

Critique of CBT and CAT by Dr Anthony Ryle

The central claim made for CAT (cognitive analytic therapy) is that it seeks to offer a comprehensive understanding of human psychology and involves therapists in forming real, clearly defined and therapeutically powerful relationships with their patients. In this respect it is a 'psychodynamic' theory and is clearly differentiated from CBT (cognitive behavioural therapy).

Understanding the immense complexity of human psychological processes needs to be based on an understanding of their development. CBT provides a model of learning but takes little account of early development and its effects upon psychological structures. CAT, in contrast, revised object relations theories in ways that sought to eliminate unverifiable assertions about 'the unconscious' and were consistent with observational studies of early development.

The current CAT model of personality emphasizes that human infants are genetically predisposed to be socially formed to a far greater degree than any other animal. They show active emotional engagement with others from birth, communicating through behaviour, expressive sounds, gestures, rhythms and imitation (Trevarthen, 2001). Over the first few years they increasingly demonstrate the highly developed human capacity to make and use symbols.

A child's unique inherited temperamental characteristics will influence its interaction with others, notably with those in its particular family. The repetition over time of early patterns of interaction are seen to initiate a unique repertoire of *reciprocal role procedures (RRPs)*. RRP's are reiterated sequences of perception, thinking, affects and action linked to the expected or elicited responses of others. Their enactments are accompanied by communication which increasingly involves pre-linguistic signs and, eventually, by language. Self processes and the self-conscious

'I' are derived from the internalization of these reciprocal interactions and communications. Conscious thought is essentially internal dialogue derived from sign-mediated exchanges with others. The *intrapersonal* procedures involved in self care, self control and self judgment are derived from the internalization of the *interpersonal* patterns characterizing early relationships and the two remain permeable to each other.

In this way CAT offers an adequately complex but accessible model of self processes whereas in CBT the self is more often referred to than defined.

The stability of role procedures

The stability of role procedures is maintained by eliciting reinforcing reciprocations from others, and this is true of both normal, functional reciprocal role patterns and of those that are harmful or restrictive. Revision occurs when others withhold the expected reciprocations or offer more functional ones or enlarge the person's awareness of them, so that conscious control may become possible. This understanding underlines the need for therapists to provide both *non-reciprocation* and *clear descriptions* of their patients' dysfunctional RRP's.

Personality structure

The most significant patterns acquired in early life are concerned with issues of *care or neglect in relation to need* and *over-control or cruelty in relation to submission*. 'The self' is normally multiple as individuals acquire a repertoire of RRP's, different ones being mobilised in ways appropriate to the context. 'Normal' multiplicity may include the manifestation at different times of contradictory patterns but in general links between patterns and awareness of the range is established. However, this is not the case where adversity and predisposition result in a *structural dissociation* of the individual's repertoire of role procedures. In such cases the sense of self is fragmented and discontinuous. In borderline personality disorder, which is the most frequently encountered type in clinical practice, patients commonly show abrupt switches between states and may have little recollection between them. This is confusing to the patient and to those around them, including clinicians, who as a result may feel 'de-skilled' and may become rejecting.

In these patients, therapists and other clinical staff need to support integration of the dissociated reciprocal patterns. This can be aided by verbal and especially by diagrammatic descriptions of the repertoire of RRP's, which demonstrate their dissociation into separate self states

and trace the switches and links between them. Self State Sequential Diagrams support the consistent, non-collusive attentive engagement of clinicians. They also have a direct therapeutic role in helping patients recognize their states and state switches and so gain more control over them. These are the essential elements of the Multiple Self States Model (MSSM) of BPD as described in Ryle (1997).

Many borderline patients are prone to switch into states of uncontrolled anger. Rather than relying on anger management the CAT response would be to trace the dysfunctional RRP that *precede* the switches into anger with the aim of establishing more adaptive modes. These prior dysfunctional modes usually represent long-term strategies evolved in response to deprivation and are attempts to avoid anger. They typically involve patterns of resentful compliance, emotional distancing or the avoidance of vulnerable need, all of which maintain a sense of deprivation and pain from which switches to rage states may be triggered. These states, whether expressed in hurting self or others, are liable to provoke rejection and hence perpetuate deprivation. CAT would seek to modify these preceding patterns as well as developing recognition and control of the switches.

How does therapy support change?

In CBT theory the emphasis is placed on the description and challenging of the links between thinking, feeling and acting. When based on a skilful analysis of the sequences and sensitively carried out this can clearly be an effective ingredient of therapy but expressed through simple-minded analyses and schoolteacherly assertions of the patient's faulty thinking it can be experienced as critical or disrespectful. The therapist's positive responses to more effective behaviours may be reinforcing but in the case of persistent negative behaviours, especially when these undermine therapy, there is little theoretical understanding of what to do. In such cases CBT therapists rely upon patient compliance with its technical procedures and the personal qualities of the practitioner to maintain the therapeutic work.

In CAT, creating an effective working relationship with patients is a main aim, but this must include skilful work with those whose destructive role procedures undermine the therapy. In CAT these are seen to represent the enactment of some part of the patient's dysfunctional repertoire; the patient brings into the therapy relationship the problems for which help is sought. Once identified and recognized with the help of the diagrammatic reformulation these can be challenged rather than reinforced by reciprocation.

In understanding RRP's in the context of the therapy relationship, sensitivity to non-verbal affective communication are crucially important. Therapists need to be aware of the feelings induced by their patients. They may be induced by actions or words but often they can only be recognized by emotional resonance to the patient's expression, posture and other indirect messages. To recognize these, therapists need to be emotionally open and also aware of their own contributions to the patterns.

This aspect of CAT theory is a re-conceptualisation of the psychoanalytic understanding of transference-countertransference, understood as a particular example of the general way in which relationships depend upon the meshing of reciprocal patterns. The CAT concept of RRP's is found accessible and useful by patients and by non-therapy staff and provides a more adequate and comprehensive framework for therapists than CBT.

Objectivity, psychotherapy research and the nature of evidence

CAT seeks to offer a scientific basis for understanding human nature but insists that objectivity, in the sense of studying humans as objects, is inappropriate. We need to observe and record evidence in ways capable of being replicated by others but full evidence concerning human behaviour and experience can only be obtained by human beings and must include *intersubjective* understanding. We know each other through shared contexts and histories, speech, observation, expressive behaviours and also through incompletely understood, non-verbal communication: 'The heart has its reasons of which reason knows nothing,' as Pascal said.

In studies of infant development it is recognized that infants' cognitive abilities are evident early and develop in observable ways but their parallel capacity to convey and respond directly to affective aspects of experience and behaviour – to '*feel other minds*', to know others non-cognitively – are neglected or denied. The overemphasis on cognition and the need to explain affects as secondary derivatives of it is dominant in cognitive-behavioural approaches. Therapy practice and research needs to acknowledge and make use of such subjective knowing and avoid the over-valorisation of cognitive processes, a view which receives strong support from studies of early development focusing on how the child develops in relation to others (Reddy, 2008). Mirror cells and other yet-to-be discovered neurophysiology can throw some light on the neural pathways involved in our coming to know other minds feelingly but the fact that we do and how we do can be experienced and further studied without the neuroscience.

Cost effectiveness and the evidence base of CBT and CAT

The problems of demonstrating clinically useful effects for a psychotherapy model are formidable. Therapy is not comparable to the prescribing of a drug; it involves two people and what happens between them is only partly determined by the model. Trying to overcome this by delivering manualised therapy seems to me to be incompatible with a humanly respectful therapy and cannot eliminate the individual variations in therapists' work. The effects of factors common to any therapy delivered with reasonable tact and attention are difficult to distinguish from the effects of specific interventions. Change may occur during active therapy but may not endure, but adequately long follow-up is costly and rarely done. The aims pursued in different therapeutic models may differ, as they do between CBT and CAT, and standard measures are sensitive to only some types of change. In controlled trials the power of the model being researched may be inflated where the control intervention – often 'business as usual' – is clearly ineffective.

These problems have not been overcome in CBT research and the loud and persistent claims that it (almost alone among therapies) is evidence-based are increasingly criticised. David Richards (2007), a past president of the BABCP, attributes the growing criticisms of CBT to its selective use of evidence and to the 'naive belief that the randomized control trial is the only weapon we now need'. He observes how 'we ourselves write the research questions that now get funded; reviews have shown that RCTs can both exaggerate and under-estimate the likely real effect ... most CBT trials are small and poorly executed; quality thresholds for RCTs in NICE guidelines are notoriously low, allowing the meta-analyses of small poor quality studies to direct policy; we pay no attention to qualitative evidence ...'. He points to the 'unproven contention that it is possible to take the results of experiments conducted by charismatic product champions in highly controlled environments and implement them in the widespread manner suggested by Layard ...'.

CAT has different weaknesses and in particular is often criticised for its small research output; it has indeed been slow to accumulate evidence from large-scale RCTs. However, small-scale descriptive and controlled studies and evaluated case studies accompanied the development of the model and research into process and into aspects of theory and practice have continued to take place. This included work on borderline personality disorder which for a long time had been neglected by psychiatrists and by dynamic and CBT therapists. CAT was shown to have an effect within a 24-session format (Ryle and Golyukina, 2000) and has been found to be particularly helpful by those who work with these

patients and with other 'hard to help' (i.e., usually unhelped) patients, including abuse survivors, the elderly and offenders. This research also contributed to an understanding of the importance of dissociation, a factor little attended to except in conditions directly attributed to trauma. It led to the development of the Multiple Self States Model (MSSM) of BPD which emphasizes the alternating dominance of a range of *dissociated self states*, each characterized by contrasting RRP's expressed in subjective symptoms and behaviours, some of which may be extreme. The MSSM is of importance in relation to diagnosis, case formulation, management and treatment. In work of particular relevance to mental health services it has been shown that brief training and supervision enables staff with no formal psychotherapy training to use CAT reformulations to plan interventions and avoid collusive responses (Kerr et al., 2007).

Outcome research

A review of CAT research will be found in Appendix 1 of Ryle and Kerr (2002). Since then a well designed RCT comparing the effect of the addition of either CAT or a humanistic cognitive intervention to a comprehensive treatment programme for late adolescent borderline patients has been reported by Chanen et al. (2008). This showed clinically relevant advantages from CAT. Other published outcome studies and those in progress are listed on the ACAT website.

In my view the findings of process research and the use of single case designs are more likely to influence therapy practice than are the large-scale RCTs on which CBT's claims to be evidence-based are based.

Other CAT research has been concerned with the development of instruments for clinical and research use. The eight-item Personality Structure Questionnaire (PSQ) (Pollock et al., 2001) was developed to assess the degree of dissociation and provides a reliable measure. High scores are characteristic of BPD; the mean scores of outpatients referred for psychological treatment are between those of normal subjects and those with BPD. Bedford, Davies and Tibbles (2009) administered the PSQ to more than 1000 outpatients; they confirmed the psychometric qualities of the PSQ and showed that scores fell in patients receiving a range of treatments while remaining stable in those not treated. The evidence suggests that the level of integration varies across the spectrum of psychological disorders.

Support for the Multiple Self States Model (MSSM) of BPD has been provided by the use of the States Description Procedure (Ryle, 2007), a clinically useful method which contributes to the reformulation of borderline patients.

Notions of happiness

Philosophers and writers have offered many different ways of considering whether 'happiness' is a desirable goal and if it is how a person might pursue it. But therapists cannot contribute by prescribing the goal or explaining the meaning of life. For most people, survival rather than happiness is the aim. I would argue that the belief that one is entitled to, or worse still should be able to purchase, happiness is a symptom of our individualistic consumer culture and may well contribute to unhappiness by ignoring the extent to which individuals need to be in a meaningful relationship with others and with their wider social context. Faced with the fact that our culture produces many hundreds of thousands of people needing relief from psychological/emotional distress and unhappiness, the proliferation of therapists, a response consistent with the Layard thesis, is like dealing with rising sea levels by issuing lots of buckets. Economic downturns, poverty, modern forms of colonialism and vast expenditure on weaponry are not natural phenomena like tsunamis, they are man-made and call for political action. Prescribing counselling or CBT for all serves to distract us from attending to the values and practices of the unhappy society in which we live.

If more resources are made available for psychotherapy and counselling a first step might be to correct the underfunded and unevenly distributed services in the NHS. But prevention would be a more logical priority, achieved by increasing what might be called psychological literacy, centrally among those involved in parenting, education and management but also more generally. In that respect the CAT model is particularly suitable because of its focus on the relationship between individual psychological functioning and the social and relationship context.

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