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Research paper

Efficacy of narrative reformulation during cognitive analytic therapy for depression: Randomized dismantling trial

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ABSTRACT

Background: Narrative reformulation (NR) is a component of cognitive analytic therapy (CAT) that is assumed to increase client engagement and improve clinical outcomes. This study set out to test these claims.
Methods: A single-blind randomized and controlled dismantling trial investigated treatment outcomes for moderate to severely depressed patients receiving CAT in Primary Care. Ninety-five participants were randomized to either full-CAT (n = 52) or CAT minus narrative reformulation (CAT-NR, n = 43). Treatment duration in both arms was 8-sessions and was matched apart from the omission of the NR in the CAT-NR arm. The primary outcome measure was the Patient Health Questionnaire (PHQ-9), with secondary outcome measures of anxiety, functioning, helpfulness and the therapeutic alliance. Outcomes were assessed at screening, every treatment session and at 8-weeks follow-up.
Results: Growth curve modelling found that NR did not enhance the efficacy of CAT for depression. There were no significant differences between groups in terms of attendance, adverse events, anxiety, functioning, helpfulness or therapeutic alliance. There were large within-group effect sizes ($d_+ > 1.5$), as CAT with or without NR produced significant reductions in depression ($p < .01$).
Limitations: The primary outcome were assessed via self-report and the follow-up period was brief.
Conclusions: These results suggest that NR may be redundant when treating depression with CAT. Whilst a brief 8-session version of the CAT model appears suitable for treating depression in Primary Care, further research regarding the need for NR is indicated.

Whilst a large evidence base validates the efficacy of certain psychotherapies for depression (Cuijpers et al., 2013), evidence identifying the specific and active ingredients of these effective treatments is scarce (Cuijpers et al., 2008). The appropriate methodologies for identifying the active constituents of psychotherapies are deconstruction trials (Carrico and Antoni, 2008) or component analyses (Bell et al., 2013). Such methodologies offer the opportunity to isolate causal relationships between therapy ingredients and outcomes (Borkovec and Sibrava, 2005) and allow conclusions to be drawn about the clinical need for specific treatment components or techniques (Czaja et al., 2003). 'Dismantling' trials assess the efficacy of a treatment when a specific component is removed, whilst 'additive' trials assess treatments with a specific component added (Ahn and Wampold, 2001). For example, an early landmark dismantling trial by Jacobson et al. (1996) found that the behavioural activation component of cognitive behaviour therapy (CBT) produced equivalent outcomes to full CBT. This study supported the application of behavioural activation as a stand-alone depression treatment (Mazzucchelli et al., 2009). Meta-analytic evidence illustrates that dismantling trials rarely yield any significant differences between study arms, whereas additive designs tend to yield small (but improved) treatment outcomes (Bell and D'Zurilla, 2009).

Cognitive analytic therapy (CAT) is a relational, integrative and time-limited psychotherapy informed by cognitive and psychodynamic theory/methods, which was specifically designed for use in pressured public services (Ryle and Kerr, 2002). Whilst CAT was initially developed in the United Kingdom (UK), it is now practiced internationally, most notably in Ireland, Spain, Italy, India, Australia and Greece (Ryle et al., 2014). CAT is typically delivered in 8, 16 or 24 session versions of the model, allocated according to patient complexity

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(Ryle and Kerr, 2002). The analytical aspect of CAT concerns the concept of reciprocal role dynamics (Ryle and Kerr, 2002), in which the patient inhabits and enacts (both in and out of therapy) unhelpful, limited and stereotyped roles, which are often formed as a result of early developmental abuse/neglect/abandonment Roles can be self-self, self-other and other-self with the patient reversing between both ends of a reciprocal role (e.g. both criticising of self/others and eliciting criticism from others and also feeling put down/humiliated by the actions of others; summarised as a criticising to humiliated reciprocal role). The cognitive aspect of the model (Ryle and Kerr, 2002) concerns procedural sequences of aim, thought, feeling, action and consequences that result from reciprocal role enactment. The cognitive and analytic aspects of the CAT model were initially theoretically integrated via the object relations procedural sequence model (Ryle, 1991) and then further assimilated via the multiple self-states model (MMSM; Ryle, 1997).

CAT differs from cognitive-behavioural therapy for depression by taking a relational approach to symptomatology, working with the past, analysing enactments within the therapeutic relationship and associated analysis of habitual relationship patterns (Ryle and Kellett, 2018). The closest version of CBT to CAT would be schema therapy, as there is an emphasis during schema therapy on family history, developmental trauma and interpersonal relationships creating and maintaining distress (Young et al., 2003). A model of how change is accomplished and achieved during CAT for depression has been recently developed using task analysis (Sandhu et al., 2017). This model shows that change is typically achieved on the foundation stone of improved self-awareness of depressogenic reciprocal roles and associated procedures, through the development of an 'observing self' (Ryle and Kerr, 2002). The first tool used in CAT to facilitate greater self-awareness is that of narrative reformulation (NR), followed by a sequential diagrammatic reformulation (SDR). NR specifies the developmental origins of dysfunctional relational roles and patterns, highlights possible enactments of such dysfunctional role procedures in the therapeutic relationship, identifies the target problem procedures underlying/maintaining the presenting problem, predicts reactions to termination and defines goals (Hamill et al., 2008). NR is presented in letter form, read to patients at the completion of assessment and patients are asked to review and then add to the NR (often as the first between-session task) and a final version is agreed (Ryle and Kellett, 2018).

NR has been proposed to be a central aspect of the CAT clinical method (Ryle and Kellett, 2018). Whilst NR only takes one session to deliver, preparation (and associated clinical supervision) time is significant due to the complexity of the task (Denman, 2001). The validity of reformulation during CAT to accurately reflect reciprocal roles and target problem procedures has previously been illustrated in a case study using the core conflictual relationship theme method and structural analysis of social behaviour - cyclic maladaptive pattern assessments (Bennett and Parry, 1998). NR can evoke both strong positive and negative emotional responses in patients (Rayner et al., 2011). A marked negative emotional reaction to NR would be viewed as a potential enactment of a reciprocal role (i.e. the patient experiences NR as criticising and feels humiliated), rather than the NR being inherently wrong in itself (Ryle and Kellett, 2018). NR has been widely assumed to be therapeutic in itself by lifting morale, strengthening therapeutic alliances via compassion, raising hope and focussing the treatment (Ryle, 1990; Ryle and Kerr, 2002). Qualitative evidence suggests that NR can help patients to feel accepted/understood, enhancing connections with self, the therapist and the therapy (Hamill et al., 2008). However, evidence concerning the symptomatic impact of NR is mixed. Two small studies (Evans and Parry, 1996; Shine and Westacott, 2010) failed to find any effect of NR on symptom amelioration. There has been evidence presented of sudden (beneficial) symptomatic change following NR in a case series of CAT for obsessive morbid jealousy (Curling et al., 2018) and during the single case experimental design evaluations of dissociative identity disorder, (Kellett, 2005), paranoid personality disorder (Kellett & Hardy, 2014), sex addiction (Kellett et al., 2016) and obsessive morbid jealousy (Curling et al., 2017). However, these small N studies are likely to be limited by selection biases and may not be representative of wider clinical populations.

In view of the inconclusive evidence outlined above, this study sought to isolate and test the efficacy of NR during CAT, due to (a) NR being potentially draining of therapist time (Denman, 2001), (b) unresolved questions concerning the clinical utility of NR, (c) the lack of depression trials within the CAT evidence base (Calvert and Kellett, 2014) and (d) the extant NR evidence base being wholly based on small studies. The primary aim of this study was to assess (in a suitably powered study) whether NR is a specific active ingredient of CAT. In order to achieve this aim, the study employed a dismantling deconstruction trial methodology (Bell et al., 2013). Therefore, treatment outcomes for depressed participants receiving treatment as usual (i.e. full-CAT), were contrasted with those who received CAT minus its narrative reformulation component (i.e. CAT-NR). The research is novel as the CAT evidence base does not contain any deconstruction trials. Study hypotheses were as follows: (1) participants in the full-CAT arm would achieve better depression outcomes and (2) experience a better therapeutic alliance and find therapy more helpful.

1. Method

1.1. Participants

Ethical and research governance approvals were obtained from the English National Health Service (*NRES reference number: 10/H0405/53*) and the trial was registered (*CT reference number: 10/H0405/53*). Participants were recruited and treated in a single Improving Access to Psychological Therapies (IAPT) service in the United Kingdom (UK), set in a socio-economically deprived community. IAPT services in the UK provide evidence-based psychological therapies in Primary Care for anxiety and depression, using a stepped-care treatment model (Clark, 2011). General medical practitioners had initially diagnosed depression in potential participants, identified the need for a 'talking treatment' and referred them to the IAPT service. IAPT staff then allocated depressed patients to the trial after a screening appointment, with trial recruitment taking place via an initial study suitability meeting. The initial screening appointments were conducted by Psychological Wellbeing Practitioners, who are graduate workers in IAPT services that provide guided self-help interventions based on cognitive-behavioural theory. National curricula and associated assessment and treatment competency frameworks are available (UCL, 2015). PWPs are therefore specifically trained in the assessment of common mental health problems and make treatment recommendations as a routine aspect of their role (Firth et al., 2015). Trial screenings were completed by the research team and if the participant was suitable for the trial then they were provided with a study information leaflet explaining the dismantling methods of the study (in lay person's language). In brief, participants were told that if they consented to participate in the trial they would be randomised to one of two arms (i.e. full treatment or treatment without a feedback letter from the therapist), and they would be blind to their allocation. No participants refused to participate in the trial after reading the information leaflet.

Fig. 1 details the flow of participants through the stages of the study and documents the reasons for trial exclusion. In total, $n = 125$ were screened for study suitability, with $n = 95$ (76%) randomised (26 males and 69 females with an age range of 19–65) and $n = 30$ (24%) excluded. Inclusion criteria were that the trial screening interview had to identify the presence of depression (interview conducted using DSM-IV criteria; American Psychiatric Association, 1994) and participants needed to have clinical case-level depression symptoms (i.e. score 10–21) on the Patient Health Questionnaire (PHQ-9, Spitzer et al., 1999). Exclusion criteria were: a PHQ-9 score <10, not meeting DSM-