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### Cognitive-analytical therapy – a most suitable training for psychiatrists?

Cognitive-analytical therapy (CAT) is a time-limited, integrated psychotherapy and its features have been extensively described (Ryle, 1990, 1995). It emerged as a formal psychotherapy method in 1990 and was developed with the aim of providing psychotherapy within the NHS. As the name suggests, the model integrates a wide range of theory and practice (psychoanalytical, cognitive and behavioural) yet retains a distinct method. This paper describes potential applications of CAT to general psychiatric practice and discusses the value of formal training for psychiatrists.

#### Background

A full description of the method is beyond the scope of this article (see Ryle, 1990), but the main distinguishing features of CAT are the joint descriptive reformulation of the patient's problem and their active participation in therapy.

Therapy (normally 16 weekly sessions) begins with clarification of the patient's presenting problems and history. The psychotherapy file is introduced after the first session, a self-completion aid to help the patient understand themselves better by recognising problem patterns. It introduces the terminology of CAT and explains how to keep a diary of unwanted symptoms and behaviours. Reformulation usually occurs in the fourth session and involves the therapist writing a letter to the patient. This attempts to link the patient's history and problem patterns with the CAT formulation. The target problems (the focus for subsequent therapy) and the dysfunctional processes that maintain them are emphasised.

#### Application of CAT to psychiatric practice

The potential application of CAT in the treatment of the spectrum of psychiatric disorders is either through practical use of tools employed in standard CAT therapy or formulating patients within its theoretical framework. CAT can be therefore be delivered in an abbreviated or modified format (over only 3–8 sessions) or the model

utilised to help clinicians understand behavioural or relationship dynamics.

#### Achieving goals

Psychiatrists usually have a relationship over many years with patients with chronic mental illnesses who present with multiple problems. In contrast the standard CAT contract is only four months, even though the patient may also have major difficulties. To maximise the chance of successful therapy it is important to set realistic goals by focusing on sensible target problems. These should focus on certain aspects of the patient's life rather than a 'complete cure'. The reformulation letter names the problems that need to be overcome (e.g. 'feeling depressed' or 'losing my temper'). This clarification can be helpful for patients with challenging or demanding problems by setting limits for what therapy (or psychiatric services) can offer. On the other hand, concise and achievable goals can also reassure vulnerable patients who are easily overwhelmed.

It is also important to have agreement on the problem goals otherwise the therapy is no longer collaborative. In the context of a long-term relationship, keeping sight of broad goals is useful particularly at times of disagreement or crisis. In 'pitching' the target problem at the right level, patients can feel empowered when they effect minor changes through therapy and helps them feel more in control of their illness. Useful target problems could include 'I don't know how to cope with these voices' or 'how can I stop being admitted to hospital so frequently?' or 'what can I do about feeling so depressed?'. These problems are sufficiently specific to focus on in only relatively few sessions yet allow the introduction of other relevant factors into the discussion.

#### Using letters and diagrams

Successful CAT depends on accurate description and reformulation of the patient's problem. In psychiatric equivalents this is correct diagnosis and identification of the behavioural procedures that perpetuate the



patient's illness. The reformulation allows the patient to acknowledge and share this information. It can also help contain patient anxiety by having a permanence that can be kept and referred back to at any time; useful in patients prone to losing touch with reality.

The value of writing to patients has been highlighted (Pierides, 1999). A written personal history (that includes their own words) can have a cathartic and insightful effect, appreciated and valued by the patient. For some patients focusing on their psychiatric history (aided by the psychiatrist using old notes if necessary) can provide helpful 'facts' or 'evidence' in subsequent analysis of previous successful treatment or relapse indicators. Patients with limited insight may need to be challenged but this is more easily done if a therapeutic relationship has already been established in the reformulation process. Similarly, attention to any positive periods in the history (long periods out of hospital, good relationships, achievements or stable employment) helps both rapport and self-esteem.

Diagrams are useful to demonstrate the sequences and circularity of recurring problems (e.g. the steps leading up to self-harm or violent outbursts) and are frequently used in CAT. If the diagram fails to make sense to the patient it is important to re-examine the procedures together to ensure they are accurate. The means of changing the sequence of events depends on providing suitable alternative behaviours or thoughts (exits) and can be added to the diagram. They can be returned to at appropriate points throughout therapy and it may be helpful to include aspects of the reformulation in care programme documentation.

## Developing self-understanding

The psychotherapy file is simple to complete although it requires reasonable concentration and attention and some degree of self-reflection. Patients in acute crisis or illness may not be able to make immediate use of the file, but it can be introduced later during the recovery phase.

It can be a valuable tool in the out-patient setting with non-psychotic patients, particularly after the initial psychiatric assessment. It is most useful in neurotic disorders if patients cannot understand their feelings, see them as irrational or find them overwhelming. It also contains a section on 'unstable states of mind' that describes well some of the common symptoms of emotionally unstable personality disorder.

The patient's reaction to the file can reflect the degree of psychological mindedness. For some it can put feelings and behaviours into words which have hitherto been difficult to express, or be the trigger for further self-inquiry. The areas the patient highlights as relevant can either confirm the psychiatric formulation or throw up surprising responses, which require further clarification. In contrast, others may perceive it as personally irrelevant, to be ignored or discarded. The file can be used as a means of gentle confrontation in such cases of denial or avoidance. The nature of the patient's response

can be a guide as to whether a brief psychological intervention is worthwhile.

## Improving the doctor-patient relationship

Resentment over compulsory treatment, substance misuse, lack of insight, non-adherence with medication all commonly present a barrier to a positive therapeutic relationship. This will always remain difficult to overcome with some, but the collaborative nature of the reformulation process in CAT does offer scope in developing a joint sense of purpose with patients. It contracts their active participation and agreement, which empowers them in the treatment process.

The reformulation should include a description of those predictable patterns of interaction that may effect the therapeutic relationship. This is done by identifying those 'reciprocal role procedures' (the consequences of specific behaviour on others and what certain behaviour will elicit in others) that are relevant to the patient. CAT uses a number of such terms to describe transference and personality configurations (Ryle, 1997). The language is not complex; patients easily understand complimentary roles of abandoning/abandoned, criticising/criticised or abusing/abused. This helps anticipate possible difficulties that might present in the course of the therapeutic relationship (when such role patterns are enacted between the doctor and patient) that might sabotage the process. This can be utilised in a number of settings (particularly ward rounds and multi-disciplinary reviews) and is important for managing patients with personality difficulties who evoke strong reactions in clinicians, yet remain difficult to help. The nature of the doctor-patient relationship creates difficult dynamics for psychiatrists practising psychotherapy, who must balance patient autonomy with the statutory power to detain patients.

CAT encourages patients to take responsibility for their behaviour yet tries to offer an explanation for the collusion or alienation that operates in the therapeutic relationship; in other words providing clear boundaries while still offering the patient help. Analysis of the relationship dynamics can prove difficult and the structure of CAT encourages refocusing back onto the target problems when this occurs, as a means of diffusing intense transference. Exploration of these relationships using CAT can help better understanding of negative reactions towards patients and therefore potentially reduce the occurrence of malignant alienation (Watts & Morgan, 1994).

## CAT and psychiatric training

The Royal College guidelines for psychotherapy training as part of general professional training (Grant *et al*, 1993) makes no reference to CAT and currently few psychiatric trainees get experience in this model of therapy. Formal CAT training is long (two years for basic qualification) and involves a commitment of approximately two sessions per week. This is impractical for most psychiatrists. However, as the number of trained CAT therapists increases, so



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more opportunities for informal training and brief workshops as an introduction to CAT theory will develop. Psychiatric trainees (and consultants) could then see 1–2 patients under supervision as they do in other psychotherapy work experience. The aim would be to establish a basic competence in the therapeutic method rather than to provide complete psychotherapy training.

There are certain advantages for psychiatric trainees training in CAT compared with other models of psychotherapy – although it cannot replace a comprehensive training. It introduces many schools of psychotherapeutic theory and is useful in the understanding of a wide range of psychiatric disorders and particularly perpetuating factors that prevent successful treatment. The collaborative nature of CAT necessitates the patient to work psychologically while the therapist uses the structure (particularly reformulation and relationship) to provide support. It also focuses on treating symptomatic disorders by attending to problem procedures underlying the symptoms, rather than addressing the symptoms directly, which may often be treatment resistant. CAT encourages a shift from the medical management of illness to a shared problem-solving focus, which improves the doctor–patient relationship. CAT importantly attends to the transference and relationship issues, fundamental to the long-term management of personality difficulties and chronic mental illness. The acknowledgement and extension of the patient's responsibility is helpful training in the management of certain disorders. CAT can be adapted according to individual need and used flexibly (in as few as 4–8 sessions) in the psychiatric setting. Successful application of CAT has already been described in the management of borderline personality disorder (Ryle & Beard, 1993; Ryle, 1997), eating disorders (Denman, 1995) and deliberate self-harm (Cowmeadow, 1994).

## Comment

It is difficult to predict the future for psychotherapy and particularly the place of a relatively new model such as CAT. The research has yet to provide a robust evidence

base for its effectiveness, but it may emerge as the preferred form of psychotherapy within the NHS. It will appeal to psychiatrists who wish to develop psychotherapeutic skills yet do not have the time or deem it appropriate to practise psychotherapies in their 'pure form'. A therapy that uses an understandable language and straightforward techniques is welcomed by patients. The CAT model, by focusing on accurate formulation, maladaptive behaviours and perpetuating factors in illness, is arguably most adaptable to psychiatry. The nature of psychiatry necessitates a pragmatic approach and the utilisation of brief therapeutic interventions. Any tools that simplify and integrate this process should be welcome additions to the treatment repertoire.

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