

## Appendix 1

# CAT-RELATED RESEARCH PUBLICATIONS AND THE EVIDENCE BASE FOR CAT

## PUBLICATIONS

### Work leading up to CAT

Ryle, A. (1979) Defining goals and assessing change in brief psychotherapy: a pilot study using target ratings and the dyad grid. *British Journal of Medical Psychology*, **52**, 223–233.

Ryle, A. (1980) Some measures of goal attainment in focused integrated active psychotherapy: a study of fifteen cases. *British Journal of Psychiatry*, **137**, 475–486.

### Controlled outcome studies

Brockman, B., Poynton, A., Ryle, A. and Watson, J.P. (1987) Effectiveness of time-limited therapy carried out by trainees; a comparison of two methods. *British Journal of Psychiatry*, **151**, 602–609.

Cluley, S., Smeeton, N., Cochrane, G.M. and Cordon, Z. (submitted). The use of cognitive analytic therapy to improve adherence in asthma.

Fosbury, J.A., Bosley, C.M., Ryle, A., Sonksen, P.H. and Judd, S.L. (1997) A trial of cognitive analytic therapy in poorly controlled Type 1 patients. *Diabetes Care*, **20**, 959–964.

Treasure, J., Todd, G., Brolley, M., Tiller, J., Nehmad, A. and Denman, F. (1995) A pilot study of a randomised trial of cognitive analytic therapy for adult anorexia nervosa. *Behaviour Research and Therapy*, **33**, 363–367.

## Uncontrolled, naturalistic outcome studies with measured outcomes

- Duignan, I. and Mitzman, S. (1994) Change in patients receiving time-limited cognitive analytic group therapy. *International Journal of Short-Term Psychotherapy*, **9**, 1151–1160.
- Dunn, M., Golyunkina, K., Ryle, A. and Watson, J.P. (1997). A repeat audit of the cognitive analytic clinic at Guy's Hospital. *Psychiatric Bulletin*, **21**, 1–4.
- Garyfallos, G., Adamopolou, A., Karastergiou, A., Voikli, M., Zlatanov, D. and Tsifida, S. (1998) Evaluation of cognitive analytic therapy (CAT) outcome in Greek psychiatric outpatients. *European Journal of Psychiatry*, **12**, 167–179.
- Kerr, I.B. (2001) Brief cognitive analytic therapy for post-acute manic psychosis on a psychiatric intensive care unit. *Clinical Psychology and Psychotherapy*.
- Pollock, P.H. (2001) Clinical outcomes for adult survivors using CAT. In: P.H. Pollock, *Cognitive Analytic Therapy for Adult Survivors of Childhood Abuse*. Chichester: Wiley.
- Ryle, A. and Golyunkina, K. (2000) Effectiveness of time-limited cognitive analytic therapy of borderline personality disorder; Factors associated with outcome. *British Journal of Medical Psychology*, **73**, 169–177.

## Detailed studies of phenomenology and change

- Clarke, S. and Llewelyn, S. (1994) Personal constructs of survivors of childhood sexual abuse receiving cognitive analytic therapy. *British Journal of Medical Psychology*, **67**, 273–289.
- Clarke, S. and Pearson, C. (2000) Personal constructs of male survivors of childhood sexual abuse receiving cognitive analytic therapy. *British Journal of Medical Psychology*, **73**, 169–177.
- Golyunkina, K. and Ryle, A. (1999) The identification and characteristics of the partially dissociated states of patients with borderline personality disorder. *British Journal of Medical Psychology*, **72**, 429–445.
- Pollock, P.H. (1996) Clinical issues in the cognitive analytic therapy of sexually abused women who commit violent offences against their partners. *British Journal of Medical Psychology*, **69**, 117–127.
- Pollock, P.H., Broadbent, M., Clarke, S., Dorrian, A.J. and Ryle, A. (2001) The Personality Structure Questionnaire (PSQ); A measure of the multiple self states model of identity disturbance in cognitive analytic therapy. *Clinical Psychology and Psychotherapy*, **8**, 59–72.
- Ryle, A. and Marlowe, M.J. (1995) Cognitive analytic therapy for borderline personality disorder: theory and practice and the clinical and research uses of the self states sequential diagram. *International Journal of Short-Term Psychotherapy*, **10**, 21–34.
- Sheard, T., Evans, J., Cash, D. et al. (2000) A CAT-derived one to three session intervention for repeated deliberate self harm: a description of the model and initial experience of trainee psychiatrists in using it. *British Journal of Medical Psychology*, **73**, 179–196.
- Walsh, S., Hagan, T. and Gamsu, D. (2000) Rescuer and rescued: Applying a cognitive analytic perspective to explore the 'mis-management' of asthma. *British Journal of Medical Psychology*, **73**, 151–168.

## Process Research

Bennett, D. and Parry, G. (1997) The accuracy of reformulation in cognitive analytic therapy: a validation study. *Psychotherapy Research*, 8, 84–103.

Bennett, D., Parry, G. and Ryle, A. (1999) An ideal model for the resolution of alliance threatening transference enactments. (Submitted).

(Note: This excludes individual case studies except those illustrating a new application or methodology.)

## THE EVIDENCE BASE FOR CAT

The above list of publications attests to an emerging, although still far from adequate, evidence base for the efficacy and effectiveness of CAT in a variety of clinical settings. The relative paucity of outcome studies so far is due in large measure to the fact that CAT is still a young and developing model and that formal, controlled studies at very early stages of theoretical development are premature and inappropriate. There were no major controlled trials of cognitive-behaviour therapy, for example, 30 years ago but this does not mean that it was not a worthwhile and emerging therapy. Similarly there could have been no trial of CAT for borderline personality disorder until very recently since the borderline model was still being developed. One result of this, however, has been the rapid dissemination and adoption of CAT on the basis of its popularity and apparent effectiveness, without, as noted by Margison (2000), passing through the 'neck' of the hourglass in Salkovskis' model describing the initial development, controlled evaluation and subsequent widespread application of any treatment.

Apart from theoretical issues, there have been and are major difficulties in obtaining resources for most psychotherapy research, the reasons for which we discuss below. In the case of CAT, this affected its early development, which was brought about by a small group of busy clinicians in NHS settings without any formal academic or research infrastructure. In addition, research funding has become increasingly difficult to obtain in this and other countries owing to the hegemony of a largely pharmacological treatment paradigm in psychiatry. This difficulty has been compounded by the need for ever larger trials due to the increasing exigencies of statistical methods used to analyse them.

Given the origins and nature of CAT as an integrative, highly structured, proactive and collaborative therapy with roots in personal construct theory, cognitive therapy, and psychoanalytic therapy, it would be very surprising if its efficacy and effectiveness were significantly different from the generic 'talking treatments' from which it arose. There are additional good reasons to expect that CAT would be in principle, and in practice is, a highly effective treatment. It is well accepted that the question facing psychotherapy in general is not whether it is effective, but rather the detailed problem of 'what works for whom' and also

what aspects of what therapy work for whom (Roth and Fonagy, 1996; Parry, 2000), also described as the issue of 'prescriptive matching'. Meta-analyses of outcome studies historically, mostly but not exclusively, based on shorter and cognitively based therapies, indicate that psychotherapy generically has a treatment effect size of the order of 0.8 to 1.0 (Karasu, 1986). In terms of treatments in medicine this is a major effect size and is considerably greater, for example, than that obtained for drug treatments of conditions such as advanced cancer or arthritis, which are nonetheless routinely administered. As noted by Holmes (1993), this is also an effect size considerably greater than that obtained in, for example, trials of aspirin for the prevention of heart attacks where, on the basis of an effect size of 0.32, a trial was discontinued and treatment given to all patients on the grounds that it would be unethical to withhold it (Rosenthal, 1990).

The outcome data collected for efficacy and effectiveness of CAT as cited above is certainly consistent with such a general effect size for psychotherapy. These data include those cases reported in extended, naturalistic studies of neurotic (Dunn et al., 1997) ( $n = 135$ ) and borderline (Ryle and Golyunkina, 2000) ( $n = 27$ ) patients, as well as in an earlier comparative trial (Brockman et al., 1987) involving both CAT ( $n = 30$ ) and 'interpretive' therapy for neurotic disorders. In all of these studies significant improvements were reported in standard, as well as CAT-specific, outcome measures. It should be noted, incidentally, that the predominantly naturalistic evidence for the efficacy of CAT does support the rejection of the primary and important 'null hypothesis' in research, namely that the treatment may be doing more harm than good. This has yet to be demonstrated for some other, mostly longer-term therapies.

There are also, as noted above, even stronger reasons for anticipating *a priori* that CAT would be highly efficacious relative to the other therapies reviewed historically. Reviews of the general features of psychological treatments which are effective have stressed that they tend to be focused on achieving a therapeutic alliance and involve targeted goals, guided practice and specific feedback (Luborsky, 1990). In studies reviewed so far, they have, on the whole, also been relatively brief (usually 15–25 sessions) (Marks, 1993), although this may not apply to more disturbed patients or those with personality disorders. A recent review of features of effective treatments for difficult or personality-disordered patients (Bateman and Fonagy, 1999a) suggests that such treatments are longer term, highly structured, have a clear focus, devote effort to treatment compliance, promote a strong attachment relationship and are based on a model comprehensible to both therapist and patient. Virtually all of these are fundamental features of CAT.

## EVIDENCE-BASED PSYCHOTHERAPY

Despite this body of naturalistic evidence and preliminary controlled evidence, CAT still lacks evidence from major controlled trials. It is suggested by the

protagonists of evidence-based medicine and psychotherapy in this country and by those responsible for managed care in countries such as the USA stressing 'empirically validated' treatments, that therapies should only be purchased and administered on the basis of adequate evidence of efficacy. Clearly this is a position which most self-critical and resource-conscious psychotherapists would subscribe to. There are, however, particular problems with this position which have particular bearing on the attempt by CAT practitioners to validate their work. These relate especially to the placing of the randomised controlled trial (RCT) at the peak of the evidence-based pyramid of evidence, on the basis of which systematic reviews of treatments for given conditions would subsequently be undertaken. This pyramid does imply the existence and validity of other 'lesser' forms of evidence such as uncontrolled naturalistic studies, case-control studies as well as case reports, although these would normally be seen as much less powerful and valid forms of evidence, particularly single case studies. These would normally be considered to be the basis for further extended study or for audit and supervision in the context of accepted indications for a particular treatment. Whilst accepting the necessity and potential power of controlled studies, ultimately required in some form to exclude the possibility that no treatment, or some other treatment, may be more effective than the one being evaluated, it needs to be borne in mind that such studies are crude and imprecise in important ways (Roth and Fonagy, 1996; Parry, 2000). This is important given the importance often inappropriately ascribed to them by funding or research bodies and on the basis of which important decisions may be made.

### **LIMITATIONS OF THE CURRENT EVIDENCE-BASED PARADIGM IN PSYCHOTHERAPY**

The well-recognised problems and limitations of RCTs (Roth and Fonagy, 1996; Parry, 1999) include the inappropriate homogenisation of cases (i.e. treating patients as if they have standard, well-defined problems), the limitations of efficacy studies due to only 'pure' cases being admitted to trials and hence the questionable generalisability ('external validity') of such studies. Such issues contribute, for example, to reservations about the findings of small trials such as that of dialectical behaviour therapy for borderline personality disorder (Linehan et al., 1993). Further problems include the assumptions of treatment standardisation when the effective factors in different therapies have not yet been elucidated, raising questions incidentally about the validity of efforts to manualise treatments, and the problems incurred by randomising patients to different treatment conditions about which they may have a preference. This may manifest in 'drop-outs' or poor engagement with treatment. It is also recognised that any placebo condition in psychotherapy cannot be concealed and any active control will have in addition a significant treatment effect size itself (usually estimated to be of the order of 0.3).

One of the most inappropriate and invalid consequences of the employment of an evidence-based paradigm is the premature foreclosure on still developing models of therapy. This may result from the inappropriate conclusion that if there exists no evidence as yet for the efficacy of a treatment, it should then be excluded from consideration for further development, evaluation or application. This tendency has been pithily criticised by noting that 'lack of evidence of efficacy does *not* necessarily imply evidence of lack of efficacy'. Given its youth as a model, as noted above, CAT is particularly vulnerable to this sort of inappropriate evaluation.

Another most important concern in undertaking RCTs is the ethical one of withholding a treatment from a control or alternative treatment group if there already exists some evidence for its efficacy. This concern may be, properly, intolerable and unacceptable to patients as well as ethical committees. In many countries where there is a tradition of strong 'consumer' rights, such pressures make randomised trials virtually impossible to conduct. It also makes it difficult for conscientious clinicians to participate in some trials. Such considerations could be a problem, for example, in evaluating CAT through a randomised controlled trial in, for example, borderline personality disorder where good preliminary evidence (Ryle and Golyunkina, 2000) of efficacy now exists.

The RCT approach is also largely based on a quantitative, 'pharmaceutical' model of testing which has questionable relevance to the complex difficulties and issues brought by psychotherapy patients who rarely present with simple and circumscribed problems. This is well demonstrated by the diverse case examples throughout this book. Such studies make, in addition, the flawed assumption that simple factors are responsible and identifiable as the 'active ingredient' in treatment and that this will be directly related to outcome as assessed by easily definable and meaningful measurements. These approaches ignore the complex relationship between process factors in therapy and outcome which, as pointed out by Stiles (1995), is characterised by complex dynamics of ultimately a 'non-linear' nature. That is to say that outcome may not relate directly to the administration or 'quantity' of one ingredient (e.g. an interpretation or an empathic comment). Because of this complexity, psychotherapy outcome research is particularly sensitive to and dependent on an understanding and evaluation of process factors in therapy, some of which may only be amenable to more qualitative research approaches. The latter would include focus, for example, on the exploration of meaning and its social construction and the use of techniques such as discourse analysis or task analysis (Stiles, 1995).

It is accepted (Parry, 2000) that alternatives to the above 'paradigm of excellence' (i.e. the randomised controlled trial) need to be considered. These include evaluation of very large series of uncontrolled treatments and more focused study of the relation of process to outcome in different therapies. In the later respect CAT, given its process research-based evolution, is well placed and

indeed has been producing interesting and important research. This has included work on the validity of reformulation (Bennett and Parry, 1998) and, through task analysis, of the significance of therapeutic alliance threatening events and their repair in therapy (Bennett et al., submitted).

We see it as important to highlight the difficulties and limitations inherent in the application of RCTs in this field given their implications whilst at the same time fully accepting the need for controlled evaluation of the efficacy of a treatment model in general and in terms of which aspects of process are effective in particular. The latter is also of importance given the so-called 'equivalence paradox' whereby, so far at least, it appears that therapeutic efficacy of different 'brand name' models tends, very approximately, to be comparable. This suggests that efficacy may depend as much on common factors and on therapist competencies as on the specific package which a model embodies. This again highlights the importance of process research in which CAT, largely through the work of Dawn Bennett and colleagues, has been active. It seems highly unlikely that efficacy will be found to be entirely independent of critical features of different models. Indeed the general evidence, as noted above, suggests that factors such as strength of the therapeutic alliance are critical in determining outcome (Orlinsky et al., 1994) and that those models which emphasize and promote this are more likely to be effective. Clearly CAT would fall into this category. In many ways we see CAT as being in a strong position to promote and undertake further research into its efficacy, bearing in mind the above caveats. We certainly do not, for example, share certain extreme psychoanalytic positions (see Taylor, 1998) that this discourse should not be conducted at all and refuse to engage in it on principle. Although research in this area is complex and involves many factors which cannot easily be conceptualised, operationalised or quantified, we do not see such a methodologically 'Luddite' position as defensible.

## CLINICAL EFFECTIVENESS

An important issue in the evaluation of any treatment is how well pure efficacy studies as addressed in RCTs translate into routine settings outside research studies. This will depend on how well a treatment engages and works with patients who may present, as in the majority of cases, with complex personality difficulties in addition to well-defined presenting symptoms. Thus attrition rates or drop-out from therapy are an important consideration since the most 'superior' treatment is of little use if patients will not or cannot stick with it. This appears to be a major problem in trials of psychoanalytic therapy for difficult patients with borderline disorders, for example. There is good evidence for the acceptability of and treatment adherence in CAT for various patients, most strikingly in the borderline personality disorder group where drop-out rates of only 12% have been reported (Ryle and Golyunkina, 2000).

Another factor of particular importance in its relevance in the real, clinical world is, of course, its cost. This is not to say that cheaper or short treatment should necessarily be preferred if others are superior, but that if a given treatment is equally effective, cheaper and briefer, then this has important implications. Again the standard, brief format of CAT offers significant advantages in this respect.

## RESEARCH RESOURCES

The difficulty of obtaining financial funding for major research projects, including RCTs, in the current climate should also be mentioned. This difficulty stems partly from a still widely held view that psychotherapy is somehow a 'fringe' or luxury activity despite the evidence for the costs of psychological disorder in terms of human suffering as well as in social economics (Gabbard et al., 1997). This view is still frequently encountered despite the evidence that as a treatment modality psychotherapy has an effectiveness as great as or greater than that for many treatments routinely employed in general medicine. Many therapists find themselves in a 'Catch-22' situation of being asked for evidence for their work but denied the means with which to research and substantiate it. In part too this can be seen as a reflection of the dominant biomedical paradigm within psychiatry, encouraged by large pharmaceutical companies who can powerfully promote their own agendas. This unacceptable situation prevails despite the avowedly biopsychosocial base of trainings and practice in the mental health professions and evidence that psychosocial factors are of critical importance in the genesis and maintenance of all psychiatric disorders from the neurotic to the psychotic. It is to be hoped that pressure from psychotherapists, as well as consumers whom we may helpfully encourage and inform, can be brought increasingly to bear on the media and political systems to rectify this alarming and improper state of affairs.

## ACAT AND RESEARCH

Despite these difficulties, research is seen within ACAT as a major priority for both scientific and political reasons and, as we have documented, continues to flourish at all levels even without much external support. This has largely been due to the energy and activity of the many practitioners who have contributed to much of what has been reviewed and discussed in this book. Several groups are currently undertaking RCTs or applying for funding for them and the ACAT research committee is involved in actively advising and fundraising to support these and other projects. Training in basic research methodology, both quantitative and qualitative, will shortly be introduced formally onto all training courses in order to encourage further a culture of research literacy and activity.

We believe that the rapid growth of CAT as reflected in the number of its practitioners and trainees, its democratic, patient-empowering principles and the gathering weight of its evidence base, combined with its being cost effective and well adapted for poorly funded public health services, augur well for its continuing development and application.

Further details of research in CAT and of its special interest groups can be obtained either from the ACAT office or from the website [www.acat.org.uk](http://www.acat.org.uk).