A trainee's guide to terms and concepts in standard CAT

Introduction

In CAT, probably more than many other forms of therapy, there is a very direct and close relationship between theory and practice, and it's a playful relationship. CAT is 'theory-rich' as well as supremely pragmatic, and to be a good CAT therapist requires understanding a range of quite complex concepts. The aim is to be able to put these concepts to use, as conceptual tools, putting theory into practice, rather than just learning them in abstract. On the Practitioner course, we tend to emphasise how you learn to do CAT as much as what CAT is. This 'knowledge-in-use' takes time to develop, by repeatedly making links between theory and practice, practice and theory. In training, some people struggle, finding some of the terms and concepts used in CAT difficult to understand.

This glossary is no substitute for making these links, via private study, teaching days, therapy hours, skills practice and case supervision, but it may be helpful in clarifying some key concepts whilst you are on this journey. We have focussed on clarifying issues that trainees commonly find puzzling, distinguishing between frequently confused terms, and naming common misunderstandings. In the appendix we have also included some practical tips for how to use the concepts e.g. in reformulation.

None of this is intended to inhibit creativity or to deny the pluralism of how theory is used and understood by a range of different practitioners. Perhaps this is best seen as addressing questions trainees often ask us, to understand and become confident about the basics before launching into innovative adaptation of technique.

Target problems and target problem procedures

Ryle developed the idea of Target Problems (TPs) in his 1979 paper.

"CAT is a time-limited therapy and is directed at helping someone change specific ways in which their quality of life is impaired and sources of distress, in the context of understanding more compassionately the wider narratives of their lives. These '***target problems***' should be identified early in therapy as part of the collaboration and to have a clear aim in view. It also gives you both a way of monitoring progress and, at the end, to decide if therapy (as it works upon recognition and revision of target problem procedures as described below) has been successful or not."

Target problems are developed from presenting complaints. During the reformulation period, there is an important process of converting a complaint into a target problem that involves turning it into something do-able, manageable and preferably couched in interpersonal language.

For example, the presenting complaint might be 'chronic headache', which in the process of discussion could yield a target problem for therapy, for example: 'I find it difficult to look

after myself and keep myself well'. This process has already introduced some leverage i.e. that it is difficult (but could change) and that it is something I am doing to myself (or feasibly to another).

Target problems are underpinned by ***target problem procedures (TPPs)***. These are the sequences of appraisal, emotion, aim, action, consequence and re-appraisal that maintain the problem. For example, the target problem: 'I find it difficult to look after myself and keep myself well' may be underpinned by this problem procedure, i.e. the whole sequence:

- feeling unwanted, inadequate and a failure (this appraisal driven by reciprocal roles 'judgemental, critical' to 'undermined, inadequate')
- aim to feel in control, to find care and meaning,
- take on too much, anxiously strive to achieve (as it feels this is the only way to meet the aim, driven by the RR 'conditionally caring to performing not feeling')
- feel exhausted and overwhelmed, develop headache,
- drop out or become ill,
- gain reluctant care from others but aim is not met; don't feel in control, feel inadequate and a failure,
- feel compelled to strive to achieve again, and so on...

Sometimes trainees only name and monitor the Target problem procedures (in this case the 'anxious striving loop') and not the Target problem or the presenting complaint. Hence in the above example, it's possible that someone started to revise the procedure by the end of therapy but was still finding it difficult to stay well and continuing to have severe headaches. We need to attend to both and to check with the client that developing Exits for TPPs does lead to improvement in TPs. If not, then there might be other as yet unrecognised TPPs contributing to the TP.

Typically in a 16 session CAT, there would be one or two identified Target Problems with up to 4 or 5 Target problem procedures.

Reciprocal roles and Reciprocal role procedures

In 1985 Ryle developed the Procedural Sequence Object Relations Model, which incorporated the idea of reciprocal roles into his earlier Procedural Sequence Model, and superseded it.

We learn a range of roles from infancy onwards in relation to others, usually starting with our parents. In CAT the self is constituted by these varieties of dialogic experience, and it is a fundamental tenet of CAT that we can only develop a sense of self in relation to another. For example, when as a baby you are responding to a comforting, soothing parent, you are learning what it is to be comforted, but also you are learning the role of being a comforter.

This can then be enacted in relation to yourself (self-soothing in infants who may suck a thumb, sing to themselves, etc) or to others (e.g. cradling a doll). Equally, when you experience a harsh, critical parent, you learn what it is to be crushed and demoralised, feeling not good enough. You also learn to be self-critical and to be critical of others. Each reciprocal role procedure (RRP) can be enacted in three different ways: others do it to me, I do it to myself, I do it to others.

Reciprocal roles (RRs) are learned from the fundamental experience and become the components of the self, similar to the concept of 'self-schema' in cognitive terms, but going beyond cognitive representations to the 'dialogic self'. Ideas from Vygotsky and Bakhtin have been incorporated so that, as Ryle suggests, "the child's sense of physical and social reality and the sense of self and others are ... profoundly affected by systems of meaning acquired through social experience... many aspects of mind are best understood as echoing or reproducing social interactions" (Ryle, 2004, p 7). We develop a repertoire of reciprocal roles, and people vary according to how flexible and 'fit for purpose' their repertoire is, or whether the same few fixed and malign roles are endlessly re-enacted in new situations, preventing us from elaborating or modifying them.

Reciprocal roles are not opposites. Each end of the pair defines the other, through a relationship. For example, 'harsh and critical to 'crushed' is a reciprocal role, but strictly speaking, 'harsh and critical' to 'relaxed and kind' is not.

RRs are usefully clustered together around key themes (e.g. absence of care, attacking care or idealised roles). The role is not just about an individual (e.g. father was neglecting and attacking) but roles that may have been occupied at different times by different figures. We build up a picture of the reciprocal roles from the person's history, from our own transference and counter-transference responses, from examples of enactments in the consulting room and in the person's narrative of everyday life.

The term 'Reciprocal role' is a hermeneutic device used in CAT to make sense of internalised relationship experience. RRs can be understood as inferred, abstract structures which, unbeknownst to us, continually influence how we appraise the world: this links to both cognitive and object relations theories. You cannot occupy a role without enacting it procedurally. The reciprocal role procedure is, as always in CAT, a *sequence* of, appraisal, emotion, aim, action, consequence and re-appraisal Reciprocal roles can be enacted and maintained through this sequence which can reinforce the original repertoire rather than allowing the person to learn from experience. The procedure is the whole sequence and includes actions and consequences. CAT aims to help people to develop new roles or procedures, have more agency within them and become an active agent or author of their own experience.

Reciprocal roles can only be "seen" (inferred) via the reciprocal role procedures. There is an initiating, formative end to the role reciprocation and a responding end. The RRP describes the interpersonal management or self management of the interaction between the two ends of the reciprocal role.

What is the difference between a TPP and RRP? Reciprocal role procedures are not necessarily problematic as many RRs are benign and do not require revision. For most people there will only be a few TPPs and amongst a wider range of functional RRPs. The focus for a brief 16 session therapy may only include some of the identified problematic RRPs which are described as the Target Problem Procedures on the map, giving rise to the Target Problems.

States and Self States

When we are in a given role, we experience a whole mental **state** in relation to it, with a particular configuration of memories, emotions, thoughts, behavioural dispositions, expectations etc. As we develop through infancy, we gradually become able to integrate the various roles we experience and develop higher level procedures ('meta-procedures') so that we can move between states without discontinuity. In this way we gradually develop a sense of self which includes a range of roles and their accompanying mental states. By having this self-awareness, we begin to be able to self-soothe and to orchestrate and regulate our emotional reactions. For example, a mother may help by saying to a child who is crying and distressed and can't get to sleep, 'you'll feel better in the morning'. With time, the child may learn to self soothe without the continual need for mother.

This self-regulation develops with good-enough parenting, i.e. the turn taking and joint activity in the zone of what the baby can cope with. Sadly, where there is neglectful, abusive, invalidating, inconsistent, harsh or punitive parenting, the integration of roles and the development of meta-procedures is inhibited or prevented. CAT therapists working with people with borderline personality disorder realised that their very extreme and volatile mood and behaviour could be conceptualized in terms of discrete, alternating "**self states**." This has been conceptualised into the *multiple self states model of borderline personality disorder*. Here, the different reciprocal roles which have formed with accompanying mental states have never been integrated and remain partially dissociated. So, when in a particular state, the person has limited access to memories or recognition of how they are when in a different state. Hence the term 'self-state' as the self is fragmented into these different experiences, which of course is extremely confusing and undermining for the person, as well as others involved.

In this way the 'self state' is a term used in CAT to imply an extreme RR pairing with dissociation from other RRs. It differs from a 'state' in that it involves both poles of the RR

pairing. CAT theory suggests that there is a continuum between well integrated and poorly integrated functioning, not a dichotomy. We can all move along this continuum and we all have some experience of "multiple selves" (e.g. in the way that we act and feel in different ways depending on the social context) but the flexibility of our RR repertoire, the degree of integration and the capacity to reflect determine how well we function.

Three levels of damage

In his paper describing and accounting for symptoms experienced by people with borderline personality disorder, Ryle (1997) suggests there are three levels of damage which occur as a result of significant abuse and/or deprivation.

Level 1 damage is exemplified by the restriction and distortion of the reciprocal role repertoire with the occurrence of a limited number of extreme reciprocal roles such as abusing to abused, abandoning to abandoned, judging to judged (as well as compensatory RRs such as rescuing to rescued).

Level 2 damage relates to the disruption of integrating procedures (or lack of meta-procedures, so that it is hard to move smoothly between different roles). This shows itself clinically in the sudden and unexpected switches between self states which can be confusing to the patient as well as to involved others.

Level 3 damage refers to a deficiency and disruption in the ability to self-reflect. In this situation, individuals find it hard to consciously think about themselves from the outside i.e where there is little capacity to take an observing stance towards the self.

In the early sessions of cognitive analytic therapy, people can be helped to develop a stable, continuous and positively-toned sense of self through collaborative work to describe the self states. This begins the process of recognising them, realising they are predictable and repetitive, and developing a more integrated 'observing eye'. Such work in itself can aid the development of a new reciprocal role of 'compassionately understanding' to 'compassionately understood'. In other words the person can be helped to develop the capacity for self-reflection, and to foster a compassionate and curious stance in relation to the self. This is enormously helpful but unfamiliar for most people with severe dissociation and is a prior step before they are able to track the rest of the damaging procedures.

Zone of Proximal Development

The zone of proximal development (ZPD) is a concept adapted from the work of Vygotsky (1978) where it was used to conceptualize the task of judging how to optimise what a child is capable of with the help of a more experienced other. CAT therapists use it to understand the need to be 'in advance' of the patient, stretching the patient, but not too far ahead. It is very close to creating a reflective space but is finer tuned in that the therapist is making a judgment about what reflection the patient is able to enter into. It is an inter subjective act

where the therapist picks up something from the patient (wish, aim, belief etc.), adds the therapist's meaning to it (reframing or challenging it, placing it in a wider context) and returns it to patient. The therapist uses their own language to describe how the patient relates to themselves in the hope that the patient will gain a new understanding, that it will stretch the patient's current awareness.

Examples of therapist interventions that are outside of the ZPD would be: 1) a too challenging/ confronting comment that leads to intense shame in the patient who then reacts by withdrawal or by recruiting retaliatory attacking and critical RRs; or 2) a not challenging enough comment or comments that leads to the patient feeling overly supported and reliant on the therapist with recruitment of idealising and specially caring RRs.

Observing self and exits

The development of the observing self is central to CAT therapy where the patient is helped to 'recognize' the procedures and reciprocal roles contributing to their difficulties. This overlaps with notions of 'mindfulness' in mindfulness-based cognitive therapy and ''mentalization' in mentalization based therapy. Being aware of these processes may be sufficient to enable procedures to be revised, but often specific 'exits' are developed as well, where specific changes to the procedures are named and the patient practises these. For example, a patient may need to become conscious that they are not sufficiently assertive and then need to think through specific ways in which they can become assertive and plan to practise these. Some practitioners find it helpful to draw the 'exits' onto the SDR or to construct an 'exit diagram' which is a map showing the revised, unproblematic procedures which create a 'virtuous' rather than a vicious circle.

Dialogic sequences

An important amendment to the CAT understanding of procedural sequences took place when Mikael Leiman introduced the idea of *dialogic sequences*. On the basis of Mikhail Bakhtin's theory of utterances, Leiman devised a Dialogical Sequence Analysis. This method starts from the assumption that every utterance has an addressee. The central questions are: To whom is the person speaking and within which RR?

Usually, we think of one listener as the immediately observable addressee. However, the addressee is rather a multiplicity of others, a complex web of invisible others, whose presence can be traced in the content, flow and expressive elements of the utterance (e.g., I'm directly addressing you but while speaking I'm protesting to a third person who is invisibly present in the conversation). When there is more than one addressee present in the conversation, the utterance positions the author/speaker into more (metaphorical) locations. Usually, these

locations form sequences that can be examined and made explicit when one listens carefully not only to the content but also the expressive elements in the conversation. Leiman's method, which analyzes a conversation in terms of "chains of dialogical patterns," is theory-guided, qualitative and sensitive to the verbal and the non-verbal aspects of utterances.

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Appendix: Some notes on the use of CAT tools

There are a variety of CAT tools – the psychotherapy file, reformulation letter, SDR, rating sheets, goodbye letter – and it is possible whilst learning the method to be driven by the need to use the correct tools in the right order in the right session, and to lose sight of the fact that they are there to facilitate therapy and are not the end purpose of therapy. Of course, there is a tension during training because you are learning to use all the tools and will need to practise them and demonstrate you can use them, whilst retaining the awareness that the use of each conceptual tool is only as good as the collaborative alliance and shared understanding that it builds.

In the end, if it does not help the alliance, it may not be right for you and the client in that moment and it should not be a source of self-blame or endless striving with something that's not working. For example, some clients just do not 'get' the psychotherapy file and do not find it useful. Others prefer textual cues and find the visuo-spatial aspects of maps quite difficult. However, it is good to try to gain a basic competence in using the tools to give you more choice and flexibility to respond to the needs of individual clients rather than be restricted by your own reluctance to use a particular method.

The reformulation letter

The move to sharing the formulation in a lengthier narrative form took place in the mid eighties as Ryle began to share his assessment letters directly with the patients (his paper on "The value of written communication in dynamic psychotherapy" in 1983 (Ryle, 1983) does not refer to the reformulation letter). He encouraged trainees, who picked up patients he had assessed, to check the assessment letters with the patients. Soon it was recognized that this procedure was rather impersonal and therapists were then encouraged to construct letters with the patient (Ryle, 2006).

The key feature of the reformulation is that it represents the therapist's understanding of the patient in a form that is attuned to the patient.

The centrality of the relationship between the therapist and the patient is captured by Ryle's statement that

> "In CAT the detailed acknowledgement of the patient's real experience is regarded as both humanly necessary and, in its re-creation of a life narrative, as an essential part of the process of integration" (Ryle, 1997).

The clarity with which many published reformulations are expressed hides the complexity of the process, combining a capacity to formulate the patient's problems and an awareness of how best to communicate this to the patient. The reformulation is based on a number of

sources: the presenting problem (which may or may not become the target problem); an exploration of the patient's history); their description of key current relationships; the Psychotherapy File; any other questionnaires that may be used by the therapist; diaries or self monitoring that the client engages in the early sessions; the therapist's awareness of the patient's reactions to them and the counter-transference feelings and thoughts they have about the patient.

The prose reformulation is an early exercise in fostering collaboration and self-reflection. It is also vital in accurately defining what is going on, giving a new perspective through an empathic narrative, making sense of the person's chronically endured pain and showing how the seemingly intransigent problems are in fact endlessly re-created and maintained by the procedures. As a process, it is a collaborative exploration rather than a 'question and answer' assessment. This process of collaboration is enabled for many clients by working side by side to develop a shared understanding. The reformulation letter itself is a complex document with many components which will be taught during the course.

The descriptions of what should be included in the reformulation letter (e.g. Ryle, 1990, 1995; Ryle & Kerr, 2002) provide not so much a definitive structure as a general guidance on the key elements. Most reformulation letters will have six parts:

1. An introductory description of the purpose of the reformulation
2. An outline what brought the patient to therapy and the target problems that will serve as the focus for the therapy
3. A description of how the central problems emerged from the patient's childhood and developmental history
4. An account of key ways the patterns learnt in childhood are re-enacted in the present
5. A description of how these procedures might emerge in the therapeutic relationship
6. An outline of target problem procedures and conclusion to the letter

Where appropriate the patient's own words or phrases are used. The reformulation letter usually varies in length from between one and three sides of A4 and is usually read out to the patient in the third or fourth session. The patient is given a copy and invited to make changes or corrections.

Kellett (2012) lists the purposes of the reformulation letter as:

- to state what brought the client to therapy
- to make connections between past neglect, abuse and trauma and current patterns of functioning
- to demonstrate overt sympathy, empathy and understanding for the current plight of the client
- to identify repeated themes, roles and patterns across the client's life and relationships

- to state the typical dysfunctional roles that the client takes up in the present and to link these to past events
- to state clearly the current target problem procedures
- to highlight and predict how the client may take up certain roles in the therapeutic relationship
- to highlight and predict how the client may rely on old procedural sequences during therapy
- to offer a realistic notion of what may be achieved during therapy and to state the identified goals of the work

This all sounds very formulaic, but in fact is never offered in a spirit of omniscient expertise but in a much more tentative, enquiring and provisional way. What the above list does not convey is that the process of arriving at the reformulation is a joint activity within the client's ZPD (q.v.). There's a danger of producing an over-polished, intrusive and dispiriting letter that makes the client feel inadequate. You are aiming for a piece of prose description which has a spontaneous, mutual and open nature, using unpolished ordinary language and staying close to the client's world. Equally important as the content of the letter is to reflect on the way the letter itself is offered and received within the relationship. It is a powerful vehicle for reciprocal role enactment, both between you and your client (a common enactment is 'expert therapist' to 'novice, inadequate and dependent client') and between you and your supervisor (where this is often echoed by 'expert supervisor' to 'novice, inadequate and dependent trainee'). It is helpful to remember that you are writing within the therapeutic ZPD of the client and yourself: you are not writing to impress your supervisor nor to show how brilliant your formulatory skills are. When done well, the process of arriving at the reformulation letter and the reformulation itself can create hope and expectancy of change, develop trust, improve the working alliance and deepen the level of emotional experiencing within a safe framework. Writing a good prose reformulation is a key competence in CAT you will develop over the training years; don't expect too much too soon.

It is easy to procrastinate about writing the letter, especially if you feel you don't yet have a grip on what's going on. Tony Ryle's advice in these situations is to formulate early, even if it's quite short and incomplete, because the feeling of not being able to write the letter is itself an enactment and needs to be recognised and named. When you find you're at session 7 without a written formulation, something's going on!

Sequential Diagrammatic Reformulation (SDR)

The purpose of the SDR is to provide, on one page, an effective visual summary of the core reciprocal role repertoire, showing how these roles are enacted through the target problem procedures to maintain the target problems. It is useful in facilitating recognition (hence the colloquial term 'map') and when problem procedures are revised, the 'exits' can be added to the diagram to demonstrate this.

A good diagram is grounded in collaborative exploration of procedures and self-states. It is never going to be perfect, just 'good enough'. Although there is no single 'correct' version, it should not be arbitrary, incomplete or changing throughout the therapy. Starting very early with simple mapping of RRs in the room or in the narrative, it moves quickly to a more 'joined up' overview of the person's sequences. It should accurately show how someone's procedures are problematic, i.e. showing self-to-self and self-to-other loops that reinforce harmful reciprocal roles and maintain the target problems. For people with greater dissociation, it shows how self-states switch. Before too long, you and your client need to agree on a working version and use it in facilitating recognition.

The process of mapping is as important as the product. It is an opportunity for joint activity and allows the therapist and client to work transparently and openly together. The capacity of the client to begin to imagine being their own therapist begins with such joint mapping. It equalises the power relationship and demands a capacity of the therapist to show his or her working and be willing to be vulnerable and not yet expert about the patient. Better a good process in the mapping relationship and a messy map than a bad process and a tidy clever map.

Two guiding principles are a) make it as simple as you can, showing the underlying structure rather than a spaghetti junction of lower level detail and b) it is flexible. It is possible to realise later in therapy that a crucial procedure has been missed, in which case it is good to add this to the diagram. However, drawing different bits of maps every session throughout therapy does not constitute a diagrammatic reformulation and can be confusing for both patient and therapist.

Mapping as a process

Many if not most CAT therapists find that sketching out the key words of target problem procedure or the movement within and between a reciprocal role or a number of provisionally identified states can help build the alliance, show the client how a CAT understanding works and prepare the ground for active participation in the therapy. Such open, side by side sketching can increase trust in the therapist that he or she is not making hidden or omnipotent evaluations and that demonstrations of the vulnerability and humanity of the therapist can help the client share their more difficult thoughts and feelings. Early sketches also help avoid the impossibility of over elaborate and over-crowded diagrams. In tandem with the work of preparing the prose description it is important in a brief structured therapy to move to a tidy diagram that the therapist has gone away and worked on (and no doubt taken to supervision) and is shared as the scaffolding for the main phase of therapy work together. It is vital that the client feels rehearsed and ready for this diagram and has had some hands on education in how it works. Similarly there will be times relating to a particular enactment, a deepening

understanding, life events that weren't anticipated during the middle and ending phase of therapy when an additional sketch will help both client and therapist.

Sequential Diagrammatic Reformulation or Self States Sequential Diagram (SSSD)?
These are different ways of drawing a map, and usually you take a decision quite early on which to go for. The SDR is often preceded by drawing smaller sketch maps in the early sessions, which are helpful as a process to encourage jointly focussed attention sitting alongside the client. The SDR or SSSD is a more complete and formal map which is best shared as soon as possible after the prose reformulation letter, say in session 5 or 6.

Self States Sequential Diagrams are maps of multiple self states and are typically offered to people who have borderline personality disorder or who score above 28 on the Personality Structure Questionnaire (PSQ: Pollock et al 2001), as it helps them to describe their different states and begin to explore how they enter and leave them sequentially, identifying the triggers. It fosters self-reflection. The person in therapy describes and identifies each self state in terms of its particular "reciprocal role procedure." To trace the switches between these self states, they trace the procedures generated from each to identify the state switches' antecedent events or actions. You can use Ryle's States Description Procedure (Bennett, Pollock & Ryle, 2005) or explore them less formally, in relation to what's been happening the week before. Either way, the diagram is developed step by step by gently building collaboration and awareness, not presented as a fait accompli.

For less dissociated people CAT usually offers a Sequential Diagrammatic Reformulation, starting with mapping little incidents of reciprocal role enactments and problem procedures, drawn from the Psychotherapy File, people's narratives or diaries and in-session mapping of significant moments. Having said this, many practitioners draw a hybrid diagram, something between an SDR and an SSSD, or they emphasise self states, even in diagrams for people who do not have a personality disturbance. There is a lot of variation in how CAT practitioners draw the map, and of course there are other kinds of diagrammatic formulations in other applications, such as contextual maps and team formulations.

There are also different ways of conveying the reciprocal role repertoire. The decision about which to use is entirely pragmatic, there are no fixed rules, but the key aim is to make the diagram intelligible and useful to the person using it. Over time, CAT therapists have devised and shared various layouts for showing the role repertoire, the procedures and the target problems. Where there is a clear split between idealised and dreaded roles, we may use a 'split egg' design, splitting the repertoire into the upper and lower parts of an egg shape, showing how the procedures reinforce the split and make the good roles unsustainable. Where splitting is not so marked, we could use a 'french loaf' design with the role repertoire laid out horizontally. With a self-states format, the reciprocal role associated with each state could be shown separately as part of a procedural sequence. The choice is yours, but

crucially, being responsive to the person you are trying to help and working out what will make most sense to him or her.

Whichever kind of map you use, try to ground the diagram in the person's experience not in abstract terms. For example, elicit real and preferably recent examples of the problem procedure in action or the reciprocal role enactment and be genuinely curious about what happened. Aim to ask open questions like 'what happened next?', 'what did you do then?'.

Goodbye letters and follow ups

The time limit in CAT therapy means that it is vital to hold the ending of the work in mind throughout and to bring this to the fore in at least the last 3 or 4 sessions. Goodbye letters help to focus the therapist's thoughts on this area and are intended to make the process more conscious and manageable for the patient. The Goodbye letter is usually given in the penultimate or final session of therapy. It usually includes a brief description of the purpose of the letter, and of what the therapy has focussed on. It describes the achievements of the therapy (for some, this may simply be having attended sessions in the face of conflicting emotions); difficulties that have arisen in the relationship, areas the patient will need to continue to work on, hopes for the future and affirmation of the follow up session. The follow up session encourages the patient to hold the therapy in mind during a long break and provides an opportunity to assess how far the patient has managed to retain any gains in the therapy and, hopefully, to make further progress independently. In a relatively small number of cases further follow ups or additional sessions may be offered after careful discussion with a supervisor to ensure that the desire to offer more is not just a re-enactment of an existing pattern.