INTRODUCING COGNITIVE ANALYTIC THERAPY

Principles and Practice

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ABOUT THE AUTHORS

Anthony Ryle qualified in medicine in 1949 and worked successively as a founding member of an inner city group practice, in Kentish Town, London, as Director of Sussex University Health Service and as a Consultant Psychotherapist at St Thomas's Hospital, London. Since retiring from the NHS he has worked part-time in teaching and research at Guy's Hospital. While in general practice he carried out epidemiological studies of the patients under his care and the experience of demonstrating the high prevalence and family associations of psychological distress influenced his subsequent interest in the development of forms of psychological treatment which could realistically be provided in the NHS. Studies of the process and outcome of psychotherapy followed and from these grew the elaboration of an integrated psychotherapy theory and the development of the time-limited model of treatment which became cognitive analytic therapy.

Ian B. Kerr graduated in medicine from the University of Edinburgh in 1977. After several junior hospital posts he worked for many years in cancer research. He subsequently completed dual training in psychiatry and psychotherapy at Guy's, Maudsley and St George's Hospitals in London. Currently he is Consultant Psychiatrist and Psychotherapist and Honorary Senior Lecturer, Community Health Sheffield NHS Trust, Sheffield, UK.

PREFACE

This book offers an updated introduction and overview of the principles and practice of cognitive analytic therapy (CAT). The last such book appeared over ten years ago and was the first systematic articulation of a new, integrative model which had been developed over a period of many years. Although there have been two specialist volumes since then (Ryle, 1995a; 1997a) it is significant that a restatement of the model and its applications is now necessary. There are many reasons for this. They include the fact that as a young, genuinely integrative model, (as acknowledged in the influential Roth and Fonagy report (1996)), it is still evolving and developing both in terms of its theoretical base and its range of applications. In this book a further exposition of the CAT model of development is given, stressing in particular an understanding of the social formation of the self based on Vygotskian activity theory and Bakhtinian 'dialogism'. We also outline an ever-expanding range of practical applications of CAT as an individual therapy as well as its application as a conceptual model for understanding different disorders and informing approaches to their management by staff teams. This trend has been described (Steve Potter) as 'using' CAT, as opposed to 'doing' it. Newer or preliminary applications of CAT reviewed here include CAT in old age, with learning disabilities, in anxiety-related disorders, in psychotic disorders, CAT for self-harming patients presenting briefly to casualty departments, CAT with the 'difficult' patient in organisational settings and CAT in primary care. In part these also reflect theoretical developments of the model which are also reviewed. Its gradually expanding evidence base is also reviewed, along with some of the difficulties, both scientific and political, inherent in research in this area.

CAT evolved initially as a brief (usually 16-session) therapy. This was partly for pragmatic reasons and related to the search for the optimum means of delivering an effective treatment to the kind of patients being seen in under-resourced health service settings. However, it also arose from consideration and evaluation of which aspects of therapy, including its duration, were actually

effective. This aspect of research is fundamental to the model and continues to be important in its continuing evolution. We suggest, incidentally, that a brief treatment like CAT, within the course of which profound psychological change can be achieved, genuinely merits the description of 'intensive' as opposed to much longer-term therapies usually described as such, which we suggest might better be called 'extensive'.

Despite the effectiveness of brief CAT for very many patients it is clear that not all patients can be successfully treated within this length of time. However, it is also evident from some very interesting work, with, for example, self-harming patients but also less damaged 'neurotic' patients, that effective work can also be done in a few, or even one session. The length of treatment has thus been modified to adapt to the needs of differing patients. Longer-term therapy may need to be offered to those with severe personality disorder, long-standing psychotic disorder, or those with histories of serious psychological trauma. Thus, there will be some patients for whom the reparative and supportive aspect of therapy over a longer period of time may be an important requirement. Similarly, more extended treatments may be offered in settings such as a day hospital, where the treatment model may be informed by CAT, as an alternative to offering it as an individual therapy.

A further reason for the present book is the ever increasing popularity of CAT with mental health professionals and the demand from trainees and others for a comprehensive but accessible introduction to it. The rapidly increasing popularity of CAT with both professionals and patients is, we feel, a further indication of the effectiveness and attractiveness of the model. In part, we see this popularity as arising from the congruence of CAT with the increasing demand for 'user participation' in mental health services; the explicitly collaborative nature of the model offers and requires active participation on the part of the client or patient. This 'doing with' therapeutic position, in addition to being demonstrably effective, appears to be very much more appropriate and welcome to a younger generation of trainees and potential therapists. This 'power-sharing' paradigm has overall, in our view, radical implications for mental, and other, health services.

The CAT understanding of the social and cultural formation of the self also highlights the role of political and economic forces in the genesis of many psychological disorders. The external conditions of life and the dominant values of current society, internalised in the individual, are seen as active determinants of psychological health or disorder. Recognising this, we suggest that, as therapists, we should strive to avoid describing psychological disorders as simply 'illnesses' and should also play our part in identifying and articulating whatever social action may be called for in response.

The book is the result of the collaborative work of two authors who share responsibility for the text. Our contributions were different, in part because AR was the initiator of the CAT model and has a much longer history of writing about it. In so far as this conferred authority it also risked complacency which,

he felt, needed to be challenged. IK brought a more recent experience of psychiatry and psychotherapy in the NHS, reflected in particular in the discussion of psychosis and of the 'difficult' patient and contextual reformulation. He also wished to emphasise the importance of a full biopsychosocial perspective. Our longest and most fruitful arguments were involved in writing the theoretical chapters (3 and 4).

THE STRUCTURE OF THE BOOK

Chapters 1 and 2 will give a brief account of the scope and focus of CAT and how it evolved and will spell out the main features of its practice. Most of CAT's relatively few technical terms will appear in these chapters; they and other general terms which may have a different meaning in CAT are listed in a glossary. In order to flesh out this introductory survey and give readers a sense of the unfolding structure of a time-limited CAT, Chapter 2 also offers a brief account of a relatively straightforward therapy. Chapters 3 and 4 consider the normal and abnormal development of the self and introduce the Vygotskian and Bakhtinian concepts which are part of the basic theory of individual development and change. Subsequent chapters describe selection and assessment (Chapter 5), reformulation (Chapter 6), the course of therapy (Chapter 7), the 'ideal model' of therapist interventions and its relation to the supervision of therapists (Chapter 8), applications of CAT in various patient groups and settings (Chapter 9) and in treating personality disorders (Chapter 10), and the concept of the 'difficult' patient and approaches to this problem, including the use of 'contextual reformulation' (Chapter 11). Each chapter commences with a brief summary of its contents and most conclude with suggestions for further reading. References to CAT published work and to the work of others are provided in the text. In addition, Appendix 1 contains a list of all CAT research-related publications available at the time of going to press. Appendix 2 contains the CAT Psychotherapy File, Appendix 3 the Personality Structure Questionnaire and Appendix 4 a description of repertory grid basics and their use in CAT.

Case material derived from audiotaped sessions is used with the permission of both patients and therapists; we gratefully acknowledge their help. Other illustrative material is either drawn from composite sources or disguised in ways preventing recognition. We have, on the whole, referred to patients rather than clients, although we use the term interchangeably.

FURTHER INFORMATION

Further information about CAT and about the Association for Cognitive Analytic Therapy (ACAT) may be obtained from The Administrator, ACAT,

Academic Division of Psychiatry, St Thomas' Hospital, London SE1 7EH (Tel: 020 7928 9292 ext. 3769) or through the website www.acat.org.uk, which also lists other CAT-related events and activities.

May 2001

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We should like to thank the many colleagues and patients who have contributed material to this book and who have been named in it. There are also innumerable others who have made important contributions to its production both recently and over a period of many years. They are too many to name but we should like to express our gratitude to them collectively. We would like to acknowledge the support provided by the staff at John Wiley and, in particular, the early encouragement offered by Michael Coombs. Finally, we should like to thank our partners Flora and Jane for making, in various and important ways, the writing of this book possible.

Chapter 1

THE SCOPE AND FOCUS OF CAT

SUMMARY

CAT evolved as an integration of cognitive, psychoanalytic and, more recently, Vygotskian ideas, with an emphasis on therapist–patient collaboration in creating and applying descriptive reformulations of presenting problems. The model arose from a continuing commitment to research into effective therapies and from a concern with delivering appropriate, time-limited, treatment in the public sector. Originally developed as a model of individual therapy, CAT now offers a general theory of psychotherapy with applicability to a wide range of conditions in many different settings.

In order to locate cognitive analytic therapy (CAT) in the still expanding array of approaches to psychotherapy and counselling and to indicate the continuing developments in its theory and practice, its main features will be briefly summarised in this introductory chapter.

CAT IS AN INTEGRATED MODEL

One source of CAT was a wish to find a common language for the psychotherapies. While there is a place for different perspectives and different aims in psychotherapy, the use by the different schools of virtually unrelated concepts and languages to describe the same phenomena seems absurd. It has resulted in a situation where discussion is largely confined to the parish magazines of each of the different churches or to the trading of insults between them. Despite the growth of interest in integration and the spread of technical eclecticism in recent

years the situation has not radically altered; CAT remains one of the few models to propose a comprehensive theory which aims to integrate the more robust and valid findings of different schools of psychotherapy as well as those of developmental psychology and observational research.

The process of integration in CAT originated in the use of cognitive methods and tools to research the process and outcome of psychodynamic therapy. This involved the translation of many psychoanalytic concepts into a more accessible language based on the new cognitive psychology. This led on to a consideration of the methods employed by current cognitive-behavioural and psychodynamic practitioners. While cognitive-behavioural models of therapy needed to take more account of the key role of human relationships in development, in psychopathology and in therapy, their emphasis on the analysis and description of the sequences connecting behaviours to outcomes and beliefs to emotions made an important contribution. Psychoanalysis offered three main important understandings, namely its emphasis on the relation of early development to psychological structures, its recognition of how patterns of relationship derived from early experience are at the root of most psychological distress and its understanding of how these patterns are repeated in, and may be modified through, the patient–therapist relationship.

Neither cognitive nor psychoanalytic models acknowledge adequately the extent to which individual human personality is formed and maintained through relating to and communicating with others and through the internalisation of the meanings developed in such relationships, meanings which reflect the values and structures of the wider culture. In CAT, the self is seen to be developed and maintained in the course of such interactions.

CAT IS A COLLABORATIVE THERAPY

The practice of CAT reflects these theoretical developments. It has been suggested that, in contrast to the traditional polarisation of health care professionals between those who are good at 'doing to' their patients (e.g. surgeons and perhaps some behaviour therapists) and those who are good at 'being with' their patients (e.g. many dynamic psychotherapists or nurses involved in long-term care), the CAT therapist is good at *'doing with'* their patients (Kerr, 1998b). This highlights the fact that CAT involves hard work for both patients and therapists and also the fact that much of this work is done together and that the therapy relationship plays a major role in assisting change.

The ways therapists describe their patients have implications for the value they accord to them and the nature of the therapeutic relationship conveys more than any particular technique. The techniques used and how they are employed must convey human acknowledgement and value. CAT therapists therefore encourage patients to participate to the greatest possible extent in their therapies; therapists do know useful ways of thinking and, in some sense,

are experts involved in activities which parallel parenting or remedial teaching, but our patients are not pupils or children and their capacities need to be respected, mobilised and enlarged through the joint creation of new understandings.

CAT IS RESEARCH BASED

One reason, or excuse, for the underfunding of psychotherapy in the National Health Service (NHS) has been the failure of dynamic therapists to evaluate seriously the efficacy of their work. The outcome research which led on to the development of CAT pre-dated the present insistence on evidence-based practice, originating in a programme dating back to the 1960s which aimed to develop measures of dynamic change. While the research base remains inadequate, the evolution of the model over the last 20 years has been accompanied by a continuous programme of largely small-scale research into both the process and outcome of therapy and this continues on an expanding scale.

CAT EVOLVED FROM THE NEEDS OF WORKING IN THE PUBLIC SECTOR AND REMAINS IDEALLY SUITED TO IT

Despite the proliferation of treatment models, a considerable proportion of psychologically distressed people in the UK (and in most other developed nations, let alone in the developing world) do not have access to effective psychological treatment. CAT, by providing a therapy which can be delivered at reasonable cost while being effective across a wide spectrum of diagnoses and a wide range of severity, is a contribution to meeting their needs. Most CAT therapists have worked in the NHS as nurses, occupational therapists, social workers, psychologists or psychiatrists; we are experienced in, and largely committed to, work in the public sector. We share a social perspective which assumes that psychotherapy services should take responsibility for those in need in the populations we serve, and should not be reserved for those individuals who happen to find (or buy) their way to the consulting room. It does, however, appear, not surprisingly perhaps, that CAT is becoming a very popular model of therapy in the private sector where many therapists make their living. Here, its time-limited but radical approach appeals to many clients who may have, possibly serious, psychological difficulties but who do not wish to spend protracted periods of time in long-term therapies of uncertain efficacy. As a model of brief therapy it is of course, for very different reasons, attractive to health insurance companies.

Our own social perspective is not new. The following description of the NHS was sent to demobilised servicemen in 1950: ‘It will provide you with all medical, dental and nursing care. Everyone, rich, poor, man, woman or child,

can use it or any part of it. There are no charges except for a few special items … . But it is not a charity. You are all paying for it, mainly as taxpayers and it will relieve your money worries in times of illness.' (Quoted in Wedderburn, 1996.) Despite the chronic underfunding of mental health services and of psychotherapy in particular, we believe that these principles can still be fought for and that CAT can contribute to their realisation.

CAT IS TIME-LIMITED

CAT is delivered in a predetermined time limit. While this time limit is clearly one important way of being cost-effective, the important argument in its favour rests on the fact that, for most people, time-limited therapy is as clinically effective as many much more prolonged interventions. The time limit is usually of 16 sessions but this can be extended in treating more disturbed and damaged patients or shortened where the threshold to consultation is low and mildly disturbed patients are seen.

CAT OFFERS A GENERAL THEORY, NOT JUST A NEW PACKAGE OF TECHNIQUES

The book aims to describe and illustrate the methods, techniques and tools developed in CAT. While largely concerned with individual therapy, applications in other modalities are considered, as are the wider implications for psychotherapy theory. While some CAT techniques could be incorporated in other treatment approaches, the model and the method involve more than these. Psychotherapy patients can make use of a great many different psychotherapy techniques and there would be no point in simply offering a new combination of these under a new label. So why do we need theory?

One robust finding from psychotherapy research is that the patient's perception of the therapist as helpful is associated with a good outcome. This being so, a major part of any therapy model must be concerned with how to achieve this, given that the central problem for many patients is that they are damaging or incompetent in their personal relationships and are mistrustful and destructive of offers of help from others. Overcoming these tendencies is never easy and becomes increasingly important and difficult as more disturbed patients are considered. Being helpful means more than being nice, indeed it may sometimes involve being 'nasty' or at least confronting; the crucial quality required is to respect the patient enough to be honest. Techniques therefore need to be understood in relation to the complex human issues which are at the heart of therapy. Those used in CAT, whether adapted from other approaches or specific to CAT, have, as their main aim, the development of the patients' capacities to know, reflect on and ultimately control their negative actions and experiences.

Other tools and techniques are designed to maintain the therapist's adherence to the methods and values of the approach; they provide a framework within which a sincere and often intense working relationship can flourish. Practice embedded in theoretical clarity must be combined with accurate empathy if therapists are to be able to reach and maintain an understanding of their patients' experiences and at the same time be fully aware of their role in encouraging change.

CAT HAS APPLICATIONS IN MANY CLINICAL SETTINGS

The book is primarily addressed to those working with psychologically disturbed adults including those who, while not 'doing therapy', have important therapeutic responsibilities. We believe that psychological understandings should play a larger part than is now the case in the management of groups such as psychiatric patients with major mental illness, forensic patients and the mentally handicapped. We believe that psychotherapists should take more responsibility for supporting staff in these fields. In addition, psychotherapists should involve themselves both directly and in supporting staff in the treatment of patients with personality disorders who are currently so poorly served by mental health services. In all these fields, and in work with adolescents, experience is accumulating of applying CAT and the model is proving to be accessible and useful to patients and clinical staff. While both psychoanalysis and cognitive therapy have contributed to these fields neither, in our view, adequately mobilises the therapeutic power of the relationship between patients and those looking after them. We believe that CAT has a major contribution here, offering a distinct, coherent and teachable model of social and interpersonal interaction which can help individuals and staff groups respond helpfully, rather than react collusively, to their patients, and which may have applications outside clinical practice.

Chapter 2

THE MAIN FEATURES OF CAT

SUMMARY

The practice of CAT is based on a collaborative therapeutic position, which aims to create with patients narrative and diagrammatic reformulations of their difficulties. Theory focuses on descriptions of sequences of linked external, mental and behavioural events. Initially the emphasis was on how these procedural sequences prevented revision of dysfunctional ways of living. This has been extended more recently to a consideration of the origins of reciprocal role procedures in early life and their repetition in current relationships and in self-management. This model—the Procedural Sequence Object Relations Model—has been further modified by the introduction of Vygotskian and Bakhtinian ideas on the social formation of mind. Practice involves early reformulation followed by work designed to recognise and then revise dysfunctional procedures in daily life and in the therapy relationship. The model of practice is illustrated by a brief case history.

This chapter will describe the development of CAT and will introduce most of the 'technical' terms employed. Although it was not defined and named as a separate model until the mid-1980s, it was derived from practice and research carried out during the previous twenty years. As this pre-history explains many of its features, this chapter will begin by summarising these sources.

Thirty years ago, there was hardly any evidence to show whether psychodynamic therapy worked. To measure the effectiveness of therapy it is necessary to declare at the start what the aims are, a task easily accomplished by behaviourists where these are defined as the relief of symptoms or modification of behaviours, but more difficult for psychodynamic therapists whose aims are

complex and are often poorly articulated or only emerge in the course of the therapy. Two small studies were carried out to address this problem. The first involved a careful reading of the notes of a series of completed therapies with the aim of finding out how early in therapy the key problems had been identified. This revealed that most therapies were concerned with only one or two key themes and that these had usually been evident early on, often in the first session. It also showed that much of the work of therapy had been directed to trying to understand why the patient had not revised the ways of thinking and acting which maintained these problems. On this basis the 'dynamic' aims of therapy could be defined early on as the revision of the identified, repetitive, maladaptive patterns of thought and behaviour.

Three patterns explaining this non-revision were identified; these were labelled dilemmas, traps and snags. Dilemmas prevent revision because the possibilities for action or relationships are seen to be limited to polarised choices; the only apparent options are to follow the less objectionable choice or to alternate between them. Traps represent the maintenance of negative beliefs by the way they generate forms of behaviour which lead to consequences (usually the responses of others) which appear to confirm the beliefs. In snags, appropriate goals are abandoned or sabotaged, because (or as if) it is believed that their achievement would be dangerous to self or others or otherwise disallowed.

The second study involved the use of repertory grid techniques. (The basic principles of this technique are summarised in Appendix 4). At the start of therapy patients completed such grids by rating how far a range of descriptions (constructs), partly elicited and partly supplied, were true of a range of elements consisting of significant people. In the case of the dyad grid (Ryle and Lunghi, 1970) the elements are the relationships between the self and significant people. Analysis of such grids provided a number of measures of the individual's way of construing self and other. Measures that reflected the issues which had been noted clinically and described in psychodynamic terms could be identified and the changes in these seen to be desirable in terms of the aims of therapy could be specified. Repeating the grid after therapy showed how far such changes had occurred. Through the use of such repertory grids, described in Ryle (1975, 1979, 1980), it became possible to derive measures of change between pre- and post-therapy testing indicating how far dynamic aims had been achieved.

What started as an exercise designed to provide evidence of the effectiveness of dynamic therapy was therefore successful; outcome research could now be based on identifying and measuring change in patients' 'dynamic' problems, described as patterns of traps, dilemmas and snags at the start of therapy, and on measuring change in the associated repertory grid measures. But the main effect was incidental to this aim, for this process, which involved explicit, joint work with the patient to identify and describe problems, had such a powerful positive effect on the course of therapy that conventional dynamic therapy was abandoned. The joint reformulation of the patient's problems became a key feature of what developed into CAT.