Chapter 1

THE SCOPE AND FOCUS OF CAT

SUMMARY

CAT evolved as an integration of cognitive, psychoanalytic and, more recently, Vygotskian ideas, with an emphasis on therapist–patient collaboration in creating and applying descriptive reformulations of presenting problems. The model arose from a continuing commitment to research into effective therapies and from a concern with delivering appropriate, time-limited, treatment in the public sector. Originally developed as a model of individual therapy, CAT now offers a general theory of psychotherapy with applicability to a wide range of conditions in many different settings.

In order to locate cognitive analytic therapy (CAT) in the still expanding array of approaches to psychotherapy and counselling and to indicate the continuing developments in its theory and practice, its main features will be briefly summarised in this introductory chapter.

CAT IS AN INTEGRATED MODEL

One source of CAT was a wish to find a common language for the psychotherapies. While there is a place for different perspectives and different aims in psychotherapy, the use by the different schools of virtually unrelated concepts and languages to describe the same phenomena seems absurd. It has resulted in a situation where discussion is largely confined to the parish magazines of each of the different churches or to the trading of insults between them. Despite the growth of interest in integration and the spread of technical eclecticism in recent

years the situation has not radically altered; CAT remains one of the few models to propose a comprehensive theory which aims to integrate the more robust and valid findings of different schools of psychotherapy as well as those of developmental psychology and observational research.

The process of integration in CAT originated in the use of cognitive methods and tools to research the process and outcome of psychodynamic therapy. This involved the translation of many psychoanalytic concepts into a more accessible language based on the new cognitive psychology. This led on to a consideration of the methods employed by current cognitive-behavioural and psychodynamic practitioners. While cognitive-behavioural models of therapy needed to take more account of the key role of human relationships in development, in psychopathology and in therapy, their emphasis on the analysis and description of the sequences connecting behaviours to outcomes and beliefs to emotions made an important contribution. Psychoanalysis offered three main important understandings, namely its emphasis on the relation of early development to psychological structures, its recognition of how patterns of relationship derived from early experience are at the root of most psychological distress and its understanding of how these patterns are repeated in, and may be modified through, the patient–therapist relationship.

Neither cognitive nor psychoanalytic models acknowledge adequately the extent to which individual human personality is formed and maintained through relating to and communicating with others and through the internalisation of the meanings developed in such relationships, meanings which reflect the values and structures of the wider culture. In CAT, the self is seen to be developed and maintained in the course of such interactions.

CAT IS A COLLABORATIVE THERAPY

The practice of CAT reflects these theoretical developments. It has been suggested that, in contrast to the traditional polarisation of health care professionals between those who are good at 'doing to' their patients (e.g. surgeons and perhaps some behaviour therapists) and those who are good at 'being with' their patients (e.g. many dynamic psychotherapists or nurses involved in long-term care), the CAT therapist is good at *'doing with'* their patients (Kerr, 1998b). This highlights the fact that CAT involves hard work for both patients and therapists and also the fact that much of this work is done together and that the therapy relationship plays a major role in assisting change.

The ways therapists describe their patients have implications for the value they accord to them and the nature of the therapeutic relationship conveys more than any particular technique. The techniques used and how they are employed must convey human acknowledgement and value. CAT therapists therefore encourage patients to participate to the greatest possible extent in their therapies; therapists do know useful ways of thinking and, in some sense,

are experts involved in activities which parallel parenting or remedial teaching, but our patients are not pupils or children and their capacities need to be respected, mobilised and enlarged through the joint creation of new understandings.

CAT IS RESEARCH BASED

One reason, or excuse, for the underfunding of psychotherapy in the National Health Service (NHS) has been the failure of dynamic therapists to evaluate seriously the efficacy of their work. The outcome research which led on to the development of CAT pre-dated the present insistence on evidence-based practice, originating in a programme dating back to the 1960s which aimed to develop measures of dynamic change. While the research base remains inadequate, the evolution of the model over the last 20 years has been accompanied by a continuous programme of largely small-scale research into both the process and outcome of therapy and this continues on an expanding scale.

CAT EVOLVED FROM THE NEEDS OF WORKING IN THE PUBLIC SECTOR AND REMAINS IDEALLY SUITED TO IT

Despite the proliferation of treatment models, a considerable proportion of psychologically distressed people in the UK (and in most other developed nations, let alone in the developing world) do not have access to effective psychological treatment. CAT, by providing a therapy which can be delivered at reasonable cost while being effective across a wide spectrum of diagnoses and a wide range of severity, is a contribution to meeting their needs. Most CAT therapists have worked in the NHS as nurses, occupational therapists, social workers, psychologists or psychiatrists; we are experienced in, and largely committed to, work in the public sector. We share a social perspective which assumes that psychotherapy services should take responsibility for those in need in the populations we serve, and should not be reserved for those individuals who happen to find (or buy) their way to the consulting room. It does, however, appear, not surprisingly perhaps, that CAT is becoming a very popular model of therapy in the private sector where many therapists make their living. Here, its time-limited but radical approach appeals to many clients who may have, possibly serious, psychological difficulties but who do not wish to spend protracted periods of time in long-term therapies of uncertain efficacy. As a model of brief therapy it is of course, for very different reasons, attractive to health insurance companies.

Our own social perspective is not new. The following description of the NHS was sent to demobilised servicemen in 1950: 'It will provide you with all medical, dental and nursing care. Everyone, rich, poor, man, woman or child,

can use it or any part of it. There are no charges except for a few special items .... But it is not a charity. You are all paying for it, mainly as taxpayers and it will relieve your money worries in times of illness.' (Quoted in Wedderburn, 1996.) Despite the chronic underfunding of mental health services and of psychotherapy in particular, we believe that these principles can still be fought for and that CAT can contribute to their realisation.

CAT IS TIME-LIMITED

CAT is delivered in a predetermined time limit. While this time limit is clearly one important way of being cost-effective, the important argument in its favour rests on the fact that, for most people, time-limited therapy is as clinically effective as many much more prolonged interventions. The time limit is usually of 16 sessions but this can be extended in treating more disturbed and damaged patients or shortened where the threshold to consultation is low and mildly disturbed patients are seen.

CAT OFFERS A GENERAL THEORY, NOT JUST A NEW PACKAGE OF TECHNIQUES

The book aims to describe and illustrate the methods, techniques and tools developed in CAT. While largely concerned with individual therapy, applications in other modalities are considered, as are the wider implications for psychotherapy theory. While some CAT techniques could be incorporated in other treatment approaches, the model and the method involve more than these. Psychotherapy patients can make use of a great many different psychotherapy techniques and there would be no point in simply offering a new combination of these under a new label. So why do we need theory?

One robust finding from psychotherapy research is that the patient's perception of the therapist as helpful is associated with a good outcome. This being so, a major part of any therapy model must be concerned with how to achieve this, given that the central problem for many patients is that they are damaging or incompetent in their personal relationships and are mistrustful and destructive of offers of help from others. Overcoming these tendencies is never easy and becomes increasingly important and difficult as more disturbed patients are considered. Being helpful means more than being nice, indeed it may sometimes involve being 'nasty' or at least confronting; the crucial quality required is to respect the patient enough to be honest. Techniques therefore need to be understood in relation to the complex human issues which are at the heart of therapy. Those used in CAT, whether adapted from other approaches or specific to CAT, have, as their main aim, the development of the patients' capacities to know, reflect on and ultimately control their negative actions and experiences.

Other tools and techniques are designed to maintain the therapist's adherence to the methods and values of the approach; they provide a framework within which a sincere and often intense working relationship can flourish. Practice embedded in theoretical clarity must be combined with accurate empathy if therapists are to be able to reach and maintain an understanding of their patients' experiences and at the same time be fully aware of their role in encouraging change.

CAT HAS APPLICATIONS IN MANY CLINICAL SETTINGS

The book is primarily addressed to those working with psychologically disturbed adults including those who, while not 'doing therapy', have important therapeutic responsibilities. We believe that psychological understandings should play a larger part than is now the case in the management of groups such as psychiatric patients with major mental illness, forensic patients and the mentally handicapped. We believe that psychotherapists should take more responsibility for supporting staff in these fields. In addition, psychotherapists should involve themselves both directly and in supporting staff in the treatment of patients with personality disorders who are currently so poorly served by mental health services. In all these fields, and in work with adolescents, experience is accumulating of applying CAT and the model is proving to be accessible and useful to patients and clinical staff. While both psychoanalysis and cognitive therapy have contributed to these fields neither, in our view, adequately mobilises the therapeutic power of the relationship between patients and those looking after them. We believe that CAT has a major contribution here, offering a distinct, coherent and teachable model of social and interpersonal interaction which can help individuals and staff groups respond helpfully, rather than react collusively, to their patients, and which may have applications outside clinical practice.