

Cognitive Analytic Therapy: Frequently Asked Questions for Commissioners



What is CAT?

Cognitive Analytic Therapy, or CAT, is a focussed, time-limited psychological therapy designed for NHS patients suffering from a wide range of mental health problems, as well as patients with disabilities and physical health problems. Patients are usually seen for between 16 and 24 weeks (once a week for an hour), and briefer CAT interventions can be used in primary care. CAT offers a collaborative way of working with the problematic ways a person thinks, feels and acts, and the events and relationships (often from childhood or earlier in life) that underlie their experiences and maintain their current problems. It is tailored to a person's individual needs and to his or her own manageable goals for change and is widely available across the NHS (as well as privately and overseas). CAT is also used in consultancy for managing patients' challenging behaviours.

Why was CAT developed for the NHS?

Dr Anthony Ryle (Guy's and St Thomas' Hospital, London) developed CAT from the 1980's onwards in order to respond to the high demand for mental healthcare for a deprived and ethnically diverse busy inner London area. CAT recognises the social origins of distress and deprivation, and the need to offer short-term focused therapy for the NHS with its limited resources. It offers a model of therapy which is inclusive, non-elitist and non-stigmatising, and equality and diversity are at the heart of its model. CAT integrates the best of different therapeutic approaches (including the cognitive psychotherapies and psychoanalytic approaches) into one integrated, user-friendly and effective therapy which is constantly being refined and is researchable.

Who can be helped by CAT?

CAT's unique feature is that it treats multiple symptoms or problems in one therapy via an active, focussed and collaborative process. CAT treatment is flexible so it can be used with a wide range of healthcare presentations, and is also personalised to the individual patient. CAT's strongly relational focus means that it deals as a matter of course with difficulties with motivation, engagement and potential disruptions within the therapy relationship which can lead to drop out or premature termination of therapy, and it can be used with groups and couples as well as with individuals.

CAT can be used to treat patients with:

- Adult mental health problems in primary, secondary and tertiary care settings, with few exclusion criteria (mainly severe substance misuse).
- Many people presenting with anxiety or depression to primary care services have a history of abuse, trauma or neglect underlying their symptoms. CAT offers a safe and clinically effective therapy intervention, compatible with the stepped care model and complementary to the existing IAPT interventions, for people who wish to work through these underlying issues rather than focus on the symptoms.
- Neurotic problems (including depression, anxiety and eating disorders), personality disorders (particularly borderline personality disorder), and some psychotic diagnoses (e.g. bipolar); suicidality or repeated self-harm;

- Difficulties in relationships, including problems of anger control, sexual difficulties, bereavement, loss and chronic trauma/abuse;
- Lifespan issues: e.g. in older adults; adolescent mental health difficulties; parenting issues re children seen in CAMHS;
- Physical health difficulties, including problems of adaptation; non-compliance with medical treatment, especially in primary care (e.g. diabetes, asthma);
- Learning disabilities, and in forensic settings.

Indirectly, CAT is widely used in secondary care for case management, i.e. as a consultative or team training tool working with the context and systems around clients in difficulty. CAT identifies and helps to contain team dynamics which can be generated by a patient's challenging behaviour, and may exacerbate it if not properly managed. The CAT model is also used to teach relational thinking and relational skills in health and social care settings to enhance general professional and psychological skills in working with people.

What about CAT and NICE Guidelines?

CAT features in NICE Guidelines for Borderline Personality Disorder and Eating Disorders. Given that the psychological therapy with the strongest evidence base in NICE guidelines is CBT, though, why should commissioners purchase CAT?

- NICE mental health Guidelines were developed from research with and apply to those patients who meet strict criteria for single psychiatric disorders. Such research is described as having “clinical efficacy”, and although the evidence is strong, it is limited in application and generalisability.
- The NICE research evidence bases thus do not apply adequately to many patients who present in routine clinical practice in primary, secondary or tertiary care settings. For such patients, therapies are required which have “clinical effectiveness”, i.e. are applicable to patients with multiple symptoms and complex presentations, or psychological problems which do not fit psychiatric criteria. (CAT's evidence base is described below).
- Research into psychological therapies for over twenty years has concluded that the most important factors influencing psychological change are to do with the quality of their relationships, including the patient's relationships with others and the relationship with the therapist. Specific techniques contribute relatively little to good outcomes in psychotherapy across the full range of clinical presentations (Lambert, 1992, Wampold, 2001).
- CAT focuses precisely on those dysfunctional relationships – with others, with oneself and with the therapist – which maintain current symptoms and problems, and which often contribute to people dropping out of treatments which are not able to

address this dysfunction.

- CAT is a highly flexible and coherent model of therapy, which integrates into one single treatment the key insights and change methods from all major methods of therapy (including many of the other therapies which NICE recommends).

What about CAT's evidence base?

Various CAT outcome studies have been published over the last decade which have ranged across evaluations of effectiveness in routine practice across disorders and efficacy trials for long-term health conditions and Personality Disorders. When all the CAT outcome evidence is considered across the various diagnoses as a whole then CAT produces a moderate effect size across trial and routine practice contexts.

The clinically and statistically significant effect of adding CAT to a well developed service for older adolescents with borderline features was reported by Chanen et al., 2008, 2009 a and b, in a large well designed RCT. Benchmarking of CAT for BPD (borderline personality disorder) across outcome studies produced a large effect size indicating clinical effectiveness in trial and routine practice contexts (Kellett et al, 2012).

A major and consistent finding across the CAT evidence is the acceptability of the therapy to patients regardless of diagnosis. The drop-out rates for CAT reported in the literature across studies are typically low and impressive.

Is CAT cost-effective?

- CAT is usually delivered in episodes of care of standard length; a 16-week therapy (once a week for an hour) with brief follow-up is offered to most patients; 24 weeks with several follow-ups over 6 months are used for clients with personality disorders and other complex problems;
- While the London School of Economics estimated that an average of 10 sessions of CBT would cost £750 (How Mental Illness Loses Out in the NHS); the cost for a 16-session CAT is approximately £550 (estimated at midpoint 7 post, 2012-2013, including supervision and on-costs);
- CAT is an effective intervention for people with Borderline Personality Disorder who do not need a complex programme of care. Schema-focused CBT for personality disorders is x 3 weekly for 12-18 months; mentalization-based therapy is x 2 weekly (individual and group) for about 18 months. Standard DBT comprises a weekly therapists' consultation group; individual therapy x 1/week for a year; skills training in groups – 2 x hourly sessions for a year and telephone crisis coaching with a therapist as necessary.
- CAT can offer a robust intervention at primary care level for clients who have suffered cumulative trauma and abuse and can prevent referral to expensive secondary care services;

- An accredited CAT clinical supervisor can treat one patient themselves in one hour – or that time can be used instead to supervise the work of other staff with four patients;
- Its use in case management (see example below) makes for effective and efficient use of the CAT model with the multiple agencies who can be involved in a complex patient's care; from GPs and District Nurses, to police and ambulance services.
- Typical outcome measures include: CORE-OM; Beck Depression Inventory (BDI); Beck Anxiety Inventory (BAI); Brief Symptom Inventory (BSI); Inventory of Interpersonal Problems (IIP); Personality Structure Questionnaire (PSQ); used to assess fragmentation in personality disorder.
- CCAT, a measure of psychotherapist competence derived from cognitive analytic therapy (CAT), can be used to audit therapists' adherence to the model.

What training is available in CAT?

- Practitioner training is designed for core mental health professionals with competence in their own field to learn the theory and methods of CAT to enhance their understanding and skills in an evidence-based psychological therapy;
- Accredited Practitioner Training – 2 years in-service, part-time; 20 training days, 8 completed supervised cases, seminars, written work, own CAT training therapy. There are about 10 training courses per annum across the UK;
- Most Practitioner trainings are Postgraduate Diplomas leading to ACAT Accreditation and a Diploma in CAT awarded by Sheffield Hallam University;
- The training is of sufficient depth and breadth to enable graduates to work with complex clients such as those with personality disorders;
- Practitioners graduate with highly transferable skills, and a multidisciplinary approach;
- CAT skills training is designed for those working in the health and caring professions to acquire a basic understanding of CAT and to apply it to their routine work, rather than to practice CAT as an individual therapy. The training may be delivered to whole teams or to groups of interested individuals. It can help clarify team tasks such as formulation and care/treatment planning. By offering a shared language for formulation it can reduce inter-disciplinary tension. It provides a non-blaming, supportive, containing framework for everyone – including the client.

A CAT patient's perspective: Alan has given permission for his name to be used

Alan was a 51 year old head teacher who had had to retire because of alcoholism. He wrote: "At 47 I was forced out of my profession through mental ill health,

chronic depression and nervous breakdown. I gave up alcohol, battled the addiction and won. Fantastic health professionals kept me alive just long enough for the liver transplant. I had been receiving psychiatric support and counselling from the very early days post operation. I lurched from one crisis to another each one deeper, more destructive than the last. At this point, I was contemplating suicide." He was referred for CAT.

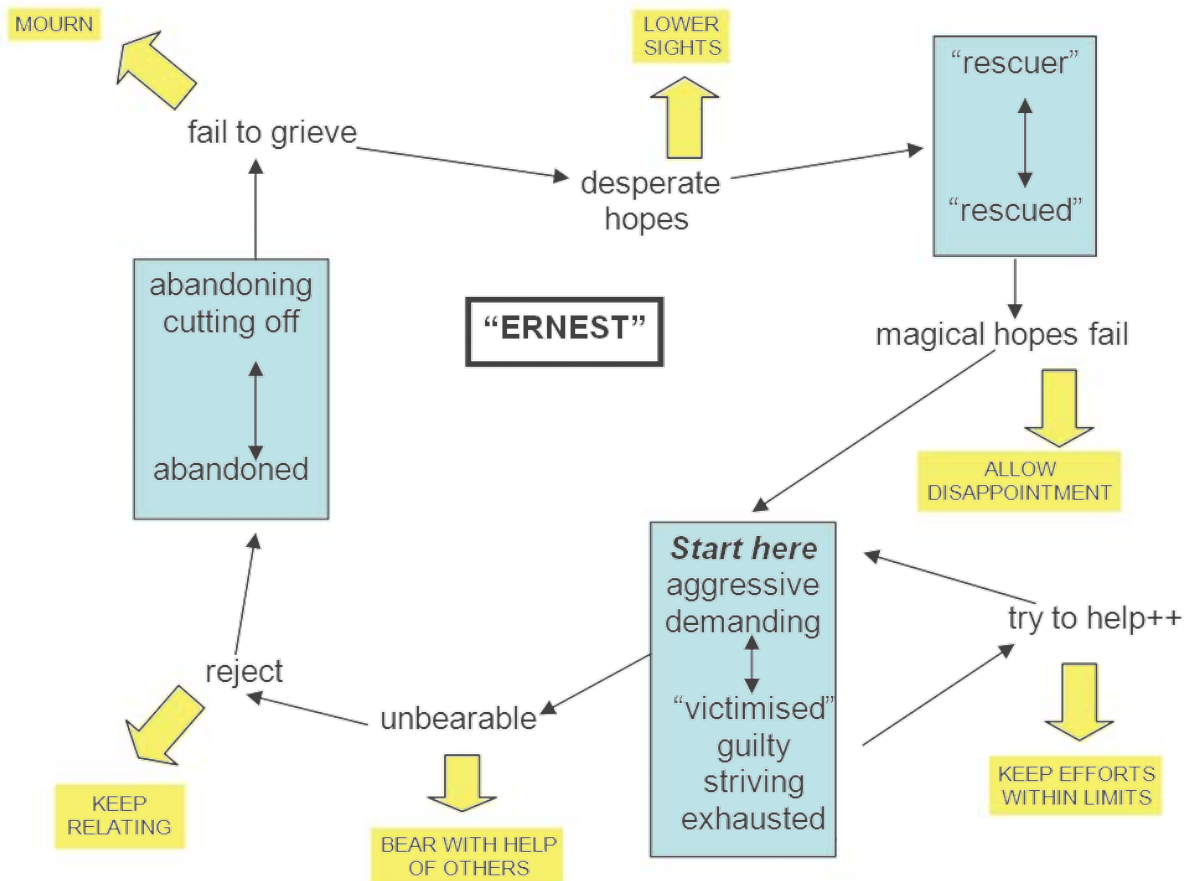
"Even from the early stage my therapist understood where I was coming from. She was intuitive and we quickly established that my current attitude, mode of behaviour was steeped in the events of the past especially my relationship with my father and mother. That being said, the first "eureka" moment was the realisation that my relationship with my grandmother and her death when I was a very young boy had critically affected my development as a man and my approach to life as an adult."

Alan began to understand how he had coped with the turmoil of a physically abusive father where no weakness was tolerated, becoming a hard working and successful individual who could show no weakness, but who then crashed into depression and alcoholism. He gradually began to recognise and manage the peaks and troughs of his moods and to manage these more successfully. Alan writes "I now ask the question 'what part did the Cognitive Analytic Therapy play?' Firstly, it helped me to come to terms with things I already knew, but hadn't accepted. Then it helped me link up the moment of my grandmother's death and its effect on the person who I had become. I now understood who I was and why I was and how I got there. I wasn't the bad person I had come to believe. I was, and am, an ordinary man with lots of flaws but lots of good parts. The key to it is accepting all facets of my character and personality, to temper the highs and lows with the understanding of who I am." (For Alan's full story see <http://www.acat.me.uk/page/client+accounts>).

Using CAT for clinical consultation – a composite example to explain how consultation works

When clients are not considered 'treatable', CAT can be used as a consultative model. For example, "Ernest", 79, had had regular changes of GP and evictions from care homes. The staff requested help to manage. Ernest had been diagnosed with borderline personality disorder. He was physically and verbally aggressive to staff and residents and had an extensive psychiatric history including episodes of self-harm. He had experienced early trauma but now had chronic physical illnesses and was in constant pain.

The consultation involved a brief input to staff and Ernest's relatives, sharing the formulation (see below), with the problematic roles enacted by Ernest and his carers in blue, with 'exits' from unhelpful loops in yellow. Managing the context (i.e. relationships in the care system) through CAT understanding was the key to reducing behavioural disturbance. There had been no evictions for several years after the CAT input.



For further information on Cognitive Analytic Therapy, visit the ACAT website: www.acat.me.uk or contact the office on 0844 800 9496.

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