Cognitive Analytic Therapy

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Opening minds to a brighter future

Integrative model

- Object-relations informed approach to cognitive therapy
  - An attempt to find a 'common language' and theoretical and practical integration of psychodynamic and cognitive ideas
- Informed by Vygotskian activity theory
  - Informed by direct observation of infants & carers

COGNITIVE

Makes full use of patient's capacity to observe and think about themselves,

- their assumptions,

- their feelings and

- their behaviour

ANALYTIC

- Unacknowledged, unconscious factors are explored and worked with, and their impact is recognised

- Use the therapist–patient relationship

Key Features

- Collaborative
- Respectful
- Developed for use in mental health systems
  - An individual therapy
  - A model for team-based care
- Time-limited (16 – 24 sessions)
- Clear descriptions of its theoretical basis and practical application

CAT is a 'relational' model

•The early relationships one is exposed to shape the relationships one finds oneself in later in life…

- •Both with ourselves, as well as with others
- •These early relationships also impact the way we think, feel and behave

•These all follow *patterns* that can be noticed and then discussed

Normal Development

Infants are born 'hard-wired' for social interaction…
even before language there is communication and relationships are forming

Most children experience a range of 'caring' relationships early in life

Early relationships are dyadic

The child not only experiences feeling 'cared for' by another, but also has the 'caring' experience modeled to it.

Model of internalisation (Vygotsky)

Each dyadic relationship pattern is first experienced with another, then practiced and rehearsed, and internalised.

Relationship patterns

The early internalised relationship patterns, are then enacted again and again throughout one's lifetime with both others, and with oneself.

Early relationship patterns become 'familiar' and 'automatic'

•The child learns how to elicit 'caring' responses, in order to feel 'cared for' in return

What about when early relationship patterns are not so 'caring'?

Internalised harsh and punitive relationship patterns

Will affect the way the child relates to both

- Others
- Him or herself

This child is more likely to go on to develop

- Self-defeating patterns of thinking, feeling, behaving

CAT jargon

'Reciprocal Roles'

'Procedures'

Reciprocal Roles (RRs)

- In CAT, these internalised dyadic relationship patterns are called RRs

    - We are all enacting our internalised RRs, all the time

    - These RRs are enacted both

        self-to-other and *self-to-self*

    - We are often not aware of them because they are 'familiar' and 'automatic'

'Procedures'

- Behaviour and experience seem to be organised into patterns
  - Some are helpful, some not
- Established early in life
- General, exist across many situations
- Resist revision
  - Neurosis is a "failure" to revise maladaptive procedures

Procedures

- Embody
  - Parental and cultural meanings
  - Values
- Transmitted by
  - Pre-verbal signs
  - Language

Problematic procedures

• Three general patterns of repeatedly used unsuccessful strategies:

- **Traps:** vicious circles
- **Dilemmas:** polarised extreme choices
- **Snags:** self-sabotage

Traps:

- Beliefs and assumptions shape behavior into self-confirming vicious circles, e.g.,

  - Depressed thinking
  - Fear of hurting others
  - Avoidance
  - Social isolation

Dilemmas

- Highly polarised choices, both options of which are extreme and dysfunctional
  - "…if I do x, then y will follow..."
  - Two major forms of dilemma:
    - Either/Or
    - If/Then
  - ***E.g., Either I keep my feelings bottled up Or I risk being rejected, hurting others, or making a mess***

Snags

- Particularly self-defeating assumptions that lead the patient to abandon his/her goals
  - Self-sabotaging assumptions such as
    - "I don't deserve a better life…"
    - "Things never work out for me…"

Key concepts in CAT

Key Concepts in CAT (Ryle 2008)

- Therapists need a theory of the development of the structure of the self and the process of change in the self

- CAT theory draws on Vygotsky and Bakhtin
  - Informed by developmental research
  - e.g. Stern, Trevarthen: stressing the infant's capacity for and active pre-disposition to 'inter-subjectivity'

Key Concepts in CAT (Ryle 2008)

- Implies the socially and culturally determined formation of the self through collaborative, meaningful, sign-mediated activity

Key Concepts in CAT (Ryle 2008)

- Human evolution makes us uniquely prepared to be socially formed
- Infants are active in seeking relationships
- Knowing the aims of others is an innate skill (supported by mirror neurones)
- Individual development occurs within relationships

Key Concepts in CAT (Ryle 2008)

- Infants and caretakers develop a repertoire of reciprocal role (RR) relationships and reciprocal role procedures (RRPs)

- These shape relationships with others and self-management

- They are sustained by repetition

Key Concepts in CAT (Ryle 2008)

- Self is largely formed of a structure of linked 'reciprocal role' relationship patterns
- The integration of these may be disrupted by trauma or deprivation

Key Concepts in CAT (Ryle 2008)

- Radically social model of the self

- The self is seen as being constituted by internalised, socially-meaningful interpersonal experience

- The self is described in terms of a repertoire of 'reciprocal role' procedures.

Introduction to CAT practice

CAT - Practice

- Integrative therapy
- Time limited (usually 16-24 sessions) and structured
- Proactive, collaborative ('doing with')

CAT Practice – early work

- Extended assessment
- Development of a joint description of maladaptive procedures & target problems
  - Reciprocal roles
- Written (narrative) description
- Diagrammatic 'reformulation'

CAT - Practice

- Subsequent work focuses on identification of enactments both outside and during sessions

    … and changing these

- Transference and counter-transference understood as enactments of reciprocal role procedures

CAT - Practice

- Final summary ('goodbye') letters by therapist and patient
- Labour intensive!

The three R's of CAT

- Reformulation
- Recognition
- Revision

Reformulation

- Sequential Diagrammatic Reformulation (SDR)

  - Collaboratively developed visual map of problematic patterns and reciprocal roles

- Reformulation letter

  - Narrative retelling of individual's story

Recognition

- Diagram to
  - Improve accuracy of reformulation
  - Minimise collusion/repetition
- Self-monitoring
  - Diaries
  - Rating sheets
- Therapeutic relationship serves as a tool for recognising reciprocal role enactments

Revision

- Identify "exits"
    - New ways of thinking, feeling and behaving
    - Practising *in vivo*
- Techniques to achieve change
    - Breaking unhelpful procedures
    - Building on adaptive strategies
    - Tailored to the patient's capacities
- Use of relational understanding to actively avoid collusion

Termination and follow-up

- The ending is on the agenda from the beginning of therapy
  - Abandonment & dependency are talked about
  - This allows both therapist and patient to discuss and consider what is helpful
- Goodbye letters
  - Therapist and patient
  - Summarise gains & work to be done

Termination and follow-up

- Follow-up sessions
  - Between 1 - 4 F/U appts over 6 mths
  - Review progress, rather than introduce new material
  - Assist patient to put new learning into practice

Model of Therapeutic Change

Model of Therapeutic Change

- Experience a different kind of relationship

  - As in early development, learning involves internalisation of relationships and procedures first enacted with another

- Development of self-reflection

  - Therapy involves the joint exploration of meaning and the joint construction of the tools of self-reflection

Model of Therapeutic Change

- 'Re-formulation'
  - Joint description of the patient's life narrative that explains the presenting problems
- Linking the past to the current repertoire of reciprocal role procedures enables:
  - Old damaging patterns are recognised and not confirmed
  - Allows development of new more adaptive patterns

Model of Therapeutic Change

- The therapy relationship offers
    - Acknowledgement
    - Exploration
    - Understanding
    - A do-it-yourself reflection kit
- Emotionally powerful real and metaphoric relationship

Model of Therapeutic Change

•The therapist works in the capacities of the individual ('zone of proximal development')

- The therapist needs to attend to the process all through the therapy
- To be truly collaborative, the therapist needs to tailor what he/she is doing so the patient can use it

Therapist's aims:

- Link the past to the current patterns
  - Why have things ended up this way?
- Encourage & develop capacity for self-reflection
- Develop more helpful relationship patterns
  - Therapist's relationship with the patient
  - patient's relationships with others &
  - patient's relationship with him/herself
- Avoid (or recover from) colluding with unhelpful patterns

What else facilitates this?

- Development of collaborative tools
  - Diagram of the 'reformulation'
  - Reformulation letter
  - Good-bye letters
  - Other tools –
    - Psychotherapy file (describes common patterns)
    - Monitoring sheets
    - Diary, journal, notes
- Exploration of patterns & relationship styles

CAT and BPD

CAT description of BPD

- 'Deficit' model of psychopathology
- Dissociation rather than repression/conflict as primary mechanism
- In addition to maladaptive procedures and reciprocal roles, describes and addresses multiple 'self states'

CAT description of BPD

- Multiple-Self-States Model (Ryle 1997)
  - Self-state = partially disassociated reciprocal role patterns

- Three forms of disorder:
  - Extreme roles
  - Partial dissociation (disruption of integrating procedures)
  - Deficient self-reflection

Extreme roles

- Damaging, restrictive and often extreme repertoire of RRP's
- Typically: abusing/neglecting in relation to deprived and victimised and/or revengeful

Partial dissociation

- Different RR's are located in different self-states
- State switches occur abruptly and often inappropriately

Deficient self-reflection

- Developmental experience is of inconsistent care
- No internalised model of concern

What works about CAT?

What works about CAT?

- Consistent team approach across all aspects of care

- Common language

  - Within team and with others

- Clear theoretical model of BPD

What works about CAT?

- Integrative, allows incorporation of
  - The range of presenting problems, including substance use
  - The variety of treatment modalities required
- Collaborative, open and respectful
  - 'doing with', not 'doing to'
  - Therapist takes a 'curious' stance
- Time-limited
  - Pragmatic model – offer 'good enough' treatment

What works about CAT?

- Provides a language for managing interpersonal difficulties respectfully & empathically
  - Between therapist & patient
    - Helps manage collusion with unhelpful patterns
    - Helps manage things that interfere with therapy
  - Between team members
    - Helps manage team tensions and differences of opinion about management

Evidence

Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial

Andrew M. Chanen, Henry J. Jackson, Louise K. McCutcheon, Martina Jovev, Paul Dudgeon, Hok Pan Yuen, Dominic Germano, Helen Nistico, Emma McDougall, Caroline Weinstein, Verity Clarkson and Patrick D. McGorry

Background
No accepted intervention exists for borderline personality disorder presenting in adolescence.

Aims
To compare the effectiveness of up to 24 sessions of cognitive analytic therapy (CAT) or manualised good clinical care (GCC) in addition to a comprehensive service model of care.

Method
In a randomised controlled trial, CAT and GCC were compared in out-patients aged 15–18 years who fulfilled two to nine of the DSM–IV criteria for borderline personality disorder. We predicted that, compared with the GCC group, the CAT group would show greater reductions in psychopathology and parasuicidal behaviour and greater improvement in global functioning over 24 months.

Results
Eighty-six patients were randomised and 78 (CAT n=41; GCC n=37) provided follow-up data. There was no significant difference between the outcomes of the treatment groups at 24 months on the pre-chosen measures but there was some evidence that patients allocated to CAT improved more rapidly. No adverse effect was shown with either treatment.

Conclusions
Both CAT and GCC are effective in reducing externalising psychopathology in teenagers with sub-syndromal or full-syndrome bipolar personality disorder. Larger studies are required to determine the specific value of CAT in this population.

Declaration of interest
None. Funding detailed in Acknowledgements.

Early intervention for adolescents with borderline personality disorder: quasi-experimental comparison with treatment as usual

Andrew M. Chanen, Henry J. Jackson, Louise K. McCutcheon,
Martina Jovev, Paul Dudgeon, Hok Pan Yuen, Dominic Germano,
Helen Nistico, Emma McDougall, Caroline Weinstein, Verity Clarkson,
Patrick D. McGorry

Objective: The aim of the present study was to compare the effectiveness of specialized team-based early intervention for borderline personality disorder (BPD) with treatment as usual.

Method: In a quasi-experimental design, 32 outpatients who received historical treatment as usual (H-TAU) were compared with 78 participants from a recently published randomized controlled trial of cognitive analytic therapy (CAT; n = 41) versus manualized good clinical care (GCC; n = 37), conducted in a specialized early intervention service for BPD (the Helping Young People Early (HYPE) programme). All participants were 15–18-year-old outpatients who fulfilled 2–9 DSM-IV BPD criteria. It was predicted that, compared with H-TAU, HYPE + GCC and HYPE + CAT would show greater reductions in psychopathology and parasuicidal behaviour and greater improvement in global functioning over 24 months.

Results: At 24 month follow up: (i) HYPE + CAT had lower standardized levels of, and a significantly faster standardized rate of improvement in, internalizing and externalizing psychopathology, compared with H-TAU; and (ii) HYPE + GCC had lower standardized levels of internalizing psychopathology and a faster rate of improvement in global functioning than H-TAU. HYPE + CAT yielded the greatest median improvement on the four continuous outcome measures over 24 months. No adverse effects were shown with any of the treatments.

Conclusions: Specialized early intervention for subsyndromal or full-syndrome BPD is more effective than TAU, with HYPE + CAT being the most effective intervention. Reform of existing services using the HYPE model might yield substantial improvements in patient outcomes.

Cognitive analytic therapy for personality disorder: randomised controlled trial[†]

Susan Clarke, Peter Thomas and Kirsty James

Background

Cognitive analytic therapy (CAT) is a theoretically coherent approach developed to address common processes underlying personality disorders, but is supported by limited empirical evidence.

Aims

To investigate the effectiveness of time-limited CAT for participants with personality disorder.

Method

A service-based randomised controlled trial (trial registration: ISRCTN79596618) comparing 24 sessions of CAT (*n* = 38) and treatment as usual (TAU) (*n* = 40) over 10 months for individuals with personality disorder. Primary outcomes were measures of psychological symptoms and interpersonal difficulties.

Results

Participants receiving CAT showed reduced symptoms and experienced substantial benefits compared with TAU controls, who showed signs of deterioration during the treatment period.

Conclusions

Cognitive analytic therapy is more effective than TAU in improving outcomes associated with personality disorder. More elaborate and controlled evaluations of CAT are needed in the future.

Declaration of interest

None.

Table 1 Means (s.d.) of demographic characteristics and outcome measures as a function of group and time

| Measure | Cognitive analytic therapy (CAT) | | Treatment as usual (TAU) | | d | n | |
	Pre	Post	Pre	Post		CAT	TAU
Demographic characteristics							
Gender, female: *n* (%)	27 (71.05)		32 (80.00)			38	40
Age, mean (s.d.)	36.86 (9.34)		34.30 (9.99)			38	40
In-patient admissions,[a] *n* (%)	13 (34.21)		13 (33.33)			38	39
Accident and emergency admissions,[a] *n* (%)	11 (28.95)		9 (23.08)			38	39
Outcome and process							
Structured Clinical Interview for DSM-IV							
Axis II, median (s.d.)**	3.00 (1.40)	1.00 (1.74)	3.00 (1.48)	4.00 (2.10)		27	30
Inventory of Interpersonal Problems**	2.16 (0.44)	1.87 (0.58)	2.12 (0.44)	2.28 (0.49)	1.00	36	36
Clinical Outcomes in Routine Evaluation**	2.18 (0.75)	1.70 (0.89)	2.41 (0.58)	2.35 (0.63)	0.80	35	39
Dissociative Questionnaire**	2.56 (0.66)	2.14 (0.68)	2.75 (0.71)	2.64 (0.56)	0.60	38	37
Dissociative Experiences Scale	23.34 (14.47)	19.46 (14.58)	24.47 (22.56)	24.71 (14.70)	0.24	20	15
Global Severity Index	1.84 (0.47)	1.32 (0.79)	2.21 (0.72)	1.97 (0.72)	0.64	21	17
Personality Structure Questionnaire*	30.32 (6.05)	27.32 (5.30)	30.94 (5.80)	30.58 (4.52)	0.50	37	36

a. Percentage of participants having one or more in-patient and/or accident and emergency admissions, based on a period of 10 months prior to the start of therapy.
*$P<0.05$, **$P<0.01$.

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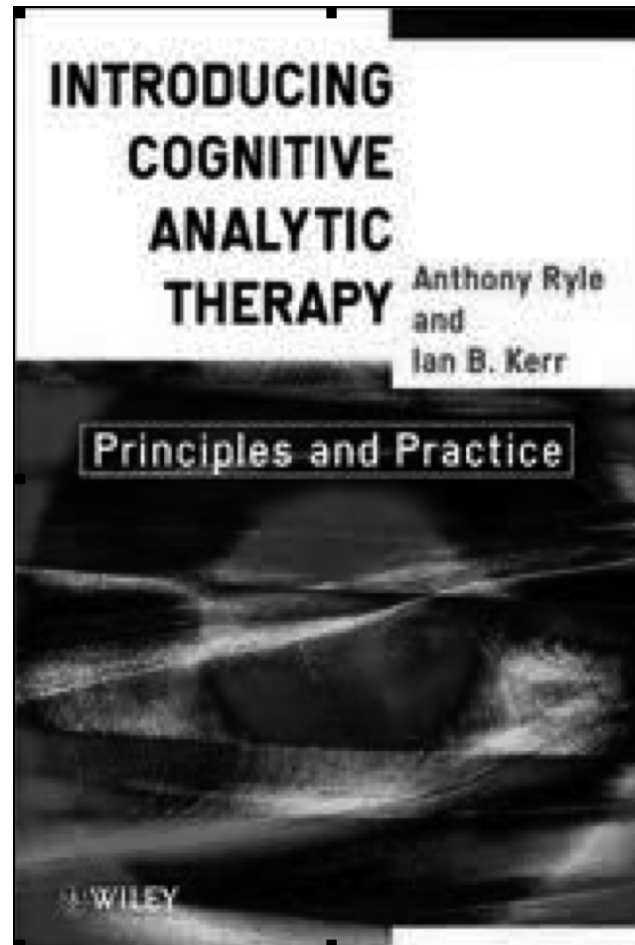
Questions?

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