Handbook of counselling and psychotherapy. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4

Part 5, p. 317 – 322

Theory and Approaches: Eclectic-integrative approaches

COGNITIVE ANALYTIC THERAPY

JAMES LOW

Brief history

Cognitive Analytic Therapy (widely known as CAT) was developed by Anthony Ryle in the 1980s while he was Consultant Psychotherapist at the United Medical and Dental Schools of Guy's and St Thomas' Hospitals in London. This approach developed out of various strands of Ryle's research interests and clinical experience: (a) Kelly's Personal Construct approach and in particular the Repertory Grid depiction of the predictability of interpersonal interaction; (b) Alexander's and French's focus on active intervention on specific psychodynamic issues; (c) the diagrammatic description of the psychological process developed by Mardi Horowitz in his ground-breaking attempt to map different 'states of mind' and the procedures effecting shifts between them; and (d) the identification of several types of commonly repeated interpersonal procedures which were then presented to patients for personal customization and rating of applicability. These and several other features (Ryle, 1990) have been incorporated into the CAT integration of cognitive-behavioural and object-relations thinking and practice.

The model is now widely practised in the UK and increasingly in Europe. A key principle in the development of this approach has been the wish to offer a time-limited and effective intervention which allows public sector health care services to offer at least minimum sufficient help to many people. New developments in the model are making it particularly useful for helping patients with borderline and other personality disorders (Ryle, 1997).

Basic assumptions

A collaborative approach grounded in a contractually defined working alliance helps to mobilize the patients' competencies and potential in the areas of thinking, feeling and acting.

Psychological problems are not entities but are manifestations of *procedures,* both intra-psychic and interpersonal. Procedures are patterns of relating which are regular in form, logical in each step (though the total sequence is often highly destructive of self and other), and usually invisible to the person until they are accurately described. These procedures can be identified and contextualized in terms of origins and on-going maintenance. The CAT *reformulation* seeks to empower the patient to a re-vision of their identity, their resources, and their possibilities.

The therapist needs to be continuously watchful to avoid (a) confirming and colluding with the patient's procedures, and (b) enacting their own procedures.

By helping patients to define a clear focus for therapeutic work that can be discussed in terms of resolution, the therapist models for the patient how to identify and work on discrete problems. A brief therapy cannot deal with all the patient's problems but by supporting the development of skills in observation, analysis, reflection, prediction, impulse recognition and control, evaluation and self-feedback, the patient is educated and empowered to continue problem-solving for themselves.

The patient's ability to revise their procedural patterns of thinking, feeling and acting is limited by fixed attributions of meaning. The therapist endeavours to engage the patient in the joint creation of conceptual tools which can then be internalized. This helps to relativize the prior fixed attributions and empowers the patient to use new ways of behaving as a support for developing and maintaining new forms of meaning and value. This strengthens the ability to perceive options and to mobilize resources towards effective choice-making.

Patients and therapists bring great stores of experience, lifeskills, and creative potential to the therapy. The clearly defined structure of the time-limited (usually 16 sessions) 'package' acts as a scaffolding around which the energy of the collaborative pair can be mobilized. The focus of the CAT is on removing the blocks that the therapist and patient identify as leading to suffering. This model encourages a pragmatic approach to removing these blocks and to identifying *exits* but has no overarching view of how the patient should live once these blocks are removed.

Origins and maintenance of problems

Problems arise from the development of fixed interpersonal positionings in response to the particularities of the early environment. These positionings are interactive and are known as reciprocal roles. Thus an infant growing up in a family where the imposition of parental control is a major feature of the interactive mood is likely to start processing a lot of what is going on, both interpersonally and intra-psychically, through the reciprocal roles of controlling-controlled. Both positions are available to the person though a common pattern would be to seek another to occupy the controlling position so that one can maintain the familiar controlled position oneself.

The reciprocal role is also enacted on oneself by, for example, carrying on an internal critically controlling conversation so that one inducts oneself into the reciprocal position of hopelessly criticized and controlled. This internalization of early experience is the key contribution of object relations thinking to the model. Each individual's on-going behaviour of eliciting specific reciprocating roles from the other becomes a means of understanding both the power of the structure's self-maintenance and the clinical phenomena of transference and counter-transference. Positionings which were useful for survival in childhood frequently remain unrevised in adult life even when they are of little help in managing changed environments and new social roles.

Extracted from *The Sage Handbook of counselling and psychotherapy*. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4

Early experiences of invasion and abandonment give rise to patterns of conflict and deficit maintained through the reciprocal roles (R-R). When the child is responding to an environment whose overpowering intensity endures for a long period of time, the range of possible responses is experientially reduced. This leads to a felt enclosure within one R-R formation so that other options become invisible. Thus repeated abuse can result in a person feeling hurt, lost, anxious, mistrustful - and thereby unable to shift to a different mode of relating. In extreme cases the person can develop a limited repertoire of R-R, each of which operates as a quasi-autonomous self-state separated by dissociation leading to a very fragmented experience of being-in-the-world (Ryle, 1997).

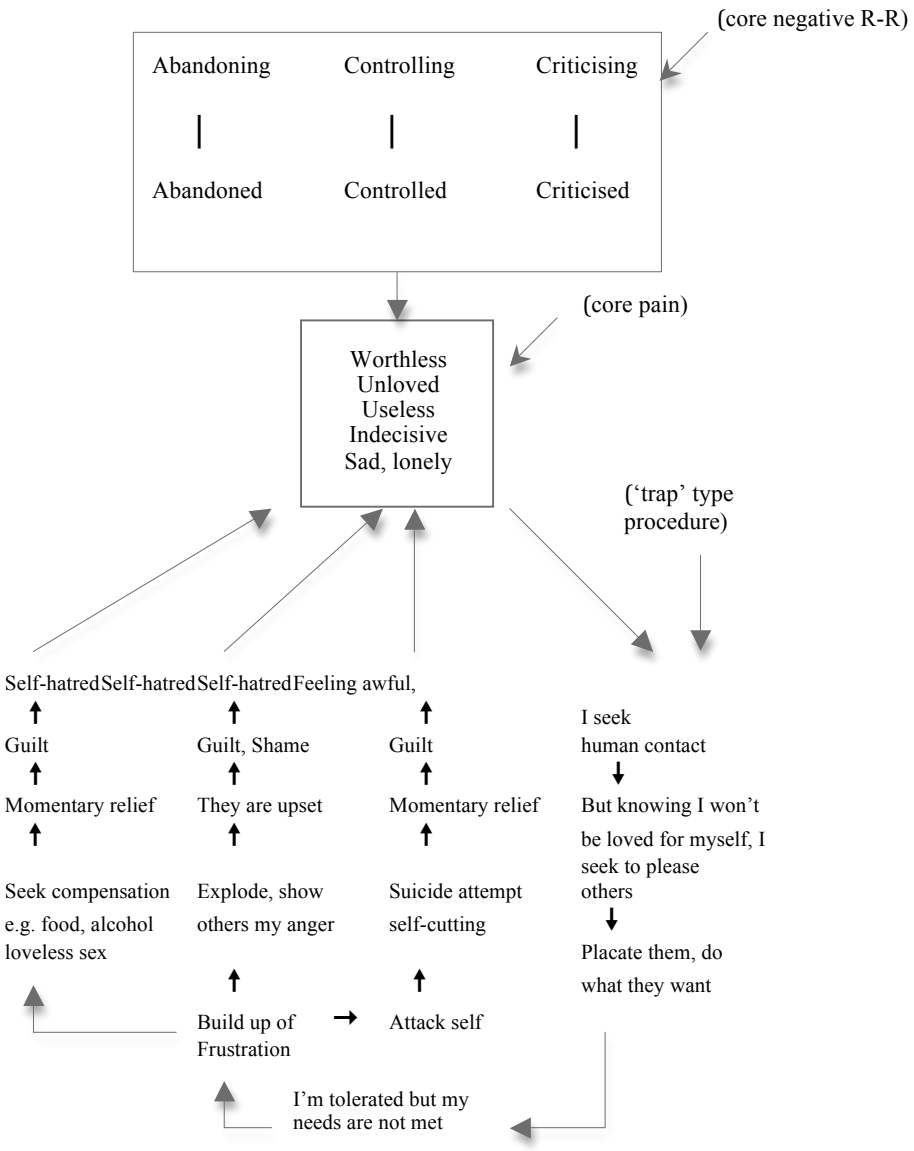
The problematic R-Rs feed into a sense of *core pain* which is the chronically endured affect-ridden sense of badness, hopelessness, worthlessness, etc. Although the child was being subjected to unnecessary and/or unhelpful experiences where they were not the causal agent, he or she will often ascribe a moral agency to their own position, feeling that it is their fault that they were hit, abused, abandoned, etc. This is often encouraged by the adult environments. Interpersonal procedures are largely responses to the environment, developed as attempts to manage the intolerability of the core pain.

The R-R structures are supported by procedures which arise from and return to them via the core pain creating a force of maintenance generated through an interplay of thinking, feeling and acting. This is described in the Procedural Sequence Object Relations Model (Ryle, 1990). This understanding is used to work with the patient towards a reformulation of their history and experience in order to help the patient avoid painful repetition. Procedures are organized in three categories though the same material can be arranged in any of these forms depending on the ease of comprehension by the patient. *Traps* are circular procedures arising from a core negative belief - no matter what is done to escape that belief it is always the final point of the procedure. *Dilemmas* are falsely dichotomous constructs of interpersonal behaviour which narrow the perceived choices to the stalemate of 'I'm damned if I do, I'm damned if I don't.' *Snags* arise where an implicit commitment or prohibition impedes an explicit goal which one mobilizes to satisfy. Thus I may long for intimacy and work hard to develop a relationship but just when security and depth of engagement become possible I sabotage or snag this effort due to the force of a parallel but consciously quite separate belief that intimacy will rob me of my sense of self and so I find a reason to withdraw.

Figure 5.24.1 shows how the causal patterns are embedded in the maintenance procedures. The terms used here are rather abstract; with an actual patient their own words would be used as much as possible to integrate the mobilizing energy of affect with the clarity of recognition promoting description. The procedure demonstrated here is a trap.

Extracted from *The Sage Handbook of counselling and psychotherapy*. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4

Figure 5.24.1: ***Example of sequential diagrammatic reformulation***.



Change

The vehicle of change is the therapist's ability to establish and maintain a warm and empathic working alliance with the patient. The model supports the therapist's confidence that even the most disturbed and disadvantaged patient is able to achieve significant change for the better. It also supports the therapist in their focused attention on not confirming the patient's habitual R-R and procedures.

The collaborative style of the therapy provides the patient with on-going feedback on *how* they continue or change their patterns of thinking, feeling and acting. The key stages of the therapy are description, recognition and revision.

Extracted from *The Sage Handbook of counselling and psychotherapy*. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4

Change occurs when the patient is able to step back from their familiar perceptions and observe new options which can be evaluated before a decision is made. This approach clearly demands that the patient is willing and able to engage in the tasks of stepping back, observing, reflecting, deciding, communicating, acting, reviewing. The therapist helps the patient do this by being fully present and useful on the creative edge of the patient's 'zone of proximinal development'. This is the area for development created by the interface of the patient's potential and desire and the therapist's presence and ability to respond in the service of the other (Ryle 1990).

The therapist helps patients to develop the new tools they need in order to think, feel and act differently. The poor parenting and environmental invasion and abandonment that are seen as strongly influencing the development of problems in adult life also cause gaps in knowledge as to how the world operates. The therapist through the *reformulation letter* highlights not only how the problems have occurred but what needs to be learned and explored in order for new and happier experiences to occur.

The therapist is not attempting to provide a regressive experience. The therapist is not the good mother providing a warm breast of generous and understanding nourishment. Rather CAT is a 'post-rusk' therapy where patients are encouraged to work on their own tasks in and with the presence and help of the therapist. This style of 'doing with' as opposed to 'being with' or 'doing for' is vital in a brief therapy and works from the beginning to increase the patient's sense of self-esteem and self-efficacy. The therapist is active and interventionist - but this is directed towards the task jointly decided on as the focus of therapy. This active collaboration comes under attack when the patient or therapist loses focus and reverts to habitual patterns of expectation and response. This is why a clearly agreed jointly formulated description of the core positions (R-R) and their supporting procedures is so vital to success in this form of therapy.

Skills and strategies

The therapist's key skills are empathic attunement, task focus, attention to the impact of their own and the patient's procedures on the task, and the ability to work effectively with the patient's zone of proximal development.

These skills are employed within the specific framework of a CAT as it progresses through the stages of description, recognition and revision.

Description is the early focus of the therapy during the reformulation phase (usually sessions one to four). The therapist explores the patient's life history in relation to the problems that have brought them for treatment. The patient is encouraged to fill in the *psychotherapy file* (a self-selection list of common procedures), to write an account of their own life, and to keep a specially designed diary to identify the factors which intensify or alleviate the problems.

The therapist helps the patient to identify a clear focus for the therapy. Usually this is in the form of a deeper understanding of the presenting problem. For example a person who presents with depression and social isolation may, through discussion of their desire and how it gets blocked, find the following to be a useful targeted problem to focus on: 'I don't know how to get close to others.'

Extracted from *The Sage Handbook of counselling and psychotherapy*. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4

This formulation of the issue has the advantage of highlighting the learning aspect of the solution and opens the way for the therapeutic relationship to be a laboratory for experimentation and focused learning.

The therapist writes the patient a reformulation letter which shows the historical development of the problematic procedures. The patient is able to really check out whether the therapist has heard and understood them. They can correct details and this empowerment of their position is often a key factor in stabilizing the working alliance. Experiencing reformulation as an empowering joint activity is very important, for the retelling of the patient's life-story helps to loosen the attachment the patient often has to an absolute sense of how things were and especially to how bad they seem. This prose reformulation is then distilled into a sequential diagrammatic reformulation (SDR) - a diagram of the type illustrated in Figure 9.

Once the patient is clear about the description and can see how it pertains to past and present experience the next phase is *recognition* in which the patient must struggle to use the description to make sense of what is going on. Often this starts with recognizing the pattern after the event has occurred but then, because the procedural description has already been checked against a wide range of experience, the patterns start to become clear as they are occurring and the observing self is strengthened. Building on this with discussion of events on the horizon, the patient starts to be able to predict how they might get hooked into a procedural response. Once this perception is established the third stage of *revision* begins whereby new options can be explored and so the closed circuit of the procedure is broken and fresh choices can be made.

With this basic CAT structure supported by the use of rating sheets for on-going joint evaluation of the therapy, and with patient and therapist exchanging review goodbye letters at the end of the sixteen sessions, there is a great focus on conscious intentionality. This allows therapists to integrate into the treatment other skills that they may have including dream analysis, use of creative arts, transpersonal exploration, and the use of gestalt contact to subvert the insistence of procedures. Thus the structure supports the therapist so that their own creativity and that of the patient can arise in the service of the contractually agreed task.

No matter what skills, strategies and techniques the therapist employs, the clarity of the agreed aim serves to support the collaborative nature of the work. CAT therapists try to be transparent in their practice and to be willing to discuss with the patient why they do the things they do. This modelling of self-reflective practice and accountability should help the patient to sustain the gains they make from therapy and continue to reflect on and be open to the richness of life's possibilities.

Research evidence

A research focus has been part of the development of CAT from the beginning (Ryle, 1990: ch. 14). Indeed the structure of each therapy involves the joint development of a hypothesis which is then investigated. This encourages the development of an observing self in the patient which supports them in forming a

Extracted from *The Sage Handbook of counselling and psychotherapy*. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4

research attitude towards themselves, leading to curiosity and a willingness to step back and evaluate how they are getting on.

Therapists also focus on single-case research as a major part of their training using tape analysis to gain a deeper and more precise sense of how their own procedures interact with those of the patients during the sessions. Investigation rather than belief forms the basis of CAT therapists' approach to their work.

Numerous descriptive studies have been published (Ryle, 1995: ch. 10), including the use of CAT with violent female offenders, cases of deliberate self-harm, and CAT groups. Reports on controlled trials have been published including a comparison of outcomes of 12-session CAT and 12-session therapy according to Mann's model, and a study of the use of CAT to improve compliance in insulin-dependent diabetics. The results are very positive, particularly in showing an increase in patients' ability to control destructive impulses.

A major randomized controlled trial on the use of CAT with patients formally diagnosed as having borderline personality disorder is now under way at Guy's Hospital.

References

Ryle, A. (1990) *Cognitive-Analytic Therapy: Active Participation in Change.* Chichester: Wiley.

Ryle, A. (ed.) (1995) *Cognitive Analytic Therapy: Developments in Theory and Practice.* Chichester: Wiley.

Ryle, A. (1997) *Cognitive Analytic Therapy and Borderline Personality Disorder. The Method and the Model.* Chichester: Wiley.

[378]

Extracted from *The Sage Handbook of counselling and psychotherapy*. 2nd ed. London: Sage Publications, 2006. ISBN 1-4129-0275-4