reflecting rates of significant improvement identical to Post-Termination levels (50% and 10%, respectively). No patient in either cohort deteriorated significantly at Follow-Up.

The IIP results indicated that measurable improvements in interpersonal distress associated with 4-session reformulatory CAT at Follow-Up were maintained and extended, with the overall effect size increasing from 0.3 to 0.5. As on previous instruments, the speculated specific effect of Prose Reformulation found further support from Follow-Up findings which reflected a continuing large effect size for the PSDR (ES= 0.9) and moderate effect size for the SDR (ES= 0.4) cohorts. Interestingly, the sub-scale with the lowest effect size (0.4) for the PSDR cohort at Post-Termination, Too Open, reflected a doubling of effect size (0.8) at Follow-Up. One interpretation of this finding might be that the integrating impact of the reformulation process has a cumulative post-intervention effect on the pattern of sharing oneself with others in a damaging way.

The findings relating to individual change on the IIP at Follow-Up, however, ran contrary to the trend on previous measures. In the case of the PSDR cohort, while the proportion of patients meeting dual criteria for significant improvement remained
sizeable, it dropped from 42.8% at Post-Termination to 25% at Follow-Up. Contrarily, the proportion of SDR patients showing improvement increased from 10% at Post-Termination to 37% at Follow-Up. One patient in the SDR cohort made a clinically significant deterioration on the IIP at Follow-Up. Small sample size limits the interpretability of these findings. One possible explanation may be that significant life events during the follow-up interval depressed the improvement rate in the PSDR cohort.

One patient in the SDR cohort deteriorated significantly on the IIP at Follow-Up.

The only idiographic measure employed in the study, the TPRS, was completed twice by patients: at Post-Termination and at Follow-Up. Outcomes on an individualised instrument might be expected to reflect more measurable change than in the case of standardised instruments. In comparison with the standardised measures, the absence of target problem ratings at the pre-intervention stage restricts the evaluation of TPRS change across time. Overall, the TPRS finding of an effect size of 0.8 across cohorts at Follow-Up suggests that measurable improvements in individualised target problems were associated with this model of intervention. While the greater effect size was obtained for the PSDR cohort (1.0), a large effect size was also obtained for the SDR cohort (0.7). The findings in relation to individual change also indicate significant improvement, with 56% of the PSDR and 48% of the SDR cohorts meeting the standard deviation criterion. Two SDR patients made a clinically significant disimprovement at Follow-Up. Overall, the greater extent of change in idiographic
compared to nomothetic change suggests that appropriately different aspects of functioning were being sampled by the TPRS and the other three standardised measures.

5.2.3 Did patients evaluate either 4-session reformulatory CAT intervention as helpful?

A further research question of interest to the study was patients' subjective short-term evaluation of the helpful and hindering impacts of 4-session reformulatory CAT. A number of researchers have suggested that rate of therapeutic change is accelerated when a time limit is imposed on psychotherapy (Eckert, 1993; Shapiro et al., 1994; Reynolds et al., 1996). Features of brief therapy that have been identified as potential catalysts of accelerated change, and are also characteristic of the CAT approach, include high levels of therapist activity, establishing specific but limited goals, maintaining a clear focus, and setting an explicit time limit (Reynolds et al., 1996). Moreover, there is now considerable qualitative and quantitative research supporting an assimilation model of therapeutic change in which a successful resolution of a problematic experience is dependent on patients' progression through a number of predictable stages (Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro and Hardy, 1990). Progression through the stages is marked by changes in patients' affective experiences and in the cognitive salience of the problems. The stages comprise: (0) warded off, (1) unwanted thoughts, (2) vague awareness-emergence, (3) problem statement-clarification, (4) understanding-insight, (5) application-working through, (6) problem solution, and (7) mastery. Research on session impact in psychotherapy has suggested that acceleration of therapeutic change in brief therapy is
mediated by more rapid progression through the assimilation stages than is the case in therapy of longer duration.

Impact refers to a session's immediate subjective effects, including (a) patients' evaluation of its helpful or hindering impact, (b) their relationship with the therapist (e.g., warmth, trust, support), and (c) their assessment of session tasks and accomplishments (e.g., achieving understanding, solving problems). Measures of impact concern patients' internal reactions to sessions, which logically must intervene between in-session events and the longer-term outcomes of treatment. In the present study, patients were asked to complete the SIS on just one occasion at the end of their intervention, rather than session-by-session for which the measure was initially devised (Elliott and Wexler, 1994). However, by exploring the overall pattern of sessions impact for patients in the PSDR and SDR cohorts a preliminary evaluation of their experience of the therapeutic process and progression through the assimilation stages can be attempted.

Overall, patient ratings on the SIS across the two cohorts converged in the mid-range and suggest that both variations of reformulatory intervention were evaluated as helpful by patients. Considerable consistency in evaluation of both the positive and negative impact domains of the SIS emerged across The PSDR and SDR cohort. The findings in relation to each of the five indexes as they apply to the PSDR and SDR cohorts will now be discussed:
5.2.3.1 Understanding Index

Ratings on the Understanding index indicated that on average patients endorsed the mid-range on this dimension, regardless of cohort. This finding suggests that patients experienced somewhat greater insight or understanding about cognitive, affective or behavioural aspects of the self and of others. It also suggests that patients acquired somewhat greater awareness or clarity about significant feelings, thoughts or memories. Such impacts are clearly consistent with the raison d'être of the reformulation process in CAT and lend some confirmation to the accuracy of its technical delivery. This finding suggests, moreover, that in terms of the assimilation model of therapeutic change, patients in both interventions evaluated themselves as having made progress towards the stage of understanding and insight in relation to their problematic experience.

5.2.3.2 Problem Solving Index

In relation to the Problem Solving index, on average patients across the two cohorts endorsed the upper mid-range on this dimension. The finding suggests that patients became somewhat clearer concerning both appropriate goals for change in life and possible ways of progressing towards them. Again, this finding would be anticipated from the early collaborative identification of appropriate aims and exits from target problem procedures in the CAT reformulation process. In terms of the assimilation model of therapeutic change, this finding supports the conclusion that patients in both cohorts evaluated themselves as having made progress towards the stages of clarification and solution in relation to their problematic experience.
5.2.3.3 Relationship Index

Ratings on the Relationship index indicated that on average patients endorsed the mid-range on this dimension, regardless of cohort. This finding suggests that patients felt somewhat more deeply understood, supported or encouraged towards coping by their therapist, the author, and somewhat experienced relief from distressing feelings. It also suggests that patients perceived a somewhat trusting and mutual patient-therapist relationship to have developed. These impacts lend indirect support to Ryle’s (1990, 1995) claim that one of the central functions of the reformulation process is to cement the therapeutic alliance through a collaborative therapeutic style. In terms of the assimilation model of therapeutic change, endorsement of these impacts suggests that patients in both interventions evaluated themselves as having made progress towards the stage of working through conflicts relating to their problematic experience.

5.2.3.4 Unwanted Thoughts Index

On average, patients across cohorts endorsed the lower-range on the Unwanted Thoughts dimension. This finding suggests that patients slightly experienced uncomfortable or painful ideas, memories, or feelings that were perceived as unhelpful and to be avoided. Such impacts would be predicted from the model of therapeutic change underlying CAT, which views integration of often disavowed thoughts and feelings with behaviour as necessary to progress. In terms of the assimilation model of therapeutic change, this finding suggests that patients in both interventions evaluated themselves as having had to struggle with warded off and unwanted thoughts in relation to resolving their problematic experience.
5.2.3.5 Hindering Impacts Index

Regarding the negative impacts of sessions, ratings on the Hindering Impacts index indicated that on average patients across cohorts endorsed the very low range on this dimension. This finding suggests that overall patients did not feel misunderstood, attacked or confused by their therapist, the author. The finding also suggests that overall patients did not experience too much pressure or insufficient direction from their therapist; nor did they come to feel impatient or doubting of the value of their intervention.

The low Hindering Impact ratings across cohorts support a conclusion that overall the active, focused and time-limited emphasis of 4-session reformulatory CAT was not experienced as unhelpful by patients. However, factor-analytic research on this dimension has sounded a note of caution in relation to interpretation. A relative scarcity of endorsements of items on the Hindering Impacts index led Stiles et al. (1994) to suggest that the index may be less a continuous scale and more a flag for distinctively difficult sessions or problematic therapeutic relationships.

Considered together, findings from a single end-of-treatment administration of the SIS allow at best an initial exploration of the differentiated impacts of 4-session reformulatory CAT. The profile of patients’ endorsements of helpful and hindering items suggests that overall both reformulatory interventions were evaluated positively. Moreover, the range of impact dimensions endorsed suggests that patients evaluated themselves as having made progress in the direction of many of the stages conceptualised in the assimilation model of therapeutic
change. Equally, endorsement of both of what can broadly be termed as process- and task-accomplishment domains on the SIS suggests that patients experienced integrative change in both affective and cognitive experience. Whereas psychodynamic and cognitive behavioural approaches to psychotherapy traditionally tend to focus on differing domains and stages of the assimilation continuum, a defining feature of the reformulation process in CAT, and arguably the basis of its effectiveness, is that it seeks to attend to and integrate change in both feeling and thought.

Within the context of patients' endorsements of the helpful and hindering impacts of reformulatory CAT it is appropriate to consider the related issue of treatment completion. The finding that all thirty-two patients completed their intervention through to completion lends further speculative support to the acceptability of reformulatory CAT as a brief treatment. While the scope and design of the study does not allow definitive comment on the factors determining the positive completion rate, the impact ratings profile suggests that the focused integrative approach to process issues and task accomplishment may be important contributary factors. At a more general level, brief psychotherapies of many complexions are known to engender high activity levels in patients and thereby reduce passivity and treatment drop-out (Garfield and Bergin, 1994).

Structural factors in service delivery are also likely to have played a part in the treatment completion rate of the present study. All thirty-two patients were referred by GPs with whom over several years of primary care working the author had
established clear mutual expectations and consensus around appropriate referrals. Moreover, motivation to enter and complete treatment was indexed through the routine use of a service 'opt-in' system that involved a patient information leaflet, the return of three completed psychometric measures, and a requirement to make contact with the author’s service within a two-week interval.

5.2.4 Were patients' ratings of the impacts of 4-session reformulatory CAT related to psychotherapeutic outcome at Post-Termination and Follow-Up?

A fourth research question in the study addressed the relation between patients’ subjective evaluation of the helpful and hindering impacts of 4-session reformulatory CAT and psychotherapeutic outcomes. Overall findings from the study suggested a predominantly low to medium negative association between sessions impact and psychotherapeutic outcome, lower outcome scores at Post-Termination and Follow-Up being associated with higher ratings of session impact. Many correlation coefficients, however, were non-significant.

In relation to the SIS Understanding index, findings indicated a non-significant low to medium association with outcome at both intervals for the PSDR cohort. A high and significant correlation (-0.8, p= .009) obtained in the case of just one outcome measure, the SCL 90R, at Post-Termination. One possible interpretation of this finding may be that patients' experiencing of new insight into aspects of the self and others, in addition to the acquisition of greater clarity about significant feeling and thoughts, was linked to reductions in overall
symptomological distress. Correlations in relation to the SDR cohort were all low-negative and non-significant.

Findings of a low association between the SIS Problem Solving, Unwanted Thoughts and Hindering Impacts indexes and psychotherapeutic outcome proved non-significant and therefore unreliable. Moreover, the underendorsement of the Hindering Impacts index as a continuous scale is likely to have invalidated the Pearson product-moment correlation and questions the appropriateness of parametric statistics with this SIS domain.

The only index revealing a substantive relationship with outcome was the SIS Relationship index. The findings suggested a statistically significant profile of low- to high-negative association with the three standardised measures. This finding may suggest that the supportive influence of the patient-therapist relationship or therapeutic alliance was linked to a reduction in symptomatology and interpersonal distress.

The disparity in sample sizes and variability of patient scores within cohorts may have distorted the correlation analysis in this study. Notwithstanding, the predictive validity of the SIS would appear to be an issue for further research. In this study, SIS ratings did not appear significantly predictive of psychotherapeutic outcome. Nowhere was this more evident than in the case of the one idiographic measure employed, the TPRS, where an association between progress in individualised target problems and subjective impact would have been strongly predicted. The results from the present
study suggest that SIS ratings may bear only a limited relation to outcomes such as symptomatology and interpersonal distress, as they tap into a qualitatively different satisfaction with aspects of therapeutic process. However, predicting change at the session level and linking session impact to outcome are complex problems requiring sophisticated analyses. Qualitative and quantitative investigations of individual sessions with particularly high or low impact ratings or that show dramatic change on target problem ratings might be a useful starting point.

5.2.5 Was severity related to psychotherapeutic outcome following 4-session reformulatory CAT?

A subsidiary research question in this study addressed the differential impact of severity of presenting psychological distress on psychotherapeutic outcome following either 4-session reformulatory CAT intervention. Approximately two thirds of the 32 patients evaluated in the study presented with baseline severity of symptomatology and interpersonal distress in the mild to moderate range, with the remaining third scoring within the minimal and severe boundaries.

The results overall were in the predicted direction and indicated that severity as measured on the BDI, SCL 90R and IIP at Screening was negatively correlated with outcome status on these instruments at Post-Termination and Follow-Up. In clinical terms, the greater was the disturbance in functioning as assessed prior to intervention, the poorer was the measurable improvement post-intervention. The size of the negative correlation for the overall 32-patient sample was an almost identical medium -0.5/-0.6 on each of the three instruments at both time intervals. The broad finding is
consistent with the dose-response curve literature which, in addition to a linear relationship between the log of the number of sessions and the probability of patient improvement, has demonstrated a differential responsiveness to psychotherapy relating to the severity and complexity of mental health problems (Howard et al., 1986; Howard, Lueger, Maling and Martinovich, 1993; Horowitz et al., 1988). This finding highlights the importance of implementing a future predictive study with the aim of identifying those patients for whom this model of intervention might be well suited.

5.3 LIMITATIONS OF THE STUDY AND DIRECTIONS FOR FUTURE RESEARCH

By its very nature, this small-scale exploratory study represents the earliest phase in the psychotherapy research sequence depicted by Salkovskis' (1995) ‘hourglass’ metaphor. The study is neither directed nor equipped to make strong causal inferences linking treatment to effects. Its purpose is confined to an initial field evaluation of two as yet untested treatment approaches, rather than a rigorous trial of clinical effectiveness. In relation to the ‘hourglass’ sequence, this research has been explicitly conducted in the absence of the rigour normally associated with systematic controlled trials, in order that the potential value and feasibility of establishing an RCT and large-scale naturalistic trial in the future can be ascertained.

Small-scale exploratory studies such as the present one are inherently restricted in the generalisability of their findings. Limitations in the present research reflect compromises of methodology, design and evaluation. In terms of the informativeness
of this study, and its contribution and integration in the broad body of psychotherapy research, specific limitations concerning design, sample characteristics, procedures, therapist factors, assessment and statistical evaluation are now considered. Research limitations will be linked to suggestions for future research.

5.3.1 Design Factors

Design factors in a preliminary patient series treatment study necessarily preclude definitive cause-effect inferences. While the outcomes associated with 4-session reformulatory CAT reported in this study merit further investigation, the research design does not allow a systematic test of treatment effectiveness. The study does feature a pre-intervention quasi-waiting list condition and allows an initial exploration of the outcomes of two alternative variations of a treatment approach. However, the absence of true comparison treatment and/or waiting-list control conditions and insufficient control over possible sources of bias and threat to validity (e.g., history, maturation, testing etc.) all constrain the inferential power of the study.

In the continuing context of the ‘hourglass’ metaphor for the developmental sequence of psychotherapy research, it would seem important that the design of future outcome studies building on the exploratory findings of the present research should entail rigour and control. Two stages of research design in sequence would seem critical to establishing the definitive utility of 4-session reformulatory CAT, one more appropriate to the research clinic and the other to service settings. Firstly, more robust controlled studies, conducted along the lines of an RCT factorial design, comparing the two variations of this intervention with a waiting-list condition and alternative formulatory interventions (for e.g., derived from cognitive behaviour therapy) would
allow confirmation or disconfirmation of the promise of early phase investigations. An RCT design would be equipped to establish the extent to which 4-session reformulatory CAT is an advance on other very brief approaches. Equally, this research design could be employed to demonstrate the extent to which the effects of 4-session reformulatory CAT might be attributable to its theoretically-derived key features by comparing it with similar brief approaches lacking these (e.g., a brief dynamic formulatory intervention).

A further stage of research design, however, would seem critical to testing the generalizability of RCT findings on 4-session reformulatory CAT to everyday clinical practice. This would necessarily involve a relaxation of the rigour associated with the RCT design in favour of the representativeness of psychotherapy services as delivered. Studies of 4-session CAT employing group comparison designs with weaker controls in addition to ‘naturalistic’ larger-scale research projects would both be both appropriate to establishing the clinical effectiveness of the approach in the field.

### 5.3.2 Patient Sample Factors

A full specification and description of defining patient and demographic descriptors is critical in psychotherapy research as such sample characteristics are often related to clinical dysfunction and adaptive functioning in ways that may impact treatment outcome (Kazdin, 1994, Garfield, 1994). As such, these variables may contribute to the generizability of research findings and are therefore relevant to future replication studies. While the present study sought to adequately profile key sample characteristics, it did not include important domains such as ethnicity, intelligence and
achievement. Moreover, none of the sample characteristics were factored into the statistical analysis of treatment outcomes as independent variables. Future outcome research on 4-session reformulatory CAT might usefully address these limitations.

Small-scale patient series studies in service settings are suited to exploring treatments to which patients have been allocated under naturalistic conditions. In controlled psychotherapy outcome research, the matching of participants on critical sample characteristics, such as severity of clinical dysfunction, and their assignment to alternative treatments or control conditions by randomisation, influences the confidence that group differences reflect the effects of manipulation. In the present study, patient groups were neither matched for size and sample characteristics nor randomised to the PSDR and SDR treatment variations, with the result that the two cohorts were not equalised prior to intervention. Future controlled studies of 4-session reformulatory CAT should attempt to select participants at very least on the basis of mental health problems of similar type, severity and breadth. In addition, the likelihood that study groups are equivalent should be optimised through a combination of adequate sample sizes and randomisation.

5.3.3 Procedural Factors

A pivotal issue in the design of a treatment outcome study is the faithful representation of the treatment approach under investigation. The objective is to ensure that the intervention being tested is not a unique or idiosyncratic version that has little relation to the treatment as usually conceived, practised or researched. Over
the last twenty years, the field of psychotherapy research has benefited considerably in this regard through advances in the manualisation of treatment (Kazdin, 1994).

A limitation of a small-scale study such as the present one is that no data permitting evaluation of treatment integrity can be provided. While the author attempted to adhere to the structured guidance on the reformulatory phase of CAT offered by Ryle (1990, 1995), no procedural checks on the delivery of the intervention were included. As a result, the possibility that the observed differences in outcome relating to the two treatment variations (PSDR and SDR) may reflect variation in treatment integrity cannot be ruled out. Checks on procedure are all the more important in service-based studies such as this, where as a matter of course all manner of departures from planning can add variability to outcome results.

Future controlled studies of 4-session reformulatory CAT might address this deficiency in several ways. In addition to formal CAT training, concurrent case supervision, listening to or viewing tapes of selected sessions, meeting regularly with therapists to provide feedback, are all likely to reduce therapist drift from protocol practice. However, definitive evaluation of treatment integrity can only really be carried out on the basis of audio- or video-tape examination after treatment has been completed. Codes for therapist and/or patient behaviours could be used to operationalise important features of reformulatory CAT and help determine whether the intervention was delivered as intended. Indeed, pioneering CAT research in this area has already been initiated by Bennett (1998) who developed a model of therapist competence in resolving transference enactments.
5.3.4 Therapist Factors

Another limitation of the present patient series study concerns the role of the author as sole therapist and, at the same time, sole evaluator. In general, controlled psychotherapy research would seek to make implausible the possibility that treatment outcome differences or the absence of differences can be attributed to therapist factors such as training and competence unless, of course, evaluation of these features was of direct interest in the design of the study. The author performing the role of therapist in this study was, at the time, at a pre-certification stage in CAT training and also possessed limited post-qualification experience as a clinical psychologist (three years). With only one therapist conducting both the PSDR and SDR treatment variations in the present design, any intervention outcomes might really reflect an effect unique to the author, amounting to a therapist effect or a treatment x therapist interaction that cannot be detected by a small-scale patient series study.

Future attempts at a controlled investigation of variations of 4-session reformulatory CAT in comparison with alternative formulatory interventions might utilise several therapists and evaluate therapist effects as part of the results. Independent evaluators should be recruited to administer and collect measures in order to control the contaminating influence of social desirability bias. As a methodological preference, therapists could be crossed with intervention so that each therapist administers each of the treatment conditions in the study. The therapist factor could then be evaluated in data analyses both alone as a main effect and in combination as an interaction effect with treatment. In practice, however, overriding obstacles relating to training, experience, skill level and treatment allegiances may dictate the separate nesting of
therapists within treatments and in this case the greater threat of therapist variance could be controlled through matching of therapist characteristics such as age, gender, and professional experience across the nests of therapists administering alternative conditions. Manualisation of a reformulatory CAT intervention may also help in this regard.

In addition to subject and demographic characteristics, a variety of therapist characteristics beyond the evaluative scope of the present research can also play an important role in treatment outcome, including level of empathic understanding, degree of openness and directiveness, expressions of warmth and self-disclosure, to name just a few (Beutler et al., 1994). Future controlled studies of reformulatory CAT would benefit from including an evaluation of such factors and should ensure that recruited therapists are sufficiently well-sampled to enable statistically sensitive tests. In the likelihood that therapist sample size must be compromised, Crits-Christoph and Mintz (1991) have suggested the use of more lenient Alpha levels (e.g., $p< .20$ rather than $p< .05$) to evaluate therapists' effects.

**5.3.5 Assessment Factors**

In its selection of outcome measures, the present study attempted to reflect the increasing consensus that outcome assessment needs to be multifaceted and measure a range of pertinent patient characteristics and domains of functioning, using both nomothetic and idiosyncratic methods (Roth and Fonagy, 1996). Since the beginning of this study, the core measures of psychotherapeutic outcome employed in the research have increasingly been superceded by the use of related abbreviated versions whose psychometric properties have been validated and evaluated. In the case of the
SCL 90R, a considerably shorter 53-item *Brief Symptom Inventory* is claimed to sacrifice little compared to its forerunner in terms of reliability and validity while at the same time being more convenient for patient, clinician and researcher alike (BSI; Derogatis, 1993). Likewise, Barkham, Hardy and Startup (1996) have developed a shorter version of the IIP (the *IIP-32*) with a reduction in items from 127 to just 32 and similar claims for psychometric status and utility. Future controlled outcome research on reformulatory CAT might benefit from including these revised versions in a core battery of nomothetic outcome measures.

This study also attempted to evaluate patient ratings of outcome on individually-identified target problems using one idiographic measure, the Target Problem Rating Scale. In accordance with the traditional practice of CAT, the TPRS was only administered post-reformulation and at 3-month follow-up. In hindsight, the use of the TPRS as a session-by-session measure following the initial identification of target problems by patient and therapist at screening would have enabled preliminary evaluation of the extent of any change occurring from the beginning of the intervention onwards. Evans and Parry (1996) have speculated that while exchange of the written reformulation in the fourth session is a culmination of the reformulation process, the impact may begin from the first session with the joint reformulatory work of therapy and patient. In terms of psychotherapeutic outcome, reformulation may be more meaningfully viewed as a continuous process across the first four sessions rather than specific only to the fourth session.

The outcome measures used in the present study tapped performance on a range of negative indicators of symptomatology and
interpersonal distress. However, no measure of pro-social functioning in positive adaptive behaviours and experiences such as participation in social activities, social interaction, and networking was administered. Adaptive functioning and symptom reduction have been shown to share little outcome variance and are not equivalent (Lambert and Hill, 1994). Assessment of prosocial behaviour should therefore be incorporated into future studies of reformulatory CAT, since it is possible that treatments appearing equally effective in reducing symptoms may vary in the extent to which they promote and develop adaptive functioning.

A further assessment issue limiting the conclusions from an initial outcome study such as the present one concerns a lack of process data. The one process instrument adapted in the study as a global measure of the subjective impact of an overall intervention, the SIS, was administered on just one occasion after reformulation. With greater resource and time, administration of the SIS on a session-by-session basis as originally conceived by Elliott and Wexler (1994) would have yielded a more discerning profile of session impacts.

It is self-evidently helpful to specify and then to assess processes within an intervention that are assumed to mediate therapeutic change. Correlation of changes in processes with changes in outcome enable a study to then become a test of the underlying model of therapeutic change as well as treatment outcome. Future studies on reformulatory CAT should combine process and outcome measures as a means to bolster the strength of research conclusions. A therapeutic relationship measure such
as the Penn Helping Alliance Questionnaire (Alexander and Luborsky, 1986) and the SIS could be used sessionally to illuminate what happens in reformulatory CAT sessions and patients' experiences of the reformulatory process. Similarly, change processes could be evaluated by asking patients to quantify helpful factors on a sessional measure such as the Helpful Aspects of Therapy (HAT; Llewelyn, Elliott, Shapiro, Firth and Hardy, 1988).

The last of the assessment issues to be considered here concerns follow-up evaluation. Follow-up raises important issues for psychotherapy outcome research in relation to the stability of therapeutic gains. Conclusions about the efficacy of an intervention or the relative effectiveness of alternative treatments can vary greatly depending on when assessments are conducted. The present study attempted to maximise the informativeness of outcome findings by repeating measures at Pre-Screening, Screening, Post-Termination and Follow-Up. While the inclusion of a 3-month follow-up interval allowed some initial evaluation of the stability of psychotherapeutic outcome, the study would clearly have benefited from further follow-up assessments. Future outcome studies might address this limitation by including repeat follow-up assessments of reformulatory CAT at 3-, 6- and 12-month intervals. Further repeated measurements would also enable the feasibility of a four-plus-one intervention to be explored (Barkham, 1989, 1990).

5.3.6 Statistical Evaluation Factors
A critical research issue is that of statistical power to detect differences between groups when differences exist within the population. As such, statistical
power reflects the probability that a test will lead to rejection of the null hypothesis and is a function of the criterion for statistical significance, sample size and effect size. As in the vast majority of psychotherapy outcome studies involving two or more alternative treatments, power to detect group differences in the present early-phase study was weakened by small sample sizes.

In studies comparing treatment versus no-treatment, effect sizes are usually sizeable and sample sizes need not be large to detect group differences (Kazdin and Bass, 1989). However, in studies such as the present one, where differences between alternative treatments or variations of treatments are investigated, effect sizes tend to be smaller and much larger sample sizes are therefore required to detect them. Future outcome research involving variations of reformulatory CAT and alternative formulatory approaches might usefully heed Aveline et al.’s (1995) recommendations of around 64 cases per group for a two-group comparative study. Such a sample size would be adequate to detect a between-group effect size difference of 0.5 on the basis of a two-sided significance level of 5% and 80% power.

5.4 CONCLUSIONS

The aim of this study was to present findings from an early-phase exploratory evaluation of two variations of 4-session reformulatory CAT, as delivered in an NHS setting. A series of pilot cases were primarily intended to evaluate the feasibility of both a PSDR and an SDR intervention rather than to pit one against the other. Indeed, the study is unequipped to draw comparative inferences, given the sequential rather than random allocation of clients to the two variations of intervention.
Findings from the study have been discussed in the context of the limitations inherent in a small uncontrolled patient series study. However, the data provide initial evidence of psychotherapeutic outcomes following two variations of 4-session reformulatory CAT with a proportion of NHS-referred patients; initial effect size comparisons with local treatment-as-usual service norms and selected brief therapy studies suggest that further research is warranted. Additionally, data at 3-month follow-up indicated that the majority of patients in this study who were responsive to 4-session reformulatory CAT either maintained or increased these gains at three months, indicating that positive outcomes may not be temporary.

The overall findings on the subjective impact of reformulatory CAT suggest that the model may have credibility for patients. The interventions were perceived as helpful and patients reported experiencing little or no hindering impacts. The credibility of the model would be likely to be enhanced by its implementation as a way to stop the build-up of waiting-lists (i.e. patients receive help quickly after referral) rather than as a means of addressing already existing waiting-lists (i.e. patients being offered the model after being held on a waiting-list for some time).

Notwithstanding positive outcomes for a proportion of patients in this study, the range of scores indicates that some patients were more responsive than others, as predicted by the dose-effect curve. This finding provides support for the rationale to carry out a predictive study with the aim of identifying those patients for whom this
model of intervention might be well suited. Such a study would represent one stage
towards being able to match specific patients to specific treatments within a
potentially cost-effective minimal-intervention service delivery system. It may emerge
that where such a brief reformulatory intervention is insufficient help for an individual,
a 'stepped-care' approach involving more intensive or extensive psychotherapeutic
interventions (which may or may not involve CAT) might be appropriate.

At the very least, findings from the present exploratory study have highlighted the
potential yield from implementing a larger scale comparative outcome trial. A future
controlled trial might usefully evaluate the effectiveness of reformulatory CAT
delivered within a four-session or four-plus-one session model in contrast to an
alternative case formulation approach, such as the approach used within cognitive-
behaviour therapy. A rigorous randomised controlled trial, such as the repeated
measures with switching replications design, would incorporate a control group who
would receive their intervention after a delay, thereby enabling a controlled
comparison of the impact of the (initial) four sessions (Beehr and O'Hara, 1987;
Shapiro et al., 1994). A design such as this would call for a sizeable sample of patients
and at least two therapists competent in both intervention approaches. Independent
variables could usefully include level of severity and anticipatory socialization to the
intervention approach. Evaluation of each intervention could be achieved through
utilizing the BDI and the validated abbreviated versions of the SCL 90R (i.e. the BSI)
and the IIP (i.e. the IIP-32). In addition, standardised process measures could be used
to evaluate session-by-session change as well as the patient-therapist relationship
(Elliott, 1995). Finally, the findings to emerge from such an RCT could be used to
guide the implementation of a large naturalistic study to evaluate the delivery of reformulatory CAT in everyday clinical service. The yield from the sequential programme of research suggested may contribute further meaningful information upon which to expand the range of effective psychotherapy services to patients.
SPECIAL NOTE

THIS ITEM IS BOUND IN SUCH A MANNER AND WHILE EVERY EFFORT HAS BEEN MADE TO REPRODUCE THE CENTRES, FORCE WOULD RESULT IN DAMAGE
Appendix 2.7.1.1.

DIRECTIONS:

1. Print your name, identification number, age, gender, and testing date in the area on the left side of this page.

2. Use a lead pencil only and make a dark mark when responding to the items on pages 2 and 3.

3. If you want to change an answer, erase it carefully and then fill in your new choice.

4. Do not make any marks outside the circles.
JUCTIONS: is a list of problems people sometimes have. Read each one carefully, and blacken the circle that describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

Example

<table>
<thead>
<tr>
<th>NOT AT ALL</th>
<th>A LITTLE BIT</th>
<th>MODERATELY</th>
<th>QUITE A BIT</th>
<th>EXTREMELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**HOW MUCH WERE YOU DISTRESSED BY:**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Nervousness or shakiness inside</td>
<td>Repeated unpleasant thoughts that won't leave your mind</td>
<td>Fainting or dizziness</td>
</tr>
<tr>
<td>Loss of sexual interest or pleasure</td>
<td>Feeling critical of others</td>
<td>The idea that someone else can control your thoughts</td>
<td>Feeling others are to blame for most of your troubles</td>
</tr>
<tr>
<td>Trouble remembering things</td>
<td>Worried about sloppiness or carelessness</td>
<td>Feeling easily annoyed or irritated</td>
<td>Pains in heart or chest</td>
</tr>
<tr>
<td>Feeling afraid in open spaces or on the streets</td>
<td>Feeling low in energy or slowed down</td>
<td>Thoughts of ending your life</td>
<td>Hearing voices that other people do not hear</td>
</tr>
<tr>
<td>Trembling</td>
<td>Feeling that most people cannot be trusted</td>
<td>Poor appetite</td>
<td>Crying easily</td>
</tr>
<tr>
<td>Feeling shy or uneasy with the opposite sex</td>
<td>Feelings of being trapped or caught</td>
<td>Suddenly scared for no reason</td>
<td>Temper outbursts that you could not control</td>
</tr>
<tr>
<td>Feeling afraid to go out of your house alone</td>
<td>Blaming yourself for things</td>
<td>Pains in lower back</td>
<td>Feeling blocked in getting things done</td>
</tr>
<tr>
<td>Feeling lonely</td>
<td>Feeling blue</td>
<td>Worrying too much about things</td>
<td>Feeling no interest in things</td>
</tr>
<tr>
<td>Feeling fearful</td>
<td>Your feelings being easily hurt</td>
<td>Other people being aware of your private thoughts</td>
<td>Feeling others do not understand you or are unsympathetic</td>
</tr>
<tr>
<td>Feeling that people are unfriendly or dislike you</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## HOW MUCH WERE YOU DISTRESSED BY:

<table>
<thead>
<tr>
<th>How Much</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT ALL</td>
<td>Having to do things very slowly to insure correctness</td>
</tr>
<tr>
<td>A LITTLE BIT</td>
<td>Heart pounding or racing</td>
</tr>
<tr>
<td>MODERATELY</td>
<td>Nausea or upset stomach</td>
</tr>
<tr>
<td>QUITE A BIT</td>
<td>Feeling inferior to others</td>
</tr>
<tr>
<td>EXTREMELY</td>
<td>Soreness of your muscles</td>
</tr>
<tr>
<td></td>
<td>Feeling that you are watched or talked about by others</td>
</tr>
<tr>
<td></td>
<td>Trouble falling asleep</td>
</tr>
<tr>
<td></td>
<td>Having to check and double-check what you do</td>
</tr>
<tr>
<td></td>
<td>Difficulty making decisions</td>
</tr>
<tr>
<td></td>
<td>Feeling afraid to travel on buses, subways, or trains</td>
</tr>
<tr>
<td></td>
<td>Trouble getting your breath</td>
</tr>
<tr>
<td></td>
<td>Hot or cold spells</td>
</tr>
<tr>
<td></td>
<td>Having to avoid certain things, places, or activities because they frighten you</td>
</tr>
<tr>
<td></td>
<td>Your mind going blank</td>
</tr>
<tr>
<td></td>
<td>Numbness or tingling in parts of your body</td>
</tr>
<tr>
<td></td>
<td>A lump in your throat</td>
</tr>
<tr>
<td></td>
<td>Feeling hopeless about the future</td>
</tr>
<tr>
<td></td>
<td>Trouble concentrating</td>
</tr>
<tr>
<td></td>
<td>Feeling weak in parts of your body</td>
</tr>
<tr>
<td></td>
<td>Feeling tense or keyed up</td>
</tr>
<tr>
<td></td>
<td>Heavy feelings in your arms or legs</td>
</tr>
<tr>
<td></td>
<td>Thoughts of death or dying</td>
</tr>
<tr>
<td></td>
<td>Overeating</td>
</tr>
<tr>
<td></td>
<td>Feeling uneasy when people are watching or talking about you</td>
</tr>
<tr>
<td></td>
<td>Having thoughts that are not your own</td>
</tr>
<tr>
<td></td>
<td>Having urges to beat, injure, or harm someone</td>
</tr>
<tr>
<td></td>
<td>Awakening in the early morning</td>
</tr>
<tr>
<td></td>
<td>Having to repeat the same actions such as touching, counting, or washing</td>
</tr>
<tr>
<td></td>
<td>Sleep that is restless or disturbed</td>
</tr>
<tr>
<td></td>
<td>Having urges to break or smash things</td>
</tr>
<tr>
<td></td>
<td>Having ideas or beliefs that others do not share</td>
</tr>
<tr>
<td></td>
<td>Feeling very self-conscious with others</td>
</tr>
<tr>
<td></td>
<td>Feeling uneasy in crowds, such as shopping or at a movie</td>
</tr>
<tr>
<td></td>
<td>Feeling everything is an effort</td>
</tr>
<tr>
<td></td>
<td>Spells of terror or panic</td>
</tr>
<tr>
<td></td>
<td>Getting into frequent arguments</td>
</tr>
<tr>
<td></td>
<td>Feeling nervous when you are left alone</td>
</tr>
<tr>
<td></td>
<td>Others not giving you proper credit for your achievements</td>
</tr>
<tr>
<td></td>
<td>Feeling lonely even when you are with people</td>
</tr>
<tr>
<td></td>
<td>Feeling so restless you couldn’t sit still</td>
</tr>
<tr>
<td></td>
<td>Feelings of worthlessness</td>
</tr>
<tr>
<td></td>
<td>The feeling that something bad is going to happen to you</td>
</tr>
<tr>
<td></td>
<td>Shouting or throwing things</td>
</tr>
<tr>
<td></td>
<td>Feeling afraid you will faint in public</td>
</tr>
<tr>
<td></td>
<td>Feeling that people will take advantage of you if you let them</td>
</tr>
<tr>
<td></td>
<td>Having thoughts about sex that bother you a lot</td>
</tr>
<tr>
<td></td>
<td>The idea that you should be punished for your sins</td>
</tr>
<tr>
<td></td>
<td>Thoughts and images of a frightening nature</td>
</tr>
<tr>
<td></td>
<td>The idea that something serious is wrong with your body</td>
</tr>
<tr>
<td></td>
<td>Never feeling close to another person</td>
</tr>
<tr>
<td></td>
<td>Feelings of guilt</td>
</tr>
<tr>
<td></td>
<td>The idea that something is wrong with your mind</td>
</tr>
</tbody>
</table>
INVENTORY OF INTERPERSONAL PROBLEMS

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, select the number that describes how distressing that problem has been for you. Then circle that number.

**EXAMPLE**

How much have you been distressed by this problem?

It is hard for me to:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>get along with my relatives</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Part I. The following are things you find hard to do with other people.**

It is hard for me to:

<table>
<thead>
<tr>
<th>The following are things you find hard to do with other people.</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>trust other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>say 'no' to other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>join in on groups</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>keep things private from other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>let other people know what I want</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>tell a person to stop bothering me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>introduce myself to new people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>confront people with problems that come up</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>be assertive with another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>make friends</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>express my admiration for another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>have someone dependent on me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>disagree with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>let other people know when I am angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>make a long-term commitment to another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>stick to my own point of view and not be swayed by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
<td>Quite a bit</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>17</td>
<td>be another person's boss</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>do what another person wants me to do</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>get along with people who have authority over me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20</td>
<td>be aggressive toward other people when the situation calls for it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>compete against other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22</td>
<td>make reasonable demands of other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23</td>
<td>socialize with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>get out of a relationship that I don't want to be in</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25</td>
<td>take charge of my own affairs without help from other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26</td>
<td>show affection to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27</td>
<td>feel comfortable around other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>get along with people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>understand another person's point of view</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>tell personal things to other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31</td>
<td>believe that I am loveable to other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32</td>
<td>express my feelings to other people directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33</td>
<td>be firm when I need to be</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34</td>
<td>experience a feeling of love for another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35</td>
<td>be competitive when the situation calls for it</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36</td>
<td>set limits on other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37</td>
<td>be honest with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38</td>
<td>be supportive of another person's goals in life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39</td>
<td>feel close to other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40</td>
<td>really care about other people's problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
It is hard for me to:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>argue with another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42</td>
<td>relax and enjoy myself when I go out with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>43</td>
<td>feel superior to another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>44</td>
<td>become sexually aroused toward the person I really care about</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>45</td>
<td>feel that I deserve another person's affection</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>46</td>
<td>keep up my side of friendship</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>47</td>
<td>spend time alone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>48</td>
<td>give a gift to another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>49</td>
<td>have loving and angry feelings towards the same person</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>50</td>
<td>maintain a working relationship with someone I don't like</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>51</td>
<td>set goals for myself without other people's advice</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>52</td>
<td>accept another person's authority over me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>53</td>
<td>feel good about winning</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>54</td>
<td>ignore criticism from other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>55</td>
<td>feel like a separate person when I am in a relationship</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>56</td>
<td>allow myself to be more successful than other people</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>57</td>
<td>feel or act competent in my role as a parent</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>58</td>
<td>let myself feel angry at somebody I like</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>59</td>
<td>respond sexually to another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>60</td>
<td>accept praise from another person</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>61</td>
<td>put somebody else's needs before my own</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>62</td>
<td>give credit to another person for doing something well</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>63</td>
<td>stay out of other people's business</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
It is hard for me to:

<p>| | | | | |</p>
<table>
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</thead>
<tbody>
<tr>
<td>64.</td>
<td>take instructions from people who have authority over me</td>
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<td>2</td>
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<tr>
<td>65.</td>
<td>feel good about another person’s happiness</td>
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<td>2</td>
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<tr>
<td>66.</td>
<td>get over the feeling of loss after a relationship has ended</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>67.</td>
<td>ask other people to get together socially with me</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>68.</td>
<td>feel angry at other people</td>
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<td>2</td>
</tr>
<tr>
<td>69.</td>
<td>give constructive criticism to another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>70.</td>
<td>experience sexual satisfaction</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>71.</td>
<td>open up and tell my feelings to another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>72.</td>
<td>forgive another person after I’ve been angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>73.</td>
<td>attend to my own welfare when somebody else is needy</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>74.</td>
<td>be assertive without worrying about hurting the other person’s feelings</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>75.</td>
<td>be involved with another person without feeling trapped</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>76.</td>
<td>do work for my own sake instead of for someone else’s approval</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>77.</td>
<td>be close to somebody without feeling that I’m betraying somebody else</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>78.</td>
<td>be self-confident when I am with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Part II. The following are things that you do too much.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>79.</td>
<td>I fight with other people too much</td>
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<td>2</td>
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<tr>
<td>80.</td>
<td>I am too sensitive to criticism</td>
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<td>2</td>
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<tr>
<td>81.</td>
<td>I feel too responsible for solving other people’s problems</td>
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<tr>
<td>82.</td>
<td>I get irritated or annoyed too easily</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>83.</td>
<td>I am too easily persuaded by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>84.</td>
<td>I want people to admire me too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>85.</td>
<td>I act like a child too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>86.</td>
<td>I am too dependent on other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>87.</td>
<td>I am too sensitive to rejection</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>88.</td>
<td>I open up to people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>89.</td>
<td>I am too independent</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>90.</td>
<td>I am too aggressive toward other people</td>
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<td>2</td>
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<tr>
<td>91.</td>
<td>I try to please other people too much</td>
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<td>2</td>
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<tr>
<td>92.</td>
<td>I feel attacked by other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>93.</td>
<td>I feel too guilty for what I have done</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>94.</td>
<td>I clown around too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>95.</td>
<td>I want to be noticed too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>96.</td>
<td>I criticize other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>97.</td>
<td>I trust other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>98.</td>
<td>I try to control other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>99.</td>
<td>I avoid other people too much</td>
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<td>100.</td>
<td>I am affected by another person's moods too much</td>
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<tr>
<td>101.</td>
<td>I put other people's needs before my own too much</td>
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<tr>
<td>102.</td>
<td>I try to change other people too much</td>
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<td>2</td>
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<tr>
<td>103.</td>
<td>I am too gullible</td>
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<tr>
<td>104.</td>
<td>I am overly generous to other people</td>
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<td>2</td>
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<tr>
<td>105.</td>
<td>I am too afraid of other people</td>
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<tr>
<td>106.</td>
<td>I worry too much about other people's reactions to me</td>
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<td>2</td>
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<tr>
<td>107.</td>
<td>I am too suspicious of other people</td>
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<td>2</td>
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<tr>
<td>108.</td>
<td>I am influenced too much by another person's thoughts and feelings</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all</td>
<td>A little bit</td>
<td>Moderately</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>109</td>
<td>I compliment other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>110</td>
<td>I worry too much about disappointing other people</td>
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<td>2</td>
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<tr>
<td>111</td>
<td>I manipulate other people too much to get what I want</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>112</td>
<td>I lose my temper too easily</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>113</td>
<td>I tell personal things to other people too much</td>
<td>0</td>
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<td>2</td>
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<tr>
<td>114</td>
<td>I blame myself too much for causing other people's problems</td>
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<td>2</td>
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<tr>
<td>115</td>
<td>I am too easily bothered by other people making demands of me</td>
<td>0</td>
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<td>2</td>
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<tr>
<td>116</td>
<td>I argue with other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>117</td>
<td>I am too envious and jealous of other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>118</td>
<td>I keep other people at a distance too much</td>
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<td>2</td>
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<tr>
<td>119</td>
<td>I worry too much about my family's reactions to me</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>120</td>
<td>I let other people take advantage of me too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>121</td>
<td>I too easily lose a sense of myself when I am around a strong-minded person</td>
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<td>2</td>
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<tr>
<td>122</td>
<td>I feel too guilty for what I have failed to do</td>
<td>0</td>
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<td>2</td>
</tr>
<tr>
<td>123</td>
<td>I feel competitive even when the situation does not call for it</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>124</td>
<td>I feel embarrassed in front of other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>125</td>
<td>I feel too anxious when I am involved with another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>126</td>
<td>I am affected by another person's misery too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>127</td>
<td>I want to get revenge against people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>
SPECIAL NOTE

THIS ITEM IS BOUND IN SUCH A
MANNER AND WHILE EVERY
EFFORT HAS BEEN MADE TO
REPRODUCE THE CENTRES, FORCE
WOULD RESULT IN DAMAGE
The questionnaire consists of 21 groups of statements. After reading each group of statements carefully, number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you feeling the past week, including today. If several statements within a group seem to apply equally each one. Be sure to read all the statements in each group before making your choice.

8 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make! decisions at all anymore.

---

Subtotal Page 1
CONTINUED ON BACK
I don’t feel I look any worse than I used to.
I am worried that I am looking old or unattractive.
I feel that there are permanent changes in my appearance that make me look unattractive.
I believe that I look ugly.

I can work about as well as before.
It takes an extra effort to get started at doing something.
I have to push myself very hard to do anything.
I can’t do any work at all.

I can sleep as well as usual.
I don’t sleep as well as I used to.
I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
I wake up several hours earlier than I used to and cannot get back to sleep.

I don’t get more tired than usual.
I get tired more easily than I used to.
I get tired from doing almost anything.
I am too tired to do anything.

My appetite is no worse than usual.
My appetite is not as good as it used to be.
My appetite is much worse now.
I have no appetite at all anymore.

19 0 I haven’t lost much weight, if any, lately.
1 1 I have lost more than 5 pounds.
2 2 I have lost more than 10 pounds.
3 3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20 0 I am no more worried about my health than usual.
1 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 2 I am very worried about physical problems and it’s hard to think of much else.
3 3 I am so worried about my physical problems that I cannot think about anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 1 I am less interested in sex than I used to be.
2 2 I am much less interested in sex now.
3 3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score
Appendix 2.7.4.1

Target Problem Rating Scale

Below are summary phrases of your main complaints, as described at your first appointment.

Please note the extent to which each of your main complaints troubled you in the last week.

<table>
<thead>
<tr>
<th>Not At All</th>
<th>A Little Bit</th>
<th>Mobility</th>
<th>Quite A Bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>4</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Sessions Impact Questionnaire

Please take a minute to think about how these sessions have affected you. Keeping your experience of the sessions in mind, try to match the descriptions in each item on the following pages with the impacts you felt. Rate on the basis of the descriptions which best match your experience. Use the rating scale below to rate each item (circle the appropriate number).

**REALISED SOMETHING NEW ABOUT MYSELF**: As a result of the sessions, I now have new insight about myself or have understood something new about me; I see a new connection or see why I did or felt something. (Note: there must be a sense of newness* as a result of something which happened during the sessions).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at</td>
<td>slightly</td>
<td>somewhat</td>
<td>pretty</td>
<td>very</td>
</tr>
<tr>
<td>all</td>
<td>much</td>
<td>much</td>
<td></td>
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</tr>
</tbody>
</table>

**REALISED SOMETHING NEW ABOUT SOMEONE ELSE**: As a result of the sessions, I now have new insight about another person or have understood something new about someone else or people in general. (A sense of newness should be present).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at</td>
<td>slightly</td>
<td>somewhat</td>
<td>pretty</td>
<td>very</td>
</tr>
<tr>
<td>all</td>
<td>much</td>
<td>much</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MORE AWARE OF OR CLEARER ABOUT FEELINGS, EXPERIENCES**: As a result of these sessions, I have been able to get in touch with my feelings, thoughts memories or other experiences; I have become more aware of experiences which I have been avoiding. Some feelings or experiences of mine which have been unclear have become clearer. (Note: refers to becoming clearer about what you are feeling rather than why you are feeling about something.)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at</td>
<td>slightly</td>
<td>somewhat</td>
<td>pretty</td>
<td>very</td>
</tr>
<tr>
<td>all</td>
<td>much</td>
<td>much</td>
<td></td>
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</tbody>
</table>

**DEFINITION OF PROBLEMS FOR ME TO WORK ON**: As a result of these sessions, I now have a clearer sense of what I need to change in my life or what I need to work toward beyond therapy, what my goals are.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at</td>
<td>slightly</td>
<td>somewhat</td>
<td>pretty</td>
<td>very</td>
</tr>
<tr>
<td>all</td>
<td>much</td>
<td>much</td>
<td></td>
<td></td>
</tr>
</tbody>
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P.T.O.
PROGRESS TOWARDS KNOWING WHAT TO DO ABOUT PROBLEMS: As a result of these sessions, I have figured out possible ways of coping with a particular situation or problem: I have made a decision or resolved a conflict about what to do; I now have the energy or resolve to do something differently.

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not at slightly somewhat pretty very
all much much

FEEL MY THERAPIST UNDERSTANDS ME: As a result of these sessions, I now feel more deeply understood, that someone else (my therapist) really understands what is going on with me or what I’m like as a person.

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FEEL SUPPORTED OR ENCOURAGED: As a result of these sessions, I now feel supported, reassured, confirmed or encouraged by my therapist; I feel better about myself, or have started to like myself better; I have come to feel more hopeful about myself or my future.

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FEEL RELIEVED, MORE COMFORTABLE: As a result of these sessions, I now feel relief from uncomfortable or painful feelings. I feel less nervous, depressed or guilty, or angry in general or about therapy.

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FEEL CLOSER TO MY THERAPIST: As a result of these sessions, I have come to feel that my therapist and I are really working together to help me: I am more impressed with my therapist as a person, or have come to trust, like, respect or admire her/him more; problem between us has been overcome.

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all much much

P.T.O.
10. **MORE BOTHERED BY UNPLEASANT THOUGHTS OR MORE LIKELY TO PUSH THEM AWAY:** These sessions have made me think of uncomfortable or painful ideas, memories, or feelings that weren’t helpful. It has made me push certain thoughts or feelings away or avoid them.

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11. **TOO MUCH PRESSURE OR NOT ENOUGH DIRECTION FROM THE THERAPIST:** As a result of these sessions, I now feel too much pressure has been put on me to do something, either in therapy or outside it. I have come to feel abandoned by my therapist or too much left on my own.

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12. **FEEL MY THERAPIST DOESN’T UNDERSTAND ME:** As a result of these sessions, I now feel misunderstood; that my therapist just doesn’t or can’t understand me or what I was saying.

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13. **FEEL ATTACKED OR THAT MY THERAPIST DOESN’T CARE:** As a result of these sessions, I now feel criticised, judged or put down by my therapist. I feel she/he was cold, bored or didn’t care about me.

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4. **CONFUSED OR DISTRACTED:** As a result of these sessions, I now feel more confused about my problems or issues; I feel thrown off or side-tracked from the things which are or were important to me.

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P.T.O.
15. **IMPATIENT, DOUBTING VALUE OF THERAPY**: As a result of these sessions, I now feel bored or impatient with the progress of therapy or with having to go over the same old things over and over again. I feel that these sessions were pointless and didn’t get anywhere.

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16. **OTHER IMPORTANT IMPACTS**: Please describe any other impact which may have occurred as a result of these sessions:

........................................................................................................

........................................................................................................
Appendix 2.8.1

taid to understanding ourselves better.

We have all had just one life and what has happened to us, and the sense we make of this, colours the way we see ourselves and others. How we see things or us, how things are, and how we go about our lives seems ‘obvious and right’. Sometimes, however, our familiar ways of understanding and acting can be the source of our problems. In order to solve our difficulties we may need to learn to recognise how what we do makes things worse. We can then work out new ways of thinking and acting.

These pages are intended to suggest ways of thinking about what you do; recognising your particular patterns is the first step in learning to gain more control and happiness in your life.

Keeping a diary of your moods and behaviour.

Symptoms, bad moods, unwanted thoughts or behaviours that come and go can be better understood and controlled if you learn to notice when they happen and what starts them off.

If you have a particular symptom or problem of this sort, start keeping a diary. The diary should be focussed on a particular mood, symptom or behaviour, and could be kept every day if possible. Try to record this sequence:

1. How you were feeling about yourself and others and the world before the problem came on.
2. Any external event, or any thought or image in your mind that was going on in the trouble started, or what seemed to start it off.
3. Once the trouble started, what were the thoughts, images or feelings you experienced.

Noticing and writing down in this way what you do and think at these times, will learn to recognise and eventually have more control over how you act think at the time. It is often the case that bad feelings like resentment, session or physical symptoms are the result of ways of thinking and acting are unhelpful. Diary keeping in this way gives you the chance to learn new ways of dealing with things.

It is helpful to keep a daily record for 1-2 weeks, then to discuss what you have noticed with your therapist or counsellor.
There are certain ways of thinking and acting that do not achieve what we want, but which are hard to change. Read through the lists on the following pages and mark how far you think they apply to you.

Applies strongly ++  Applies +  Does not apply -

1. TRAPS

Traps are things we cannot escape from. Certain kinds of thinking and acting result in a 'vicious circle' when, however hard we try, things seem to get worse instead of better. Trying to deal with feeling bad about ourselves, we think and act in ways that tend to confirm our badness.

Examples of Traps

1. Fear of hurting others Trap

Feeling fearful of hurting others we keep our feelings inside, or put our own needs aside. This tends to allow other people to ignore or abuse us in various ways, which then leads to our feeling, or being, childishly angry. When we see ourselves behaving like this, it confirms our belief that we shouldn't be aggressive and reinforces our avoidance of standing up for our rights.

People often get trapped in this way because they mix up aggression and assertion. Mostly, being assertive - asking for our rights - is perfectly acceptable. People who do not respect our rights as human beings must either be stood up to or avoided.

Depressed thinking Trap

Feeling depressed, we are sure we will manage a task social situation badly. Being depressed, we are probably not as effective as we can be, and the depression leads us to exaggerate how badly we handled things. This makes us feel more depressed about ourselves.
Feeling uncertain about ourselves and anxious not to upset others, we try to please people by doing what they seem to want. As a result, we end up being taken advantage of by others which makes us angry, depressed or guilty, on which our uncertainty about ourselves is confirmed; or sometimes we feel out of control because of the need to please, and start hiding away, putting things off, putting people down, which makes other people angry with us and increases our uncertainty.

Avoidance Trap:

We feel ineffective and anxious about certain situations, such as crowded streets, open spaces, social gatherings. We try to go back into these situations, but feel even more anxiety. Avoiding them makes us feel better, so we stop trying. However, by constantly avoiding situations our lives are limited and we come to feel increasingly ineffective and anxious.

Social isolation Trap:

Feeling under-confident about ourselves and anxious not to upset others, we worry that others will find us boring or stupid, so we don't look at people or respond to friendliness. People then see us as unfriendly, so we become more isolated from which we are convinced we are boring and stupid, and become more underconfident.

Low self-esteem Trap:

Feeling worthless we feel that we cannot get what we want because a) we will be punished, b) that others will reject or abandon us, or c) as if anything good we do is bound to go away or turn sour. Sometimes it feels as if we must punish ourselves for being weak. From this we feel that everything is hopeless so we give up trying to do anything which confirms and increases our sense of worthlessness.
2. DILEMMAS (False choices and narrow options)

We often act as if we do, even when we are not completely happy with it, because the only other ways we can imagine, seem as bad or even worse. Sometimes we assume connections that are not necessarily the case - as in "If I do 'x' then 'y' will follow". These false choices can be described as either/or or if/then dilemmas. We often don't realise that we see things like this, but we act as if these were the only possible choices.

Do you act as if any of the following false choices rule your life? Recognising them is the first step to changing them.

**Choices about myself: I act AS IF:**

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1. Either I keep feelings bottled up or I risk being rejected, hurting others, or making a mess.

2. Either I feel I spoil myself and am greedy or I deny myself things and punish myself and feel miserable.

3. If I try to be perfect, I feel depressed and angry; If I don't try to be perfect, I feel guilty, angry and dis-satisfied.

4. If I must then I won't; it is as if when faced with a task I must either gloomily submit or passively resist (other people's wishes, or even my own feel too demanding, so I put things off, avoid them).

5. If I must not then I will; it is as if the only proof of my existence is my resistance (other people's rules, or even my own feel too restricting, so I break rules and do things which are harmful to me).

6. If other people aren't expecting me to do things, look after them etc., then I feel anxious, lonely and out of control.

7. If I get what I want I feel childish and guilty; If I don't get what I want, I feel frustrated, angry and depressed.

Either I keep things (feelings, plans) in perfect order, or I fear a terrible mess.
Choices about how we relate to others: I behave with others as if:

1. Either I'm involved with someone and likely to get hurt or I don't get involved and stay in charge, but remain lonely.

2. Either I stick up for myself and nobody likes me, or I give in and get put on by others and feel cross and hurt.

3. Either I'm a brute or a martyr (secretly blaming the other).

4a. With others either I'm safely wrapped up in bliss or in combat;

b. If in combat then I'm either a bully or a victim.

5. Either I look down on other people, or I feel they look down on me.

6a. Either I'm sustained by the admiration of others whom I admire or I feel exposed

b. If exposed then I feel either contemptuous of others or I feel contemptible.

7. Either I'm involved with others and feel engulfed, taken over or smothered, or I stay safe and uninvolved but feel lonely and isolated.

8. When I'm involved with someone whom I care about then either I have to give in or they have to give in.

9. When I'm involved with someone whom I depend on then either I have to give in or they have to give in.

0. As a woman either I have to do what others want or stand up for my rights and get rejected.

0. As a man either I can't have any feelings or I am an emotional mess.
Snags are what is happening when we say "I want to have a better life, or I want to change my behaviour but......". Sometimes this comes from how we or our families thought about us when we were young; such as 'she was always the good child', or 'in our family we never...'. Sometimes the snags come from the important people in our lives not wanting us to change, or not able to cope with what our changing means to them. Often the resistance is more indirect, as when a parent, husband or wife becomes ill or depressed when we begin to get better.

In other cases, we seem to 'arrange' to avoid pleasure or success, or if they come, we have to pay in some way, by depression, or by spoiling things. Often this is because, as children, we came to feel guilty if things went well for us, or felt that we were envied for good luck or success. Sometimes we have come to feel responsible, unreasonably, for things that went wrong in the family, although we may not be aware that this is so. It is helpful to learn to recognise how this sort of pattern is stopping you getting on with your life, for only then can you learn to accept your right to a better life and begin to claim it.

You may get quite depressed when you begin to realise how often you stop your life being happier and more fulfilled. It is important to remember that it's not being stupid or bad, but rather that:

1) We do these things because this is the way we learned to manage best when we were younger,
2) we don't have to keep on doing them now we are learning to recognise them,
3) by changing our behaviour, we can learn to control not only our own behaviour, but we also change the way other people behave to us,
4) although it may seem that others resist the changes we want for ourselves (for example, our parents, or our partners), we often under-estimate them; if we are firm about our right to change, those who care for us will usually accept the change.

Do you recognise that you feel limited in your life:

- for fear of the response of others: eg I must sabotage success for example as if it deprives others, as if others may envy me or as if there are not enough good things to go around.
- by something inside yourself: eg I must sabotage good things as if I don't deserve them.
Some people find it difficult to keep control over their behaviour and experience because things feel very difficult and different at times. Indicate which, if any of the following apply to you:

1. How I feel about myself and others can be unstable; can switch from one state of mind to a completely different one.

2. Some states may be accompanied by intense, extreme and uncontrollable emotions.

3. Others by emotional blankness, feeling unreal, or feeling muddled.

4. Some states are accompanied by feeling intensely guilty or angry with myself, wanting to hurt myself.

5. or by feeling that others can't be trusted, are going to get me down, or hurt me.

6. or by being unreasonably angry or hurtful to others.

7. Sometimes the only way to cope with some confusing feelings is to blank them off and feel emotionally distant from others.
The Psychotherapy File was developed by Dr Anthony Ryle, Consultant Psychotherapist, Department of Psychiatry, United Medical & Dental Schools (UMDS) of Guys and St Thomas's Hospital, London.

For further information about Cognitive Analytic Therapy - CAT please contact the CAT Co-ordinator, Muncaster Clinic, Guys Hospital, London SE1 9NT.
Everybody experiences changes in how they feel about themselves and the world. But for some people these changes are extreme, sometimes sudden and confusing. In such cases there are often a number of states which recur, and learning to recognise them and shifts between them can be very helpful. Below are a number of descriptions of such states. Identify those which you experience by ringing the number. You can delete or add words to the descriptions, and there is space to add any not listed.

1. Zombie. Cut off from feelings, cut off from others, disconnected.
2. Feeling bad but soldiering on, coping.
3. Out of control rage.
4. Extra special. Looking down on others.
5. In control of self, of life, of other people.
7. Provoking, teasing, seducing, winding-up others.
8. Clinging, fearing abandonment.
9. Frenetically active. Too busy to think or feel.
10. Agitated, confused, anxious.
11. Feeling perfectly cared for, blissfully close to another.
12. Misunderstood, rejected, abandoned.
13. Contemptuously dismissive of myself.
14. Vulnerable, needy, passively helpless, waiting for rescue.
15. Envious, wanting to harm others, put them down, pull them down.
16. Protective, respecting of myself, of others.
17. Hurting myself, hurting others.
18. Resentfully submitting to demands.
19. Hurt, humiliated by others.
20. Secure in myself, able to be close to others.
21. Intensely critical of self, of others.
22. Frightened of others.
23.
APPENDIX 2.8.3.1

Prose Reformulations for the Prose plus Sequential Diagrammatic Reformulation (PSDR) Cohort
Dear

You came seeking help suffering disabling feelings of rejection and abandonment. The end of that relationship has opened raw in you all the pain of loss you experienced after the death of your mother, feelings which you are only beginning to come to terms with. In relation to others you find that you tend to be taken for granted or abused. Moreover you have difficulties in handling conflict as it inevitably arises in dealing with others in the course of life and you are often left regretting the consequences. Regarding life more generally you are hindered by that feeling that you are spoilt whenever some happiness does come your way.

During the first couple of sessions you managed to acknowledge and explore the roots of some deeply threatening feelings - roots which have had an impact on much of the course of your life. You recall your early life with a mixture of fond memories and profound sadness. At home you got everything you ever wanted as the only child to the point where you believe your mother, particularly, spoilt you. Throughout your childhood your relationship with your mother was extremely close and special. You described your mother as a kind affectionate person who was always there for you through thick and thin. The sudden loss of your mother when you were 14 was a devastating wrench from which you had little time or opportunity to come to terms with through grieving. Your relationship with your father had always felt critical and unloving back then as he objected to your mother’s pampering of you. But with the death of your mother and your father’s speedy entry into another relationship you felt overwhelmed both by your feelings of being cast aside by the new union and the sense that your mother had already been forgotten about. While your childhood memories were full of holidays and happy Christmases the teenage years left you feeling completely lost and abandoned. That vulnerability led you into an abusive relationship with Mark which you found the courage to eventually finish. By the time Gill arrived into your life you were starving for
all the love and protection you had known in childhood and allowed Gill to swamp you with every drop of mothering care and affection you could possibly squeeze from her. The inevitable splitting up of that relationship more recently resurfaced within you again all the memories and pain of loss and abandonment which you had suffered at 14.

Those formative years growing up in a world where from being pampered and protected you suddenly lost everything only to be abused and rejected left you feeling abandoned, very dependent, guilty and spoilt. To try and cope with those painful feelings you found yourself striving for the approval of others excessively in an effort to avoid further rejection. The neediness which all that loss left inside you has often left you feeling guilty and spoilt when some happiness in life does come your way. Moreover, close relationships are difficult because that very neediness can often lead you into being over-demanding of others for fear that you will come out of conflict situations with little or nothing. As these attempts to cope with difficult feelings inside you have become more and more habitual over time, the result has often become a vicious circle of spiralling striving, perceived rejection, guilt, and over dependency regarding others and at the same time, the loss of a sense of yourself and your own self-worth.

The problems you brought for help concern the loss of a sense of your own person after splitting with Gill, feelings of childish neediness, and difficulties managing conflict situations in close relationships. The key self-defeating patterns underlying your distress and which you can learn to recognise and revise through practice can be summarised as follows:

1. Striving to Please Pattern

Fearing hurting others and their rejection of you, you often find yourself over-striving for their approval. You then feel ignored or abused or taken for granted which makes you feel angry and childish. Then you feel guilty for feeling childishly angry and fear hurting others and their rejection of you even more. Then the self-defeating cycle starts over again.

The aim here is to learn to recognise the negative cycle as soon as it begins and to break the pattern by not over-striving to please others. Then you will maintain your self-respect and win the respect of the other person also.

2. Feeling Needy but Childish Pattern

Like everybody you have needs (social, emotional etc) which must be fulfilled. However, you act as if there were only two extremes in relation to what can happen with your needs: Either you have needs met, demanding of others, feeling childish and spoilt, and then guilty for it; Or your needs are left unmet, with you feeling frustrated and deprived, and then angry and low.

The aim is to learn to recognise the pattern and break it by realising that your needs are important but no more nor no less important and deserving to be met than the needs of anybody else. In coming to realise this you can then start to allow yourself some enjoyment of life when it comes your way, without feeling guilty or spoilt for it.

3. The No Compromise Pattern
You try to manage the conflict situations which inevitably crop up in life. However you act as if there were only two extreme options in terms of how to deal with conflict: Either you have to give in to others, feeling hurt or abused, and then angry, and feeling guilty for feeling angry Or others have to give in, feeling abused and hurt and then angry with you, leaving you feeling guilty.

The aim here is to become aware of this self-limiting pattern and to break it by realising that you can deal with conflict more satisfactorily by learning to compromise so that both you and the other party are allowed to share some satisfaction in the result.

The above 3 self-defeating patterns are illustrated on the Diagram which has already been provided so that you can work at recognising and revising them.
Dear

You came seeking help having long suffered disabling feelings of low self-worth. More often than not you have felt alone and let down by others and there are times when you feel so up in a knot inside that you wonder how much more you can cope with. Moreover you can feel swamped by angry thoughts and being excessively on the defensive with others makes handling conflict situations particularly difficult to deal with.

During the first couple of sessions you managed to explore the roots of some distressing feelings - roots which have had an impact on much of the course of your life. You recall your early years and family life with an profound sense of loss and resentment. For as long as you can remember the atmosphere in your family has always been turbulent and you took the brunt as your parents forever lived out the difficulties in their marriage. Neither parent has ever been able to show you real care and the absence of physical affection and encouragement has left you rejected and underconfident. You describe your mother as a brittle personality, oversensitive and too pre-occupied with her own vulnerabilities to be able to provide you with the secure childhood for which you are left mourning. The unpredictability of your mother’s insecurity meant that while growing up you never knew where you stood in her esteem from one moment to the next. On the other hand the nature of your relationship with your father has always been fraught with feelings of rejection, victimisation and humiliation. You characterise your father as an arrogant aggressive man whose insecurity has always distanced him from any overt admission of care or affectionate feelings. Your academic prowess and accession to Oxford provided the ticket for that long awaited escape from an unhappy home life. Your hopes and dreams for Oxford are acknowledged by you as including a quest for a place you can feel belonging and wanted in a way that your own family life has been unable to provide for you. Yet a part of you also clings to that ambivalent hope for some peace and care at home.
Those formative years growing up in an atmosphere marked by neglect, rejection, bullying, criticising and idealisation has left you feeling cheated, angry, attacked, contemptible and unworthy. To try and cope with these difficult feelings you have come to find yourself often giving up on the future for fear that it will continue to have little happiness in store for you and let you down yet again. The strength of pain and anger at life lead you to bottle up your feelings for fear of the explosion and annihilation that might ensue if you were to open them up. In relationships you keep a safe distance for fear that closeness might result in repeated let down and hurt again, just like at home. Moreover in potential conflict situations you have found yourself tending to avoid sticking up for yourself least you be seen as a bully. As these attempts to cope with distressing feelings have become more and more habitual over time the result has often become a vicious circle of spiralling mistrust, perceived rejection, anger and idealisation regarding others and, at the same time, an inner confusion and the loss of a sense of your own self-worth.

The problems you brought for help concern low self-esteem, feelings which are difficult to cope with, a sense of abandonment and let down, difficulties handling conflict situations. The key self-defeating patterns underlying your distress and which you can learn to recognise and revise through practice can be summarised as follows:-

1. Self-Sabotage Pattern

You wish for a fulfilling life. Yet part of you feels undeserving or that the future is bound to turn sour and re-write the pain of the past. And so you find yourself giving up or abandoning your chosen life course. Inevitably then life must stand still and the freezing of progress towards your goals lowers your belief in yourself and your own self-worth. This leads to feelings of hopelessness and your continued wish for a fulfilling life. Then the self-limiting cycle starts over again.

The aim here is to become aware of this vicious circle by realising that the future is an unwritten book which will contain not solely ‘sour’ experiences but ‘sweet’ ones as well. Moreover breaking this cycle of despair will entail avoidance of giving up on or abandoning your chose path.

2. Bottling Feelings Pattern

You try to handle your feelings. However you act as if there existed only two extreme options in relation to how to manage feelings: Either tight shut, with stress mounting, feelings festering, put others at a distance leaving you little support, with the result that you’re feeling that you can’t cope; Or burst open, seen as weak, or abusing others, and then rejected by them.

The aim is to become aware of this pattern as it starts and to break it by learning to express how you feel. Running feelings underground will only imbue them with volcanic explosiveness later.
3. Relationship Pattern

You wish for a relationship where you could feel secure and fulfilled. However, you act as if there were only two extreme options in terms of how to be in relationships: Either allowing yourself to get close, idealising the attentions of others as a compensation or replacement for what you are missing at home, vulnerable to be let down and hurt as people fail your idealised aspirations; Or keeping a distance, staying ‘safe’, in control and in charge but left feeling lonely and unworthy.

The aim is to recognise this self-limiting pattern early on as it happens and to learn to break it by realising that it is possible to get close to people without inevitably being hurt or let down or losing autonomy. It will be particularly important to accept both yourself and others as human beings with strengths and weaknesses rather than idealising or rubbishing them as knee-jerk reaction.

4. Attacking or Attacked Pattern

You try to handle the inevitable conflicts with others as they arise. Yet you act as if there were only two extreme options in relation to how to manage conflict: Either attacking to stick up for yourself, hurting or abusing in the process, then rejected by the victim with you left feeling isolated; Or attacked and bullied into submission, feeling hurt and crushed, and left with a sense of powerlessness.

The aim is to recognise this self-limiting cycle as it arises and to learn to break it by realising that it is possible to resolve conflict without being left feeling isolated or humiliated. The adoption of compromise as the legitimate outcome leaves both parties sharing control and mutual respect.

The above four self-defeating patterns are illustrated on the Diagram which has already been provided so that you can work at recognising and revising them.
Dear

You have come seeking help having suffered a major loss in your life in the form of your livelihood. For the first time that you can remember the future seems uncertain and you have noticed a drop in your self-confidence. You are concerned that alcohol could become a false friend and you feel that life is turning sour.

During our sessions you have managed to confront the impact on you which losing your job entailed. Unemployment after so many years of certainty has shaken your belief in yourself and in the world around you so that good fortune feels like it cannot be taken for granted anymore. The structure which work put into your everyday has been removed and you fear for whether or not you will ever find a replacement for it again.

Suddenly you find yourself with too much time on your hands and you're starting to realise how little time you put into developing other abilities and sides of yourself outside your job down through the years. Too much time not doing anything has left your belief in yourself knocked. What's more the loss of your job has made you feel a bit more insecure socially so that you find yourself seeking too much refuge in alcohol both to numb the sadness and to give you false courage. The problem here is that too much the night before leaves you feeling lethargic and unwell in the mornings so that it then becomes difficult to motivate yourself to keep active.

The problems you brought for help concern loss of self-confidence, feeling depressed, and dependence on alcohol. The key self-defeating patterns underlying your distress which you will learn to recognise and revise through practice over the next 12 weeks can be summarised as follows:-
1. Inactivity and Low Self-Confidence Pattern

Feeling depressed, when you go to try to do something or handle a situation, you either have difficulty making the decision or you don’t allow for feeling low. This leads you to exaggerate how badly you handled things and then you either abandon or avoid trying again. Because you have nothing to show for it your self-confidence then lowers so that you go on to become even more depressed with the whole vicious circle repeating itself.

The aim here is to become aware of the self-defeating pattern and to break the cycle, for example by giving yourself credit for doing things and not abandoning or avoiding activities until you have something to credit yourself for.

2. Life Turning Sour Pattern

You seek a fulfilling life like you used to have. However, you act as if because of your job loss everything must turn sour and then abandon or avoid trying. Once you abandon or avoid trying then life can’t move forwards and you inevitably feel lower wishing that life could be fulfilling like it was again. Then the vicious circle starts over again.

The aim here is to become aware of the pattern and interrupt the self-defeating cycle by realising that because you have suffered one major loss doesn’t mean that the future must repeat the past. Most importantly you will break this pattern by ceasing abandoning or avoiding life.

3. Alcohol, Lethargy and Low Self-Confidence Pattern

With your confidence having recently taken a knock you are more uncertain of yourself socially and fear losing your popularity. You try to win people’s approval by living up to their expectations of you socially and use alcohol to hide behind. Alcohol leaves you with side-effects the next day which make you feel lethargic. You consequently become inactive as you struggle with the hangover and getting moving seems more difficult. Inactivity leaves you with nothing to credit yourself for and even more underconfident and uncertain of yourself. Then the vicious circle continues on again.

The aim here is to notice this pattern as it happens and to learn to stop the vicious circle, for example by cutting down on alcohol and trying to overplease your friends.

The above three self-defeating patterns are illustrated on the Diagram overleaf so that in the coming 12 weeks you can work at recognising and revising them.
Dear

You came seeking help having long felt low and stuck in a rut. You have difficulty in voicing your own needs and feelings and suffer from disabling shyness in the company of those you don’t know well. Moreover you find that your life is increasingly limited by the range of situations you avoid for fear of panic attacks.

During the first couple of sessions you have managed to acknowledge and explore the roots of some deeply threatening feelings - roots which have had an impact on much of the course of your life. You recall your early life at home as happy and secure. However as the only child you have always been particularly close to your mother who in order to show her love for you tended to over-protect and spoil you. Your grandmother also tried to show her care for you in the same manner. You describe your father as a caring outgoing man who you have also experienced as critical and less tolerant of that over-protectiveness and spoiling. Both of your parents tended to bottle up their true feelings around you as you were growing up. At school concentration on academic work was difficult and you felt insecure about making friendships.

These early years left you feeling overprotected, underconfident, helpless and ashamed. To try and cope you found yourself bottling your own needs and true feelings to try and go along with others. Avoiding life seemed the only way to reduce the risk of failing further. In the same way isolating yourself from others socially has increasingly become your attempt at avoiding those feelings of rejection ('they'll think I'm stupid) as well as avoiding that fear of anxiety attacks. As these coping patterns have continued into your adult life the result has become a vicious circle of spiralling shame and perceived rejection regarding other people, and an increasing inner sadness at the loss of a sense of oneself and one’s self-worth.
The problems you brought for help concern under assertiveness, fearing panic feelings, feeling low, and stuck-in-a-rut, and social shyness. The key self-defeating patterns underlying that distress which you can learn to recognise and revise through practice over the next 12 weeks can be summarised as follows:

1. Overpleasing and Giving in Pattern

Fearing hurting others and their rejection, you bottle your true feelings and needs and always go along with what others want to win their approval. Inevitably you end up feeling take for granted by others which makes you angry and frustrated at yourself and others for letting it happen. You the feel guilty for experiencing angry feelings which leaves you fearing hurting others and their rejection even more.

The aim here is to begin to be aware of the pattern and to learn to gradually interrupt the cycle by, for example, not bottling true feelings and needs.

2. Avoidance Panic and Underconfidence Pattern

Feeling anxious and underconfident you fear panicking in certain situations (for example town) so you find yourself leaving early. Leaving early gives you temporary relief from tension but makes going there even more fearful for next time. As a result you then find yourself avoiding those situations which means that life becomes more and more limited. This fact makes you feel guilty and low and you are left feeling even more anxious and underconfident. Then the vicious circle starts over again.

The aim here is to learn to recognise this self-defeating pattern and to find ways to stop it by, for example, avoiding avoidance of situations so that you learn to tolerate the fearfulness and overcome it.

3. Inactivity and Depression Pattern

Feeling sad bored and hopeless you go to try and start something. Immediately, you find yourself thinking ‘what’s the point. I’m going to fail’, so you walk away leaving it unfinished with nothing to show for your efforts. As a result your confidence is lowered and you are left feeling guilty and helpless. This then in turn intensifies your feelings of sadness and hopelessness even further.

The aim here is to become more aware of this self-limiting pattern and to interrupt the chain reaction for example by becoming more active gradually to enable your confidence to build.

4. Underconfidence and Social Isolation Pattern

Feeling underconfident and fearing rejection you tend to assume that other people will think that you are stupid when they meet you. You then keep quiet and as a result feel the odd-man-out and tense. This results in you either leaving the social situation early or avoiding social situations altogether with the result that you don’t allow yourself to find out that others don’t think you are stupid. Nor do you give yourself the chance to build up social skills. The result of course, is that your feeling of under confidence and fear of rejection become even more intensified.
The aim here again is to watch out for where the pattern happens and to gradually learn to break the vicious circle by, for example, not leaving early or avoiding social situations. Only then will you get used to being with new people and build some social skills.

The above four self-defeating patterns are illustrated on the diagram overleaf so that in the coming 12 weeks you can work at recognising and revising them.
Dear

You came seeking help having long suffered from disabling fear that people might be critical or disapproving of you. You find yourself needing to feel liked by everybody to feel secure in yourself. This makes it difficult for you to feel comfortable around people in a way that stifles your self-confidence and results in you being over-preoccupied about not saying or doing anything that might be taken the wrong way. Public transport and travelling any distance from home leaves you particularly apprehensive and often when you think about your life you feel that much of what it has to offer is passing you by.

During the first couple of sessions you managed to explore the roots of some distressing feelings - roots which have had an impact on much of the course of your life. Your earliest memories are of feeling frightened at nursery and comparing yourself negatively to others. You have always been very close to and dependent on your mother who you describe as a loving and supportive, if somewhat insecure person who has tended to shy away from difficult situations and feelings, and give in too easily. You recall your natural father as a very caring and affectionate worrier who would always fear the worse and was therefore very protective of his family, even to excess. Although your young age cushioned you from the realities somewhat, the loss of your father suddenly when you were 7 shook the foundations of your family, and that very insecurity made you all pull together and depend on each other even more. That insecurity within you intensified during your teenage years. Those years were not enjoyable not least because you suffered the hurt of being bullied at senior school and always remember being afraid to have a go at life in the way that other teenagers seemed to.

Those formative years growing up in an atmosphere marked by avoidance of risks, over-protectiveness, bullying and rejection left you feeling over-dependent, inferior, afraid, easily got at by others, angry and guilty. To try and cope you have often found yourself avoiding life for fear that you couldn't cope with it. You tend to bottle up your needs and feelings from
other people for fear that they will not accept them. You have come to try and cope with your insecurity within yourself by trying to have everybody like or approve of you and your actions. As these attempts to cope with difficult feelings inside you have become more and more habitual into adulthood the result has often become a vicious circle of spiralling striving, fearfulness, avoidance, and perceived rejection regarding others and, at the same time, an increasing disillusionment and loss of your own sense of self-worth and confidence.

The problems you brought for help concern anxiety and fearfulness, over-sensitivity to offending and being rejected by others, feeling uncomfortable socially, and low self-confidence. The key self-defeating patterns underlying your distress and which you will learn to recognise and revise through practice can be summarised as follows:

1. Panic and Avoidance Pattern

Feeling insecure and underconfident, certain situations (involving others) make you panicky. So you tend to leave these situations quickly and get some temporary relief from anxiety. However, it then becomes more difficult to enter that situation next time so you avoid it altogether or go as little as possible. Then life becomes an every narrowing prison and you feel yourself coping less well. This then makes you feel even more insecure and underconfident then the vicious circle starts over again.

The aim here is to recognise the pattern as it begins to happen each time and to stop it by learning not to avoid or leave quickly from feared situations. Only then will the fear reduce to coping levels and your confidence and feelings of security will grow.

2. Bottling Feelings Pattern

You try to handle your feelings and needs. However, you act as if there existed only two extreme options: Either tight shut, offending nobody with you usually having to give in, left feeling resentful and angry, and then feeling guilty for the anger; Or wide open, offending everybody, then rejected by others and left feeling isolated.

The aim is to become aware of when the self-limiting cycle is taking place and to break it by learning to express your feelings and needs for which others must respect you. Learning to be more direct with feelings will stop them from festering inside you.

3. Needing to be Liked Pattern

You want to get on with people. However, you act as if there were only two extreme ways to be with others: Either striving to be liked by everybody, with you always giving in, seeking their approval, and losing a sense of ‘you’ and your own self-respect in the process; Or feeling a failure, with no value of your own apart from the opinion of others, feeling rejected, and worthless.

The aim here is to recognise the self-defeating pattern and to break it by realising that you have value quite apart from the opinion of other people. This will then allow you to gradually become more comfortable with others as you stop trying always to win their approval for you to respect yourself. Your self-respect and worth as a person is only partly to do with other people and not completely so.
4. Life Passing Me By Pattern

You want to take charge of your life. However you fear failing and not being able to cope. So you avoid doing things and sampling experiences only to find that life inevitably stands still for you. Then you feel that the opportunities to enjoy life are passing you by as you watch more and more helpless. Naturally your confidence continues dropping and you become increasingly disillusioned. Then you find yourself wanting to take charge of your life again and the vicious circle repeats itself.

The aim here is to learn to recognise the pattern as it's happening and to break it by deliberately trying out new experiences even if there is a risk of failure. Failure is not the end of the world.

The above four self-defeating patterns are illustrated on the Diagram which has already been provided so that you can work at recognising and revising them.
Dear

You came seeking help having for a long time suffered disabling feelings of low self-worth. In particular you have found yourself being abused in several relationships where you trusted others and you fear for a future where history could repeat itself.

During the first couple of sessions you have managed to acknowledge and explore the roots of some threatening feelings - roots which have had an impact on your early adult life. You recall your early years with a sense of happiness, and security. Indeed it was to come as quite a shock to discover as you spread your wings outside the home that not everybody was as caring. You describe your mother and step-father as loving and supportive parents who have always encouraged you. They loved you that much that as best they knew how they attempted to over-protect you by concealing truths which they thought would break you. As a result you remember feeling devastated and angry at the way in which you learnt about your step-father. For a time it was difficult to trust again and the world was to seem a very confusing place. It concerns you that to this day there are such subjects which your family continues to avoid talking about in their bid to over-protect you. As your childhood years passed, friendships and a happy school life were both enjoyed. However it was on leaving school in your mid-terms and your first moves towards the adult world of relationships that you were to suffer a series of abusive experiences from which you are only beginning to recover. In these relationships you suffered the trauma of emotional and physical violence and it was only through your strength and realisation of your own self-worth that you managed to begin to free yourself from the prison of several years of escape-goating, domination, and victimisation.

To try and cope with this combination of influences down through the years you found yourself keeping feelings and needs bottled while trying to meet others expectations of you to their approval and vicious circle where at times life can seem dominated by spiralling mistrust and abuse regarding others, and an inner, confusion at the loss of a sense of oneself and ones self-worth.
The problems you brought concern low self-confidence, abusive relationships and fear of history repeating itself. The key self-defeating patterns underlying your distress which you will learn to recognise and revise through practice over the next 12 weeks can be summarised as follows:

1. **Bottling Feelings and Over-Pleasing Pattern**

Fearing hurting others and rejection you bottle up or devalue your own needs and feelings and strive for the approval of others instead while ‘Keeping a brave face’ on it. Inevitably people then take you for granted, ignore, or abuse you, leaving you hurt and angry both with yourself for allowing it to happen and, of course, with the abuser. However, instead of using that anger you feel guilty for it. The guilty feelings make you feel even more fearful of hurting others and rejection and so the self-defeating pattern starts off all over again.

The aim here is to learn to value and express your own needs and feelings appropriately, and to interrupt this vicious circle by learning to stop bottling them up.

2. **Bully/Victim and Distrust Pattern**

When in conflict with others you behave as if there were only two alternatives: Either I must be the bully, with others always giving in, hurting others, and then distrusted, and avoided by them, with me left feeling guilty and isolated; Or I must be the victim, always giving in, hurt and distrustful of others, avoiding closeness, and left feeling alone.

The aim here is to become aware of the pattern and learn that there are other more constructive and mutual ways to handle conflict in relationships, for example by respecting the rights and needs of the other in equal partnership and learning compromise.

3. **‘Life Always Turns Sour’ Pattern**

You seek happiness and fulfillment through identifying what you want from life. However, you act as if the future is snagged by the past and must turn sour. This self-sabotage makes you feel despondent and helpless so you stop striving for your happiness and fulfillment. As a result life slows down or goes nowhere and you leave yourself feeling powerless and in despair.

The aim here is to learn to recognise this self-defeating pattern and to interrupt the circle by, for example, reminding yourself that just because there were pains in the past doesn’t mean that they must be repeated in the future.

The above three self-defeating patterns are illustrated on the Diagram overleaf so that in the coming 12 weeks you can work at recognising and revising them.
Dear

You came seeking help with disabling feelings of fearfulness when alone at night. Moreover you are aware that your feelings of self-worth and confidence are often found wanting and relationship difficulties can leave you feeling vulnerable and abused.

During the first couple of sessions you have managed to acknowledge and explore the roots of some of those threatening feelings - roots which have had an impact emotionally and on the subsequent patterning of your relationships in adult life. You recall your early years in the midst of your father's physical violence towards your mother as something you have become detached and hazy about and those years are a taboo area with your mother. Indeed you note that much of that abuse pattern has been repeated in your own adult life. You describe your mother as the dominant influence on your formative years as she herself struggled to keep the family afloat under very difficult and uncertain circumstances. You remember feeling safe and secure in the care of your mother and wonder if in fact she was over-protective of you growing up, not least because they were very insecure times for her and her children. However, there seemed little time and space for showing feelings in the growing years and the very unconditional acceptance and affection which are the seeds of self-worth and self-confidence in later life were seldom expressed. You recall your father as a temperamental angry man with whom it was difficult to know where one stood and recognise the similarities with Mark. The uncertain, insecure, and unpredictable background that was your growing years was made no less difficult by unhappy school years where you frequently came to be picked on and bullied with grand mother coming to the rescue. Indeed your grandmother was to provide much of the stability and happy memories which your own broken home could not.
To try and cope with all the uncertainty and turbulence of those formative years of your life, you found yourself keeping tight reign on your needs and feelings while doing as was required of you became an increasingly easier option than confronting the tide of expectation and made you feel protected. As this pattern of coping inevitably continued habitually into your adult life, the result has become an often insecure picture: a vicious circle of spiralling mistrust, guilt, avoidance and perceived rejection regarding others, and a confused sense of yourself and your own self-worth.

The problems you brought concern avoidance, low self-esteem, and insecure relationships. The key self-defeating patterns underlying your distress which you will learn to recognise and revise through practice over the next 12 weeks can be summarised as follows:

1. **Overpleasing and Bottling Feelings Pattern**

   Fearful of hurting others and then rejection, you bottle up and devalue your own needs and feelings as if they were childish and you didn’t deserve them. Instead you find yourself striving to overplease the expectations of others (often aiming for their approval through your perfectionism) and inevitably they ignore, neglect, abuse or take you for granted. You then feel angry both with yourself and the abuser, sometimes exploding destructively instead of constructively after you have contained it for too long. In any case your anger quickly gets converted into guilt and the very fearfulness of hurting others and rejection with which the vicious circle began becomes more intense. The self-defeating pattern then starts over again.

   The aim here is to learn to recognise the self-defeating circle and find ways to interrupt the pattern for example by developing more respect for your needs and feelings and gradually being more open with them.

2. **Avoidance and Low Confidence Pattern**

   Feeling insecure and under-confident, you find yourself avoiding situations (for eg nighttime noises etc) and being over self-protective. Avoiding gives very temporary relief from anxiety. However, by constantly avoiding the feared situation seems disproportionately more fearful than reality requires, your coping resources aren’t allowed opportunities to develop. Moreover life becomes ever more limited and your very insecurity and under-confidence become even more intensified. The vicious circle starts over again.

   The aim here is to become more aware of the avoidance pattern in your life and to learn to interrupt the cycle, for example by gradually reducing avoidance and over-protectiveness.

3. **Relationship Pattern**

   In relationships you act as if there were only two available options: Either involved with someone, having to always give in, abused or door-matted, and invariably ending up hurt; Or not in a relationship, ‘safe’ and in control, but lonely and isolated.

   The aim here is to learn to recognise the pattern, and to find ways of interrupting the cycle by coming to realise that there are other less self-defeating ways of being in relationships, for example by mutual sharing of control and mutual respect for feelings and needs.
The above 3 self-defeating patterns are illustrated on the Diagram overleaf so that in the coming 12 weeks you can start to work at recognising and revising them.
Dear

You came seeking help at a time of creeping disillusionment with life; a sense of feeling blocked in enjoying what it has to offer. Moreover your self-esteem has been found wanting and your unease socially has often left you feeling isolated on the margins.

During the first couple of sessions you have managed to acknowledge and explore the roots of some threatening feelings and roots which have had an impact emotionally and on the subsequent patterning of your adult relationships. You recall your early life as secure and driven by expectations for getting on. However the very unconditional acceptance and affection which are the seeds of later confidence-building in life were seldom expressed. You describe your mother as very much the dominant influence on you and at times experienced her standards and aspirations for you as you were growing up to have been somewhat over-controlling. In comparison with your only sister you were aware that as the more able you were conferred as the family standard bearer in relation to subsequent success and achievement. The culture you were to grow up in placed getting on in life at the forefront while savouring the present and its enjoyment came to assume the status of a devalued currency.

To try and cope with such an atmosphere in the formative years of your life you found yourself keeping feelings and thoughts to yourself while doing as was required of you became an increasingly easier option than confronting the tide of expectation. As this pattern of coping inevitably continued habitually into your adult life the result has become a vicious circle of spiralling mistrust, guilt and perceived rejection regarding others and an increasing disenchantment with your sense of your own self-worth.

The problems you brought concern low self-confidence, social unease, and disillusionment with life. The key self-defeating patterns underlying your distress which you will learn to recognise and revise through practice over the next 12 weeks can be summarised as follows:-
1. Bottling Feelings and Over-Pleasing Pattern

Feeling insecure and fearful of rejection, you bottle up your needs and feelings and strive to overplease others expectations of you instead. Inevitably people take you for granted, abuse, or ignore your feelings and needs leaving you hurt and angry. This then makes you liable either to explode with uncontrolled anger or, more often, on realising your anger with yourself and the abuser you feel guilty. The guilty feelings have the effect of making you feel even more insecure and fearful of rejection and so the self-defeating pattern starts off all over again.

The aim here is to express your own feelings and needs appropriately and to interrupt this vicious circle by learning not to bottle them up.

2. Low Self-Esteem and Social Isolation Patterns

Feeling under-confident and fearful of rejection you worry that others will find you boring so you hold back socially and don’t initiate or respond to friendliness. People then see you as disdainful and so you become more isolated from which you are convinced you are boring and become more under-confident and fearful of rejection. The self-defeating pattern then starts off all over again.

The aim here is to become more aware that this vicious circle is happening and to find ways to break the cycle, for example by learning to take a proportion of the responsibility for conversational silences (instead of 100%) and, indeed, learning to tolerate silences as natural inevitable pauses rather than self-incriminating evidence of your ‘boringness’.

3. Disillusionment Pattern

You want to enjoy all that you’ve worked hard to achieve. All the ingredients for an enjoyable life (eg family, work) are within your grasp. Yet you act as if enjoying life and what it has to offer is less important than striving and working for it so you sabotage that enjoyment by rejecting or abandoning it in favour of ‘keeping busy’ instead. Then you feel disillusioned with your inability to enjoy the moment and the cycle of wanting to enjoy what you have achieved starts over again.

The aim here is to learn to claim your right to enjoy what you have worked for and to gradually find ways to interrupt the cycle, for example by refusing to devalue pleasure and by increasingly building uninterrupted ‘pleasure’ time into the working week.

The above 3 self-defeating patterns are illustrated on the Diagram overleaf so that in the coming 12 weeks you can start to work at recognising and revising them.
Dear

You came seeking help having long suffered disabling fear that you might let others down. In particular you always find yourself anticipating the worst and your fear of panic attacks means that you rarely go out alone. As a result life over the years has become ever more restricted and you are left disillusioned feeling that all it has to offer is simply passing you by.

During the first couple of sessions you managed to acknowledge and explore the roots of some distressing feelings - roots which have had an impact on much of the course of your life. You recall your early years with a sense of belonging and contentment in a family and community where everyone looked after each other. The pillar of that secure homelife was your mother who you describe as a near-selfless giver always putting the needs and feelings of others before her own, even to the point of being over-protective. On the other hand you describe your father as more like yourself: A loving family man whose devotion to providing for his wife and children meant long hours working and indeed, you recall seeing little of him when a child as a result. Outstanding about your father has always been his tendency towards perfectionism as well as his aspiration towards high standards which you remember being instilled in you from an early age. So much was your desire to aspire to those standards that you recall disabling fear both at your 11+ exam and soloing for the school choir least you fail others by somehow letting them down.

Those formative years growing up in an atmosphere of perfectionism, high standards and over-protectiveness left you forever striving too high and thereby feeling a failure and over dependent on others living in perpetual fear. To try and cope you found yourself trying to be the perfect daughter and person so as to maintain the love and acceptance of your parents, particularly your father. Rather than risk failure you found yourself avoiding the taking of risks in the first place and understretched yourself instead. As these coping patterns continued
into your adult life the result has become a vicious circle of spiralling striving, fearfulness and avoidance as well as an increasing disillusionment and loss of self-confidence.

The problems you brought for help concern fearing failing others, fearing panic attacks, feeling that life is passing you by and always living in anticipation of the worst. The key self-defeating patterns underlying your distress and which you will learn to recognise and revise through practice can be summarised as follows:-

1. Trying to be Perfect Pattern

You want to be a good wife and mother. However, you have a tendency to act as if there were only two extreme options in relation to these roles: Either you strive to be perfect, forever fearing failure and letting others down, frenetically busy and worn out, with other satisfactions in life passing you by; Or you will become a complete disaster as a wife and mother, failing others utterly, on a downward spiral into chaos, and left feeling out of control and rejected by those you love.

The aim here is to become aware of the pattern and to interrupt or stop it, for example by realising that you will be a more effective and happier coper by simply aiming to perform your roles to a 'good enough' standard.

2. Panic Through Avoidance Pattern

Feeling underconfident and anxious, you fear panicking in a range of situations so you find yourself leaving those situations quickly. This gives some temporary relief from anxiety but makes the thought of going the next time even more difficult. Then you find yourself avoiding that situation altogether. Life becomes an ever more confining prison of fear while you feel yourself to be coping less and less with it. From this you become even more underconfident and anxious with the whole vicious circle repeating again.

The aim here is to recognise when this pattern takes place and to increasingly learn to break the self-defeating cycle by gradually approaching feared situations more and more until your fear begins to subside. Practising the relaxed breathing exercises from the earliest sign of discomfort will also help.

3. Self-Sabotage Pattern

You deserve and want to claim a wider more fulfilling life for yourself. Basically you know the type of experiences that you would like to try but you hamper yourself by being over-concerned about the cost of failure and in letting others down in some way. And so you sabotage yourself by holding back from new experiences only to see life passing you by. This then leaves you feeling disillusioned, underconfident and wanting to claim a more fulfilling life for yourself again. Then the self-defeating cycle starts over again.

The aim is to learn to recognise how you, often subtly sabotage yourself in this way and to break the cycle by exposing yourself to more and more of those experiences you feel you are missing. Realising that failure may or may not happen and in any case is not the end of the world will help. So too will the realisation that far from letting down those around you, they will be the better for the company of happier, more fulfilled person.
4. Fearing Chaos Pattern

Feeling insecure, you try to control your feelings. However, it is as if for you there are only two extreme possibilities in life: Either you strive for certainty and perfect order, depending on life always going according to plan; but forever living in fear that it won’t and that you will descend into absolute chaos; Or life will swamp you with uncertainty, with feeling and plans descending into uncontrollable disaster, and with you left powerless to cope.

The aim it to become conscious of where this self-defeating cycle takes over and to interrupt the pattern by realising that life is neither about perfect absolute order nor is it about total chaos. Coping better will be about learning to live with a healthy degree of order and a healthy degree of flexible uncertainty in your life.

The above four self-defeating patterns are illustrated on the Diagram which has already been provided so that you can work at recognising and revising them.
APPENDIX 2.8.3.2

Sequential Diagrammatic Reformulations for the Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Cohorts
2. Distancing Feelings Pattern

1. Strong or Rejected Pattern

Imaging offending others

Fearing on explosion

Chaos and loss of control

Core Dialogue

Controlling Perfectionistic Conditional Love

Striving Out of control Insecure Tense Distant

Try to handle feelings

Either Bottled up

Keeping feelings at distance

Physical tension

Feel guilty

Feelings fester

Feelings hurt others and their rejection

Over-strive for approval as "Tower of strength"

Put own needs/feelings aside excessively

Feel put upon

Feel guilty

Feel annoyed and resentful
Sequential Diagrammatic Reformulation

Patient No. 2

2. Feeling Needy but Childish Pattern

Feel childish and spoilt

Feel demanding

Either I get what I want

Or I don't get when I want

Feel frustrated

Deprived

I feel guilty

Avoid me

Then angry with me

They feel hurt and abused

Then angry

Try to fulfill my needs

Over-strive for their approval

Ignored

Abused

Taken

For

Granted

Fear hurting others + rejection

Then guilty

Core Dialogue

Criticizing

Abusing

Rejecting

Pampering

Controlling

Criticized

Abused

Rejected

Spoilt

Controlled

Angry

Guilty

Clingy

Helpless

Try to manage conflict

Either I must give in

Or they must give in

They feel hurt and abused

Feel hurt and angry

Then childish

Feel frustrated

Then angry

Then low

Then guilty

3. The "No Compromise" Pattern
Sequential Diagrammatic Reformulation
Patient No. 3

2. Denial of Feelings Pattern

1. Over Pleasing Pattern

Put own feelings/needs aside

Over-please others

Taking advantage of

Feel angry at self and others

Core Dialogue

Demanding
Sacrificing
Idealizing
Judgemental
Over-Protecting
Rejecting

Feeling guilty
Striving
Neglected
Angry

Rejected

Fearing Tide of sadness/anxiety

Hurt others

Try to control feelings

Or burst open

Either bottled up

Hiding behind the "mask"

Bursting for expression

Forever festering inside

Failing every body

Want to be a good person

Neither trying to be perfect

Either trying to be perfect

Trying to up to uphold impossible standards

No standards

Inevitably falling short

Feeling a failure to others

Feel guilty for feeling angry

Feeling a failure to others

Feel angry at self and others

Core Dialogue

Demanding
Sacrificing
Idealizing
Judgemental
Over-Protecting
Rejecting

Feeling guilty
Striving
Neglected
Angry

Rejected

Fearing Tide of sadness/anxiety

Hurt others

Try to control feelings

Or burst open

Either bottled up

Hiding behind the "mask"

Bursting for expression

Forever festering inside

Failing every body

Want to be a good person

Neither trying to be perfect

Either trying to be perfect

Trying to up to uphold impossible standards

No standards

Inevitably falling short

Feeling a failure to others

Feel guilty for feeling angry

Feeling a failure to others

Feel angry at self and others

Core Dialogue

Demanding
Sacrificing
Idealizing
Judgemental
Over-Protecting
Rejecting

Feeling guilty
Striving
Neglected
Angry

Rejected

Fearing Tide of sadness/anxiety

Hurt others

Try to control feelings

Or burst open

Either bottled up

Hiding behind the "mask"

Bursting for expression

Forever festering inside

Failing every body

Want to be a good person

Neither trying to be perfect

Either trying to be perfect

Trying to up to uphold impossible standards

No standards

Inevitably falling short

Feeling a failure to others

Feel guilty for feeling angry

Feeling a failure to others

Feel angry at self and others

3. Try to be Perfect Pattern
2. Depressed Thinking Pattern

- Attempt task/activity
- Make no allowances
- Exaggerate outcome
- Feel failure
- Put off or avoid
- Confidence decreasing
- Want to make social contact
- Fear hurting and rejection
- Avoid people
- Social confidence decreases

1. Over-striving for Approval Pattern

- Over strive for approval of others
- Feel insecure
- Feel empty/let down
- Explode
- Feel guilty
- Suffering alone
- Feeling Festering
- Trusting nobody
- Either shut tight and ordered
- Or wide open and chaotic
- Feeling guilty and isolated
- Rejected by others
- Fatigued and isolated

Core Dialogue
- Neglecting
- Blaming
- Rejecting
- Withdrawing
- Protecting

- Neglecting
- Criticized
- Rejected
- Isolated
- Unsafe
- Cheated
- Helpless
- Angry

3. Bottling Feelings Pattern

- Feel isolated
- Rejected by others
- Fearing offending others
- Feeling guilty and isolated
- Try to manage my feelings

4. Social Isolation Pattern

- Social confidence decreases
- Want to make social contact
- Fear hurting and rejection
- Avoid people
- Feel isolated
- Feel low
- Over strive for approval of others

Patient No. 4
Sequential Diagrammatic Reformulation
Patient No. 5

2. Bottling Feelings Pattern

1. Over Pleasing Pattern

Core Dialogue

Overprotective
Critical
Rejecting

Insecure
Criticized
Rejected
Cut off

Fear rejection

Over please
Others

Put own feeling/needs aside

Feel taken for granted

Feel angry with self and other (somethings exploding later on)

Feel guilty

Feeling low

Confidence lowers

Fear rejection and embarrassment

Anxious with people

No practice

Avoid "people" situations

Fell looked down on

3. Avoidance Pattern
Sequential Diagrammatic Reformulation
Patient No. 6

2. Social Isolation and Avoidance Pattern

1. Striving to Over Please Pattern

Relief on anxiety temporary

Leave early

Social situation difficult and anxious

Anticipate rejection

Bottle feeling & needs

Fear hurting + rejection

Try to over please

Ignoring taken for granted abused

Feel angry

Positively resist

Sometimes explodes

Feel guilty

Identity swamped

No sense of control

Always having to give in totally

Hurt or smothered

Either involved

Either perfect order

Or perfect chaos

Striving for the ideal

Stressed out

Feeling of failure

Feel safe in control

But lonely

Need secure relationship

Others always giving in

Others hurt and isolated

Sentiments hurt and isolated

Identity swamped

Feel guilty

Always falling short

Others hurt and isolated

Striving for the ideal

Stressed out

Both perfect order

Or perfect chaos

4. Perfection and Order Pattern

3. Relationship Pattern
2. Panic Pattern

A fast catastrophise symptoms

Over breathe

Co2 /O2 imbalance

Catastrophise more

Embarrassed and ashamed

Fearing rejection

Feeling for peace with myself

Core Dialogue

Conditional love
Rejecting
Distancing
Critical

4. Striving Pattern

Applause and elation

Perform to "expectations" of extrovert

Rejection and low

"Mask" becomes heavy

Feel inferior and pitiful

Feel inferior fear rejection

Feel insecure

Feel anxious and insecure

Normal anxiety symptoms

1. Striving to Perform Pattern

3. Perfection Pattern

Or worthless

Either perfect

Always striving for ideal

Fearing rejection

Feeling low and angry

But falling short

Guilty

Searching for peace with myself

Frustrated

Inadequate

Self pity

Scared

Dependent

Fraudulent

Striving

Rejected

Distant

Critical

3. Perfection Pattern
 Sequential Diagrammatic Reformulation
Patient No. 8

1. Over-Exertion Pattern

- Over-exertion
- Exhaustion compounded
- Achieve even less
- Feel hopeless/confidence knocked
- With me sinking into the abyss
- Chaotic and out of control

   Make no allowance for ME
   Try to cope by pushing self
   Need to socialize set out more
   Core Dialogue
   Demanding Controlling
   Not Coping Angry Frustrated Hopeless
   Q.O.L lower/feel isolated
   Thrown back
   Taking too much out of self
   Need to direct my life
   Either life ordered and in control
   Or life becomes a mess

2. Social Isolation Pattern

- Fear burdening others
- Keep away/go out less
- Core Dialogue
- Demanding Controlling
- Not Coping Angry Frustrated Hopeless
- Q.O.L lower/feel isolated
- Thrown back
- Taking too much out of self
- Need to direct my life
- Either life ordered and in control
- Or life becomes a mess

3. Order and Control Pattern
Sequential Diagrammatic Reformulation
Patient No. 9

3. Alcohol Lethargy and Low Self-Confidence Pattern

1. Inactivity and Lowered Self-Confidence Pattern

Try to please expectations of others
Too much alcohol
Side effects next day
Lethargy and inactivity
Self-esteem lower
Feel low
Then nothing can happen

Core Dialogue

Criticizing
Rejecting

Criticized
Rejected
Demoralized
Striving
Undervalued
Powerless

Feel low
Seek fulfilling life like before
Abandon or avoid doing again
Self-Confidence lower
Exaggerate how badly I coped
Don't allow for knock to confidence
Try to do things
Try to please expectations of others
Fear not being popular
Too much alcohol
Side effects next day
Lethargy and inactivity
Self-esteem lower
Feel low
Then nothing can happen

2. Life Turning Sour Pattern
Sequential Diagrammatic Reformulation
Patient No. 10

2. Bottling Feelings Pattern

Uncontrollable avalanche

Over-please others

Put own needs and feelings aside

Fear offending and rejection

Taken for granted + abused

Feel angry

Core Dialogue

Abusing
Rejecting
Controlling
Critical

Wish for fulfilling relationship

Feel disillusioned

Feel guilty

No fulfillment possible

But as if disallowed by others or by fate

Ingredients within grasp

Butlonely and isolated

Feel "safe"

Feel low and alone

Feel guilty

Feel injured

Feel engulfed and rejected

Feel low and alone

Feel guilty

Feel low and alone

Feel safe

Want to claim a fulfilling life

Feel angry

Feel guilty

Feel low and alone

Feel guilty

Feel low and alone

Feel low and alone

Feel guilty

Feel injured

Feel engulfed and rejected

Feel injured

Feel engulfed and rejected

Feel low and alone

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**Sequential Diagrammatic Reformulation**  
*Patient No. 11*

### 3. Inactivity and Depression Pattern

- **Start something**
- **Bottle feelings + needs**
- **Always give in for approval of others**
- **Fear hurting others + rejection**
- **Ignored or taken for granted**
- **Angry and frustrated of self and others**
- **Feel guilty**
- **Feel under confident, fear rejection**
- **Feel insecure and anxious and under confident**
- **Feel guilty and low**
- **Life very limited**
- **Avoid altogether**
- **But more difficult next time**
- **Temporary Relief**
- **Leave early**
- **Avoid altogether**
- **Leave early to avoid altogether**
- **No opportunities to practise**
- **Feel guilty and low**
- **Feel under confident, fear rejection**
- **Feel insecure and anxious and under confident**
- **Feel guilty**
- **Feel under confident, fear rejection**
- **Feel guilty and helpless**
- **Fear hurting others + rejection**
- **Ignored or taken for granted**
- **Angry and frustrated of self and others**
- **Feel guilty**
- **Feel under confident, fear rejection**
- **Feel guilty and helpless**
- **Start something**
- **Walk away**
- **Nothing to credit self for**
- **Confidence lowered**
- **Social situation**
- **"They'll think I'm stupid"**
- **Keep quiet**
- **Feel odd-man-out and more tense**
- **Leave early to avoid altogether**
- **No opportunities to practise**
- **Feel under confident, fear rejection**
- **Feel guilty and helpless**
- **Start something**
- **Walk away**
- **Nothing to credit self for**
- **Confidence lowered**
- **Social situation**
- **"They'll think I'm stupid"**
- **Keep quiet**
- **Feel odd-man-out and more tense**

### 4. Under Confidence and Social Isolation Pattern

- **Keep quiet**
- **Feel odd-man-out and more tense**
- **Leave early to avoid altogether**
- **No opportunities to practise**
- **Feel under confident, fear rejection**
- **Feel guilty and helpless**
- **Start something**
- **Walk away**
- **Nothing to credit self for**
- **Confidence lowered**
- **Social situation**
- **"They'll think I'm stupid"**
- **Keep quiet**
- **Feel odd-man-out and more tense**

### 1. Over pleasing and Giving in Pattern

- **Always give in for approval of others**
- **Fear hurting others + rejection**
- **Ignored or taken for granted**
- **Angry and frustrated of self and others**
- **Feel guilty**
- **Feel under confident, fear rejection**
- **Feel guilty and helpless**
- **Start something**
- **Walk away**
- **Nothing to credit self for**
- **Confidence lowered**
- **Social situation**
- **"They'll think I'm stupid"**
- **Keep quiet**
- **Feel odd-man-out and more tense**

### 2. Avoidance Panic and Under Confidence Pattern

- **Panic in situations (e.g. town)**
- **Leave early**
- **Avoid altogether**
- **But more difficult next time**
- **Temporary Relief**
- **Avoid altogether**
- **Life very limited**
- **Feel guilty and low**
- **Feel under confident, fear rejection**
- **Feel guilty**
- **Feel under confident, fear rejection**
- **Feel guilty and helpless**
- **Start something**
- **Walk away**
- **Nothing to credit self for**
- **Confidence lowered**
- **Social situation**
- **"They'll think I'm stupid"**
- **Keep quiet**
- **Feel odd-man-out and more tense**

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*Note: The diagram illustrates a pattern of behavior and emotional responses for Patient No. 11, with detailed steps and conditions leading to specific emotional states.*
Sequential Diagrammatic Reformulation
Patient No. 12

1. Over pleasing Pattern
- Put own feeling/needs aside
- Feel taken for granted

2. Bottling Feelings Pattern
- Exploding everywhere
- Hurting others
- Over pleasing
- Feel guilty and rejected
- Exploding everywhere
- Or burst open and chaotic

Core Dialogue
- Conditional Love
- Strict Perfectionist
- Striving
- Overcontrolled
- "On Edge"
- Disillusioned

Ingredients within grasp
- Disappointing others
- Want to fulfill personal needs
- Want to be "good"
- Want to be "good"
- Very stressed
- Forever falling short
- Fear low and angry
- Feel guilty
- Explode
- Feel angry
- Feel taken for granted
- Over please
- Feel guilty and rejected
- Exploding everywhere
- Or burst open and chaotic

Self Sabotage Pattern
- Self sabotage by paying, for or undoing fulfillment with guilt
- Act as if disallowed

3. Perfection Pattern
- Standards plummeting
- Or fearing the abyss
- Either striving for perfection
- Very stressed
- Forever falling short
- Fear low and angry
- Feel guilty
- Explode
- Feel angry
- Feel taken for granted
- Over please
- Feel guilty and rejected
- Exploding everywhere
- Or burst open and chaotic

Choose any dialogue and cut off the path from it. Fix the last cycle and turn it into a triangle.
3. Self-Sabotage Pattern

But fear failure

And fear letting others down

So I hold back/sabotage myself

Feel life passing me by

Feel disillusioned and under confident

Feelings and plans a complete mess

Life total chaotic

Or total uncertainty

Either certainty and order

Willing that life always going according to plan

But living in fear that it won’t

Life becoming a prison

Try to control my Feelings

Fearing chaos

Coping less

Feel under confident and anxious

Fear panic in situations

Leave early

Temporally relief

4. Fearing Chaos Pattern

1. Trying to be Perfect Pattern

Forever fearing failure and letting others down

Want to claim more fulfilling life

Worn out

Life passing by

Want to be good wife and mother

Failing others

Chaotically disorganized

Feeling rejected and out of control

Feel under confident and anxious

Fearing Failure

Disillusioned

Terrified

Guilty

Clingy

Soldiering on

Perfectionistic

Frenetically

Active

Over Protective

Conscientious

2. Panic Through Avoidance Pattern

Either trying to be perfect

Or complete disaster

Want to be good wife and mother
Sequential Diagrammatic Reformulation
Patient No. 14

4. Running From Feelings Pattern

Feelings would keep gushing
Or wide open and chaotic
Guilty + shame
Try to manage my feelings
Either bottled up and ordered
Feelings festering and split off
Feel alone
Hurt never mends
Anger never mends
Need to enjoy my life

Feel I don't deserve to

Some good things happen

Core Dialogue
Critical Rejecting Untrusting Demanding Abusing
Rejected Isolated Abused Angry Guilty Inadequate Unworthy

Feel guilty for feeling angry
Feel ineffective and fear failure or imperfection
But confidence ever decreasing
Temporary relief from anxiety

Avoid certain situations and people
I turn them into negatives/sabotage them

3. Life Always Sour Pattern

Put own needs aside
"Marty" my self to the expectations of others
Fear being seen as offending "brute" and rejected
Ignored/Taken for granted
Feel angry with self and others (sometimes exploding)
Feel guilty for feeling angry

2. Avoidance Pattern

1. Over striving to Please Pattern

Try to manage my feelings
Either bottled up and ordered
Feelings festering and split off
Feel alone
Hurt never mends
Anger never mends
Need to enjoy my life

Feel I don't deserve to

Some good things happen

2. Avoidance Pattern

Try to manage my feelings
Either bottled up and ordered
Feelings festering and split off
Feel alone
Hurt never mends
Anger never mends
Need to enjoy my life

Feel I don't deserve to

Some good things happen

3. Life Always Sour Pattern

Put own needs aside
"Marty" my self to the expectations of others
Fear being seen as offending "brute" and rejected
Ignored/Taken for granted
Feel angry with self and others (sometimes exploding)
Feel guilty for feeling angry
Feel ineffective and fear failure or imperfection
But confidence ever decreasing
Temporary relief from anxiety

Avoid certain situations and people
I turn them into negatives/sabotage them
Sequential Diagrammatic Reformulation
Patient No. 15

2. Admired or Vulnerable Pattern

Or exposed and rejected/worthless
Hurt and guilty
Feel inadequate/uninteresting
Core Dialogue
Ideal Care
Protective
Critical
Belittling
Dependent
Inadequate
Abandoned
Rejected
Insecure

Either admired on a Pedestal/special
Straining to keep image
Awaiting the "fall"
Anxious and lonely
Seek perfect relationships
Perfectly close for a while ("Special")
Disappointment and anger
Feel low and inadequate
Overprotective
Life stagnates
Avoid calculated life risks

1. Social Isolation Pattern

Verbal vomiting to compensate
People withdraw/withdraw
Feel rejected and guilty
Isolate myself
Feel insecure

Need to get on with others
Exposed and rejected/worthless
Hurt and guilty

3. Ideal Relationships

4. Over-Protectiveness Pattern
Sequential Diagrammatic Reformulation
Patient No. 16

Bottling Feelings & Over pleasing Pattern

Ingredients all within grasp

Angry with self + abuser

Taken for granted abused ignored

Over please expectation of others

Bottle own feelings and needs

Core Dialogue

Distrusting
Controlling
Demanding

Rejecting
Criticizing
Withholding

Devolving

Guilty
Rejected
Disillusioned

Over-Controlled
Striving

Isolated
Disillusioned

Left isolated

Avoided by others

Seen as disdainful

With hold withhold socially

Feel under-confident/fear rejection

Low Self-Esteem and Social Isolation Pattern

Enjoyment inferior to striving and work

Pleasure rejected/abandoned

Want to enjoy life

Feel guilty for anger

Overplease expectation of others

Bottle own feelings and needs

Fear rejection feel insecure

Disillusioned

Distrusting

Demanding

Controlling

Rejecting

Criticizing

Withholding

Devolving

Guilty

Rejected

Disillusioned

Over-Controlled

Striving

Isolated
Sequential Diagrammatic Reformulation
Patient No. 18

3. Always Giving In Pattern

- Overcontrolled by me
- Their needs ignored
- Resentful of me
- Guilty
- Fear being offensive "brute" and rejected
- "Martyr" myself to the expectations of others
- Put own needs and feelings aside
- Ignored taken for granted abused
- Feel guilty for feeling angry
- Feel worthy
- Feel unqualified
- Feel worthy
- Feel unqualified
- Life feels narrow and isolated
- Need wider social contact
- Fear burdening others and having to wear "mask"

Core Dialogue
Rejecting
Critical "Special"
Untrusting "Too busy"
Rejected "Put down" Unworthy Guilty A "Nobody"

4. Avoidance Pattern

1. Over-striving to Please Pattern

Or they have to give in

Wish for a balanced relationship

Either I always give in

Overcontrolled by others

My needs ignored

Feel unworthy and resentful

Low mood

Temporarily relief from anxiety But!!

Can't cope

Try to manage my feelings

Feel fragmented inside

Real feelings not aired or come to terms with

Feel guilty for feeling angry

Feel angry with self and other (sometimes exploding)

Feel angry with self and other (sometimes exploding)

Feel guilty for feeling angry

Feel guilty for feeling angry

Feel worthy

Feel worthy

Feel unqualified

Feel worthy

Feel unqualified

Life feels narrow and isolated

Need wider social contact

Avoid socially

Rejected by others

Either ordered and bottled up

Or chaotic and wide open

Flooded by distress

Feel guilty for feeling angry
Sequential Diagrammatic Reformulation
Patient No. 19

3. Striving to be Perfect Pattern

- Standards gone completely
  - Or Total failure
  - Rejected by others
  - Feel guilty
  - Want to be a good person
- Core Dialogue
  - Critical
  - Conditional
  - Love
  - Strict
  - Protective
  - Striving
  - Inadequate
  - Criticized
  - Dependent
  - Guilty
  - Afraid
  - Angry

1. Over Pleasing Pattern

- Feel taken for granted
  - Try to over please
  - Fear disapproval
  - Feel angry (sometimes exploding)
- Rejected by others
  - Feel angry
- Feel guilty
- Fear disapproval
- Feel taken for granted

2. Avoidance Pattern

- Bottle up Feelings Pattern
  - Feeling festering
  - Or Burst open
  - Tension mounting
- Feelings lower
- Confidence lowered
- Avoid altogether
- But more difficult next time
- Try to handle my feelings
- Fearing avalanche

- Feel I'm letting others down
- Depressed and angry
- Can't keep it up
2. Bully/Victim and Distrust Pattern

Always giving in → Hurt and untrusting of others → Avoiding closeness for protection → Feeling alone → Feel guilty for anger

Or I must be victim → Try to handle conflict → Either I must be bully → They always give in → Abusing and trusted by others → Left feeling guilty an isolated → Abused Controlled Criticized Bullied Rejected Unworthy Guilty Let down Striving → Despair

Then avoided by them → Things happen less → Stop trying; Start worrying → Act as if not allowed "must turn sour"

1. Bottling Feelings and Over pleasing Pattern

Angry with self and others → Taken for granted abused ignored → Over please expectations of others with "front" → Bottle or devolve own needs and feelings → Fear hurting others and rejection

Core Dialogue
Abusing Controlling Criticizing Bullying Rejecting

Seek happiness + fulfillment

Define my goals (relationship job etc.)
3. Bottling Feelings Pattern

- Fearing an avalanche
- Or Burst open
- Try to handle Feelings
- Either Bottled up
- Tension increases
- Feelings fester out of proportion
- Explosion
- Feel guilty and ashamed
- Coping ability decreases
- But fear is fueled
- Temporary relief from tension
- Avoid key situations/leave early

1. Over-striving for Approval Pattern

- Over-strive for approval
- Neglect feelings and needs
- Feel ignored/taken for granted
- Feel angry
- Sometimes explode
- Feel guilty
- Fear confrontation

Core Dialogue

- Untrusting
- Conditional Love
- Rejecting/Critical
- Controlling

- Lonely
- Striving
- Rejected
- Overcontrolled
- Insecure

Feel rejected and "weak"

Feel disapproval/appearing "weak"

Feel rejected and "weak"

Feel guilty and ashamed

Feel rejected and "weak"

Feel disapproval/appearing "weak"

Over-strive for approval

But fear is fueled
Sequential Diagrammatic Reformulation
Patient No. 22

2. Bottling Feelings Pattern
- Fearing an avalanche
  - Or Burst open
  - Trying to handle feelings
    - Either Bottled up
      - Feelings driven underground
        - Fear of break down and loss of control
          - Resulting in physical stress
            - Descent into the abyss
              - Need to take control of life
                - Or Fearing chaos
                  - Either Striving for order and "peace"
                    - In pursuit of certainty
                      - In pursuit of certainty

1. Over-striving Pattern
- Over-perform/over-strive for approval
  - Fearing utter collapse
    - Fearing rejection and feeling guilty
      - Neglect own feelings + needs
        - Feel undervalued and overstretched
          - Feel angry and stressed out
            - Sometimes exploding
              - Feel guilty
                - Desiring love
                  - Sometimes exploding
                    - Feel anxious
                      - Nervous system overactive
                        - Over breathe
                          - C.N.S. Symptoms
                            - 02/C02 imbalance

3. Order or Chaos Pattern
- Loss of confidence in ability to cope
  - Feel cheated and drained
    - No time to relax and savour
      - In pursuit of certainty
        - In pursuit of certainty

4. Anxiety Attack Pattern
- In pursuit of certainty
  - In pursuit of certainty

...
Sequential Diagrammatic Reformulation
Patient No. 23

2. Bottling Feelings Pattern

Abusing others

Or
Burst open

Trying to handle feelings

Either
Tight shut

Stress festering

Forever festering

Distancing others

But feel lonely and unworthy

In charge

Descent into the abyss

Or
uninvolved

Either involved

Idealizing relationships

Idealizing

Critical

Rejecting

Contemptuous

Untrusting

Attacking

Core Dialogue

Pursue fulfillment

Feel undeserving

Give up/abandon

Feel bound to sour

Self-esteem lower

Feel hopeless

Isolated

Rejected

Hurting others

Either
Attacking and sticking up for self

Try to handle conflict

Hurt + let down

Feeling hurt

Bullied into submission

4. Attacking or Attacked Pattern

Feel powerless

Try to handle conflict

Or
Attacked

Feeling hurt
Sequential Diagrammatic Reformulation
Patient No. 24

2. Bottling Feelings Pattern

Offending everybody

Or wide open

Rejection and isolation by others

Try to handle my feelings and needs

Either tight shut

Offending nobody

With me always giving in

Feel resentful and angry

Want to take charge of my life

Fear failure and not coping

Avoid action

Life stands still

Feel life passing me by/helpless

Feel disillusioned

Avoiding

Over protective

Rejecting

Criticizing

Provoking

Core Dialogue

Over dependent

Inferior

Rejected

Criticized

Attacked

Angry

Guilty

1. Panic and Avoidance Pattern

Panicky in situations

Temporary relief

Leave early

But more difficult next time

Avoid altogether

Life becomes a prison

Can't cope

Losing a sense of "me"

Seeking their approval

With me always giving in and depending

Either liked by everybody

Try to get on with people

Or a total failure

A rejected by all

With no value as a person

Confidence drops

4. Life Passing Me By Pattern

3. Needing to be Liked Pattern
Sequential Diagrammatic Reformulation
Patient No. 25

2. Bottling Feelings Pattern

Fearing unstoppable avalanche
Or Burst open and chaotic
Trying to handle my feelings
Either Bottle up and ordered
Pushing my feelings away
Feelings festering with no outlet
Never coming to terms
Feel guilty
Shame
Into the abyss
Or Failure
Either perfection
Forever striving and exhausted

Protective Critical Frenetic Controlling
Insecure Abandoned Split Choked Up

Core Dialogue
Left rejected and feeling guilty
Want to claim my happiness
But fear disappointment
Sabotage today with worry about tomorrow
Feel disenchanted and low
Fear failure and rejection
Anxious in situations
Confidence lowered
Fall short
Avoid altogether
Unreachable standards
But more difficult next time
Temporary relief
Leave early
Aim for fulfilling life
Feel low + angry
Shame

1. Self-Sabotage Pattern

Ingredients all there
But fear disappointment
Ingredients all there

3. Avoidance Pattern

4. Striving for Perfection Pattern
4. Ordered or Chaotic Pattern

1. Post-Natal Depression Pattern

- Fearing collapse
- Make no allowance
- Exaggerate performance in coping
- Chastise self
- Intensify stress on self

Core Dialogue

Demanding
Controlling
Idealisms

Striving
Unsure
Anxious
Out of control
Guilty
Dependent

Feel low/run down

Feel guilty

Feel unsure

Feel alone

Hide behind mask

Or
Chaotic

Either
Ordered

Striving for certainty

Tension and worry

Feel guilty and dissatisfied

Looked down on by others

Want to seek fulfillment

Either perfect

Striving for the ideal

Fearing short comings

Feel unnatural

Mask becomes burden
2. Trying to Please Pattern

- Over-pleasing to others
- Feel taken for granted
- Put own needs aside
- Fear rejection
- Feel guilty
- Feel hurt and rejected
- Controlled by others
- Or Abused/Attacked
- Try to handle conflict

1. Avoidance Pattern

- Phobic about situations and people
- Leave early
- Temporary relief
- But more difficult next time
- So avoid altogether
- Life more limited

Core Dialogue

- Abusing
- Attacking
- Critical
- Rejecting
- Controlling
- Demanding
- Idealizing

Abused
Attacked
Put down
Rejected
Manipulated
Let down
Angry
Needy

Self confidence decreasing

Ingredients now available (events and people)

Want to claim my happiness

Controlling others

Feel guilty

Fearing rejection

Feel cheated

Happiness rejected

Sabotage as if not deserving (with illness)

4. Abusing or Abused Pattern

3. Self-Sabotage Pattern
Sequential Diagrammatic Reformulation
Patient No. 28

1. Bottling Feelings Pattern
- Fearing total chaos
- Or Feelings wide open (often with alcohol)
- Fearing rejection
- Trying to handle feelings
- Either Bottling up or denying feelings
- Never coming to terms
- Tension forever mounting into rage
- Explosion on innocents
- Wish for some happiness
- Happiness close by
- Happiness evades me
- Sabotage happiness to avoid disappointment

2. Pleasing and Perfect Pattern
- Try to over please/be "perfect"
- Temporary relief
- Feel ignored abused taken for granted
- Feel angry at self and others (sometimes exploding)
- Feel guilty
- Hurt/rejected
- Always "Giving in" to their control
- Feel engulfed
- Either Close
- Wish for mutual relationship
- Or distant
- Engulfing others
- Others always "giving in"
- Feel "safe"

3. Life Always Sour Pattern
- But "alone"
- Happiness close by
- Happiness evades me
- Sabotage happiness to avoid disappointment
- Feel guilty
- Always "Giving in" to their control
- Engulfing others
- Others always "giving in"
- Feel "safe"
- Wish for mutual relationship
- Or distant
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- Feel guilty
- Hurt/rejected
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- Feel "safe"
1. Under Assertiveness Pattern

- Over-strive for approval
- Belittle own needs + feelings
- Feel ignored, abused, "Door-mat"
- Feels empty, alone
- Festering inside
- Rejection and guilt
- Feel guilty
- Tension + symptoms
- Feel empty and alone
- Distant from self and others
- Either Bottled up and ordered
- Try to handle feelings
- Or Burst open and chaotic
- Fearing destruction and hurt

2. Binge/Starve Pattern

- Bingeing
- Or I fear being overwhelmed by my own neediness
- I fear being overwhelmed by awareness of neediness
- Feel out of control and guilty
- Trying to deal with my own needs
- Starvation
- Overwhelmed by awareness of neediness
- Feel in control
- But then empty and lonely
- Fearing rejection of others
- Or Worthless
- Need for approval from others
- Feel "failure"
- Rejection and guilt
- Depression
- Fearing destruction and hurt
- Tension and exhaustion
- Forever striving

3. Perfect of Guilty Pattern

- I fear being overwhelmed by my own neediness
- Or I completely deny my own needs
- Starvation
- Overwhelmed by awareness of neediness
- Feel in control
- But then empty and lonely
- Fearing rejection of others
- Or Worthless
- Need for approval from others
- Feel "failure"
- Rejection and guilt
- Depression
- Fearing destruction and hurt
- Tension and exhaustion
- Forever striving

Core Dialogue

- Rejecting
- Critical
- Over-protective

- Rejected
- Put down
- Clingy
- Striving
- Angry
- Envious

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- Or Worthless
- Need for approval from others
- Feel "failure"
- Rejection and guilt
- Depression
- Fearing destruction and hurt
- Tension and exhaustion
- Forever striving
Sequential Diagrammatic Reformulation
Patient No. 30

Overpleasing and Bottling Feelings Pattern

- Devalue + bottle up own needs + feelings as if childish and didn't deserve them
- Fear hurting and rejection
- Strive to meet expectations of others (perfectly)
- Ignored abused taken for granted
- Angry with self + others sometimes exploding
- But lonely
- In control and "safe"

Avoidance + Low Confidence Pattern

- Temporary relief
- But avoidance intensifies fear
- Avoid + overprotect
- Phobic situations (e.g. night time)
- Feel insecure/under confident/low self-esteem

Core Dialogue

- Ridiculing
- Abusing
- Over protecting
- Blowing
- Criticizing

- Neglecting
- Bullying
- Rejecting
- Controlling

- Hurt
- Abused

Relationship Pattern

Or uninvolved

Either involved

Seek mutual relationship
APPENDIX 3.1.1

Raw Data Listing for All 32 Patients
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APPENDIX 3.3.2.2.1

Reliable Change Index (RCI) Scores at Post-termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Patients on the Beck Depression Inventory (BDI)

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### APPENDIX 3.3.2.2.2

Reliable Change Index (RCI) Scores at Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Patients on the Global Severity Index (GSI) of the Symptom Checklist 90R (SCL 90R)

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Reliable Change Index (RCI) Scores at Post-Termination and Follow-Up for Prose plus Sequential Diagrammatic Reformulation (PSDR) and Sequential Diagrammatic Reformulation (SDR) Patients on the Inventory of Interpersonal Problems (IIP)

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