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Editorial
Cognitive analytic therapy: A case study in treatment development

Frank Margison
Editor

A summary of the main literature on cognitive analytic therapy (CAT) is given. Ryle first developed CAT over 20 years ago, and use of the model is increasingly widespread in diverse settings and with various conditions. CAT stands as an example of modern dialogical approaches to therapy, and the underlying theory is consistent with that stance. The developments within training stress self-reflexive practice and the maintenance of a collaborative approach. In contrast, however, to the rapid development in training and practice the research summarised here is primarily descriptive with a small number of open trials and one randomized controlled study in a physical disorder (Type I diabetes). The urgent need for randomized controlled research in this treatment is highlighted.

Introduction

The special section of the Journal which follows deals with four different applications of cognitive analytic therapy (CAT). These papers concern deliberate self-harm, male survivors of childhood sexual abuse, asthma and borderline personality disorder. This breadth of applications suggests that CAT is establishing itself in the psychological treatments repertoire at the dissemination phase of treatment development. This means that there are diverse applications of the basic method described originally by Ryle (1979, see also 1980, 1982, 1985, 1990). A summary of the main achievements to date in CAT is given below. CAT training is now well established, but there has not been a parallel growth in the publication of outcome results, although there are several small case series and many descriptive accounts which make the work accessible to a wider audience. The relative lack of outcomes oriented research is discussed in terms of a general treatment development paradigm described by Salkovskis (1995) as the 'hourglass model'.

The treatment development paradigm

Treatment development is usually conceptualised as having three phases. The initial phase is characterized by single case studies and small uncontrolled or quasi-randomized trials alongside the development of treatment descriptions, manuals and measures of adherence. CAT therapy trials of this type were published 20 years ago (Ryle, 1979, 1980, 1981).The second phase forms the 'neck' of the 'hourglass' model (Salkovskis, 1995) characterized by a relatively small number of studies optimized for internal

validity (by use of treatment allocation concealment, randomization and prior power analysis to determine appropriate sample size), typically in the standard form of a randomized, controlled trial (RCT). This is the widely-accepted 'gold standard' in evidence-based practice because of the unique way that the design randomly assigns potential confounders between those randomized to receive different treatments (whether considered to be such by the investigator or not). Of course, this paradigm has its critics. In particular the tight selection of participants threatens external validity or generalizability, but it is useful to see it as the neck of the hourglass through which all new treatments pass.

This describes the RCT rather like a rite of passage before becoming mature as a therapy. This metaphor is ill-judged as there may be considerable work improving treatment delivery and integrity, but the lack of evidence from this type of evaluation makes it difficult to get subsequent research funding and so there is a danger of a potentially efficacious treatment being marginalized in the outcomes research world.

After the rigours of the 'neck of the hourglass', the third phase of treatment development involves dissemination of the method in less tightly defined populations, and extensions into new conditions. CAT has moved into this phase to a substantial degree whilst almost completely bypassing the RCT phase.

Whilst no-one expects the development of a treatment to follow precisely these steps, CAT is unusual in being increasingly widely practised without following the full three-stage model of development. It has been argued that the repeated finding of treatment equivalence in comparative studies (the 'dodo bird' effect) makes the pursuit of yet more comparative treatment RCTs redundant.

From within CAT, some have also argued that it would now be unethical to withhold a treatment (through randomization against no treatment or 'treatment as usual') which is already assumed to be effective. Taking CAT as a case study, it could be argued that the treatment has developed so quickly because of its appeal directly to practitioners, but an unintended consequence may be that randomized controlled trials have been a low priority. The process of professionalization of CAT has been remarkably rapid and elaborate training structures were built to regulate entry to the practice of CAT, and to restrict entry to the profession of CAT therapists to one professional organization.

Given the evidence of the impact of researcher allegiance, it may not be desirable to have all research on any new method of therapy restricted to its proponents. It is particularly unfortunate that CAT is lacking in formal, research peer-reviewed evaluation as the practitioners of CAT espouse critical self- and peer-review of practice as part of the emerging 'practice-based evidence' paradigm.

The remainder of this review summarizes the theoretical basis for CAT, and the published studies to date. Although the list of publications is not exhaustive it covers the majority of studies reporting clinical outcomes, and most of the theoretical developments within CAT.

Development of a theory for CAT

There were two phases to the development of a theory of CAT. Initially, Ryle and colleagues developed the Procedural Sequence Model (PSM). This suggested an integration between cognitive theory and the constructivist theories first developed by George

Kelly. The PSM model was intended to be a theory of aim-directed action. Procedures describe how things are organized and sequences describe the order in which they occur. Procedures are hierarchically organized with sub-procedures subsumed under higher-order procedures. Neurosis is then defined as the persistent use of procedures which are ineffective or even harmful. Also, in neurosis, these procedures have not been open to revision in the usual way. This approach led to an emphasis within the therapy for accurate description followed by improved early recognition and finally revision of the problematic procedures.

A later refinement incorporated terminology from psychoanalytic theory of object relations. The theoretical model became the PSORM (Procedural Sequence Object Relations Model). Ryle has published several critiques of Kleinian object relations theory, reformulating psycho-analytic theory in the language of CAT (for example, Ryle, 1992, 1993, 1994, 1995, 1996). This preoccupation with arcane aspects of psycho-analytic theory has not been matched with parallel developments offering a critique of cognitive theory, although in practice CAT draws widely on cognitive therapy in the use of homework assignments, use of written material, monitoring progress using rating schedules and accessible 'tools' to aid the understandability of formulations.

Some of the most characteristic features of CAT are in those therapeutic processes which are intended to build a focused but collaborative alliance (the psychotherapy file, the reformulation letter, the sequential diagrammatic reformulation and the goodbye letter). The links with cognitive-behavioural theory are at times remote although both draw on an overlapping conceptualisation of motivation and action which Ryle links through activity theory (Ryle, 1991).

Jellema (1999) made the useful point that CAT may be conceptually closer to attachment theory than Kleinian object relations theory. However, Ryle has been concerned throughout with a particular view of object relations. He stresses the internalization of a model of a relationship, drawing on the language of personal construct theory by suggesting prototypic self-to-self and self-to-other relationships. Following from this model he suggests that repertory grids are an important method of evaluating change.

Leiman's substantial contribution to the development of theory (1992, 1994, 1995, 1997) has emphasised the fundamentally dialogical nature of this model. Although he draws on the work of Vygotsky and Bakhtin, there are close similarities with models more widely known in the UK and USA. For example, Harry Stack Sullivan developed a radically interpersonal theory of psychiatry and psychology, being among the first to suggest that identity is co-constructed in the form of a series of models of relationships. These models are connected in the form of internalized dialogues, a concept central also to Hobson's Conversational model of therapy (Hobson, 1985). Stiles acknowledged that metaphoric connection in the title of his contribution to this area of theory, referring to a 'conversation in progress' (Stiles, 1997).

These developments from a procedural sequence model to a sign-mediated model are still being assimilated into cognitive analytic therapy. As the sign-mediated concepts have taken hold there has also been a shift towards clinical work with people who experience abrupt 'state shifts' such as those with borderline personality who demonstrate the phenomenon of abrupt shifts in dialogical position, perhaps with concurrent shifts to different internalized 'voices'.

Clinical studies

As well as the various themes developed in this special issue, there have been several recent papers suggesting extended uses for CAT. These include a pilot study of CAT against educational behaviour therapy in the treatment of anorexia nervosa (Treasure *et al.*, 1995); and a randomized controlled trial of CAT in poorly controlled Type I diabetes (Fosbury, Bosley, Ryle, Sonksen, & Judd, 1997). No difference between CAT and the comparison treatment was found, perhaps because the trial was under-powered.

Changes in personal constructs after therapy were reported in women who had been sexually abused (Clarke & Llewelyn, 1994), and Pollock has used CAT extensively in secure forensic settings and described a pilot study with seven female offenders who had experienced earlier abuse (Pollock, 1996). Cowmeadow (1994) reported an earlier study of two patients with deliberate self harm linked to the rapidly-growing literature on the treatment of borderline states (Beard, Marlowe, & Ryle, 1990; Dunn, 1994; Golynkina & Ryle, 1999; Kerr, 1999; Leighton, 1997; Marlowe, 1994; Ryle & Marlowe, 1995; Ryle 1997a, 1997b).

Some work has been described on the use of CAT as a way of conceptualizing harmful work environments as an aid to improved awareness of work stress (Walsh, 1996), but the most characteristic work in the field of self-reflexive practice has been the attempt by Bennett and colleagues to describe and rate the processes occurring when the therapeutic alliance is damaged by in-session re-enactments (Bennett, 1994; Bennett & Parry, 1998). As part of this work they demonstrated that expert judges could reliably rate CAT methods and their accuracy.

Comments

Ryle's early experience in developing an accessible model of therapy in student counselling settings, and in general psychiatric and out patient psychotherapy clinics in London, has been linked to the development of a collaborative and fundamentally dialogical model of therapy. The theory draws widely from cognitive psychology, models of intentionality, internalized models of relationships and from various psychoanalytic writers, and to that extent is best seen as integrative in both theory and practice. As the model is potentially so all-inclusive it is important that Bennett and colleagues have developed a reliable measure of therapeutic adherence and competence so that the model can be differentiated from other approaches in future studies.

CAT is now a model of therapy with a well-established training structure, and is increasingly influential in NHS practice. However, the total number of patients formally reported in the literature even in open studies is still remarkably small. The studies that do exist, however, are diverse in terms of conditions treated and the treatment setting. The methods for measuring change have varied, but the clinical studies have tended to draw from the range of self-report outcome measures commonly used in the field, but with particular emphasis on repertory grid methods which are highly congruent with the theory of CAT.

This Journal has played an important role in disseminating knowledge about CAT, and this issue has reports of four further valuable studies, forming a timely staging point in the development of the model. There is a choice open to those wishing to carry out

research within the CAT paradigm: it would be possible to focus increasingly on small-scale non-randomized studies of practice with continuing theoretical debate, or, as favoured by this Journal, there could be a return to the neck of the hourglass to remedy the current lack of RCTs before moving further into dissemination into yet more diverse fields.

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