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7 CAT in relation to cognitive therapy

John Marzillier and Gillian Butler

Cognitive Analytic Therapy (CAT) is an avowedly integrative therapy. It has its theoretical roots in object relations theory, Kelly's personal construct theory, cognitive and behavioural science and developmental psychology. The therapeutic approach includes aspects of psychoanalysis (e.g. the interpretation of transference and countertransference), behaviour therapy (e.g. goal setting), cognitive therapy (e.g. challenging irrational beliefs), personal construct therapy (e.g. reappraisal of personal meaning), transactional analysis (e.g. parent–child–adult roles) as well as features that are unique to CAT such as the Sequential Diagrammatic Reformulation (SDR). The relative brevity of the therapy (between 12 and 24 sessions) is designed to make it affordable to public services and accessible to most clients. With this background CAT might be seen as the magpie of psychotherapies, snatching up the treasures of others and claiming them for its own. A more positive view would see CAT as one of a new breed of integrative psychotherapies which attempts to combine the best aspects of the traditional schools into a rich and potent mixture that has greater impact than the original recipes.

Aware of potential criticism of atheoretical eclecticism, Ryle (1990, 1994a) has sought to develop a theoretical model which he claims underpins the uniqueness of the approach. He originally called this the Procedural Sequence Model (PSM). *Procedures* are defined as 'linked sequences of mental and behavioural processes' guiding purposive action. *Sequences* describe the order in which procedures follow one another. These are normally hierarchical, with higher-order procedures (e.g. to enjoy life) being served by lower-order ones

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(e.g. to take care of my health) and by specific sub-procedures (e.g. not to smoke cigarettes). The sequences include both feedforward and feedback loops, with seven stages being worked through from defining the act to reviewing and revising the procedures and aim.

Psychological problems are viewed as the persistent use of ineffective or harmful procedures. CAT specifies them as Traps, Snags and Dilemmas and the goal of therapy is to identify and modify these maladaptive patterns. Successful therapy should lead to patients learning more effective procedures and thereby feeling more able to identify and manage the problems that brought them to seek help in the first place. Ryle (1990) acknowledges that the PSM is a cognitive theory in the broadest sense. Within a broad cognitive framework, CAT has claimed allegiance to theorists such as Kelly, Vygotsky, Mead and Bruner and to the constructivist position adopted by Mahoney, Arnkoff and others (see Leiman, 1994; Ryle, 1990, 1994b).

Stated in this way, CAT seems to bear a close resemblance to many cognitive therapies. (By 'cognitive therapy' we mean the therapeutic approach first developed by Beck (1970, 1976) which has stimulated a great deal of research and practice over the past 20 years.) Like CAT, cognitive therapy (CT) is a structured and generally brief therapeutic approach. The therapy entails identifying the way problems are maintained by maladaptive or ineffective patterns of thinking and behaviour such as negative automatic thoughts, vicious circles or dysfunctional beliefs. Through guided discovery and collaborative empiricism, patients learn alternative ways of thinking and behaving with the result that they gain greater understanding of and control over their emotional problems (e.g. Beck et al., 1979; Hawton et al., 1989).

One of the main questions asked in this chapter is whether there is something unique or different about CAT which sets it apart from other cognitive therapies. Or, to put it slightly differently, is CAT one version of the generic set of 'cognitive therapies' or is it something else altogether? As its name implies CAT incorporates ideas and techniques that stem from the psychoanalytic tradition. Ryle (1990, p. 208) declared: 'Largely despite themselves, and maybe without knowing it, cognitive psychotherapists' preoccupations are beginning to converge with the agenda of psychoanalysis. In CAT and the PSM can be found the matchmaker capable, I believe, of encouraging this desirable union.' Theoretical developments in CAT over the last decade have resulted in a more explicit incorporation of object relations theory into the procedural model, resulting in its extension and a change of name to Procedural Sequence Object Relations Model (PSORM) (Leiman, 1994; Ryle, 1985, 1992, 1994a). Certain basic procedures, which are captured in the psychoanalytic notion of object relations, take the form of *reciprocal role procedures* (RRPs). That is, they entail the capacity to understand, predict

and adapt to the actions and behaviour of others, thus emphasising the *relational* and *reciprocal* nature of human experience. RRPs are acquired from early experience, in particular parental and other family relationships, and from the basic culture in which people live. They operate primarily at an unconscious level and embody the essential rules that govern reciprocal human relations.

This leads us to the second question in this chapter, which is to do with the part played by psychoanalytic theory in CAT. For, to some, the unholy alliance of object relations theory and cognitive theory causes eyebrows to raise and leads to some intriguing questions. For example, what role is given to unconscious motivation? Or, to what extent would CAT endorse the Kleinian view of phantasy in infants? Or, how does the PSORM fit with the idea of primary process? These issues are discussed in detail elsewhere (Leiman, 1994; Ryle, 1994a, b and in this book). From our point of view we ask a simpler and more specific question: to what extent does CAT's incorporation of object relations theory take it outside the pale of modern cognitive therapies? Are there aspects of CAT that would preclude it from being considered a cognitive therapy?

This chapter is primarily concerned with theoretical issues. However, we have chosen to illustrate our analysis using a clinical case. The patient we describe was treated by the senior author using CAT. In presenting this case we ask the question: what would a cognitive therapist do differently and why? To some extent this is an artificial exercise since the therapeutic approach determines what clinical material is seen as relevant and so one can never truly know what another approach may have revealed. Nevertheless, the clinical case provides a good opportunity to see how apparent theoretical differences translate into actual practice. It has long been recognised that what may seem to be substantial theoretical differences often evaporate when practice is examined.

Meanings, conscious and unconscious

In recent years there has been a shift within cognitive therapy towards accepting ideas that seem to be more at home within psychoanalysis. For example, there is a growing acceptance that much of behaviour is governed by unconscious processes (e.g. Bowers and Meichenbaum, 1984; Horowitz, 1994; Mahoney and Freeman, 1985; Safran and Segal, 1991). There is a difference, of course, between what is sometimes known as 'the dynamic unconscious' and the recognition, long known to cognitive psychologists and indeed everybody else, that people do many things unawares. Within psychoanalysis unconscious processes seem to operate as subversive and powerful agents

whose aim is to distort the truth and defend against unpalatable feelings or memories, although this Freudian heritage is not the only nor the most balanced account of the dynamic unconscious (see Gordon, 1993). The simple notion that we are unaware of most things that we do is not seriously debated. As Erdelyi (1988, p. 82) put it: 'The notion of unconscious processes, in the sense of psychological processes unfolding outside consciousness, is about as uncontroversial in experimental psychology today as it is in psychoanalysis.' But, as he went on to say, it is at 'finer-grained levels' that problems arise.

One 'fine-grained' problem is to do with *meaning*. Within CT, meaning was originally equated with appraisal: so the quotation from Epictetus, much-loved by cognitive therapists, points to our being moved not by things themselves but by the meanings we give to them. That this originally referred to *conscious* meaning is clear in the following extract from Beck (1976, pp. 53–54):

> The behavioral and psychoanalytic models are similar in that they minimize the importance of meanings that are accessible to introspective observation and report. The behaviorists reject meaning totally and the psychoanalysts emphasize unconscious meanings. . . . The psychoanalytic and behavioral models skirt the common conception of why a person becomes sad, glad, afraid, or angry. The cognitive approach, however, *brings the whole matter of arousal of emotion back within the range of common-sense observation* (our italics).

Through 'common-sense observation', people can come to know the meaning of their emotional experiences, at least at one level. This is different from the psychoanalytic understanding of meaning in which unconscious processes play such a powerful role. It was, and still is, a hallmark of CT that meaning should not be arbitrarily assumed or inferred, but that all meanings should be seen as hypotheses which may be verified or not through observation, empirical testing and reflection. If someone were depressed because he thought that others looked down on him, for example, he might be encouraged to test the meaning of his belief and hopefully disconfirm it. If a therapist believed that a woman's panic attacks were an expression of her feeling trapped in an unhappy relationship, then the therapist would need to find evidence to support this interpretation and be prepared to discard it if that evidence were not forthcoming.

CAT also gives particular importance to enlarging conscious understanding by self-reflection. As Ryle (1990) put it: 'Reformulation, with the development of new tools of self-reflection, offers in most cases, the possibility of rapid change, mediated by practice and sustained by self-observation at a conscious level' (pp. 214–215). CAT therefore aligns itself with other cognitive therapies in drawing on meanings that are open to introspection and empirical testing. However, unconscious meanings are not rejected outright. In fact, they play a central role in the formulation and explanation of problems. In the Sequential Diagrammatic Reformulation (SDR) it is common to portray one or more

'core states' which contain inferences about possible unconscious feelings (e.g. envy, rage). The procedural loops that emerge from such states can have unconscious as well as conscious elements. For example, a placatory trap can be understood in conscious terms as seeking to please others in order to be accepted because one has learned not to value oneself; but it also may signify an unconscious defence against the expression of anger because of a fear that this may unleash a murderous rage.

We now turn to the clinical case to illustrate how CT and CAT deal with the possibility of unconscious meaning. (All names used in this case example are fictional and some details have been changed in order to ensure confidentiality.)

Melanie was a 33-year-old woman who worked as a director of a small company. Following the break-up of a relationship with a work colleague she became anxious and depressed and sought help from her family doctor who referred her on for psychotherapy. She was an attractive, youngish looking women, dressed with studied casualness in a light blue shirt and denim jeans. She related very easily but rather superficially to the therapist (male) and poured out her story, interrupted by frequent bouts of sobbing. She reported a history of repeated failure in relationships with men and thought that there was something fundamentally wrong with her. She expressed feelings of despair and hopelessness. She was moderately depressed though not suicidal and scored 23 on the Beck Depression Inventory (Beck et al., 1961), ticking items such as 'nothing to look forward to', 'a lot of failures in my life', 'expect to be punished', 'self-critical' and 'guilty'.

Melanie said that all her relationships with men had ended badly. At college she had had a long and stormy affair with a tutor who abused her physically and emotionally. Despite her distress she had felt unable to end the relationship and did so only after several attempts. She had had a series of relationships with men over the years, some casual and some more sustained, but found that on each occasion she was let down in some way. Once she had become pregnant and had the pregnancy terminated; she still felt considerable grief when she thought of the abortion. The relationship that precipitated her referral had been an intense and difficult one with Richard, a colleague at work. Eventually, he had broken it off with her. She had subsequently discovered that he had also been seeing a previous girlfriend for almost a year. Melanie was mortified: she felt abused and betrayed.

Melanie was the younger child of older parents. Her father, now retired, had worked as a manager of a shop. Melanie described him as a difficult and rather distant figure whose views dominated the family household. She was acutely aware of his preference for boys over girls; for example, he refused to countenance paying for his daughters' education because they were mere girls. Melanie described her mother as anxious and protective. There was considerable tension at home with frequent rows between her parents. Her mother withdrew from the family, seeking solace in drink and, later, spiritual healing. Melanie had an older sister, Christine, who was married with two young children. Melanie had shared a bedroom with Christine and said she had always felt in her shadow. She saw her as the successful child, academically bright, well organised, hard-working and her father's favourite. In contrast, Melanie saw herself as scatty and unsuccessful despite the fact that she had a high status and well-paid job.

Melanie hoped that therapy might somehow magically transform her and make it possible for her to have a successful relationship with a man. She was convinced that there must be some deficiency in her that had led to all her relationships with men breaking down: if this could be found and put right then perhaps there was a chance that she could be happy. 'I know,' she said, 'I *should* be happy now. I have a job which I enjoy, and am good at, and is well paid. I have my own flat and lots of friends. I travel a lot. But why is it that whenever I get interested in a man, it always goes wrong? It must be something in me, something that I do. But I don't know what. That's what gets me so down.'

For Melanie her repeated difficulties in relationships with men led her to believe that she was deficient in some way. This was the *meaning* that she gave to those experiences. Understandably this made her feel depressed, for in addition to believing herself to be deficient she also felt unable to change her way of behaving. From a CT perspective, this would lead to an exploration of meaning starting from identifying negative thoughts (e.g. 'I am stuck', 'there is nothing I can do', 'I am useless', 'nobody likes me'). Then examples of irrational or maladaptive thinking and assumptions would be elicited (e.g. 'Relationships always go wrong', 'If a man does not like me, then there must be something wrong with me', 'If I care about someone, I have to give in to them'). Finally, the underlying dysfunctional beliefs and schemas would be identified (e.g. 'I don't deserve to be happy', 'I am unlikeable', 'I am a stupid person'). Thus, the *conscious meaning* would be the starting point, but the exploration of meaning would extend further. In this case we might end up with ideas about underlying meanings which Melanie might not, initially at least, be conscious of. For example, a hypothesis might be that she had a 'defectiveness schema'—that is, one which encapsulated a fundamental belief that she was flawed as a person. Thus, while the original emphasis in CT had been on conscious meaning and commonsense observation, this has not precluded making assumptions about possible unconscious meanings: schemas, for example, describe processes that occur mainly unconsciously.

In CAT the process is very similar although the language is different. The client is given the Psychotherapy File where the basic assumptions of the approach are outlined and expressed in CAT language (Traps, Snags, Dilemmas, States of Mind). Melanie rated two of the Traps as particularly significant to her: depressive thinking and trying to please (placatory trap). She also pinpointed the Dilemma, 'If I care about someone, then I have to give in to them', as this seemed to epitomise her difficulties in relationships with men. She also reported experiencing intense emotions such as guilt and anger which she felt she switched into extremely quickly. At other times, she felt a sense of blankness and confusion. This material, together with the information from interviews, led the therapist to make the following preliminary formulation:

At the heart of Melanie's problems lay a doubt about her capacity to sustain a close and intimate relationship particularly with a man. The seeds of this were sown in her experiences as a child when she felt unloved and unwanted (if only she had been the boy her father wanted . . .). Because she felt fundamentally undeserving. Melanie had failed to set appropriate boundaries or assert her own needs in relationships with others. She had been drawn to exciting but untrustworthy men who had exploited her, sometimes abused her, and eventually discarded her. Despite being a successful career woman she felt unfulfilled. Her sister was married and had a family and Melanie felt inadequate and miserable when she met her, comparing herself unfavourably to her. Her conflicted feelings towards her father indicated a persistent and unresolved problem which is broadly Oedipal in nature. In her relationship to the therapist, Melanie also epitomised these problems to some degree. From the beginning she poured out her troubles, letting the tears flow. Her distress, while real, also had a superficial quality about it and the therapist felt 'appealed to' as though he would have to sort her out (but eventually let her down). Her sexuality came into subsequent sessions in the form of wearing sexy clothes and mild flirtation. This suggested that transferential aspects would be an important component of the therapy.

How does the CAT formulation differ from one that a cognitive therapist might have arrived at? Firstly, we should point out that there is likely to be considerable similarity. The focus on Melanie believing herself to be undeserving could, in CT terms, be seen as an 'undeserving schema' underlying her depression and her relationship difficulties. Further, both therapies seek to describe *patterns* that serve to maintain the problem: Traps and Dilemmas in CAT, negative thinking and vicious circles in CT.

The CAT formulation has also gone beyond the conscious meaning in two other ways. Firstly, there is the interpretation that Melanie's problems with men may have stemmed from an unresolved Oedipal problem with her father; that is, in her adult relationships with men she is in part unconsciously re-enacting an earlier, sexualised relationship to her father. Secondly, there is the interpretation that, in her relationship with the male therapist, Melanie replays transferentially some aspects of her general relationship to men. These interpretations come from a psychodynamic perspective and point to possible wider meanings which to the patient are unconscious. Would such unconscious meanings be acceptable within CT?

In CT there has always been the recognition that problems such as depression or anxiety are the product of earlier experiences. This is explicitly contained within the notion of *schema* which describes 'an extremely stable and enduring pattern that develops during childhood and is elaborated throughout an individual's life' (Bricker and Young, 1993). When an emotional problem arises this may be seen as the reactivation of a schema or schemas that have been dormant for many years. An important part of CT concerns the identification and modification of such schemas (see Beck et al., 1979; Kovacs and Beck, 1978). In some problems, for example personality disorders, CT is predominantly concerned with schema identification and modification (Beck and Freeman, 1990; Young, 1990).

It is perfectly possible to infer that in Melanie's case her relationships with her father, which she reported as difficult and distant, could have been a significant factor in the development of an 'undeserving' schema. This is not exactly the same as the Oedipal interpretation, but in both cases an inference is made to events in the patient's childhood and to experiences that are seen to be particularly significant in understanding her presenting problems. In CT there is nothing in principle that would outlaw such interpretations, including the Oedipal one, provided they were couched as hypotheses that would be tested. The cognitive therapist would not too readily jump to such interpretations without having good evidence and would be prepared to modify or discard them if they failed to be supported. Such caution would commonly be found in CAT too.

A similar point can be made with respect to the second interpretation. Transference is not a concept that features in the theory of CT. Nevertheless, the therapeutic relationship may be used as a source of information and hypotheses derived from the relationship about processes that may be operating elsewhere in the patient's life. Generally, patient and therapist seek to work together in a collaborative alliance. But where difficulties arise, these can be seen as due to the activation of particular schemas and the cognitive therapist would be attuned to these and seek to understand them. A cognitive therapist would not be surprised to discover that Melanie might seek to please her therapist even to her own detriment, nor that she might react to the older, male therapist in ways that echoed the way she related to her father.

In conclusion, it is clear that, in both CAT and CT, understanding and clarifying the meaning of the patient's problems is central and in both therapies this entails attention to both conscious and unconscious meanings. Although each approach has an interest in particular and sometimes different meanings, and different ways of going about exploring meanings, both recognise that problems can be understood at various levels of meaning. In CAT the influence of psychodynamic ideas is more obvious than it is within CT. However, in the development of schema-focused cognitive therapy and the work with personality-disordered patients, psychodynamic ideas have begun to appear more frequently in CT (Young, 1990).

Core states, schemas and unconscious motivation

The Sequential Diagrammatic Reformulation (SDR) is the key or blueprint to the CAT treatment. In Figure 7.1 the SDR that was drawn up for Melanie is shown. The central part is a 'core state' in which powerful feelings of emptiness, being lost, in a mess, uncared for and angry are experienced. All bar one of these feelings were directly reported by Melanie as occurring at

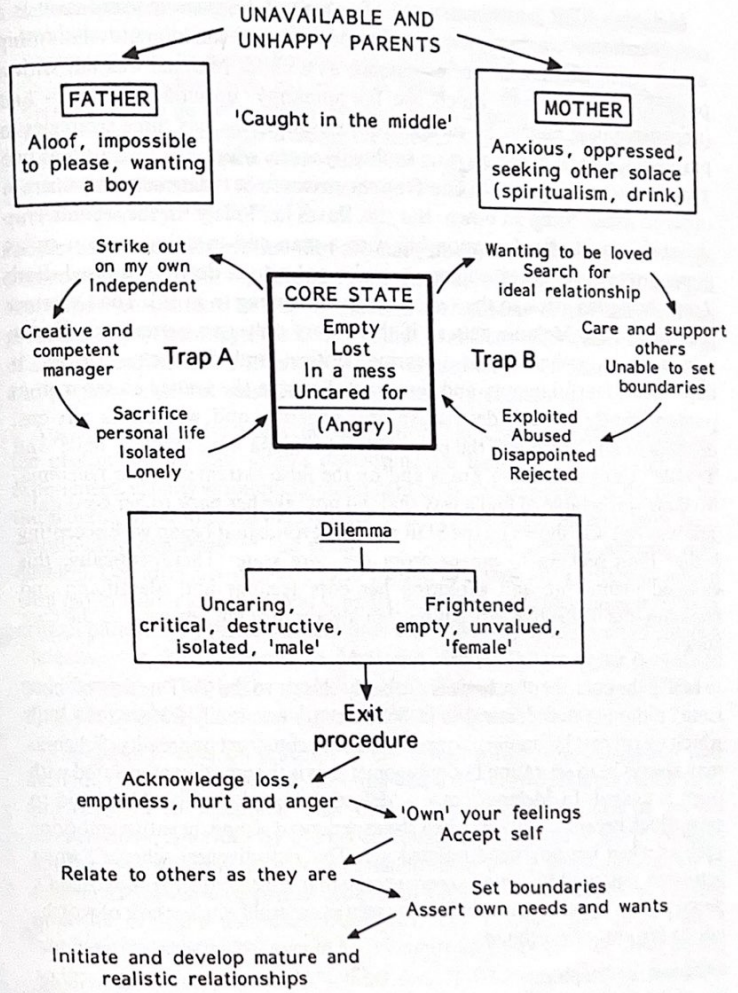

Figure 7.1: Melanie's SDR

times when she experienced this state of mind. The exception is anger which is hypothesised by the therapist as a feeling that was experienced unconsciously. As an indication of its hypothetical nature, it is placed in brackets and separated from the other feelings.

Melanie's SDR was constructed after several assessment sessions. It is a simplification of what may happen when Melanie seeks an intimate relationship with a man. Because of her experience as a child, Melanie was left with a powerful core state in which she felt unhappy, unfulfilled, unloved and (unconsciously) angry. To escape from this state she has three strategies in particular, although there are undoubtedly more, which are portrayed as two Traps and one Dilemma. In one Trap she strives to be independent of others in order to avoid being let down. But this leaves her lonely. In the second Trap she seeks an idealised relationship with a man and in doing so fails to set appropriate boundaries, ending up by being hurt, let down or abused. Both Traps bring her back to the very state she is seeking to avoid. The Dilemma illustrates how Melanie acts as if there were only two extreme choices in relationships: either she is uncaring, critical and destructive or she is dependent, fearful, empty and unvalued. Because she tended to see men as predominantly critical, destructive and uncaring and women as anxious, dependent and unvalued, the poles of the Dilemma were labelled 'male' and 'female'. Caught in these Traps and by the false extremes of the Dilemma, Melanie was unable to find a way that did not take her back to her core state. The way out was shown on the SDR as an exit route that began with accepting rather than seeking to escape from her core state. Therapeutically, this entailed identifying and exploring her core feelings and identifying and changing the ineffective procedures that always brought her back to the core state.

In CT the concept of *schema* is probably closest to the CAT notion of 'core state', although not identical to it. Schemas are essentially frameworks with which we process incoming information and so construct our reality. Schemas may always be in operation but only sometimes is the emotion associated with them activated. In Melanie's case a 'defectiveness schema' could be said to exist which became activated when she experienced strong, negative emotions such as when her boyfriend rejected her. The 'defectiveness schema', when activated, coloured Melanie's experiences so that, for example, her boyfriend's deceit and eventual rejection of her was seen as exemplifying *her* lack of worth, not as *his* untrustworthiness.

Recent developments in CT have seen a greater interest in describing particular schemas or constellations of schemas. Thus, Safran and Segal (1991) have stressed the interpersonal nature and origins of such schemas. Young (1990) has identified 16 different 'early maladaptive schemas' and developed a questionnaire to aid the identification of those that may be relevant to the presenting problem. There is also increasing recognition that schemas, like core states, cannot be easily changed. To quote Bricker and Young:

> Schemas are important beliefs and feelings about oneself and the environment which the individual accepts without question. They are self-perpetuating, and are very resistant to change. For instance, children who develop a schema that they are incompetent rarely challenge this belief, even as adults. The schema does not usually go away without therapy. Overwhelming success in people's lives is often still not enough to change the schema. The schema fights for its own survival, and, usually, quite successfully. Even though schemas persist once they are formed, they are not always in our awareness. Usually they operate in subtle ways, out of our awareness. (1993, p. 2)

People may have a schema that they are unaware of, that will resist attempts to change it and that will 'fight for its own survival' often successfully. Such a description would not be out of place in an account of the unconscious processes in psychoanalysis. It is also similar to and consistent with the notion of a 'core state' in CAT which also motivates behaviour, is resistant to change and parts of which at least are presumed to be unconscious.

Another common feature is the recognition that schemas and core states are the product of an individual's developmental history; it is through early experiences, usually emotionally significant ones, that schemas are formed. So the schema of 'emotional deprivation' often arises when parents have been emotionally depriving to the child. The 'failure to achieve' schema may develop if children are put down and treated as if they are a failure at school with parents failing to give good support, discipline and encouragement. Very critical parents may make their children feel unworthy of love and so create a 'defectiveness/shame' schema. In Melanie's case the failure of her parents to pay attention to her led her to believe that she was not worthy regardless of what she might achieve, resulting in a 'defectiveness' schema.

The greater focus on schemas in CT brings with it the recognition that individual behaviour can have meaning which the individual is unconscious of and resistant to accepting. This view is endorsed in the idea of *schema compensation*, described by Bricker & Young (1993) as one of the three ways schemas work (along with *schema maintenance* and *schema avoidance*). In *schema compensation* a person behaves in a manner which appears to be the opposite of what the schema suggests. For example, someone with a 'subjugation' schema behaves in a very controlling way towards other people so that no one will get the better of her; that is, she compensates for her basic sense of weakness by seeking to be strong. This is in effect Adler's notion of 'the inferiority complex'. Another person may present himself as someone who does not need people in order to avoid feeling dependent, which is part of a 'functional dependence' schema. Melanie would seek the attention of others, men in particular, by making herself appear really attractive. In that way she hid her feelings of defectiveness beneath a veneer of sexual attractiveness.

Schema compensation is another way of describing unconscious motivation:

it is presumed that the schema motivates behaviour in a way of which the individual is unaware. CAT also incorporates the idea that people behave in ways that are unconsciously motivated in the sense that people may be driven by a desire to avoid or escape from a core state. For example, a man who has been hurt by a brutalising childhood has a core state in which there are deep feelings of hurt, fear and loneliness. His behaviour towards others is either to avoid intimacy altogether and exploit people for his own ends, or to control those he is close to in order to ensure that they will not be able to hurt him. In doing this he is quite unaware that his behaviour is motivated by the need to avoid such a core state; his motivation is primarily unconscious. In CT terms this would exemplify all three processes of schema compensation, maintenance and avoidance, the schema being either 'mistrust/abuse', 'emotional deprivation' or 'entitlement/self-centredness' or a combination of the three.

In both CAT and CT, therefore, there is an acceptance of the part played by motives of which people are unconscious. The PSORM admits of the role played by unconscious motivation in the incorporation of psychoanalytic notions such as defence mechanisms as examples of procedural sequences (Ryle, 1990, 1991, 1992). Also the hierarchical nature of the procedural sequences is such that conscious intentions and actions are the end results of largely unconscious mental processes. Theoretical models within CT have similarly moved towards the view that people's thoughts, behaviour and feelings are governed by processes of which they are quite unaware. This is apparent in the revised role given to emotional experience.

Emotion

In the early cognitive models of emotional responding it was believed that the cognitive process of appraisal determined the nature of the emotional response in a more-or-less linear relationship. Hearing a sound in the middle of the night will give rise to fear if it is appraised as the presence of a burglar; it might give rise to relief, however, if it is appraised as one's teenager daughter returning late from a party. The appraisal determines the emotional response. However, following Zajonc's (1980) critique, this simple linear notion has been called to question. Emotions are not simply the product of cognitive appraisal. Apart from the evidence that shows that emotions and cognitions are on the whole reciprocally interrelated (Teasdale, 1983), there is also a growing recognition that some forms of emotional experience are processed directly without any conscious appraisal process intervening. Further, the nature of the relationship between affect and cognition is more complex than any linear, causal relationship would suggest.

There are two important implications of this theoretical shift. Firstly, it

allows a more significant and powerful role to emotion than hitherto in cognitive theory. Secondly, it opens the door to the incorporation of unconscious processes into the theoretical explanation of emotional disorders. The Interacting Cognitive Subsystems model, or ICS, is a recent example of a theoretical framework in which such ideas have been developed (Barnard and Teasdale, 1991; Teasdale and Barnard, 1993). The basic assumption in the ICS model is that mental activity reflects the collective action of several *specific* processes, each with a particular function to perform. This produces a dynamically interacting system with a range of subsystems, some peripheral and some central. In the ICS model nine subsystems are proposed of which four are central. Cognitive processing depends upon the interactions between subsystems, each of which is specialised in the way it handles specific information. For example, the acoustic subsystem encodes dimensions such as sound frequency, timbre, intensity etc.; the body state subsystem encodes information in relation to bodily sensations of pressure or pain, positions of parts of the body etc.; the object subsystem encodes information that relates to the attributes and identity of visual objects, their spatial positions and their dynamic characteristics.

In the ICS model, emotion is the result of system-wide activity. Each of the nine different types of information can contribute, directly or indirectly, to the experience of emotion. Human emotion, at the adult level, is a distributed phenomenon although the *implicational* subsystem has a prime importance in its production. In this subsystem, sensory and propositional meanings are integrated and high-level regularities, or schematic models of experience, are captured. This is associated with an holistic sense of knowing things about the world which is neither rational nor logical. An important distinction is drawn between different forms of knowledge which reflect the operation of different subsystems. This corresponds to what people say when confronted with the irrational nature of their beliefs: they can recognise their irrationality at an intellectual level, but still believe them 'emotionally'. For example, Melanie might be able to see that she is not in fact worthless or undeserving, that she has a job which she does well, good friends who seem to value her company etc., but such facts do not shake the emotional strength of her conviction in her undeservingness. Within ICS, the 'intellectual' and 'emotional' belief correspond, respectively, to meanings at the Propositional and Implicational levels. The former corresponds to the sense of knowing something 'with the head' while the latter corresponds to a more holistic, intuitive, or implicit sense of knowing something 'with the heart'. It is quite possible for those meanings to be discrepant.

Further details of the ICS model are beyond the scope of this chapter and readers are referred to the original sources. It is an exciting advance in cognitive theory particularly in the way the complexity of emotional production

is recognised. One of the nagging problems with the early models underlying CT concerned their over-reliance on the notion of rational and irrational thinking. If someone were depressed and believed that no-one held him in any esteem, liked him or wanted to spend any time with him, then a therapeutic tack might be to show him that these beliefs are untrue. He could come to recognise that there were people who clearly valued him and liked his company etc. But, not surprisingly, while the irrationality of the belief could be recognised intellectually, it often made little difference to the felt conviction. ICS suggests that this is because the focus on irrationality, on what they call the propositional meaning, is not enough. Attention is needed to meaning at the implicational level. What does this mean?

According to Barnard and Teasdale (1991) the implicational subsystem integrates information from a variety of sources (sensory, proprioceptive, propositional). The knowledge that one is underserving is a product of sensory information (one's own bodily feelings for example), the proprioceptive feedback from others such as tone of voice or facial expression, as well as propositions about the world around (e.g. that men abuse and exploit one). Thus a purely rational demonstration that other, important people do in fact value one would have little impact without sensory and proprioceptive information: it would have 'intellectual' value only. This opens the way to the use of therapeutic procedures that are only indirectly related to cognitive appraisals. For example, changes in body state can have a powerful effect on mood. Physical exercise, Gestalt techniques or the use of emotive imagery all have an impact at the implicational level of meaning. Emotional focusing, a technique developed by Gendlin (1981), entails attending to the bodily feelings that seem to come spontaneously resulting in what is called a 'body shift'. This shift is experienced physically and can be accompanied by a powerful emotional change. Within the ICS model important sources of information are being tapped by the use of such techniques.

The ICS model recognises explicitly that emotions are often the product of sources of which the individual may be unconscious. As Barnard and Teasdale (1991) put it: 'Because the information processed by one set of subsystems will not necessarily be propagated to all subsystems, it is quite possible for a person to experience emotion subjectively without having any clear conscious awareness of the source of the emotion.' It is not necessary for subjects to have conscious awareness of the reasons why they are experiencing certain feeling states. In this way the ICS model encompasses the experience of emotions whose origins are, at least in part, unconscious. The parallel with psychodynamic theories of emotional responding is striking.

Aims and methods of therapy

In CAT the aims of therapy are conceptualised within the SDR and actualised as Target Problem Procedures (TPPs). The TPPs provide the formal focus of therapy, and summaries are recorded on a Rating Chart and monitored at the end of each session. The TPP combines description and hypothesis. For example, Melanie's Target Problem was the difficulties she experienced in maintaining an intimate relationship with a man. The TPP that most clearly related to this was summarised as the 'search for an idealised caregiver'. This involved a trap in which she failed to set appropriate boundaries or to assert her own needs because, it was hypothesised, she felt fundamentally unworthy. The consequence was that she often selected men who, superficially, gave her a good time but then treated her badly. While this made her unhappy and angry, she felt unable to express these feelings or blame the men in question. Her unhappiness confirmed her belief in her unworthiness as she felt she was to blame. This also made it difficult to express how angry she felt to the extent that her feelings of anger were predominantly unconscious. To escape from this procedure Melanie needed to be able to accept and then express her true feelings, including negative feelings, in the context of a close relationship and discover that she was not rejected as worthless. In other words, she needed to begin to value herself and be valued for herself. This process could take place both in therapy and in her relationships outside of therapy. The therapist's role is part educational (using the SDR and the TPPs to help Melanie see how to change), part supportive and affirmative (giving her the unconditional support that she normally did not get), and part interpretative (encouraging her to understand the patterns of behaviour, their origins and the way they operate in her current life).

The 'work' of therapy can take place both in terms of material arising out of the therapeutic process (e.g. transference material) and in terms of relationships and other experiences outside therapy. For example, early on in therapy Melanie reported how she had approached Richard, her ex-boyfriend, who had then made it clear that he did not want to live with her. As she told the therapist about the experience, she became overwhelmed by feelings of hopelessness and despair. Her whole body was racked with sobs to the extent that she was unable to speak. The therapist sat and listened, giving support and encouragement. Then as she calmed down, he drew attention to the SDR and pointed out how she seemed to be experiencing her core state in the session and, that in acknowledging and sharing her true feelings, she was beginning the process of change. This then led on to Melanie talking about the therapy. She worried that coming for treatment confirmed her own weakness and unworthiness. She was also worried about what would happen when it ended: would she be able to cope? The therapist was able to acknowledge her fears

about therapy ending as genuine and understandable. He suggested that far from being weak in seeking therapy, Melanie was being courageous, and that this was evident in the way she had had to confront very painful feelings. In this way Melanie's experiences in therapy and outside could be brought together and through the structure of the SDR and TPP given a different, more hopeful meaning.

From a CT perspective these therapeutic strategies would not seem odd or unusual although they might not be used in exactly that way. As in CAT there is a concern to organise the therapy around a formulation and to work in a structured and focused way. The patient's experiences become the material for the work of therapy. In addition, specific tasks would be agreed for the patient to attempt outside the sessions and to report back on. The therapeutic work might have centred on helping Melanie identify how her experience with Richard had triggered off certain beliefs and how these beliefs might then have resulted in her selectively attending to certain information. However, change is possible once this process was recognised and understood. Melanie could have learned to behave differently, for example, and to attend to other sources of information, thereby beginning a process of changing her belief in herself as defective or inadequate. In a very similar way to the CAT therapist, the CT therapist would strive to be educational, supportive and interpretative in order to promote beneficial change.

Recent developments in CT have seen greater emphasis given to the understanding and interpretation of the therapeutic relationship. This is particularly the case in schema-focused therapy where maladaptive schemas are examined as they are expressed in the context of the therapeutic relationship. According to Bricker and Young:

> Interpersonal techniques highlight the client's interactions with other people so that the role of the schemas can be exposed. One way is by focusing on the relationship with the therapist. Frequently, clients with a *Subjugation* schema go along with everything the therapist wants, even when they do not consider the assignment or activity relevant. They then feel resentment towards the therapist which they display indirectly. The pattern of compliance and indirect expression of resentment can be explored to the client's benefit. This may lead to a useful exploration of other instances in which the client complies with others and later resents it, and how they might better cope at those times. (1993, p. 5)

An increasing range of therapeutic techniques has been used in CT. In addition to behavioural methods (e.g. goal setting, social skills training) and cognitive change methods (e.g. cognitive restructuring, the Socratic dialogue), emotive techniques such as guided imagery and Gestalt methods have become more common. The use of methods that generate emotions and bodily reactions is consistent with the theoretical analysis we described earlier (the ICS model). In order to access schemas and ultimately to change them, there should be more than Socratic dialogue or rational restructuring. The patient

should actually experience the physical concomitants of the emotional response. The success of behavioural methods in the treatment of phobias and anxiety states, for example, may in part due to their ability to gain swift access to emotional experiences.

Conclusions

We have considered how two therapeutic approaches CT and CAT, have several points of convergence both in theory and in practice, CAT is, as its name clearly indicates, a *cognitive* therapy. Ideas from other therapeutic orientations have also been incorporated into CAT, notably from the psychodynamic tradition. Theoretical analyses have been elaborated and extended to take into account the integrative nature of CAT. We asked two questions at the outset of this chapter: is there something unique or different about CAT that sets it apart from other cognitive therapies? Does the inclusion of psychodynamic ideas make CAT less acceptable as a cognitive therapy? From our analysis we would tend towards answering No to both these questions. However, we are very aware that it is all too easy to 'translate' techniques from one school into the language of another and claim that there is no difference between them. This can mask significant theoretical differences and lead to a wishy-washy eclecticism where 'anything goes'. We are absolutely against any such development. It is significant that in both CAT and CT there is a strong emphasis on *theoretical analysis* and that technical advances are considered within broad but distinct theoretical frameworks which are elaborated over time. The fact that there are significant similarities between CAT and CT should not make us lose sight of the value of theoretical differences, nor of the need for theoretical advances in our understanding of complex clinical phenomena.

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8 How analytic is CAT?

A discussion between Tim Leighton and Anthony Ryle

Cognitive Analytic Therapy has always been concerned to acknowledge its debt to, and to differentiate itself from, psychoanalysis. An essay by Tim Leighton challenging the right of CAT to call itself analytic was the provocation for a discussion between A.R. and T.L. The latter has been working mainly in the field of addiction and is one of the first generation of CAT qualified psychotherapists. The following is an edited record of the conversation.

T.L. When I first came across CAT, I was interested in the integration. At the time I was very interested in psychoanalysis (and still am) and I saw CAT through psychoanalytic lenses. As I found out more about how CAT actually worked it began to look very cognitive and not particularly analytic. It seemed to me that most of what would be characteristic of psychoanalysis had been eliminated or attenuated—there wasn't any interpretation in the analytic sense, or any theory of drive, and there wasn't the layering that happens in psychoanalysis where over a length of time the analysis uncovers more and more strata of symbolisation and displacement, so that the pictures that emerge during the early part of the therapy can change to very different ones later. I wasn't wanting to insist on all these features, but there did seem to be very significant differences. Also, the CAT model struck me as very much a 'top-down' theory rather than a 'bottom-up' theory.

A.R. That's 17 points there! First of all I should say that I never had any experience of cognitive therapy as such; my experience was analytically based therapy. But working with Kelly's grids and, later, reading the

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