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Title

Cognitive Analytic Therapy (CAT) at Thirty

Biographies

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Completed his core training in Clinical Psychology at the University of Sheffield (1986-1990) after working in the corporate sector as an Organisational Psychologist. Worked in Secondary Care in Barnsley in adult mental health on qualifying and progressed to a Lead Consultant Clinical Psychologist. Completed CAT practitioner training (2000-2002) and is currently completing CAT psychotherapy training. Currently Consultant Clinical Psychologist with Sheffield Health and Social Care NHS Foundation Trust and IAPT programme Director at the University of Sheffield. Interests include testing the efficacy and effectiveness of CAT in routine clinical practice.

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Declaration of Interest

Anthony Ryle is the originator of the CAT model and President of ACAT (Registered Charity No 1141793) and has written and edited books on the topic of Cognitive Analytic Therapy.

Jason Hepple is Chair of ACAT and has written and edited books on the topic of Cognitive Analytic Therapy.

Abstract

This paper describes the development of the CAT model, analyses the existing evidence base for CAT and looks at the future direction of research and training in the model in order to further enhance CAT's place in the overall provision of psychological therapies for patients.

Cognitive analytic therapy (CAT) was proposed as a psychotherapy modality in 1984 by Dr Anthony Ryle, as clinical integration of psychodynamic therapy and personal construct / cognitive psychology and was based upon many years of GP-based clinical experience of psychological problems and on-going research into the structure and change of self-processes. This clinical innovation enabled the development of a brief, user-friendly and relational therapy, applicable to the wide range of emotional problems typically seen in public mental health settings. CAT provides a coherent model of development and psychopathology that centrally views the self as socially formed and embedded.

Distress is formulated as being sustained through a repertoire of dysfunctional reciprocal role procedures involving persistent and stereotyped interpersonal maladaptive patterns. These are challenged and modified by the therapist's or

staff group's non-collusive relationship with the patient and recognition of patterns apparent in the alliance. Each patient's unique difficulties and relevant history are identified and recorded in collaboratively derived narrative and diagrammatic formulations. Formulations therefore extend patient's self-reflection skills, support therapists in recognising/avoiding collusive relationships, repairing therapeutic ruptures and starting the work of therapeutic change. Termination (agreed in advance after 16-24 sessions) is kept on the agenda from the outset and therapist and patient prepare goodbye letters for the final session to facilitate emotional processing of the ending. CAT is not a manualised therapy and is a principle rather than protocol-driven approach. Therapists' fidelity and adherence to CAT's core principles can be reliably measured by a standard analysis of audiotapes using a well validated competency measure (CCAT).

The development of CAT has involved many small scale research studies into the process and effects of the approach. Its popularity and associated rapid uptake has meant that training has been prioritised over research production. No central academic base was formed and this made large-scale efficacy studies initially difficult to complete. Recently, RCTs testing efficacy (particularly with personality disordered patients) have been completed and deconstruction trials are also underway. An analysis is provided of the existing CAT outcomes studies and presented as a forest plot. This analysis suggests that there is evidence of the effectiveness of CAT under routine clinical practice and clinical trial conditions across a diverse range of presenting difficulties. The future direction of research into CAT is discussed.

CAT as an established psychotherapy modality is starting to take its place at the table of extant psychological therapies being recommended for provision in NHS settings - with recent inclusion in the IAPT-SMI personality disorder competency framework and NICE guidelines. Because of its core relational understanding, CAT has also been increasingly applied to team contexts/systems enabling a 'common language' for team formulation.

CAT offers what Peter Tyrer has recently called a 'humanised skilled psychotherapy.' CAT therapists are often able to quickly formulate and treat complex, 'hard to help' patients but this skill requires a relatively high level of training and continued supervision to practice effectively. The future challenge is to advance the evidence base whilst making CAT therapy and trainings even more accessible to patients, therapists and teams. This needs to be achieved without compromising CAT's commitment to quality, via on-going supervision and development of its therapists.

Introduction

It is thirty years since Anthony Ryle gave the name Cognitive Analytic Therapy (CAT) to the integrative and relational psychotherapy approach he had been developing since the 1960s. Since then, CAT has continued to grow in the UK and in a dozen or so countries overseas, most notably Finland, Ireland, Spain, Italy, Australia and Greece. An Indian CAT Association has recently been established in Bangalore. To celebrate CAT's 30th birthday, it seemed timely to present an overview of the therapy for this journal and its readers. It was difficult to decide what to include or discard in a relatively short paper, but we decided

to try to give a sense of the history, development and unique features of the CAT approach, a review of the current state of the evidence base and a view on CAT's current position amongst the range of psychological therapies available to patients in the UK. It is hoped that by focussing on these three areas, the reader will gain something of a 'gut feel' for CAT from the perspective of a CAT therapist (and how CAT might be experienced by a patient), as well as knowledge of the research base and the various clinical applications.

The authors include the originator of CAT therapy, Dr. Anthony Ryle. Because of this, we have chosen to write this paper in sections attributed to different co-authors so that the first person voice of Tony can be heard in the first section on the development of the model, as he gives a personal account of CAT's development and its theoretical and ethical roots.

Features and sources of CAT

Anthony Ryle

The main features defining CAT are summarised in Box 1.They emerged over time, many of them preceding any plan to develop a psychotherapy model. Their sources are summarised in Box 2. In the text, the sources are described in the approximate order in which they emerged; ideas and practices which endured as part of CAT are indicated by italics.

Early origins

I proposed CAT as a formal psychotherapy model in the mid-1980s. I had developed the defining features of practice and the core theoretical principles,

over the preceding three decades, during which I had worked largely on my own in general practice and in a University Health Service. I had not completed a formal training in psychiatry or psychotherapy and had therefore experienced neither the support nor the constraints of established theories, therapies or institutions. While many others have contributed new ideas and have pioneered new applications in the past 25 years, the core features of the model can be understood as being derived from both my personal and social attitudes and from my clinical and research experience.

Therapeutic technique

CAT therapists make use of techniques which are shared with, and often derived from, other therapy models, in particular, behavioural and cognitive models. The specific technical aspects of CAT are concerned with establishing a collaborative and mutually respecting working relationship with patients and with the descriptive reformulation of their problems, on the basis of which past and present problems, the impact of the therapy relationship and of specific therapeutic procedures will be understood. In essence, therapeutic 'technique' involves the continuing application of CAT theory.

Influence of general practice

The diagnosis of general practice patients consulting with physical and psychological symptoms involves careful listening and this (and my curiosity) encouraged many patients to discuss emotional problems in ways which they found helpful. As my interest in psychological issues evolved, I responded more actively and my practice came to embody the common features described in ‘Persuasion and Healing’ by Jerome Frank (1975), and I was influenced by

behavioural and the emerging cognitive models. But, I felt that treating many of the ‘problems in living’ which my patients brought to my door required more complex theories. The appeal of psychoanalysis lay in its claim to understand these broader existential issues, but it had many practical and theoretical inadequacies.

Developing NHS relevant practice

Epidemiological studies of general practice populations, including my own, demonstrated a high prevalence of largely untreated psychological problems. I was deeply committed to the egalitarian principles embodied in the NHS and realised that a practicable psychotherapy approach would have to be time-limited. In my attempt to make sense of psychoanalytic ideas I re-stated them in cognitive terms and eliminated assertions about unconscious processes. Having attempted to develop a common language with which to describe how therapists of different schools worked, I came to believe that integration at the level of theory was needed. Such a theory should be compatible with work outside the psychotherapy world, notably in developmental and social psychology.

Supervision

In practice I sought occasional supervision, but avoided formal training. At Sussex University, I received supervision of my clinical work from a psychoanalyst and whilst I remained very dubious about the theory, I was helped by the understanding of the feelings between therapists and their patients (transference and counter-transference). I was also encouraged to take more account of the object relations theorists' focus on the internalisation of

early infant-caretaker interactions, even though psychoanalysts showed little interest in observational studies and obscured the field by contrasting and rival assertions about unconscious, innate factors.

Developing a theory

My theoretical development was fuelled by two lines of research, one focusing on why the negative outcomes of dysfunctional thoughts and actions do not lead to their useful revision, the other using repertory grid techniques to investigate relationships and self processes.

Outcome research – the focus on non-revision

In outcome research, I focused on trying to understand why people continued to think and act in ways that produced unwanted outcomes. A study of the case notes of completed therapies showed that non-revision of problem processes was categorised as involving three general patterns:

1. *Traps*, where underlying negative assumptions are reinforced by outcomes.
2. *Dilemmas*, where possible modes are restricted to polarised alternatives.
3. *Snags*, where desired outcomes are avoided because they provoke, or are felt to provoke, forbidden or dangerous outcomes.

Impact of research on practice

Therapists worked with patients to create descriptive reformulations of the presenting problems in these terms. These were recorded in writing and diagrams, collaboratively constructed with the patient's participation. CAT aims to recognise and challenge the restrictions and distortions imposed by persistent dysfunctional intra and interpersonal patterns. The *psychotherapy*

file, which explains symptom monitoring, describes traps, snags and dilemmas and labels problematic states, helped patients to identify which descriptions particularly applied to them. These patterns became the focus of patient self-monitoring and supported therapists' recognition and non-collusion with their manifestations in the therapy.

I later recognised that the processes accounting for the non-revision of dysfunctional processes were similar to those accounting for the stability of normal processes. This contributed to the first general theory: *The Procedural Sequence Model (PSM)*, discussed below.

Research using repertory grid techniques

People can describe their individual thoughts and acts, but not the repeated patterns of memory, assumptions, activity and avoidance characteristic of their relationships with others and their sense and management of their selves. In completing repertory grids, subjects rate how far individual elements (objects, experiences, actions, people, relationships and so on) are described by a list of relevant constructs. Statistical analysis of the ratings can demonstrate the underlying patterns of judgement. This work suggested an alternative account of the phenomena described in object relations theories, without involving the acceptance of psychoanalytic beliefs. Parallels between self-parent relationships and self- management patterns empirically supported the formative role of early experience. Dyad grids, where self to other and other to self were rated, suggested that relationships rather than individuals were internalised and illustrated the concept of the *reciprocal role*.

The Procedural Sequence Model (PSM)

Psychotherapy models need to understand the nature of stability and change. Behavioural models of reinforcement and cognitive models of belief-behaviour links are incomplete and frequently cannot account for the success or failure of attempts to change human behaviour. The PSM model of aim-directed action, summarised in Box 3., offers a more adequate indication of how change may be achieved or resisted. Descriptions of a procedural sequence describe the aim, context, memory, enactment, outcome and the confirmation or revision of the aim and sequence. In human relationships, the aim of each is to find or elicit the reciprocating response of the other. For example, someone with dependent needs will seek a care-giving other or a domineering person will find a submissive other. Everyone will acquire an individual repertoire of *reciprocal role procedures (RRPs)* which determines and restricts how they interact with others.

Origins of the self

A person's repertoire is derived from the interaction between the infant's genetically determined temperament and the attitudes/actions of caretakers and siblings. As well as shaping relationships with others, they are internalised as patterns of self care, management and judgement and may be manifest in internal dialogue. Clinical management and psychotherapy are supported by the reformulation of the presenting problems in the *reformulation letter*, based on this understanding of how the individual is socially formed and sustained. For the patient, the reformulation offers a non-judgemental basis for self reflection and for the therapist, it allows the patient's expectations and pressures to be recognised - and not colluded with.

Symptoms

Symptoms and symptom complexes such as eating disorder or OCD originate in the need to replace or avoid forbidden or feared reactions to unmanageable experiences. The role of many symptoms is illustrated by a story - I think a Buddhist one - of a drowning man who was saved when a raft drifted by. In recognition of his gratitude he strapped the raft to his back and carried it for the rest of his life. Many symptoms can be relieved by the recognition and modification of the avoided procedure.

Structural dissociation; The Multiple Self States Model (MSSM).

The model was further elaborated in order to make sense of abrupt switches occurring between contrasting self states (identified by their dominant RRPs) in ways not resulting from obvious external events. The reformulation of such people, who have usually experienced unmanageable levels of abuse, abandonment and neglect, requires identifying two or more separate systems. Fig.1. (need this) is such a diagram, describing structural dissociation between states characterised by idealisation and angry rejection. Structural dissociation is often unrecognised as patients (and clinical services) may avoid confusing state switches by establishing defensive RRPs involving avoidance, compliance and emotional blankness, commonly associated with somatic and depressive symptoms.

Fig. 1. here please

These understandings were summarised in the *Multiple Self States Model (MSSM) of borderline personality disorder* (Ryle 1997). Structural dissociation can be reliably identified in a few minutes by the patient's completion of the 8-item *Personal Structure Questionnaire* (PSQ) (Pollock 2001, Ryle 2007, Bedford 2009). Scores on this range from 8 to 40. Community samples had mean scores around 20, patients referred for psychological treatment had mean scores in the mid 20s and patients diagnosed with personality disorders score over 30. Intended as a screening device, the PSQ has surprisingly good psychometric qualities and is sensitive to therapeutic change. Where scores are high, the characteristics of the dissociated self states need to be identified by detailed questioning and observation or through the use of the *State Description Procedure* (Bennett 2005). This enables therapists to avoid colluding with negative states, discuss alternative modes and support integration.

Summary of the course of treatment

CAT Therapy is delivered in 16-24 sessions, plus one or more follow-ups. The first two stages described below may be a basis for group or community treatment.

Stage 1: Assess suitability. Exclude active psychosis and gross substance abuse. Outline nature and duration of treatment.

Stage 2: Sessions 1-4. Reformulation on the basis of history taking, the evolving therapy relationship, use of the Psychotherapy File and the Personality Structure Questionnaire. Joint creation of narrative reformulation letter and Sequential Diagrammatic Reformulation. Agree aims.

Stage 3: Session 5 onwards. Use diaries and self- monitoring to recognise identified problem procedures. Work on the basis of the reformulation to understand developments in therapeutic relationship and assimilate memories and feelings accessed as a result of the work. Use appropriate techniques taking account of the reformulation. Maintain awareness of termination date.
Stage 4: Consider implications of ending and record these in goodbye letters. Arrange follow-up(s).

The stages of individual CAT therapy are summarised in Box 4.

Key skills for a CAT therapist

These are summarised in Box. 5.

Concluding thoughts

The main sources of my early formation of the CAT model were my observing, describing and recording a wide range of common non-psychotic psychological disorders. In this I was guided by the curiosity and egalitarian political attitudes which influenced how I related to my general practice patients.

Theory-free description was extended by the use of repertory grid techniques and the development of a general model depended on a critical incorporation of aspects of existing behavioural approaches and by an increasingly irritated failure to provoke thoughtful responses from psychoanalysts. In Ryle (1982: p. 4) I wrote: *'Psychoanalysis makes an attempt that is proper in range and ambition, but it has become trapped by theoretical confusion and restricted in its method by institutional pressures. Cognitive and behavioural*

approaches, on the other hand, offer effective therapies over a limited range on the basis of theories that attend to only segments of human experience.'

The later development of CAT, supported by increasingly numerous and sophisticated colleagues, has involved the incorporation of the findings of observational studies of early development and by an increasing clinical and research basis.

The CAT Evidence Base

Stephen Kellett and Rachel Calvert

Introduction

When CAT was conceived as a modality, it was explicitly designed in order that it was researchable. The subsequent evolution of CAT research has proven this point to be true, with an evidence base that straddles both the utilization of practice-based methodologies examining clinical effectiveness conducted in routine practice and evidence-based practice controlled clinical efficacy trials (Barkham 2003, Barkham 2010). The popularity of CAT in routine practice has meant that the evidence-base for treatment features a greater proportion of practice-based studies. The aim of this section is to demonstrate the breadth of outcome research conducted regarding both the efficacy and effectiveness of CAT and to make a quantitative assessment of the effect size of CAT intervention, via a forest plot analysis. A forest plot is a graphical display which summaries and illustrates the relative strength of CAT treatment effects across the multiple outcome studies conducted.

Search terms and inclusion/exclusion criteria

An electronic literature search of PsycInfo, Medline, CINAHL and the Cochrane library was conducted (using the search term “cognitive analytic*”) that identified 253 papers published between 1960 and 2013. Studies were selected based on the following criteria: (1) individual or group CAT delivered, (2) use of psychometrically sound outcome measures, (3) at least pre-post outcome scores available, (4) written in English, (5) accepted for publication in a peer-reviewed journal and (6) independent datasets reported. Accordingly, the following papers were excluded; 9 non-English language papers, 4 unpublished theses, 93 books/book reviews, 5 Cochrane protocols, 30 papers did not cite CAT and 89 CAT papers reported insufficient psychometric outcomes and/or qualitative methodologies.

A final sample of N = 26 studies was retrieved for inclusion and Table 1. contains a summary of these studies. Studies are grouped according to diagnosis and then analysed according to methodology (i.e. practice-based evidence studies conducted in routine practice versus evidence-based practice randomised controlled clinical trials; Barkham 2003, Barkham 2010). The CAT evidence base consists of 4 RCTs, in additional to 22 studies of effectiveness conducted in routine clinical practice using a variety of outcome methodologies. Table 1. demonstrates that the majority of published CAT outcome studies (42.30%) have been completed with patients with more severe difficulties (e.g. Personality Disorder).

Insert Table 1. here please

Calculating outcomes across CAT studies

Outcome data from each study was converted to a common metric, namely, Cohen's *d*. To be included in calculations of an overall uncontrolled effect size, studies were required to have (1) used psychometrically sound outcome measures at least pre/post-CAT and (2) reported mean and SDs of outcomes at pre and post-CAT and associated sample sizes. Twelve CAT outcome studies met these inclusion criteria. Uncontrolled effect sizes were calculated by dividing the mean change score achieved pre/post-CAT by the mean pre-CAT standard deviation and then sample sizes determined each study's percentage contribution to the overall effect size (Barkham 2005, Westbrook 2005). For studies reporting multiple outcomes, the analysis utilised the Brief Symptom Inventory (BSI) (Derogatis 1993) or Symptom Checklist 90 Revised (SCL-90-R) (Derogatis 1976) as a common outcome metric. If a measure of global functioning was not reported, the authors selected the most widely used and validated measure.

The effectiveness of CAT

The effect sizes for the 12 CAT outcome studies ranged between 0.19 and 1.11 and had a standard deviation of 0.26. Figure 1 contains the forest plot of the outcome study effect sizes[1] and figure 2 an associated funnel plot. In the forest plot the left-hand column lists the authors of CAT outcome studies in chronological order. The right-hand column is a plot of the measure of effect (i.e. an odds ratio) for each of the studies (this is represented by a square) incorporating confidence intervals represented by horizontal lines. The overall meta-analysed index of CAT's clinical effectiveness is represented on the forest

[1] The heterogeneity chi-squared was non-significant (F = 4.24, df =11, p = 0.962), indicating that the CAT outcome studies were homogeneous. I^2 (variation in effect size attributable to heterogeneity) = 0.00% and the test of effect size = 0, z = 9.70, p = 0.000.

plot as a dashed vertical line. This meta-analysed measure of CAT's clinical effectiveness is also plotted as a diamond in Figure 1., the lateral points of which indicate confidence intervals for this estimate. The vertical full line represents when there is no clinical effect. Should the confidence intervals for individual CAT outcome studies overlap with this vertical full line, it demonstrates that at the given level of confidence, the effect size does not differ from 'no effect' for that individual study. Whilst the confidence intervals in N=4 of the CAT studies indicate detrimental effects, all these studies had small sample sizes resulting in much broader confidence intervals (Lueger 2010). The same rule applies for the meta-analysed measure of overall effect: if the points of the diamond overlap the line of no effect, then the overall meta-analysed result cannot be said to differ from 'no effect' at the given level of confidence. The weighted mean CAT effect size was $d_+ = 0.83$ with a 95% confidence interval from 0.66 to .1.00 (k = 12, N = 324). According to Cohen's (1988) power primer, $d_+ = 0.20$ is a "small" effect, $d_+ = 0.50$ is a "medium" effect, $d_+ = 0.80$ is a "large" effect. This result indicates that CAT treatment for mental health problems has large effect on reducing psychiatric symptoms.

A funnel plot is a scatterplot of treatment effect against a measure of study size and is used as a visual aid to detecting bias or systematic heterogeneity in studies (Stern & Egger, 2001). A symmetric inverted funnel shape indicates that publication bias is unlikely, which asymmetry indicates a relationship between treatment effect and study size. Asymmetry suggests the possibility of publication bias or a systematic difference between smaller and larger studies. The area that appears somewhat under-populated in the CAT funnel plot is in the bottom right, which would correspond to the small sample ($N<10$) studies with a large effect ($d>1$). If the studies were excluded with the

biggest standard error (which corresponds to studies with N<=10) then a smaller, more coherent range of effect sizes (d = 0.65-1.1) is found. Funnel plot asymmetry in Figure 2 may suggest the possibility that some studies have been systematically excluded - possibly through publication bias, but it's implausible that CAT studies were excluded for showing too big an effect.

Insert Figure 1 and 2 here please

Discussion of the evidence base

This analysis suggests that there is evidence of the effectiveness of CAT under routine clinical practice and clinical trial conditions across a diverse range of presenting difficulties. This has been the first attempt to quantify effect sizes across studies and the further expansion of the CAT research base size will facilitate full meta-analytic procedures, both across and within diagnoses. It should be noted that the large uncontrolled effect size was achieved using a therapy that is brief and has a time-limited approach, typically in patients with complex presentations. Calvert and Kellett's (submitted) systematic review of the methodological quality of the CAT outcome studies indicated that 52% of studies were categorised as high quality and that most outcomes studies have been completed in typically 'hard to treat' clinical populations, such as personality disorders. CAT appears to be a common and effective treatment method in the face of patient complexity. That review also highlighted that the drop-out rate for CAT was low compared to other modalities. This suggests CAT is a talking treatment with high face validity and good acceptability across patient groups. Commissioners of services need to take note of evidence of effectiveness and what patient's want and can tolerate. Evidence from the CAT

single case experimental designs indicates that narrative and diagrammatic reformulations are often key change points during the therapy, often demonstrating 'sudden gain' events. The number of studies available for analysis indicates that the development of a robust CAT evidence base is a nascent endeavour, clearly needing further development and support. Large-scale pragmatic trials (Goodyer 2011) offer a methodology in harmony with Ryle's original research ambitions for CAT. Practice-research networks (Castonguay 2010) would also enable the rapid development of large-scale datasets, given the increasing and enduring popularity of CAT in routine clinical practice.

CAT in 2014

Jason Hepple

Humanised and skilled

CAT is a 'humanised and skilled psychotherapy' (Tyrer 2013) and contains some key features that demarcate it from the majority of psychological therapies available in the NHS today. As CAT is not manualised, but rather based on consistent and compassionate delivery of a set of principles (alongside the narrative and diagrammatic reformulations and goodbye letters), therapists' adherence and fidelity to the model is an important aspect of service delivery. The development of the competency assessment tool - the C-CAT (Bennett 2004) facilitates competency assessment during clinical trails, training and supervision, via analysis of recorded clinical sessions. The ten domains of competency for CAT are: (1) phase-specific tasks (such as engagement skills in early sessions), (2) making theory-practice links, (3) CAT tools (such as

narrative reformulation), (4) boundaries, (5) common factor skills, (6) collaborative climate, (7) assimilation of warded-off or problematic states, (8) making links and hypotheses, (9) managing threats to the therapeutic alliance and (10) awareness and management of therapist's own reactions / feelings. When CAT therapists in routine practice with personality disordered patients have been competency assessed, there is evidence of consistent fidelity to the CAT model across sessions and therapists (Kellett 2013).

CAT's principle-driven approach allows the way the therapy is conducted to be closely attuned and melded to the emotional and relational needs of the patient and the unique encounter that takes place in the therapy relationship. This may be why CAT has gained a clinical reputation for engaging with patients who do not naturally take to the psycho-educational and solution-focused approaches shown to help many patients with less severe mental health difficulties.

CAT, providing a relational and dialogic model of self and development does not easily mesh with a system of rigid diagnostic categories based on symptom clusters. This has been a problem for CAT as the NICE guidance for psychological therapies has been based on these categories, although CAT has succeeded in being acknowledged in the guidance for BPD and Eating Disorders. CAT understanding is closer to the 'post-psychiatry' understanding of Bracken (2005), where the categories of the person seeking help are as important as those of the person or system delivering the help. It is not that CAT is overlooking of symptoms and diagnostic labels or dismissive of biological and genetic factors, but that CAT emphasises the meaning of these labels for the patient in context so they can be a starting point for exploration. CAT can

provide a complementary alternative to a neurobiological model of mental illness. The recent controversy around the revisions to international diagnostic systems may show that the time has come for more of a range of perspectives in psychiatry and psychological therapies.

The future of training in CAT

The ability to use CAT tools expertly and to reflect, often in real time, on the complex re-enactments taking place between client and therapist and to use all this to advantage, is a difficult skill-set to learn and takes time, supervision and a serious amount of training. This is a current challenge for CAT in the UK. CAT is being seen as a good second line approach for 'complex' patients, those with prominent unhelpful personality traits and disorders and for those with multiple diagnoses that do not fit neatly into pathways of care. CAT is now recognised as an approach for people with personality disorder in the IAPT Serious Mental Illness developments. There is demand for more training and faster training. But, how can CAT become more accessible to a range of psychological therapists, including IAPT therapists, without simplifying itself too much and throwing away, with the bath water, the baby it has taken 30 years to develop! This is a challenge that ACAT must answer by the development of more flexible, targeted and accessible trainings across the UK to supplement its regular complement of about twelve two-year practitioner trainings and the one national psychotherapy training currently available.

Conclusions

CAT offers an effective yet different approach that is practical enough to be affordable in NHS settings and remains popular with clients and therapists. It is hoped that, in the NHS, there will remain room for a psychological therapy that uses a relational and developmental paradigm as an alternative to an over-reliance on therapies and interventions based on diagnostic clusters linked to a neurobiological understandings of mental illness. CAT is a humanised and skilled psychotherapy that adapts its principles and tools to the needs, concerns and differing starting points of the patients it seeks to help. It is this flexibility that makes it effective with complex presentations and with patients who are not easy to engage with other methods.

Acknowledgements

With thanks to Dave Saxon for help with the forest plot bench-marking CAT outcome studies.

Learning Objectives

- Describe the core principles of the CAT approach
- Appreciate the evidence base for CAT
- Understand CAT's place today

MCQs

1. Outside of the UK, CAT is most well established in the following country:

- Finland (correct)
- Germany
- New Zealand
- India
- France

2. ‘Where desired outcomes are avoided because they provoke, or are felt to provoke, forbidden or dangerous outcomes’ is a CAT definition of a:

- Trap
- Dilemma
- Snag - correct
- Reciprocal role
- Self state

3. The Personal Structure Questionnaire (PSQ) is a validated measure of:

- Structural dissociation – correct
- The number of self-states exhibited by the patient
- The severity of childhood trauma reported
- The types of target problems brought by the patient
- The likelihood of therapeutic rupture during the therapy

4. The following is <u>not</u> a major influence on CAT theory and understanding:

- Social formation of the self (Lev Vygotsky)
- Personal construct theory (George Kelly)
- Observational studies of infant-caretaker interactions
- Object relations theory

- Unconscious drives and processes – correct

5. The evidence base for CAT suggests:

- CAT is ineffective in the treatment of personality disorder
- CAT should be targeted at patients with particular symptom clusters
- CAT may be effective in routine clinical practice across a range of conditions – correct
- Patients tend to drop our more frequently in CAT
- CAT outcome studies have low methodological quality

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*Denotes studies included in the overall effect size calculations

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Is there a ref missing here that is in the forest plot?

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Boxes, Figures and Tables

BOX 1. FEATURES OF CAT

- Designed for use in the public service / NHS
- Applicable to a wide range of disorders
- Delivered within a predetermined time limit
- Involves early joint descriptive reformulation of patients' problems in terms of underlying processes
- Extends patients' capacity for self-reflection and control

BOX 2. SOURCES OF CAT

- Derived from clinical work and research in general practice
- Contains the common therapeutic features identified in ‘Persuasion and Healing’ (Frank 1975)
- Influenced by studying the non-revision of dysfunctional behaviours and by repertory grid research
- Developed a model of self and relationships influenced by object relations theories, by Vygotsky's (1978) description of the social formation of individual self processes and by observational studies of early infant-caretaker interactions

BOX 3. THE PROCEDURAL SEQUENCE MODEL OF AIM-DIRECTED ACTION

- Describe the context and aim
- Consider capacity to pursue aim and consequences of doing so
- Consider possible action plans
- Enact selected plan
- Review effectiveness of the plan
- Review consequences of the enactment
- Confirm or revise the aim and the underlying assumptions

BOX 4. STAGES OF CAT IN INDIVIDUAL THERAPY

- Assessment of suitability
- Agree duration and note session number each time
- Write descriptive reformulation of patient's problems in terms of underlying procedures
- Relate specific treatment procedures and developments in the therapy relationship to the reformulation
- Especially in last sessions, explore implications of ending in terms of reformulation
- Exchange goodbye letters and arrange follow-up

Box 5. KEY SKILLS FOR A CAT THERAPIST

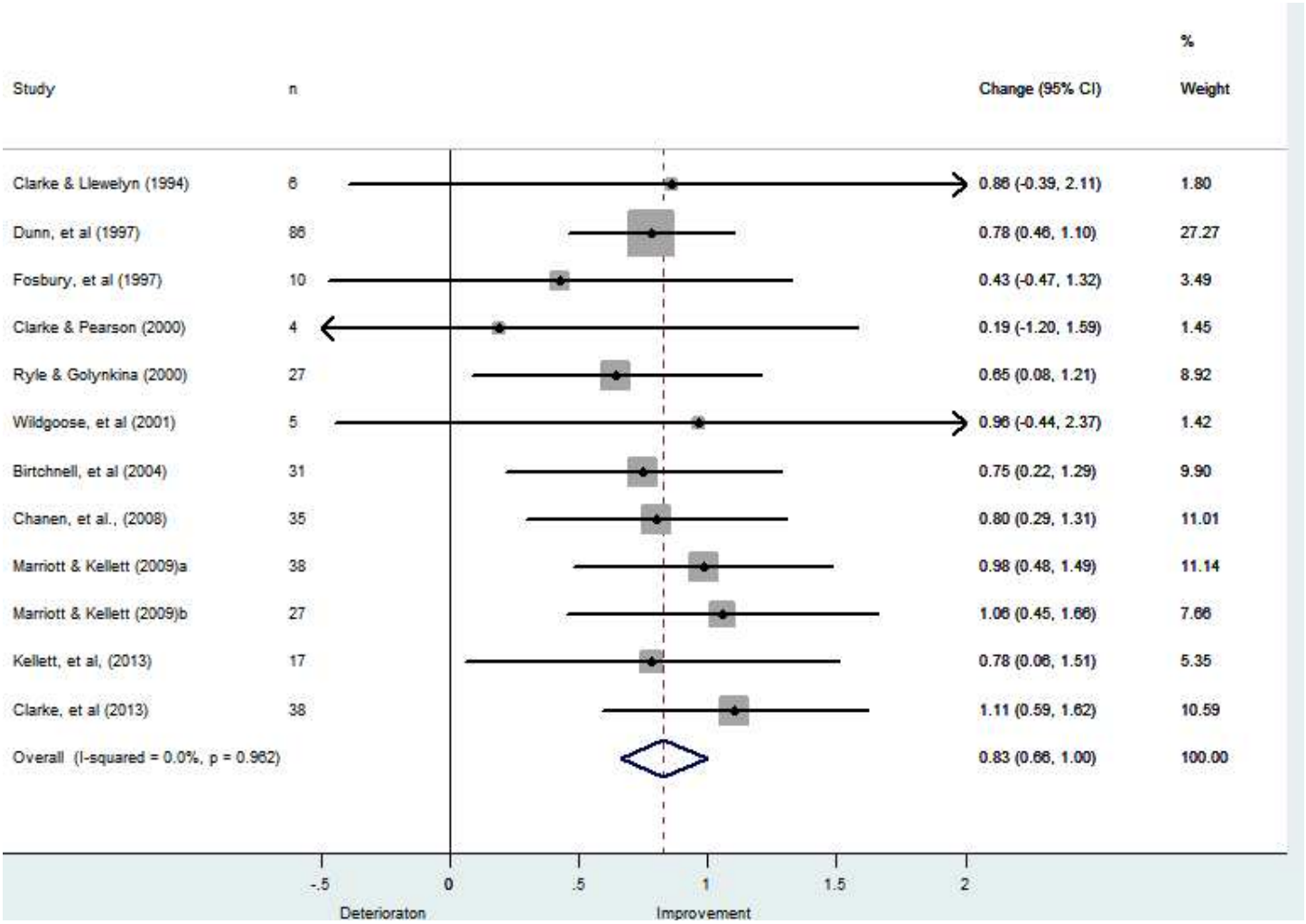
- Understand individual personality and problems in relation to the social relationships which formed and maintain them, including those in the treatment context.
- Work with patients on the reformulation of their problems. Use and discuss the Psychotherapy File and the Personality Structure Questionnaire.
- Consider the impact of biological/genetic influences, of medical treatments and of specific psychotherapy techniques in relation to the patient's social context and the nature and integration of the individual's repertoire of RRPs.

Table 1; disorder, outcome studies and methodologies in the CAT outcome evidence base

Disorder/Diagnosis	*Studies*	*Evidence-based practice (RCTs)**	*Practice-based evidence (PBE)*
Personality Disorder	Chanen et al (2008)* Chanen et al (2009) Clarke et al (2013)* Duignan & Mitzman (1994) Kellett (2007) Kellett et al (2013) Kellett & Hardy (in press) Mace et al (2006) Ryle & Beard (1993) Ryle & Golynkina (2000) Wildgoose et al (2001)	2	9
Anxiety/Depression	Bennett (1994) Birtchnell et al (2004) Brockman et al (1987)	0	6

	Dunn et al (1997) Hamill & Mahoney (2011) Marriott & Kellett (2009)		
Eating Disorder	Dare et al (2001)* Treasure et al (1995)*	2	0
Survivors of sexual abuse	Clarke & Llewelyn (1994) Clarke & Pearson (2000)	0	2
Dissociative Disorders	Graham & Thavasothy (1995) Kellett (2005)	0	2
Morbid Jealousy (obsessive sub-type)	Kellett & Totterdell (2013)	0	1
Long-term physical health conditions	Forsbury et al (1997)* Yeates et al (2008)	1	1

Figure 1; forest plot demonstrating uncontrolled effect sizes for CAT outcome studies[2]



[2] *ES=Effect size and 95% confidence interval; % weight=sample size determines the weighting of each study towards the overall effect size*

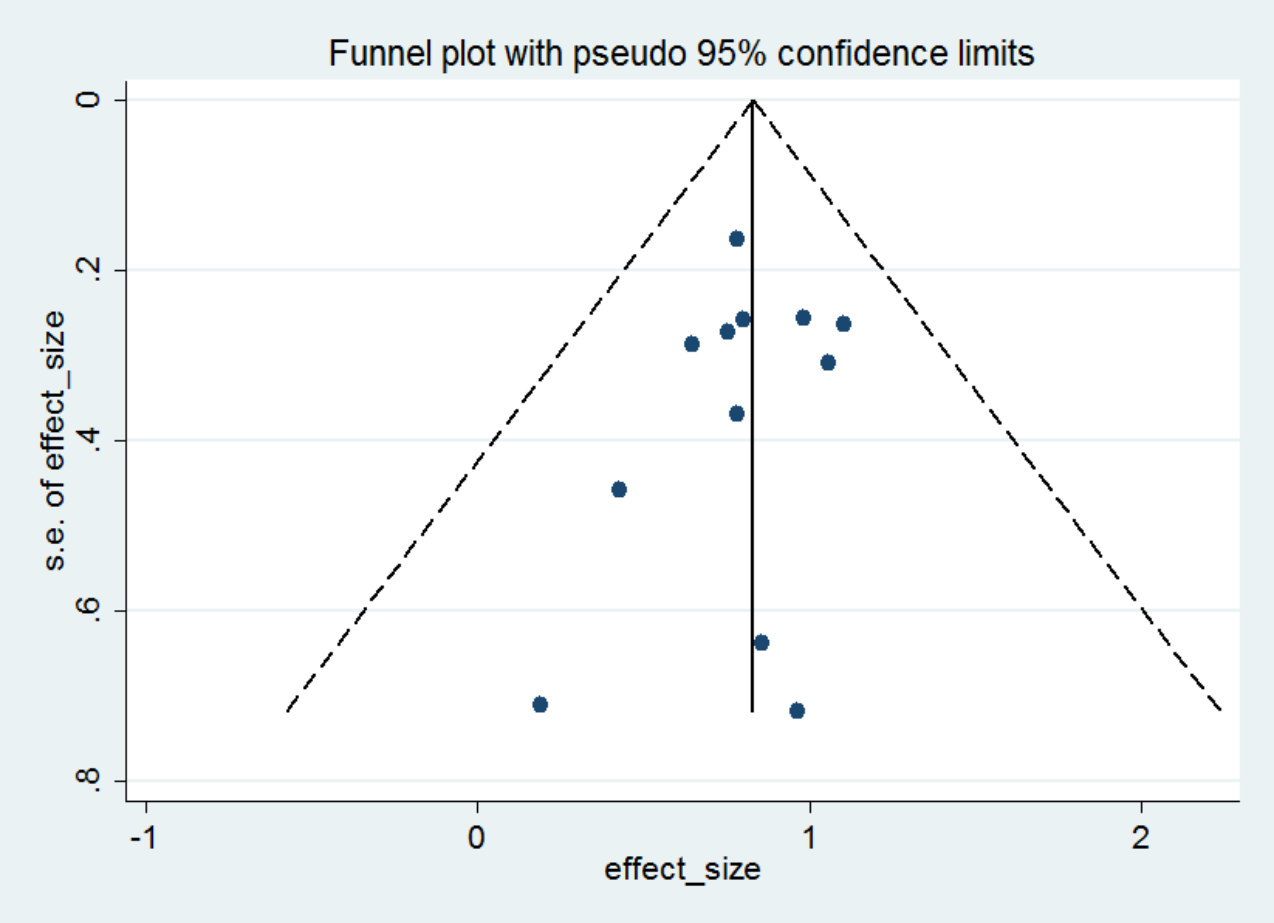



Figure 2; funnel plot of the CAT evidence