The audit described here also shows how a relatively simple exercise of defining quality standards for the documents of CAT and the use of a simple and fairly standard battery of outcome measures can constitute the core of an achievable rolling audit for CAT. It would be valuable now for the community of CAT therapists as a group to define a basic audit package which should ideally be incorporated into the practice of CAT as a general rule. This might include the use of quality standards applied to audiotapes of therapy (which would clearly have advantages over audit of notes), but equally such an endeavour might be too time-consuming for routine audit. Naturally it will be vital to introduce regular reviews of the results of such auditing and to make sure that practice does change as a result. CAT therapists ought to be good at this; it is, after all, what they are meant to be doing in therapy.

Editor's note

A computerised audit system was established after Dr Denman's departure from Guy's, and therapist cooperation has been achieved. Therapist training and supervision have improved. Audit of the 1993 cohort of patients shows that the attrition rate of patients who attended their first session was only 17%, and that despite markedly higher psychometric scores at intake the scores on discharge were only marginally higher than before.

References

Beck, A.T., Ward, C.E., Mendelson, M., Mock, J.E. and Erbaugh, J.K. (1961). An inventory for measuring depression, *Archives of General Psychiatry*, **4**, 561–571.

Chiesa (1992). A Comparative Study of Psychotherapy Referals. *British Journal of Medical Psychology*, **65**, 5–8.

Denman, F. (1993). Quality in a psychotherapy service: a review of audiotapes of sessions, *Psychiatric Bulletin*, **18** (2), 80–82.

Derogatis, L.R., Lipman, R.S. and Covi, M.D. (1973). SCL-90: an outpatient rating scale: preliminary report, *Psychopharmacology Bulletin*, **9**, 13–29.

Donabedian, A. (1988). The quality of care: how can it be assessed?, *Journal of the American Medical Association*, **260**, 1743–1748.

Fonagy, P. and Higgitt, A. (1989). Evaluating the performance of departments of psychotherapy, *Psychoanalytic Psychotherapy*, **4** (2), 121–153.

Horowitz, L.M., Rosenberg, S.E., Baer, B.A., Ureno, G. and Villasenor, V.S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications, *Journal of Consulting and Clinical Psychology*, **56**, 885–892.

Parry, G. (1992). Improving psychotherapy services: applications of research, audit and evaluation, *British Journal of Clinical Psychology*, **31**, 3–19.

Ryle, A. (1990). *Cognitive Analytic Therapy: Active Participation in Change. A New Integration in Brief Psychotherapy*. Chichester, John Wiley.

Watson, J.P. and Ryle, A. (1992). Providing a psychotherapy service to an inner London catchment area, *Journal of Mental Health*, **1**, 176–196.

Weissman, M.M. and Bothwell, S. (1976). Assessment of social adjustment by patient self-support, *Archives of General Psychiatry*, **33**, 1111–1115.

10 Research relating to CAT

Anthony Ryle

The relation of psychotherapy research to theory and practice is a complex one. We are a very long way from being able to enunciate a theory of human nature and change which could generate hypotheses capable of elegant disproof through experimental designs. The attempt to emulate such designs has generated some distressingly simple models, but the pressure to demonstrate and measure what psychotherapy can achieve has nonetheless been a healthy one, providing some safeguards against the bias generated by enthusiasm for particular models (which is not to deny that such enthusiasm is probably a potent therapeutic factor).

The first presentation of a new therapy is usually in the form of individual case histories. When well observed, these can be as valuable as were the contributions of natural history to biology, providing the starting point for more critically designed studies of a number of cases through which some idea of the general effects of, and specific indications for, the approach may be gained. Traditionally the next step is a controlled trial comparing the approach with an alternative. While the placebo effect which confounds drug trials should not be a problem—for maximising the effect is a legitimate aim of psychotherapy—the standardisation of input (the same dose of the same substance) cannot be reproduced, each patient–therapist pair being necessarily unique. The matching or homogeneity of populations on the basis of psychometric and clinical data, already somewhat dubious in drug trials, is a real problem when one considers, to take one example, how many different human experiences and personalities may contribute to the development of

Cognitive Analytic Therapy: Developments in Theory and Practice, Edited by A. Ryle

depression. The bulk of the research carried out in past decades on this model has failed to demonstrate clear advantages for any one approach over any other, although intervention is more effective than no intervention, and in a few cases particular treatments are shown to be better for particular conditions.

In the face of this, two trends have become dominant in psychotherapy research. The first is to standardise input by careful, detailed manualisation of procedures and by checking their delivery from audio or video tapes of sessions. Despite the risk of damaging the normal joint evolution of a working alliance by patient and therapist, this has led to a welcome clarity about the guiding assumptions behind different approaches. Associated with this has been an increasing concern with the microanalysis of the therapeutic process, through which the short-term effects of particular interventions can be assessed for their impact on, for example, the therapeutic alliance or the patient's reports of the session. The quality of small-scale interventions can, in turn, be related to outcome. The use of individually focused measures related to each patient's problems and designed to identify the specific kinds of change which the particular approach seeks to achieve can further strengthen such approaches (e.g. Curtis and Silberschatz, 1986; Goldfried, Greenberg and Marmar, 1990; Orlinsky and Howard, 1986).

In the present chapter, CAT-related research (not including individual case histories) is presented and reviewed. With hindsight, of course, (and with more funds) much of it would have been differently designed, but it can at least be claimed that the evolution of CAT theory and practice has occurred in a context where research has always been a factor. Rather than present the research in historical order, the following structure is employed: research influencing the model; descriptive, uncontrolled studies; controlled trials and studies of process and its relation to outcome.

Research influencing the development of CAT

A major influence in the emergence of CAT as an integrated approach was the work carried out over many years in which patients in weekly dynamic psychotherapy were studied simultaneously with repertory grid techniques. Grid methods offer patients a way of describing themselves and others, or, in the dyad grid (Ryle and Lunghi, 1970), their relationships with others. The analysis of grids generates mathematical or graphic representations of associations between the elements (people or relationships) and constructs (terms of comparison and contrast) and between elements and constructs. Much of this work was summarised in Ryle (1975), in which preliminary attempts to link psychoanalytic and cognitive descriptions were made. The main indirect effect of this work was that it showed me how much patients and

others could learn from the act of completing a grid and from discussing the results after analysis. Patterns and generalisations which emerged from the systematic completion and analysis of the grid gave new and useful understandings to the person, understandings which were at once accessible and usable, and had nothing to do with the 'dismantling of defences'. And the dyad grid, in giving access to the patterns determining self-care and relationship with others, offered a new way of describing some of the ideas of object relations theory (Ryle and Breen, 1972; Ryle and Lipschitz, 1975).

Indirectly, therefore, repertory grid techniques, applied in this way, were both a source of integrative understandings and an example of how patients could be actively involved in self-observation, while the results of grid techniques represented a jointly created tool of value in the process of therapy. More directly, the initially descriptive uses to which grid results were put suggested ways in which, in outcome research, specific changes relating to the individual problems of the patient could be defined in advance so that the grid changes which should occur could be predicted. This opened up the possibility of matching the behaviourist's measures of changes in visible symptoms or actions with measures of cognitive or 'dynamic' change. To do this, however, an agreed definition of desirable change had to be arrived at, at the start of therapy.

A study of a set of notes of completed therapies yielded the three patterns of Traps, Dilemmas and Snags which were the basis of what became the reformulation process. Of these, Dilemmas can be seen to derive from grid techniques, in which the options open to an individual can be seen in polarised, graphic form (in the graph of the first two components) or mathematically in the form of unusually high or low correlations between constructs which suggest 'if-then' or ' either-or' Dilemmas.

The first paper based on these descriptions, linking patients' ratings of change in relation to them to predicted changes in construct correlations in the grids, showed that the changes were in the predicted direction in 27 out of 36 instances (Ryle, 1979). This paper, based on six patients, and a further outcome study (Ryle, 1980) established many of the defining features of what later became CAT.

Descriptive studies

Five studies describing the application of CAT to defined populations and reporting measures of change, but not offering controls, are summarised here.

A community mental health centre in Greece

Garyfallos and his colleagues (1993) reported a series of cases attending a community health centre in Thessalonika. The aim of the study was to measure change using a standard post-therapy interview, and pre- and post-therapy testing with the MMPI. At the post-therapy interview patients were also asked how well they remembered their TP and TPP descriptions, and how helpful they had found various aspects of CAT practice such as the Psychotherapy File, self-monitoring and diary keeping, rating sheets, the relationship with the therapist and the time-limit. The patients were diagnosed using DSM-III(R) criteria; they showed a predominance of anxiety and depressive disorders and a high proportion received Axis 2 diagnosis. Of 56 cases in whom Axis 2 diagnoses were reported, 17 met borderline personality disorder criteria. Patients were assessed two and 12 months after termination. Of 85 patients recruited, 10 dropped out of therapy and 11 remained in therapy at the time of writing. Of 64 completers, 56 attended the 2-month follow-up, and 33 of the 39 eligible attended at 12 months. Six patients at two months and none at 12 months requested further therapy, and recall of their reformulations was high at both follow-up occasions. The MMPI repeated at two months showed significant mean changes on nearly all scales and this was still true at 12 months. Patients' recall of the reformulation was good and the average response concerning the helpfulness of the various CAT elements was positive on both occasions.

Comment This study provides information about the patients treated and about the impact of therapy, and reports some data on patients' reactions to the therapy. It offers, therefore a (cross-cultural) 'yardstick' against which other services can measure their effectiveness, or in relation to which other approaches serving similar populations can be assessed.

Cases of deliberate self-harm

The application of CAT to patients admitted to hospital after episodes of deliberate self-harm is reported and case material described in Cowmeadow (1994). It was considered that CAT was helpful in its flexibility, early focus, rapid engagement and inclusion of problem-solving techniques. The fact that assessment and the brief or very brief interventions were carried out by the same person was important in this population of people who are characteristically very sensitive to rejection. The brevity and time-limit, however, may not have been helpful for some patients. Further material from this study is presented in Chapter 3.

Comment This is a valuable clinical study of a poorly served patient group, in which the early focus on describing the long-term antecedents of deliberate self-harm seems to have been of particular value.

Childhood sexual abuse survivors

Clarke and Llewelyn (1994) report the treatment of seven female survivors of childhood sexual abuse with 8–16 sessions of CAT. Six patients completed therapy and measures of symptoms and of self-abuse showed improvement in the completers. Patients completed single-element and dyad grids before and after therapy. From these it was apparent that, while two of the women revised how they construed the relations of men to them, the view of how women related to men (as victims) was little altered. The authors suggest that some of these patients might have benefited from longer therapies, and that transference work with a male therapist might have been of benefit.

Comment The use of multiple outcome measures in this study was important, in that the limited evidence of dynamic change from the grid prevented over-estimation of the effects of therapy. The grid data was not used in the reformulation process; its value in identifying the complex implications of victimisation is illustrated in the next paper.

Two women who stabbed their partners

Pollock and Kear-Colwell (1994) report the detailed grid analysis and the treatment along CAT lines of two women seen in a forensic setting who had stabbed their male partners. It provides an interesting extension of some of the issues raised by Clarke and Llewelyn (above). Both women experienced serious and prolonged abuse and both had experienced re-victimisation. The patients both completed role construct repertory grids with supplied role titles, including a number of versions of the self. Both patients saw themselves primarily as guilty offenders and, following their offences, were unable to see themselves as victims. Therapy focusing on the 'abusing–abused' reciprocal role procedure and on related procedures, and making use of Sequential Diagrammatic Reformulation, was effective in both cases. One ceased self-mutilation and was made an informal patient, and the other was discharged into the community. Both entered into new relationships with men, evidently on different terms.

Comment This is a model presentation of the use of grids in the reformulation process of two very disturbed offenders. It suggests that the use made of grid techniques (as in the early stages of the development of CAT) as an aid to reformulation, and not only as a measure of change, should be more widely employed.

A CAT group

Duignan and Mitzman (1994) and Mitzman and Duignan (1993) report the first use of CAT techniques in group therapy. Each author was involved in one to three of four individual pre-therapy sessions, during which a psychiatric diagnosis was made, psychometric tests and grid testing was carried out and a reformulation letter and an SDR were agreed. Duignan and Mitzman report that three of the eight patients met borderline personality disorder criteria and one narcissistic personality disorder. Seven of eight patients completed the 12 group sessions, of whom only two requested further therapy. Psychometric scores fell significantly and changes in grid measures were of the same order as those reported for individual therapy in the study of Brockman and colleagues reported below. In the paper by Mitzman and Duignan the specific use made of SDRs in the group was demonstrated by following one patient through the group and showing how key interactions with others were explicable in terms of matching the two SDRs.

Comment This study combines process and outcome measures and describes a new application of CAT methods. It has clear implications for practice. The audiotaped records of interactions in the group provided strong evidence for the relevance and value of SDRs.

Controlled trials

A hospital outpatient service

Brockman et al. (1987) report the outcome of treatment in 48 outpatient randomly assigned to either 12 sessions of CAT or 12 sessions of treatment following the model of Mann (Mann and Goldman, 1982). The therapists, trainees from various professional backgrounds, treated patients in both conditions under common supervision. Mann's model was chosen as it resembled CAT in the time-limit and the explicit sharing with the patient of a focal issue. Measures of change were psychometric (Beck Depression Inventory, General Health Questionnaire, Crown Crisp Inventory) and grid measures. The latter were based on a standard dyad grid and included nomothetic

measures, namely Positive and Negative Self Attitude scores (PSA and NSA), based on the sum of the angular distances between the element self-to-self and three positive and three negative constructs respectively. Ideographic measures were (a) the Grid Prediction Score (GPS) based on the mean predicted angular distance change in construct correlations identified as related to the patients dilemmas pre-therapy, and (b) patient ratings post-therapy on Target Problems Procedures agreed at a pre-therapy assessment meeting.

There were significantly better outcomes for the CAT sample on the TP and TPP ratings, but these disappeared when initial score levels were allowed for. CAT produced significantly larger changes in the grid measures. Effect size calculations for CAT over the Mann condition were calculated as 0.53 for the PSA, 0.38 for the NSA and a little under 0.5 for the GPS.

Comment While the design was intended to minimise the chance of showing a difference in outcome, it would have been stronger had it been possible to have the two conditions separately supervised by supervisors committed to their model. It is a pity that no dynamic therapists have used the grid as a means of measuring change. It seems likely that this study has demonstrated a real effect; CAT, with its explicit focus on aspects of 'cognitive structure', seems to produce more cognitive restructuring than a purely dynamic approach.

No formal replication of this study has been carried out, but in unpublished studies many patients have been assessed on similar lines. As in this study, the Grids Prediction Score was based on the analysis of self-to-other elements only, as in some cases the values of this differ markedly from those for other-to-self (an observation awaiting systematic investigation). Changes in the grid measures were in the same range, with the Grid Prediction Score usually being around 20° of angular distance, a figure is close to the standard deviation for construct angular distances in the populations studied. TP and TPP ratings are not now considered as research measures, as those devised by patient and therapist are better regarded as part of the therapeutic process. Intercorrelations between difference outcome measures seldom reach significance, especially those between grid measures and self-report questionnaire scores. It remains my view that grid techniques continue to give access to psychological variables of central interest to psychotherapists, and the failure of researchers in the field to utilise them or devise other methods of measuring 'dynamic change' is regrettable.

Poor self-management in insulin-dependent diabetic subjects

A sizeable proportion of insulin-dependent diabetic subjects have poor control over their blood sugar levels and are at greatly increased risk for

serious medical complications. This results from their failure to carry out blood tests, follow diets and take insulin in appropriate dosage. The provision of specialist nurse education and other interventions, mostly behaviour therapy, have had little sustained impact on this patient group (Surwit, Scovern and Feinglos, 1982; Leventhal and Cameron, 1987; Bloomgarten, Karmally and Metzger, 1987). Measurement of haemoglobin A1 fraction gives a reliable indication of mean level of blood sugar over the previous three months and can be used to identify subjects at risk and the effect of intervention.

The causes of poor self-care are complex. Psychiatric illness is not a common factor, although depressive self-neglect may be one cause and neuroticism scores are moderately associated with poor control.

This problem has been studied over many years at St Thomas's Hospital in cooperation with Professor Sönksen and his colleagues, initially by Milton and subsequently by Fosbury. Milton (1989) described, through case vignettes, the many ways in which emotional and psychological factors can influence self-care. In an unpublished study of 32 patients selected on the basis of HbA1 levels of over 11% and randomised between CAT, intensive nurse education, neither or both, she showed that CAT, with or without education, produced a significantly greater fall in HbA1 levels at a 9-month follow-up. In an associated grid study she showed that poor self-management was associated with a negative construal of clinic staff.

Fosbury has followed this pilot study with a further randomised trial comparing nurse education and CAT (up to 16 sessions). Recruitment of patients who are, by definition, non-compliant, many of whom were secondary or tertiary referrals and lived far from the hospital, was not easy. Of those recruited, 50% showed medical complications and the mean duration of their diabetes was 16 years (range 3–30); their mean HbA1 level was 11.9% (normal range 5-7%). In this study particular use was made of SDRs, and the various non-compliant acts such as omitting insulin, over-eating and drinking were located on the procedural loops and hence linked with other aspects of self-care and relationship patterns. Case examples are reported in Ryle, Boa and Fosbury (1993).

Preliminary results of this study show that, while education is associated with a drop in HbA1 levels at the end of the intervention, this is not sustained, whereas CAT produces a significantly greater drop at the 9-month follow-up ($p < 0.02$) (Fosbury, 1994a).

In a linked study, Fosbury (1994b) has assessed 28 newly diagnosed cases of insulin-dependent diabetic subjects, with the aim of establishing how far it may be possible to identify those likely to have future problems in self-care. In view of the high personal and service costs of poorly controlled diabetes, this study is particularly important as it could open the way to intervention before

negative procedures in relation to clinical staff and self-care become entrenched.

Comment It is unusual to have biochemical outcome measures for psychotherapy, and it is gratifying that CAT seems to be the first treatment to produce sustained alterations in patient self-care. If the full results confirm this, this research could be influential in supporting funding for therapy in medical settings. While diabetes is particularly demanding on the sufferer, other conditions in which poor self-care is a serious problem might also benefit from this kind of intervention. One such condition, asthma, is considered below.

Poor compliance with treatment for asthma

Bosley (Bosley et al., 1992; Bosley, Fosbury and Cochrane, submitted) has carried out an investigation into the impact of CAT on treatment compliance in asthmatic subjects, as part of a larger study of psychological problems and compliance carried out with Dr. G.M. Cochrane (UMDS at Guy's Hospital). Subjects' compliance was measured through the use of Turbohaler inhalation computers, which recorded the time and date of each inhalation, without the subjects being aware. Half of all patients omitted one-quarter or more of their prescribed dosage. Non-compliant patients were offered counselling, without the fact that their non-compliance was known being declared. The intervention was focused on general issues of self-care, but including asthma management. This was linked to the appropriate procedures described in the SDRs. Compliance, measured in the Turbohaler computers, was significantly improved by the intervention over a 12-week follow-up.

Comment While its treatment is less complex to carry out than that for diabetes, poor compliance is common in asthma and is associated with higher rates of morbidity and mortality. This research reinforces the suggestion that rational education needs to be combined with therapeutic approaches in many medical conditions, and demonstrates that time-limited CAT can be an effective intervention.

Outpatient treatment of anorexia nervosa: a comparison of educational behaviour therapy and CAT

Thirty patients aged over 18 and suffering from anorexia nervosa were assigned randomly to outpatient treatment with either educational behaviour therapy or CAT, for 20 weekly sessions. Therapists were experienced in the former but had only brief introduction and ongoing supervision in CAT. The study supported the idea that outpatient treatment is suitable so long as severely ill patients are excluded. The outcome at one year was similar for the

two groups on objective measures. CAT patients reported subjective improvement as significantly greater, and there was a non-significant tendency for fewer CAT patients to stay in the poor-outcome category.

Comment This pilot study serves to demonstrate that CAT is at least as safe and effective as a more educational approach. The small size of the sample and the relative inexperience in CAT of the therapists are likely to have reduced the chance of demonstrating differences; it is to be hoped that further studies will be carried out.

Process studies

Self-state sequential diagrams and the self-states grid

Ryle and Marlowe (1995) describe five patients with borderline personality disorder in whom identified separate self-states were the elements in repertory grids completed by the patients. The descriptive features of the self-state, as recorded in the grids, were compared with SDRs constructed in the early sessions. The study showed that patients can discriminate between self-states in terms of constructs referring to mood, access to emotion, sense of self and sense of other. These descriptions, in most details, were consistent with those recorded in the SDRs, suggesting that the reformulation process was satisfactory; but the routine use of self-state grids during reformulation is recommended. The value of conceptualising borderline patients in terms of self-states and state shifts is supported by this study.

Comment The SDR and self-states grid are not, of course, arrived at totally independently, as both emerge from the work of recognition and reformulation. The grid, in this sense, is a means of actively involving the patient in the process through a method which can clarify the discriminations made.

Impact of reformulation

Evans and Parry (in press) report a study of four patients with borderline personality disorder treated with CAT. The aim was to investigate the impact of reformulation of these 'hard to treat' patients. Three questionnaires were administered after each session (Personal Questionnaire, Penn helping alliance and perceived helpfulness of therapy ratings). In addition, 3–4 sessions after the reformulation letter was read out, subjects were given a semi-structured interview at which the impact of the reformulation was explored. The

interview suggested a major positive impact from the reformulation, but none of the questionnaires recorded significant short-term impact. The authors consider how far this reflects the focus of the instruments used, and how far the impact of reformulation may be spread over the prior joint collaborative work and subsequent use of the reformulation.

Comment This paper suggests an interesting area for further research.

The relation of SDR self-states to variations in transference and countertransference

Two of the five patients described in Ryle and Marlowe (1995; see also Ryle, 1995) rated their attitude to the therapist after each session on the Therapy Experience Questionnaire. Therapists similarly recorded their sense of each session on the Sessional Grid. Variations in scores derived from these instruments were related to the sequential diagrams. It was considered that the self-states and procedures described in the SDR served to predict and explain the interactions implied by the TEQ and Sessional Grid.

Comment These papers offer further evidence for the accuracy and value of self-state SDRs.

The accuracy of reformulation in CAT: a comparison of methods for identifying recurrent relationship themes

Bennett (personal communication) and Bennett and Parry (in preparation) describe studies in which audiotape records of sessions 1 and 2 were scored using two established methods, namely the Core Conflict Relationship Theme method and the Structural Analysis of Social-Behaviour-Cycle Maladaptive Pattern. Comparison of the themes identified by these methods with those recorded in the SDR showed very high levels of agreement, indicating that it is possible for therapists and patients to arrive at descriptions of the patients' core interpersonal and intrapersonal patterns.

Comment This work is part of an ongoing study of process from which a clear picture of CAT practice and clear criteria for measuring therapists compliance with the model should emerge. Incidentally, the standardised methods of identifying relationship themes are considerably more time-consuming than the reformulation process.

Current research

Three of the studies described above (those by Ryle and Marlowe, Ryle, and Bennett and Parry) are part of a long-term cumulative study of patients with borderline personality disorder (BPD), in which the overall impact of CAT will be assessed and related to process measures.

There are very few outcome studies of borderline personality disorder in the literature. The view generally held is that these patients have a tendency to drop out of therapy and that successful psychotherapy needs to be prolonged and intensive; three times weekly for at least four years is indicated according to Gunderson and Sabo (1993), although these authors report some slight support for time-limited work. Recent reports include that concerning the impact of 'dialectical behaviour therapy' (Shearin and Linehan, 1993), a model involving individual and group work (total about two-and-a-half hours weekly), usually for two years. They report positive effects over the first 31 weeks of therapy, associated with the patient's perception of the therapist as supportive and not critical. This behavioural approach pays considerable attention to the therapist's countertransference. Stevenson and Meares (1992) report on a series of patients treated twice-weekly for one year in a model derived from a range of self psychologies, in which therapists received supervision on audiotapes of their sessions. The subjects showed improvements on a range of measures and 30% no longer fulfilled BPD criteria at follow-up. CAT shares features from each of these two approaches, and comparison with the further work of the two teams, in terms of clinical method and outcome, will be important.

In the present study, patients presenting with BPD are recruited from outpatient referrals on the basis of a standard diagnostic interview. They are psychiatrically assessed and medication, if prescribed, is managed independently of the project. Routine psychometry is carried out. Up to 24 sessions are offered, the number being negotiated at around session 10, and follow-up sessions are offered at one, two, three and six months. The post-therapy research assessment takes place after three months, with a repeat of the diagnostic interview and psychometry and with a tape-recorded post-therapy interview covering all the issues identified at assessment or reformulation, on the basis of which both patient and therapist rate symptomatic and dynamic (procedural) change. All sessions are audiotaped and used for self-supervision; therapists each get 30 minutes of supervision weekly, in groups of three. Sessional audiotapes and the routine therapy documents and the questionnaires described in the papers reviewed above are also assessed as part of the process analysis.

Of 22 patients recruited to the project and attending the first session, two

were referred out as unsuitable, two attended once only, one moved away and two dropped out, one of whom re-presented and completed therapy in the next year. Thirteen of the fifteen patients who have completed therapy have been assessed around four months after termination. Eight of these no longer met borderline diagnostic criteria. Two of these and the five with persistant borderline status were referred on for a variety of treatments. Five patients have been assessed one year later; all showed further reductions in psychometric scores and only one remained in treatment.

Comment This is very much a work-in-progress report. The speed and detail with which the process and outcome studies can be accumulated will depend on whether research support is acquired, and long-term follow-up will be attempted. It does seem, even on what has been done, that CAT has a claim to be considered as an appropriate part of any comprehensive psychiatric service. Its ability to produce profound change in at least some patients in a six-month intervention reflects, I would believe, the powerful impact of reformulation in terms of the self-state SDR, but clearly this claim needs more research backing.

Future research

Despite its research origins, the momentum of research activity in CAT has been slow to gather speed. This can be attributed to the demands of service provision and of training and, of course, to resource limitations, but it is to be hoped that these excuses will have decreasing influence. The inclusion of a research component in the Advanced CAT training has already indicated that active curiosity can be combined with clinical skills, and some of these student projects may well develop into formal research enterprises. It may also be the case that, having achieved recognition as a defined therapy making claims which some see as outrageous, CAT will attract the interest of academic researchers with commitments to different approaches.

References

Bennett, D. and Parry, G. (in preparation). The accuracy of reformulation in cognitive analytic therapy: a comparison of two methods for the identification of recurrent relationship patterns.

Bloomgarten, Z.T., Karmally, W. and Metzger, R.N. et al. (1987). Randomised controlled trial of diabetic patient education: improved knowledge without improved metabolic status, *Diabetes Care*, **10** (3), 263–272.

Bosley, C.M., Fosbury, J., Parry, D.T. and Higgins, A.J. (1992). Psychological aspects

of patient compliance in Asthma, *European Respiratory Journal*, **5** (suppl. 15).
Bosley, C.M., Fosbury, J.A. and Cochraine, G.M. (submitted). The psychological problems associated with poor compliance with treatment in asthma.
Brockman, B., Poynton, A., Ryle, A. and Watson, J.P. (1987). Effectiveness of time-limited therapy carried out by trainees: comparison of two methods, *British Journal of Psychiatry*, **151**, 602–609.
Clarke, S. and Llewelyn, S. (1994). Personal constructs of survivors of childhood sexual abuse receiving cognitive analytic therapy, *British Journal of Medical Psychology*, **67**, 273–189.
Curtis, J.T. and Silberschatz, G. (1986). Clinical implications of research on brief dynamic therapy: formulating the patient's problems and goals, *Psychoanalytic Psychology*, **3** (1), 13–25.
Cowmeadow, P. (1994). Deliberate self-harm and cognitive analytic therapy, *International Journal of Short-Term Psychotherapy*, **9** (2/3), 135–150.
Duignan, I. and Mitzman, S.F. (1994). Measuring individual change in patients receiving time-limited cognitive analytic therapy, *International Journal of Time-Limited Psychotherapy*, **9** (2/3), 151–160.
Evans, J. and Parry, G. (in press). The impact of 'reformulation' in cognitive analytic therapy with difficult-to-help clients, *Clinical Psychology and Psychotherapy*.
Fosbury, J.A. (1994a). Cognitive Analytic Therapy with poorly controlled type 1 diabetic patients. European Association for the study of diabetes, Conference Abstract, 27 September–1 October 1994, p. A175.
Fosbury, J.A. (1994b). Cognitive Analytic Therapy with poorly controlled insulin-dependent diabetic patients. In: Coles, C. (Ed), *Psychology and Diabetes Care*. Chichester, PMH Production.
Garyfallos, G., Adampoulou, M., Saitis, M., Sotiriou, M., Zlatanos, D. and Alektoridis, P. (1993). Evaluation of cognitive analytic therapy (CAT) outcome, *Neurologia et Psychiatra*, **12** (3), 121–125.
Goldfried, M.R., Greenberg, L.S. and Marmar, C. (1990). Individual psychotherapy: process and outcome, *Annual Review of Psychology*, **41**, 659–688.
Gunderson, J. and Sabo, A.N. (1993). Treatment of borderline personality disorder: a critical review. In: Paris, J. (Ed), *Borderline Personality Disorder: Etiology and Treatment*. Washington, American Psychiatric Press.
Leventhal, H. and Cameron, L. (1987). Behavioural theories and the problem of compliance, *Patient Education and Counselling*, **1**, O. 117–138.
Mann, J. and Goldman, R. (1982). *A Casebook in Time-Limited Psychotherapy*. New York, McGraw-Hill.
Milton, J. (1989). Brief psychotherapy with poorly controlled diabetics. *British Journal of Psychotherapy*, **5** (4), 532–543.
Milton, J. (unpublished). Brief psychotherapy compared with nurse education for improving diabetic control in insulin-dependent patients showing poor self-care: a pilot study.
Mitzman, S. and Duignan, I. (1993). One man's group: brief cognitive analytic group therapy and the use of sequential diagrammatic reformulation, *Counselling Psychology Quarterly*, **6** (3), 183–192.
Orlinsky, D.E. and Howard, K.I. (1986). Process and outcome in psychotherapy. In: Garfield, S.L. and Bergin, A.E. (Eds), *Handbook of Psychotherapy and Behaviour Change*. New York, John Wiley.
Pollock, P.H. and Kear-Colwell, J.J. (1994). Women who stab: a personal construct analysis of sexual victimisation and offending behaviour, *British Journal of Medical Psychology*, **67**, 13–22.

Ryle, A. (1975). *Frames and Cages*. London, Chatto and Windus.
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 focussed, integrated, active psychotherapy: a study of fifteen cases, *British Journal of Psychiatry*, **137**, 474–486.
Ryle, A. (1995). Transference and countertransference variation in the course of cognitive analytic therapy of two borderline patients: the relation to the diagrammatic reformulation of self states, *British Journal of Medical Psychology*, in press.
Ryle, A., Boa, C. and Fosbury, J. (1993). Identifying the causes of poor self-management in insulin-dependent diabetics: the use of cognitive analytic techniques. In: Hodes, M. and Moorey, S. (Eds), *Psychological Treatment in Disease and Illness*. London, Gaskell (Society for Psychsomatic Research).
Ryle, A. and Breen, D. (1972). The use of the double dyad grid in the clinical setting, *British Journal of Medical Psychology*, **45**, 483–489.
Ryle, A. and Lipschitz, S. (1975). Recording change in marital therapy with the reconstruction grid, *British Journal of Medical Psychology*, **48**, 39–48.
Ryle, A. and Lunghi, M. (1970). The dyad grid: a modification of the repertory grid technique, *British Journal of Psychiatry*, **117**, 323–327.
Ryle, A. and Marlowe, M.J. (1995). Cognitive analytic therapy of 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** (1), in press.
Shearin, E.N. and Linehan, M.M. (1993). Dialectical behaviour therapy for borderline personality disorder: treatment goals, strategies and empirical support. In: Paris, J. (Ed), *Borderline Personality Disorder: Etiology and Treatment*. Washington, American Psychiatric Press.
Stevenson, J. and Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder, *American Journal of Psychiatry*, **149** (3), 358–362.
Surwit, R.S., Scovern, A.W. and Feinglos, M.N. (1982). The role of behaviour in diabetes care, *Diabetes Care*, **5** (3), 337–342.
Treasure, J., Todd, G., Brolly, M., Tiller, J. and Denman, F. (1994). A randomised trial of cognitive analytical therapy versus educational behavioral therapy for adult anorexia nervosa, *Behaviour Research and Therapy* (in press).