Therapeutic Challenges in Work With Childhood Sexual Abuse Survivors: The Contribution of Cognitive Analytic Therapy

Susan Llewelyn, PhD

Cognitive Analytic Therapy (CAT) provides a useful therapeutic structure for addressing the range of difficulties presented by survivors of childhood sexual abuse. The concept of reciprocal roles can be helpful when addressing dysfunctional relationship patterns, especially as shown in therapeutic ruptures. Two case histories are presented that demonstrate the importance of attending to repetitive patterns in relationships in order to avert therapeutic impasse. It is suggested that CAT as a collaborative and time-limited therapy is well placed to facilitate brief treatment from the point of view of both client and therapist. [Brief Treatment and Crisis Intervention 2:123–133 (2002)]

KEY WORDS: survivors of childhood sexual abuse, Cognitive Analytic Therapy, therapeutic ruptures.

Cognitive Analytic Therapy (CAT), a brief therapeutic intervention devised by Ryle (1990, 1995, 1997) has been adopted as a treatment of choice for survivors of childhood sexual abuse (CSA) by many therapists working in Britain and elsewhere. By using key techniques from a range of therapeutic frameworks, principally psychodynamic and cognitive, CAT endeavors to achieve change quickly and effectively, adapting the approach according to each client’s specific presentation (Pollock, 2001). In this article, I argue that CAT is well suited for brief work with CSA survivors because of its theoretical breadth and wealth of intervention techniques. Such breadth is especially pertinent to CSA therapy since surviving CSA is not itself a diagnosis; rather it appears to be associated with a variety of symptoms and behaviors that may at most constitute a syndrome. As a consequence therapists have to be alert to a range of presentations, and the possible applicability of a number of therapeutic approaches, which is a strength of CAT. In this article, I also argue that CAT can help therapists to become aware of some of the challenges that can lead to premature termination, or harmful therapy, an issue that is particularly pertinent when working with a client group particularly susceptible to therapeutic difficulties.
Models of CSA

Effective treatment is dependent upon an effective conceptual framework for delivery of therapy. Yet there is as yet no convincing and widely accepted model of the consequences of CSA for survivors. Possibly the most widely used is that of post-traumatic stress disorder (PTSD), arguably a diagnostic label used because of the need to categorize survivors for administrative purposes. Some PTSD features apply to some survivors (e.g., intrusive reexperiencing, and avoidance) but the model is not convincing in accounting for the experience of most survivors. Finkelhor’s model of traumagenic dynamics (1990) suggests that CSA has cognitive, affective, and behavioral outcomes, which lead to four traumatic sequelae: traumatic sexualization, stigmatization, betrayal, and powerlessness. This model however fails to address closely the dynamic origins of the trauma, or the relational consequences, and it has not been widely applied in therapy. The developmental model of Cole and Putman (1992) does attempt to account for the way in which ongoing development is compromised through difficulties in social functioning, self-functioning, self-regulation, and integrity, but again, relational issues are not adequately addressed. Jehu (1988) and Kennerly (2000) have proposed a cognitive model that views cognitive distortions such as “I must have been to blame for the abuse because it went on for so long” as key features of the distress experienced by survivors. Again this model has been helpful, but struggles to account for some presentations, especially borderline personality functioning. Spaccarelli (1994) proposed the transactional model that views CSA as a stressor consisting of abuse and abuse related events, together with disclosure related events, which increase the risk of maladaptive outcomes. These are mediated via cognitive appraisal and coping responses, and moderated by developmental and environmental factors. Although more comprehensive, and relating clearly and helpfully to the cognitive therapy, such models fail to account adequately for the intra- and interpersonal persistence of abusive experiences.

In this article, I contend that as an integrative approach, CAT has much to offer the CSA survivor and just as crucially, the therapist. CAT is informed theoretically and therapeutically by cognitive and behavioral theories, and recognizes the therapeutic efficacy of exposure and cognitive restructuring, as well as being informed by the insights of object relations theories, and notions such as reciprocal role relationships and attachment. The central place of a theoretically derived formulation, which is shared with the client, allows a tailor-made therapy to be delivered, without the specific presentation overwhelming the therapist. Hence individual concerns are addressed, but theoretical issues are used all the time to understand the client’s behavior, feelings, and thoughts.

Tools and Techniques of CAT

CAT is a time-limited therapy that aims to make maximum use of recognized therapeutic techniques from a variety of models to effect a shift in dysfunctional patterns of behaving, feeling, thinking, and relating. It is hypothesized that patterns or procedures in a client’s life can be observed in behavior but are generated and held internally through internalized relationships with self and others. The aim of CAT is to first to observe and then to formulate dysfunctional patterns or procedures so that the client is able to make changes by developing other more functional procedures. This is achieved by examining and moderating the internalized patterns or relationship templates that partially drive the dysfunctional behaviors. As an integrative theory it avoids the risk of theoretical confusion by placing these reciprocal relationship patterns as central, and by continuously referring to the written formulation of these patterns, working collaboratively with the client.
There are a variety of reasons why CAT may be helpful specifically for CSA clients as well as for clients with borderline personality disorders (Ryle & Golynkina, 2000). At its most basic, CAT provides a language, or a structure, which permits client and therapist to make sense of what is going on. The chaotic inner life of many CSA survivors, together with their distressing and destructive patterns of behavior, such as promiscuity and inability to escape from subsequent abusive relationships, means that therapy may provide the first opportunity the client has to reflect with any clarity on what has happened to him or her. Bateman (2000) suggests that therapy is effective when it allows the client to become the subject of reliable, coherent, and rational thinking. That is, it helps because client and therapist are able to take the client seriously and to try to understand what has happened and why. This thinking starts to develop the client’s self-awareness, and eventually self-confidence and self-esteem.

The tools used by CAT therapists to achieve this include the joint construction of a written reformulation of the client’s predicament (an example is given below) followed by a sequential diagrammatic reformulation (SDR), also constructed with the client, which calls particular attention to dysfunctional relationship patterns. These documents provide an opportunity to name and hence to contain the often chaotic experiences and feelings of the survivor. Events and emotions that seemed to the client to be out of control and unpredictable, once named start to be understood and hence to become more controllable. Dissociation, often observed in CSA survivors, can also be understood in terms of the development of different repertoires of interrelating, which may become separated usually as a form of self-preservation. The collaborative nature of CAT additionally challenges the powerlessness often experienced by CSA survivors, and promotes a sense of agency and control.

Just as significantly, the therapist’s own experiences with the client become clearer and hence more manageable. Common therapeutic relationship problems when working with survivors of abuse include boundary violations, premature termination, and divisions among teams of care or health workers, threats of and/or actual self-harm, and challenging countertransference reactions from therapists. The use of the concept of reciprocal roles in particular allows therapists to understand and hence respond appropriately to such developments if and when they occur. This aspect of CAT is the particular focus of this article and will now be explored in greater detail.

**Understanding the Dyadic Nature of the Therapeutic Encounter: The Contribution of Reciprocal Roles**

From object relations theory, CAT has developed the notion of reciprocal roles, which refers to the dyadic nature of relationship patterns that structure social interaction. It is assumed that children learn from caregivers both how to relate to others and to self: the loved child reciprocates both love and effective self-care, while an abusive caregiver will establish the child’s position as abused, but also potentially as an abuser of self and others by providing the relationship template and forcing the child to comply with this. In abuse survivors the abused role is normally demonstrated as depression, while the abuser role is shown in self-abuse (self-harm) but may also be manifest in the emotional (and occasionally sexual) abuse of others. The concept of reciprocal roles gives therapists the ability to reflect on their own contribution to therapeutic problems, and rather than locating the problem inside the patient, it can be seen as a relational issue that is hence more amenable to change if understood, processed, and altered by at least one party to the relationship. Bennett and Parry (1998) have shown that accuracy of reformulation allows therapists to recognize and respond appropriately to reenactments of unhelpful procedures, and that failure to recognize...
these reenactments can lead to therapeutic stalemate. A client whose presentation is engaging and charming, for example, may initially be easy to work with, but unless the therapist recognizes the pattern of interaction whereby the client is the enchanting performer to the admiring but passive spectator, therapeutic efforts to develop a more profound understanding of relationship difficulties will never progress. More seriously, therapists who fail to formulate the reciprocal role relationships of a client whose strategy in intimate relationships is to sexualize them may not establish appropriate boundaries, with potential disastrous consequences for all concerned. One recognized sequela of childhood abuse is revictimization whereby survivors are more likely than others to find themselves again in abusive relationships, possibly failing to protect themselves by choosing inappropriate partners or not avoiding dangerous situations (Clarke & Llewelyn, 1994; van der Kolk, 1989; van der Kolk, Perry, & Herman, 1993).

Recognizing reciprocal roles is crucial both in avoiding repetition of relationship patterns outside therapy, and collusion and inappropriate countertransference inside.

Termination, and how it is addressed, is also seen as an opportunity to examine relationship patterns in stark relief, by clarifying unhelpful procedures and damaging reciprocations. Termination raises the question of emotional risk for all clients, but especially for these clients for whom relationships are often seen as damaging, betraying, or intrusive. Open discussion of a planned ending allows examination of these issues, as well as reducing dependency on the therapist.

**Case Studies**

Two examples will now be given of how CAT can help to unravel some of the dynamics of therapy as well as clarifying the client’s particular difficulties. Some identifying details of both cases have been changed to preserve anonymity.

**Case Study 1: An Unhelpful Intervention**

Carla, a 22-year-old White woman, presented to the antenatal clinic when 5 months pregnant. The pregnancy appeared to be progressing normally but Carla revealed some anxieties during routine screening, which led to her referral for assessment to the psychological services. These anxieties included her recent separation from her husband Joe, worries that the baby may have been harmed by his alcohol and substance abuse, and her current estrangement from her own family. Carla had left her husband following a rapid deterioration of their relationship after their marriage and his negative reaction to the pregnancy. Joe had become physically and verbally abusive towards her, threatening to take a new partner as he said she was no longer attractive to him. Carla’s mother wanted Carla to have a termination since Joe was of Caribbean origin. Carla had previously had a termination when in a previous relationship and did not want to lose this baby. She said she really wanted to make a happy home for the baby as she herself had had few positive childhood experiences, with parental arguments and alcohol abuse dominating her early years.

During the first part of the consultation Carla appeared withdrawn and monosyllabic. She gradually relaxed and then talked openly about her relationship with Joe and how she had ignored warning signs during their dating concerning his abusiveness. She wept while she described Joe’s brutal reaction when she had revealed to him the sexual abuse she had experienced from a neighbor when she was 10 years old. Joe had encouraged her to tell him everything, had then demanded sex, and left her alone over the weekend. This had exactly paralleled her experience with her own father who had reacted to learning...
about Carla’s sexual assault by walking out of the family home, leaving her in the care of her alcoholic mother. Despite this, Carla had managed to complete her education and had obtained training as a telesales operative. In parallel, since leaving Joe, Carla had demonstrated her resourcefulness by managing to secure another job and to find a new apartment where she was intending to live with the baby. Carla then said that she wanted to understand all of these patterns in therapy and move on.

Carla’s psychologist was relatively inexperienced and was working under close supervision. She also felt somewhat overwhelmed by Carla’s story. She therefore followed normal practice by asking Carla to wait for a few minutes while she left the room to consult her supervisor regarding the most appropriate therapeutic intervention to suggest for Carla. A series of competing demands meant that the supervisor was unavailable for some time. By the time Carla’s psychologist returned to the consultation room, prepared to discuss therapy arrangements with her, Carla had walked out of the unit. Later that afternoon, Carla telephoned the antenatal clinic saying that she would seek maternity care elsewhere.

In retrospect, the psychologist realized that she had herself repeated the same pattern: yet again Carla had appeared composed despite exposing her vulnerability and distress, only to be abandoned. In supervision the psychologist could see, albeit too late, that Carla’s well-established interpersonal procedure was being repeated. Carla had learned that she could only rely on herself. Her vulnerability led to abuse and abandonment, people could not be trusted but abandoned her. An analysis of Carla’s repertoire of role reciprocations, and greater awareness of patterns that occur within and outside the therapy room, might have kept Carla in treatment. It is possible that a more experienced therapist who would be alert to the patterns of behavior described by Carla would have noted these and reacted faster to Carla’s distress, and the crucial need not to reciprocate Carla’s vulnerability with abandonment.

**Case Study 2: A Helpful Intervention**

Karen, a 35-year-old White woman, was referred by a community mental health team after multiple admissions to psychiatric units. She had two young sons, both of whom had different fathers. She and the boys lived in a council flat and had until recently had intermittent contact with Karen’s mother who was herself divorced. Karen described herself as feeling torn between wanting to care for her children and yet not being able to cope with their demands. When she felt she could not cope she took her children to her mother’s, or telephoned social services in a state of panic demanding foster care. She had taken numerous overdoses and had badly scarred arms from self-cutting. On occasions she drank alcohol to excess. She had just ended a stormy relationship with a boyfriend, which had been following an on/off pattern for several years. She had several part-time jobs as a domestic cleaner, but found it difficult to keep regular hours, which meant that she would eventually be asked to leave. Her employers often felt sorry for her, but eventually became exasperated by her unreliability.

The incident leading up to the referral was the consequences of a revelation by a female cousin that the two girls had been sexually abused by the cousin’s father. Karen had never before disclosed her abuse, or discussed it with her cousin. The revelation by the cousin had led to a court case in which Karen was one of the key witnesses. The family had split between those who believed the girls and those (the majority) who did not. The court had decided to convict the man who had been imprisoned. Karen’s mother, although accepting that the girls had been abused, considered that Karen should not have spoken up, and blamed her for her uncle’s incar-
ceration. Since this time Karen’s mother had refused to provide care for the two boys. Karen had felt deeply depressed, had made another serious attempt on her own life using alcohol and medication, and the boys had been taken into foster care. The community mental health team were divided between those who considered that Karen was attention seeking and manipulative, and those who saw her as a hurt and damaged victim of abuse. It was decided that she might benefit from CAT. She was also being prescribed medication including antidepressants and Antabuse.

Karen reported being eager to try CAT. Her depression had lifted slightly, and it had been agreed that the boys would remain in foster care until the situation had stabilized. She had been discharged from the inpatient unit, but had agreed to a series of follow-up appointments with the GP to review her medication, as well as attending for CAT therapy. Karen described herself as feeling chaotic and bad, and said that she still felt the urge to self-harm as being the only way to let the badness out of her. She also felt that she might hurt the children, although there was no evidence of her having done so. Tentatively Karen and her therapist agreed that the aim of the CAT should be to try to help Karen to develop other more effective methods of self-care than her repeated trips to hospital, as well as to allow her to develop enough stability to feel confident enough for her boys to return home.

During therapy Karen repeatedly canceled appointments, which led to rising levels of anxiety among the team. Nevertheless the therapist felt that she had begun to make an alliance with Karen, and after session six was able to discuss the formulation.

Dear Karen,

Since we have been meeting you have told me about yourself and what has been happening to you recently. You told me about how difficult you find it to take care of your two boys, despite wanting to do so. It feels as if their needs are overwhelming at times, especially Craig’s. Being with them seems to recreate in you an uneasy and uncomfortable memory of being a little girl. You told me that you remember how your mother and father didn’t seem interested in you and how frightened you were when your father came home drunk. You can remember hiding in the cupboard and hearing them arguing. Your aunt and uncle moved in, which made things worse, although you liked having your cousin around. You never told anyone about your uncle’s sexual approaches to you, as you felt convinced that your mother would reject you if she found out. When your father left the family home, you felt convinced it was because of something bad about you, and you felt you could not protest when your mother started to abuse you emotionally. For several years you tell me that she would shout at you and blame you for his departure. Things were very tight money-wise, especially when your relatives moved away too, and you always felt guilty for this. You enjoyed school, which seemed to be an escape, but at the age of around fourteen you started getting involved with a group of boys who also abused you. You didn’t feel able to refuse them sex, although you hated it. When you had school exams to take, you truanted, feeling that no one would care what happened to you anyway. It seemed as if the only way you got any attention and affection was from sex, but you didn’t enjoy it. Drinking seemed to ease this a bit but it didn’t last. When you became pregnant with Rory, you thought you might have found someone to love, but his babyish demands seemed overwhelming. Both Rory’s dad and Craig’s dad seemed to be what you wanted but in the end the relationships broke down, too, making you feel even less secure in your worth. The same seems to have happened with your boyfriend who sometimes seemed just perfect for you and at other
times seems to betray you and let you down. There were times when you wondered whether it was all worthwhile.

Nowadays it seems as if you are on a roller coaster of emotions. First, it seems that when things go wrong, like when someone lets you down, you have a strong feeling that you ought to be blamed for things and that you deserve to be punished. This leads you either to drink or to want to cut yourself. This seems to reduce the bad feelings, but means you have to bandage yourself up or go to hospital, which annoys other people and reinforces your feeling that you are bad. At other times, however, you feel very angry and scared of how much you might hurt someone else, like the children (although you tell me that you have never in fact done so). You feel angry and want to push people away. One way out of this seems to be drink but that makes you feel lousy in the long run.

From thinking about your life, and from what you have told me, it seems to me that there are a number of patterns in your life that we might be able to understand, and hence start to control. First, it seems that you feel that you have little control over the different parts of you: that there are switches from one state to another that are bewildering and difficult. Some of these switches can leave you feeling intensely emotional, or muddled and blank. The clearest example of this is your treatment of the children but the swings of feelings also happen nowadays. It seems important for us to find and label those parts of you and to put you back in control to give you a sense of stability. Other times this happens seems to be with other people when you sometimes feel good and valued, and other times when you feel like rubbish. Feeling like rubbish is so horrible that either you want to harm yourself, or someone else. This feels awful, too, so you lash out and hurt yourself, instead.

It seems to me that we have two tasks ahead of us, which are:

1. To understand and try to bring under your control the different parts of yourself, which most probably got themselves out of your control because of your earlier experiences. If we can do this you will be able to have a fuller, more accepting sense of yourself, and no longer need to sabotage yourself;

2. To find a way out of the trap that if you feel bad about yourself, you react by being angry and rejecting, which proves how “bad” you are, and then leads you to hurt yourself because you feel you deserve it.

During our time together in therapy I hope we can develop an understanding of where all of these emotions have come from and how you can get back in control of them. I would like to work with you on this plan, if it fits in with how you see things, and of course I see it as something we can do together. You have tried several times with psychiatric help to sort some of this out, and I hope we will be able to make some more progress, building on your earlier experiences, and to enable you to move on from here.

In subsequent sessions Karen and the therapist made regular reference to the reformulation that the therapist used to develop her and Karen’s awareness of the reciprocal roles generated between them. For example, there was a noticeable absence of distress in the story when Karen talked about herself in the past, but simultaneously a sense of challenge. The therapist felt herself to be simultaneously a powerless spectator, and somehow implicated in the history. This appeared to parallel the story that Karen told in which as a child Karen had felt powerless while watching her parents drinking and arguing, somehow responsible for their unhappiness, and angry at the same time. When the therapist tentatively pointed this out, Karen agreed that she was trying not to overwhelm the
therapist, and was trying not to let herself feel
distress in the session. The therapist related this
to Karen’s feelings of responsibility for her
mother, at which Karen became less guarded
and subsequently allowed herself to cry and ex-
press anger openly (addressing task 1).

In supervision, the therapist reported that
while she found Karen a di
ffi

difficult and demand-
ing client, she did have a sense that they had es-
tablished a collaborative relationship and that
progress was being made. This was in contrast to
the angry and demanding interactions reported
by Karen’s community mental health team. This
seemed consistent with Karen’s pattern of ideal-
izing good care, while invoking a mixture of re-
jecting and nurturing responses from others. Li-
aison with the team averted a potential readmis-
sion to hospital on at least two occasions.

Throughout therapy, Karen made a series of
challenges to the alliance. For example, on the
morning of one session, a departmental reorga-
nization led to a problem in the allocation of ther-
apy rooms. Although the therapist greeted Karen
on time, she was unable to locate a room for their
normal meeting for about 15 minutes. When the
therapist did eventually find a room, it meant a
short walk for them both to another building.
When eventually seated, Karen was evidently
furious. The therapist apologized for the disrup-
tion beyond her control and proposed they ex-
tend the session by 15 minutes. Karen did not
speak for several minutes, and then only an-
swered in monosyllables. The therapist suggested
this is how she might often have felt when her
needs were not recognized or were subsumed to
the needs of others (addressing the second task).
She used the formulation to draw out how Karen
felt when she experienced herself as devalued.
The therapist also pointed out how the ideali-
zation of therapy had led Karen to antici-
pate complete responsiveness to her needs, and
when this did not happen, had felt catapulted
into a painful sense of rejection, and how this
paralleled relationships with her boyfriend and
mother. Karen agreed with this, and told the
therapist how much she still wanted help.

Over the weeks, therapy covered a range of ar-
eas. At first Karen did not see the relevance of
talking about her abusive experiences, seeing
them as over and done with. The therapist al-
lowed her to talk about how painful it had been
as a child when she could not help her mother
when her father was verbally abusive during
drinking bouts, but how angry but also sad she
had felt when her mother started drinking too.
Karen acknowledged her pain and began to be
less dismissive about her own past. She then
started to think about how her own children
must feel and for the first time realized they
might be missing her when with their foster
parents. She also connected her feelings of anger
with her mother in the past, and her anger with
her mother’s reactions to the trial of her uncle.
Towards the end of therapy she suddenly re-
called her mother once saying that this same
uncle (Karen’s mother’s brother) had also inter-
fered with her, but that she had never dared say
anything. Karen started to see how difficult things
had been for her mother in a different social cli-
mate, fifty years ago, when children had often
been disbelieved, and said that she was glad that
at least she knew that her mother had believed
her. At the final session, therapist and client ex-
changed brief letters outlining Karen’s progress
and possible strategies for extending the pro-
gress made so far. Karen was encouraged to no-
tice and challenge patterns that echoed unhelp-
ful reciprocations, and to monitor changes in
terms of the two therapeutic tasks noted in her
reformulation.

Discussion

CSA survivors present a variety of challenges,
which although not unique to this client group,
are pervasive. These include challenges to the alliance because of difficulty with trust and intimacy, hypersensitivity to implications of criticism or rejection, difficulties in distinguishing sexual from other intimate feelings, and a tendency to overidealize the therapist. Therapists themselves may experience both compassion for the abused child and irritation with adult behaviors, or may fail to respond appropriately to erotic signals from the client. The maintenance of boundaries is crucial for these clients but is often severely tested. Teamwork may be beset by splitting and even interprofessional hostility as different agencies react differently to the client. Some of these challenges have been demonstrated in the two case studies above.

Therapeutic models provide the containment and structure for therapists to respond appropriately to such challenges. As a structured but flexible approach, CAT places relationship reciprocations openly at the center of therapy, through the reformulation shared with the client. This open sharing prevents the development of some of the less helpful forms of dependency, and decreases the likelihood of acting out erotic transference or countertransference. Therapeutic ruptures can be tracked and understood relatively easily as reenactments of unhelpful procedures, or dysfunctional reciprocations. Sharing the CAT formulation with other team members can also reduce the likelihood of inconsistent reactions to the client by agencies involved.

As greater numbers of clients now feel able to reveal histories of abuse, therapeutic agencies have to be prepared to respond to the unique needs of individual clients, as well as to provide an adequate level of service to the population as a whole. This means providing a short-term, responsive therapy, which can adapt to a variety of presentations. CAT is well placed to do this as well as equip therapists with effective responses to the therapeutic challenges often presented by this group of clients.

Conclusions and Further Directions for Clinical Research

Further studies of CAT are clearly needed to examine its applicability to a variety of client groups. Researchers in Britain, for instance, are particularly interested in developing and evaluating CAT services for clients diagnosed with borderline personality disorder, a group that inevitably includes many survivors of abuse (Herman, Perry, & van der Kolk, 1989). Ryle and Golynkina (2000) and Clarke and colleagues (2001) are carrying out randomized trials of the efficacy of CAT with borderline personality disorder, and results so far seem encouraging. Other clinical groups where CAT has been found useful include people with insulin-dependent diabetes who are noncompliant (Fosbury, 1994), deliberate self-harmers (Cowmeadow, 1995), asthma sufferers (Walsh, Hagan, & Gamsu, 2000), and outpatients with anorexia (Denman, 1995). All of these groups may present in crisis, and an understanding in CAT terms may be helpful to both the clients themselves and also to the staff who are trying to make sense of apparently self-destructive behaviors. Recognizing the coexistence of a number of self-states and reciprocal role enactments may increase understanding and hence self-control of otherwise inexplicable acts, such as self-cutting in abuse survivors, or noncompliance with life-preserving medication routines.

In addition, the detailed procedural descriptions in CAT offer themselves easily to clinical process research, for example via detailed examination of enactments of reciprocal role procedures. It would be most interesting, for example, to try to replicate the case studies in the current article, probably within the context of a larger outcome study, in order to examine how most effectively to recognize and respond to challenges to the therapeutic relationship. Other possible process studies of CAT include an ex-
amination of the helpfulness or otherwise of the formulation (see for example the study of the impact of the written reformulation by Evans & Parry, 1996), or the impact of CAT supervision on the work of CAT therapists in a variety of service settings.

In conclusion, in this article I have presented CAT as a theoretically coherent approach to working with clients in distress, which attempts to make maximum use of techniques and concepts found helpful in other models, as well as adding its own emphasis on the often dysfunctional nature of the relationships and patterns of behavior that clients frequently develop. It is dependent on paying accurate attention to what clients say, and how they relate to themselves and other people. Many therapies have been found to be effective in working with abused clients, and very possibly no one approach, even CAT, will ever be found to be the best. It is therefore imperative that through clinical research, CAT and other therapeutic approaches remain open to developing understandings of this client group, and how the difficulties of abused clients may most effectively be resolved.

References


Spaccarelli, S. (1994). Stress, appraisal and coping in


