Cognitive Analytic Therapy (CAT), Obsessions and Overvalued Ideas: Developing a Model and a Method

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Abstract:
Psychological therapies, including CAT, can have limited efficacy when working with more complex people, with disorders that feature overvalued ideas and obsessions, such as Obsessive Compulsive Disorder and Anorexia Nervosa. This paper develops the CAT model and method for working with these problems. Theoretical exploration is grounded in clinical practice and a series of workshops in the UK and Greece. Ideas are drawn from CAT theory, cognitive theory, trauma theory, psychoanalysis and literature, to present a 'third' CAT guide map for working with obsessionality. It offers detailed suggestions as to adaptations to the method presented under the headings of the C-CAT adherence tool.

Key Words:
Cognitive Analytic Therapy (CAT), Obsessive Compulsive Disorder (OCD), Anorexia Nervosa, Overvalued ideas, Treatment method, Trauma

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Overvalued ideas and obsessions

My starting point comes from psychiatric phenomenology and the concepts of 'obsession' and 'overvalued idea'. Andrew Sims (1988 p.92) explains the latter: 'An overvalued idea is an acceptable, comprehensible idea pursued by the client beyond the bounds of reason.' The idea falls short of being a delusion (and thus not a psychotic idea) because there is some sense of rationality; if only the idea could be held in balance and

not go on to dominate the person's life. So for example, it is good to consider hand hygiene, but to be trapped in the bathroom all day by obsessional doubt is excessive. Similarly, obesity is a new epidemic in the developed world and some restriction on eating and on avoidance of unhealthy food types is good for health, but not when the person's Body Mass Index (BMI) falls to dangerous levels. It is the dominance of the overvalued, or obsessional idea, whether it be about weight, body shape or contamination, and the affective grip it has on the person, that connects OCD and Anorexia and some rarer disorders such as Body Dysmorphic Syndrome and some forms of Hypochondriasis, Hoarding Disorder and Morbid Jealousy. I am using the term 'obsessionality' to describe this commonality that I see as behind *some* presentations of OCD, Anorexia and the other rarer conditions I have mentioned above.

Clinicians working with people in these areas will be aware of how difficult it can be to engage the person in challenging the core idea that drives the disabling behaviours. It is as if the main relationship for the person is with an internal idea rather than with people in the outside world like the therapist. The driving idea is out of dialogue and non-negotiable. This, as we will see later, has profound *interpersonal* effects.

Obsessionality, CAT and CBT

Ryle and Kerr (2002 p.138) give a case example of a client with OCD, which is a description of how CAT is often applied to obsessionality. They draw attention to the safety of ritualization in cultural settings (for example, religious and military rituals) and emphasise the need to gain control in order to manage anxiety. The dilemmas 'absolute order or dangerous chaos' and 'absolute success or shameful failure' are used in formulations. At the heart of the map is the reciprocal role controlling to controlled. Procedures map the effects of these patterns on the self and others. There is encouragement of the expression of feelings and the sharing of responsibility for managing anxiety. They note that in more severe cases, when the behaviours are very disabling, a behavioural approach, like response prevention, or medication may be needed.

Protogerou et al (2008) present a brief report of the outcome of using CAT to treat 64 patients with obsessive-compulsive personality disorder. They showed significant improvement in depression scores and anhedonia. Boogar et al (2013) have published a controlled outcome study of a 16 session group CAT intervention for patients with OCD showing significant improvement in symptom severity. Kimber-Rogal

(2008) has described using CAT with an obsessional client and emphasizes the interpersonal aspects of treatment.

Cognitive Behaviour Therapy (CBT) has a clear formulation of obsessionality as being driven by intrusive thoughts that cause doubt and an emotional response involving anxiety. This is followed by some form of behavioural or mental activity that causes temporary relief but then the resurgence of doubt, with the acknowledgement that the more the doubts are acted upon the worse the problem becomes over time (for a review see: Foa, 2010). Emphasis in treatment is on response prevention and challenging the rationality of the thoughts that trigger the whole cycle. The 'CBT cycle' is a very helpful description of the thoughts, feelings and behaviours that are the apparent problem or symptom and, in my view, should be present on any CAT map.

My reservation with both the standard CAT and CBT models is that there is a lack of emphasis on underlying causes and the question 'why?' CBT is explicitly symptom focussed and in CAT, the therapist is often drawn into mapping symptoms and their effects in the present while perhaps neglecting links to the past. The client may never have been invited to go beyond a discussion of their symptoms before, so making it difficult to make the sorts of connections that a CAT therapist would normally draw attention to in a reformulation letter (for example, early loss or an anxious/controlling parent).The therapeutic dialogue can end up as a circular monologue about symptoms and their devastating effect.

How can CAT be adapted to make it possible for the client to link the present to the past in the normal CAT way? How can obsessionality be formulated as a complex protective system against a real but possibly disavowed core pain? This attempt is in no way intended to dismiss biological, genetic and possibly epigenetic factors that are well documented in these conditions, but is an attempt to offer a CAT relational angle that may benefit some clients, especially when medication and other treatments have not been successful.

In 2014, Tony Ryle wrote in the paper celebrating CAT at thirty (Ryle et al, 2014 p.260):

> 'Symptoms and symptom complexes such as eating disorder or OCD are seen to originate in the need to replace or avoid forbidden or feared reactions to unmanageable experiences. The role of many symptoms is illustrated by a story – I think a Buddhist one – of a drowning man who was saved when a raft drifted by. In recognition of his gratitude he strapped the raft to his back and

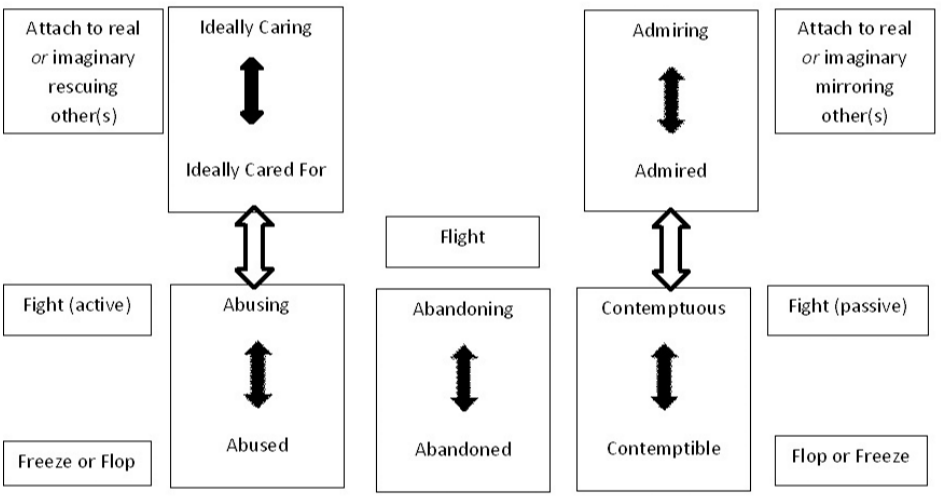
carried it for the rest of his life. Many symptoms can be relieved by the recognition and modification of the avoided procedure.'

This timely metaphor not only linked OCD and eating disorders, but started me on a journey of trying to think 'outside the box' when it comes to obsessionality.

Trauma, Submission and Sacrifice

If you look up 'responses to trauma' on the internet (see for example Reisinger, 2017) you get a growing list of possible survival strategies. In addition to the traditional fight and flight responses there are now freeze, flop, attach and submit (sometimes called 'fawn'). It is interesting to think about these in terms of the existing CAT borderline and narcissistic guide maps (see Fig 1). It is easy enough to see where fight and flight may fit in (with the narcissistic fight taking a more passive form without direct physical aggression but with more subtle forms of contemptuous attack). Freeze and flop are bottom role protective positions. The attachment strategy can be seen as initiating a state shift to the idealised self state; either seemingly finding a rescuer (even if this is at other times the abuser) or in the narcissistic case, seeking escape through the admiration of mirroring others (which may be in the real world or sometimes only in an imaginary future world).

Fig 1: Borderline and Narcissistic CAT Guide Maps and Trauma responses



When it comes to obsessionalty, I was immediately drawn to the trauma response 'submit'. The word 'obsession' comes from the Latin *obsessus* – the perfect passive participle of *obsideo*; meaning 'to have been possessed'. People with OCD often talk about their OCD as a tyrant; indeed there is a statue of the 'OCD bully' by Steve Caplin commissioned by the South London and Maudsley Trust. The figure resembles a devil. The Tarot card of the devil often shows a man and a woman chained in misery at its feet; having made a pact with the devil, they are enslaved for all eternity. Submit is a way of surviving overwhelming threat and certain death. To lie prostrate and swear undying and unconditional allegiance to a powerful, annihilating other gives you a chance of survival. My hypothesis for obsessionality is that some people when faced with such a seemingly overwhelming threat use obsessional mechanisms to turn to an *internal* protector/tyrant that they can serve. They have signed a contract without having had a chance to read it. They have no idea how long the slavery will last or what they have to do to fulfil their obligations. As time goes on the demands of the tyrant get more and more draining and exhausting.

My hypothesis is that this can be due to an early environment of uncontainment and neglect as opposed to explicit abuse or narcissistic contempt and conditional admiration. In my experience there are some attachment patterns that come up again and again. For example, a mother with OCD; an anxious self-absorbed parent combined maybe with early loss of a parent or sibling; an uncontained family break-up in early adolescence. The fundamental strategy seems to be to try to solve an overwhelming problem on your own *for the sake of everyone else.* In J. D. Salinger's *Catcher in The Rye* (1951), the title of the book alludes to the fact that the main character, in an attempt to compensate for the tragic loss of his younger brother, imagines a sacrificial role for himself running out of a field of rye to catch children as they are about to fall over a cliff to their deaths.

Ideas from Psychoanalysis

Psychoanalytic theories relating to obsessionality also make connections to themes of threat, dread and striving to protect the self and others. Freud (1955a) described a short analysis of a man with obsessional neurosis, often known as the case of 'Rat Man', who used rumination to protect himself from the fear of his girlfriend and mother undergoing horrific torture. In 'Inhibitions, Symptoms and Anxiety', Freud (1955b)

describes two main obsessional defences: 'undoing' (sometimes called 'magic undoing') and 'isolation'. In undoing, some action or behaviour is attempting magically to reverse or ward off some feared happening. In isolation there is an attempt to isolate or disconnect unmanageable fears from more manageable day-to-day worries. It is safer to worry about having dirty hands, for example, than to consider the death of a loved one.

There is also something greedy about the obsessional protector/tyrant in that its demands are '. . . exceeding what the subject needs and what the object can or wishes to give' (Klein, 1957 p.181). Hanna Segal expands: '. . . the destruction (of the object) is incidental to the ruthless acquirement' (Segal, 1988 p.40). The internal obsessional tyrant demands more and more over time. It can never be satiated and leaves the person controlled, drained and exhausted, and feeling guilty for the effects their obsessionality can have on others as they have no intention to cause harm to those close to them.

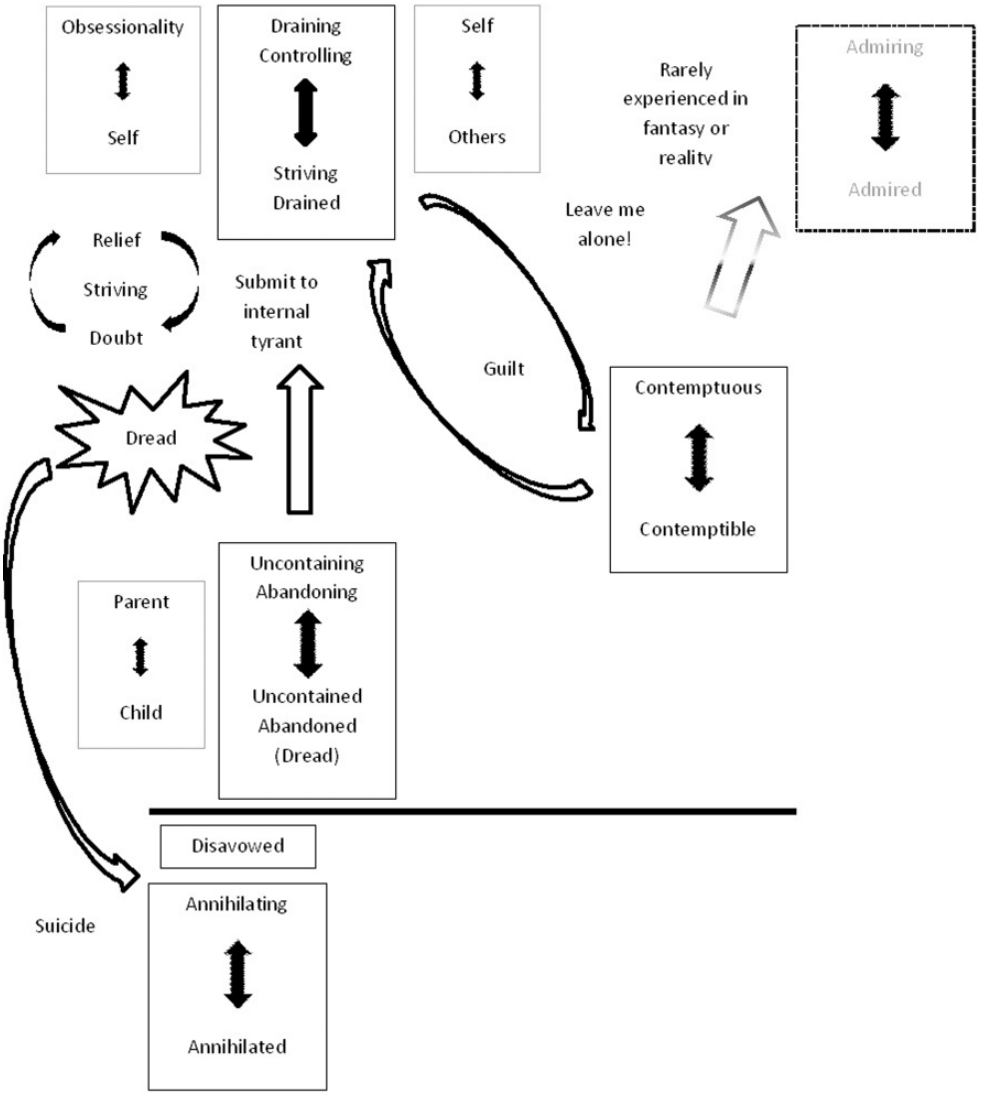
For example, a person feels worried about having left the cooker on when on the way to a holiday. They are overwhelmed with dread and know that they will not be able to relax on their holiday until they have gone back to check. Others try to reassure but this has no effect. The person becomes distressed and eventually critical: 'You have no idea what I am going through. Someone needs to take risk seriously!' The whole family have to go back due to the needs of the obsessional doubt. The person ends up feeling ashamed and guilty. The family feel drained and as if their needs have not been understood or met.

There are also links to be made with Fairbairn's (1952) description of a schizoid personality as being characterised by omnipotence, detachment and preoccupation with fantasy and inner reality. Ralph Klein draws attention to the master/slave aspect of the internal relationship: 'The basic attachment unit of the schizoid patient is the master/slave unit, the basic nonattachment is the sadistic object/self-in-exile unit' (Klein, 1995 p.52).

The 'third' CAT Guide Map

In the template map below (Fig.2) I have pulled together the themes discussed.

Fig 2: CAT Guide Map for Obsessionality and Overvalued ideas



annihilating to annihilated

At the bottom of the map is the disavowed role, annihilating to annihilated, with its associated emotion 'dread'. To me, dread is the worst of all fears as it is not even clear what you are afraid of. The worst thing. The Bogey Man. Many obsessional procedures, I think, can be linked to an attempt to protect others from annihilation in some magical way. The

annihilating pole concerns fears about the destructiveness of the self (towards self and others); at some level perhaps feeling responsible for a death, illness or catastrophe. At the core of a client's obsessional cleanliness, for example, was the overvalued idea that her body fluids were as dangerous as anthrax to other people. The top role annihilating can also be enacted when, often after many years of striving and exhaustion, the person sadly contemplates taking their own life.

uncontaining to uncontained

The key formative reciprocal role can be summarised as uncontaining/abandoning to uncontained/abandoned. There are many different variants on this in terms of the parent-derived pole; an anxious and self-absorbed mother, a parent unavailable due to intoxication or severe depression or psychosis, an abandoning parent due to death of incarceration. Often there is a life event like the loss of a sibling combined with a family's inability to grieve or contain this loss. The core unmanageable feeling is dread and the lack of a containing relationship to help the child feel that they can survive. At some point the child decides to take matters into their own hands and do something they can do, as this is better than nothing; to submit to, and seek protection from, an internal tyrant who makes it clear what needs to be done (washing, not eating, seeking to change the shape of a part of the body, hoarding, ruminating).

It may not be possible to directly link dread to an event. It seems to me that dread is a normal part of growing up and is regularly experienced throughout life. It is having the resilience and self-containment to survive dread (through previous containing relationships) that prevents it becoming all-consuming. There are likely to be temperamental differences in how likely a child is to use obsessional procedures like this. Another child, maybe with access to more narcissistic procedures, would survive uncontainment by soothing itself with real or imaginary admirers or a future when success and recognition would be attained.

draining/controlling to striving/drained

This is the 'master to slave' relationship; the submission to an internal protector/tyrant. This describes the relationship of the client to the obsessional idea. The CBT cycle of doubt, striving and relief is a procedure coming from and returning to the bottom pole of this reciprocal role. This reciprocal role also describes the harder-to-see enactment between the person with obsessionality and others in their life (remember the

family returning from their holiday to check that the gas was turned off). Carers of people with OCD often end up getting involved in the compulsions and rituals and find they are also serving the 'OCD tyrant'. This indirect enactment between the obsessional person and others is harder to name or think about as the natural reaction to someone with severe obsessionality is concern and empathy for the distress and exhaustion they experience. It is as if the internal tyrant draws in new slaves by showing them a struggling victim; once the 'good Samaritan' has started to help with the obsessional tasks in hand, they can also be drawn in and find it hard extricate themselves.

This enactment, of course, can also be part of the relationship between client and therapist. Often from a position of empathic counter transference (perhaps with some element of admiring to admired), the therapist commits much emotional energy to trying to find a new way of working to relieve such distress. Over time the therapy may seem to get stuck. The client can seem to demand more and more time in the session, to off-load how much they are suffering at home with the obsessionality, and express despair that the therapist cannot really help or understand. Links with the past can be acknowledged as 'obviously true but so what?' and the client may say that they cannot engage in any homework or behavioural experiments as this will make the distress worse. They will get 'pay back' later for even talking about this in the session. The therapist can become drained and exhausted and perhaps turn the tables by feeling critical and demanding of more collaboration from the client to show that they have a therapeutic alliance. Fundamentally, there is a draining dynamic at work and a lack of the exit reciprocal role: *freely giving to gratefully receiving.*

admiring to admired; contemptuous to contemptible

This represents on the diagram the narcissistic 'side-arm' of the obsessional map. It can often be mistaken for the core of the problem when the uncontainment and dread is disavowed by client and therapist. This is a modified narcissistic pattern. Basically, the client gets frustrated and hurt by the demands of the therapist to engage in homework or the joint activity of co-creating CAT tools and can become contemptuously dismissive. They are saying 'leave me alone, you just don't understand that you are making things harder for me', and this can push the therapist into another attempt at striving to make progress or into an unconditional empathic position; where they started in the first place. The client often feels guilty and bad for the contemptuous attack and will have to make

up for this at home with more obsessional striving. The therapist can become burnt out and rejecting of the client and contemptuous of the purpose of continuing therapy.

The admiring to admired self-state is rarely fully enacted. Just occasionally in specialist treatment centres one client can become special; the lowest in weight or the most burdened by OCD and looked up to or in competition with other clients. There can be a splitting between the admired and desired specialist treatment centre and the contemptuously dismissed, local treatment on offer, like CAT. Having severe obsessional problems like Anorexia or OCD, does not attract admiration as onlookers can easily see the distress and disability of the client.

Working with obsessionality in CAT

So, how do we make progress in CAT in the face of these powerful enactments and times when it seems as if there is a limited therapeutic alliance? I will finish with some suggestions and illustrations in the broad domains of the C-CAT tool (Bennett and Parry, 2004).

1. phase specific therapeutic tasks

Some of the conditions that I have grouped under the heading 'obsessionality' can have a range of causes linked to functional and organic mental illness (particularly Morbid Jealousy, Hoarding Syndrome and Hypochondriasis), and a prior psychiatric assessment is advised. If the problems seem amenable to psychological treatment and particularly for CAT, may be 'refomulatable', I think that it is important at the outset to give the client information about the sort of therapy CAT is; that it is concerned with the past and finding relational patterns or survival strategies that may link to current problems and distress (even if these links may initially be hard to see or disavowed). This is basically informed consent for the process of reformulation. It is important to acknowledge that CAT does not have a strong evidence base for obsessionality and is not a first-line treatment in NICE guidelines, but that it may be helpful when medication or CBT has already been tried and the client is interested in thinking more relationally, with an acknowledgement that the process of reformulation may exacerbate obsessional symptoms. At the same time the therapist will be attentive to arousal and distress in the client and will monitor these and the client's views on the therapy in order to negotiate the pace of therapy or even agree an early ending or referral for other treatments.

Negotiation of the client's Target Problems (TPS) will need to allow for the agreed possibility of a relational procedural understanding that underlies them. For example, a belief that 'I am too fat' without objective truth or preparedness to link this to the past will be difficult to make progress with. A preparedness to link the onset of hand-washing to the loss of a sibling, for example, even in a tentative way, would show joint agreement for reformulation.

2. theory practice links

The theory underpinning CAT with obsessionality is fundamentally CAT, but the therapist will need to have awareness of the 'third' guide map model, with the emphasis on making connections between the present and the past and powerful disavowed emotions related to uncontainment and dread, and have appropriately informed supervision. Care is needed in terms of managing the Zone of Proximal Development (ZPD) in the therapy relationship and in managing client arousal and distress (see 3. and 7. below).

3. CAT specific tools and techniques

Reformulating procedures: Below are illustrations of procedures for OCD and Anorexia. They show how obsessional symptoms and behaviours can be linked to anxiety generated by past events and also to current intrapersonal and interpersonal relationships.

> Target Problem: My life is dominated by my need to wash my hands.
> Target Problem Procedure: Because of my anxiety about the safety of my family following the loss of my brother and my mother's breakdown after this tragic event, I started washing my hands more and more frequently. It is as if this 'obsession' has promised me a way to feel less anxious, look after everyone and to get in control of a situation I felt helpless and alone in. Unfortunately, the more I wash my hands the more I have needed to until the point when it is dominating my whole life. Other people are exhausted with trying to help me and then try to bully me into 'being normal', which makes my anxiety worse. I feel totally alone and as if no one understands.

> Target Problem: I feel overweight and restrict my eating to lose weight, which is badly affecting my health.
> Target Problem Procedure: Because of the way I felt helpless and out of control when I was thirteen when my parents announced they were going to split up, I started to restrict my food intake and lose weight. This made me feel more in control and seemed to

help keep my parents together as they had me to worry about rather than their own disagreements. As time has gone on I feel more and more need to lose weight to the point when I have collapsed and other people feel that I look very thin, although I can't see it myself. It is as if restricting food is protecting me from my deepest fears about being alone and abandoned. Unfortunately, I have ended up in hospital where I feel very alone and my parents seem more and more frustrated with me for not getting better. Again, I feel out of control and don't know what to do for the best.

Mapping: Fig 2 illustrates positioning some form of uncontainment as the central 'core-pain' with its disavowed unmanageable feelings of dread and fear of annihilation. The internal relationship to the obsessionality is mapped as: draining/controlling to striving/drained, with clear links to the possible interpersonal consequences of enacting this role with family and in the therapy relationship. The narcissistic extension may or may not be present.

In Fig 3, I have added some example exits. In the therapy relationship the therapist can overcome a feeling of uncontainment by being attentive but not collusive and proceeding carefully within the ZPD of the client and with an eye to managing arousal and backing off, or even agreeing to end therapy when necessary. This zone (ZPD) may be very restricted at the beginning due to the client's fear that talking about hidden feelings and fears can make the obsessionality worse. Therapy cannot go forward without some reciprocation; *freely giving to gratefully receiving* in the therapy relationship. If the client is unable to complete the tools like the Psychotherapy File or other homework tasks, then maybe slow down and try to engage in some joint activity in the session. Maybe the client can bring a dream to talk about, just read something suggested by the therapist and have an opinion on it. It may be that, for the client, giving will seem less dangerous than receiving at first. They will probably not be able to receive the reformulation letter until there is some history of giving and receiving in the relationship.

Later on in the therapy, the focus will be on moving forward into a more engaged and creative life with the chance of mutually respectful and caring relationships. As I heard Tony Ryle say about working with OCD: 'Just talk about their life.' It is a nice metaphor to suggest that the client may need 'give up guilt' and 'take the obsessionality with you'. It is good to acknowledge that there is no way to defeat or eradicate this protector/tyrant entirely and at times of stress it will again loom large. But, if the client is able to move on into a life with other people as the priority, the obsessionality will begin to shrink and its voice become less powerful and easier to ignore.

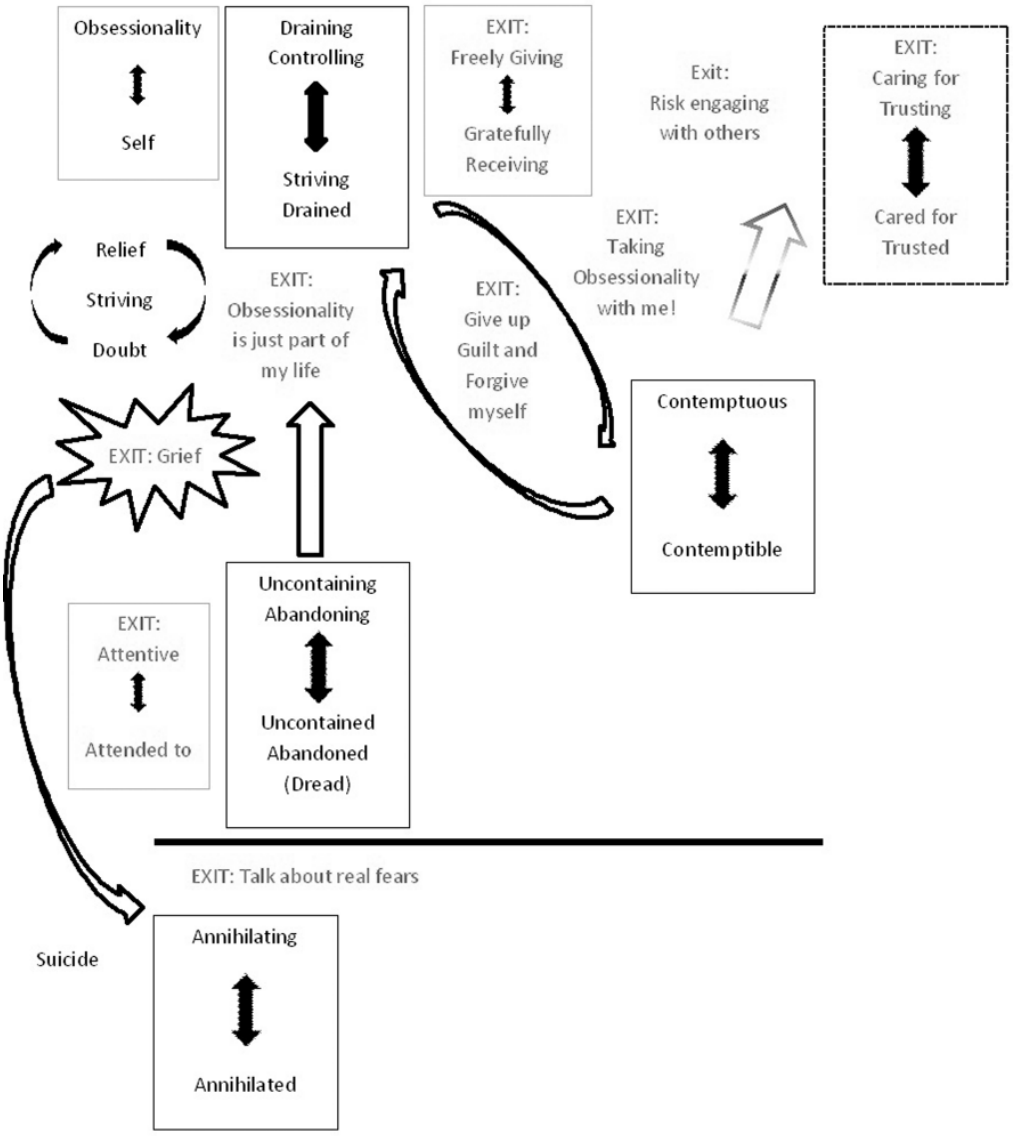


Fig 3: Guide Map with Exits

4. establishing and maintaining external framework

Clients with obsessional problems can find it difficult to get to sessions on time, or at all, as the fear of exposure causes a sabotaging rise in obsessional behaviour. One new client with OCD spent the first three sessions stuck at home in her shower and arrived at the fourth session 40 minutes late. It was important to acknowledge this as a success and not to criticise the client or be too rigid with the local 'DNA policy'. Negotiation of a shared agenda for each session may allow some time for the client to discuss symptoms and distress, with the therapist able

to spend time making links and using CAT tools. Obsessional clients may benefit from extended follow-up sessions as change in the real world can be slow and often limited by opportunity (possibility of relocation or meeting new people).

5. common factors: basic supportive good practice

The therapist's position is attentive and hopeful but not overly striving or unrealistic in terms of the extent of the change achievable within the duration of the therapy. Small changes need to be recognised as significant. For example, a client said that he had been able to reflect on the therapy at home and had re-read the reformulation letter which he had previously just 'filed away'. Breaks in therapy and the end of the therapy may cause strong disavowed feelings of dread and abandonment that need to be anticipated and acknowledged. Conversely, grief and sadness for the end of the therapy could be seen as an exit and can be shared as a mark of the connection made in the therapy relationship.

6. respect, collaboration and mutuality

Respect is modelled in the therapy relationship as the therapist empathically identifying with the client's suffering but not being subsumed by it or recruited in to it. Attention to the ZPD and acknowledgement of the reality of the sometimes small scale of progress being made allows the client to feel tolerated and contained and able to forgive themselves for being stuck for so long and to counter the shame they feel comparing themselves to others who have gone on to seemingly achieve more in their lives.

7. assimilation of warded-off, problematic states and emotions

Disavowed feelings are at the heart of the CAT formulation of obsessionality. It may be that the therapist feels some of the dread and/or grief for the client initially when hearing about some past events like a sudden bereavement. The client may seem to feel little but the therapist can bring the empathic counter-transference into the dialogue and attend to this in the reformulation letter and process. It is good to notice when there is a hint of sadness or a tear that marks out grief from the frozen grimace of dread.

It has been my experience that clients will gradually bring more emotional content to sessions as trust builds up and they may want to

go back to a CAT tool or discussion weeks later, as they have been thinking about it. Therapy or no-send letters, particularly to people who have been lost, may be a great opportunity, but may be very difficult for some clients. Grief is a major exit here; grief for people who have been lost; grief for all the wasted time the obsessionality has soaked up over the years and disavowed grief for the loss of the therapist at the end of the therapy.

Fears about the destructiveness of the self (annihilating role) can sometimes be present. In some ways the bereaved child may have blamed themselves for the loss of a parent or sibling and the obsessionality is a form of sacrifice in order to make amends.

The Burden:
I have written a narrative tool for use in obsessionality that visits these emotions. It is called: 'The Burden'. It is available on the ICATA website as an appendix to this paper. It is a story about a child who loses a sibling and an encounter with an angel. It has some elements of a reformulation and is extremely sad. I will leave the reader to read it. The task is to write a new ending to the story. I have used it with clients later on in therapy when I have wanted to bring more emotion into the room. It is important to think about the ZPD of the client and the timing of this tool as it is very powerful and not for everyone. It is free for the reader to use. I have versions so far with a male, female and de-gendered protagonist and translations into Greek, Spanish and Polish.
www.internationalcat.org/journal.burden

8. making links and hypotheses between therapy and client's past and client's other relationships so facilitating awareness of procedures that are operating

In the recognition phase of CAT therapy, it may be important to try to extend the awareness of the distressing effect of the reciprocal role: draining/controlling to striving/drained beyond the suffering relationship of the client to the internal obsessional protector/tyrant. This will be by looking at the effects of the obsessionality on those close to the client, for example: 'I wonder how your mother felt after she was up all night with you checking the bins again?', and also to its presence in the therapy relationship. This reflection risks intense feelings of guilt and fear of abandonment in the client. Sometimes it is safer to look back on an example in an earlier session. For example: 'Do you remember that session when you were so stressed that I couldn't get a word in edgeways?'

9. identifying and managing 'threats' to the therapeutic alliance
Frequently negotiated engagement may help maintain a therapeutic alliance. The therapist's ability to tolerate the client abandoning them due to the demands of the obsessionality (both in the room if they are distracted/ruminating and in the external world when they are unable to come at all) may allow the client to use the sessions to partly shed some of their exhaustion and frustration but also to allow the therapist to offer 'surplus of vision' and new ideas and perspectives. I have found it useful to say frequently that I am not dismissing how hard it is for the client but I will still try to take the opportunity to 'do some CAT' when I think it is safe.

Abandonment and lack of response to communications is the most likely kind of therapeutic rupture, where the client has just decided that coming to sessions stirs things up too much and it is safer to stay in the internal world at home. It may be good to try to re-engage the client over a period of time: 'If you would like to come to talk about re-starting therapy I would be very pleased to give you another appointment.' The therapist may feel contemptuously dismissed in these circumstances, and may be tempted to dismiss the client from their caseload prematurely. It may be helpful to re-identify with the client in their silent world of obsessionality and realise this is about the client's need and is not attack on the therapist.

10. therapist's awareness and management of own reactions and emotions
Strong emotions can be disavowed in obsessionality and are replaced by non-specific anxiety and dread, that the therapist may experience in a disconnected way, that is not easy to link to a specific client. More healthy and healing emotions like sadness and humour are likely to enter the room through the therapist first and can usually be introduced directly into the therapy dialogue. For example: 'I felt really sad when you told me about your dad just then'. The most likely feeling that a therapist will need help with in supervision is exhaustion. It is perhaps a golden rule in CAT that when you are striving and exhausted, the best thing, and sometimes the only thing to do, is to stop striving. □

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