Reviews

Psychotherapy research and CAT

- **The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work** (Second Edition) (2015) Bruce E. Wampold and Zac E. Imel London: Routledge (pps. 323) £38.99

- **Journal of Psychology and Psychotherapy, Theory, Research and Practice** Special issue **on** *Cognitive Analytic Therapy: Research Developments and Insights* **Vol. 94, (S1)**

Frank Margison

It is unusual to review a book that is already six years old – especially a second edition – but in discussion with the editors we agreed it is a book that focuses many of the current debates around research in psychotherapy. This review is in the context of a recent special journal issue dedicated to research in CAT. In February 2021 the *Journal of Psychology and Psychotherapy: Theory Research and Practice* published a special issue on *Cognitive Analytic Therapy: Research Developments and Insights,* edited by Peter Taylor and Samantha Hartley (2021).

This extended review goes beyond discussion of The Great Psychotherapy Debate and looks at developments within CAT research to develop the book's main themes.

The special issue also addresses some of the comments I made in an editorial article just over twenty years earlier (Margison, 2000) in the same journal (then called British Journal of Medical Psychology).

> 'A summary of the main literature on cognitive analytic therapy (CAT) is given. Ryle first developed CAT over 20 years ago and use of the model is increasingly widespread in diverse settings and with various conditions. CAT stands as an example of modern dialogical approaches to therapy, and

> the underlying theory is consistent with that stance. The developments within training stress self-reflexive practice and the maintenance of a collaborative approach. In contrast, however, to the rapid development in training and practice the research summarised here is primarily descriptive with a small number of open trials and one randomized controlled study in a physical disorder (Type I diabetes). The urgent need for randomized controlled research in this treatment is highlighted.' (p. 145)

In turn, that editorial was looking back a further twenty years to the period when CAT was first formulated (Ryle, 1980). Later in this review we can compare the views of the special issue editors to the comments above and look ahead to the options for the *next* twenty years.

The Great Psychotherapy Debate

The Great Psychotherapy Debate critiques the 'medical model' underlying psychotherapy research – a stance that might be welcomed by many CAT therapists. They suggest a 'contextual model' as an alternative, which, with its focus on the therapeutic relationship, may be much more congenial for many readers. But, even this contextual model still poses some important challenges for those interested in developing research in CAT as discussed later.

The Contextual Model sits at the centre of the debate between, on the one hand, proponents of evidence-based treatments (essentially the medical model under another name the authors argue) and, on the other, proponents of the so-called 'common factors' (key ingredients of successful psychotherapy that transcend tribal boundaries) (Wampold & Imel, 2015, p.viii).

> 'The current version of the Contextual Model explicates three pathways that purportedly explain the benefits of psychotherapy. The model is grounded in what is known about humans and human healing – that is, the model is grounded in the social sciences, broadly speaking. The basic premise of the model is that the benefits of psychotherapy accrue through social processes and that the relationship, broadly defined, is the bedrock of psychotherapy effectiveness (*op cit.* p.50) . . .
>
> 'Before the three pathways can be employed, the therapist and the client must form an initial bond. After the bond is formed, the therapist and patient create a 'real' relationship, the first pathway to client change. Through explanation and treatment actions, expectations about therapy are created, which in and of themselves create a second process of change.
>
> 'The third pathway involves change that is a result of carrying out treatment actions'. (*op cit*. p.53)

Although the book examines each component in some detail and provides a good vantage point for reviewing the state of psychotherapy, it is striking how difficult such a model is to disprove. Perhaps one point we can conclude from the book is that testable hypotheses that can refute a theory are very difficult to

formulate in psychotherapy research and that we should also consider research methods that improve practice. In dismantling the premises of the medical model, we can also see the limitations of a 'winner that takes all' approach and find space for looking at alternative ways of doing research.

Dismantling the Medical model

The authors address what they see as the main pillars of the medical model – diagnosis, evidence based medicine, and the randomised controlled trial [RCT].

The authors start with a section critiquing 'The Medical Model' more generally (*op cit.* p.8), but this section would be better described as a critique of the *disease concept* in medicine, especially when applied to mental health problems. They point out that traditionally, a disease entity has five key elements:

- An illness or disease can be delineated
- A biological explanation is proposed for the disease
- Associated physiological mechanisms of change are identified
- These changes lead logically to therapeutic procedures
- The procedures have a specificity in relation to which treatments work and why

The logic of these elements is attractive, but predictably most of medicine (rather than just psychiatry) fails to meet these idealised criteria.

The book in fact focuses mainly on the 'specificity' argument:

> 'In medicine, specificity is established in two primary ways. First, the treatment can be shown to be more effective than a placebo treatment, thus ruling out incidental causes related to the context of the treatment. . . The second means to establish specificity is to establish that the medical treatment operates through its intended mechanism.' (*op cit*. p.9)

They point out that 'ruling out incidental causes' in this context can be reformulated as 'throwing out the baby with the bathwater' as key aspects of therapy are neglected. For example, the placebo effect is not something that *interferes* with psychotherapy but actually *contains* important aspects of the change process.

Partly in response to criticisms about specificity, however, there was a new push towards medical treatments being selected by rigorous and systematic review of evidence designed to overcome underlying biases:

> 'Evidence-based practice is the integration of best research evidence with clinical expertise and patient values' (p. 147). This definition has been described as a 'three-legged stool,' in that the use of evidence (first leg) is to be balanced with the expertise of the clinician (second leg) and characteristics and context of the patient (third leg). Nevertheless, an examination of the seminal book on evidence-based medicine, *Evidence-*

based Medicine: How to Practice and Teach EBM (Sackett *et al*., 2000) reveals that the focus is on evidence related to the quality of diagnostic tests and effectiveness of treatments [rather than the desired three-legged approach].' (*op cit*. p.11).

The development of Practice Based Evidence [PBE] as a counterweight to Evidence Based Practice is described as a way of restoring balance (Barkham & Margison, 2007), by building evidence from the ground up. PBE has the advantage of being able to collect huge samples with participants who are more typical of the general population. The focus is on effectiveness [change occurring in ordinary practice] rather than efficacy [clients treated under heavily controlled research conditions]. Interesting as this approach is, it is essentially tangential to their main argument, which concerns a deeper level of medicalisation of psychotherapy (*op cit*. p27-28).

The book demonstrates the extreme medicalisation of psychotherapy research in the last half-century by exploring the primacy given to randomised controlled trials [RCTs] as the 'gold standard' (*op cit*. p 11) and the 'introduction of the placebo' condition (*op cit*. 13), where the so-called 'nuisance variables', may, of course be what matters most to an individual client:

> 'Although the use of placebo control groups in psychotherapy research is problematic, historically [they were] emblematic of psychotherapy's close connection with medicine. Psychotherapy was adopting models of research that were used by medicine to demonstrate the effects of medications, thereby conceptualizing psychotherapy as a medical treatment. This is a trend that has increased over the decades such that beginning in the 1980s psychotherapy began to label its outcome research as clinical trials as it sought to establish the viability of particular treatments for particular disorders'. (*op cit*. p.24)

The book gives an effective critique of the idealisation of the medical model of psychotherapy research, but to my mind understates the extent to which this ideology determines where almost all research funding goes. This way of allocating research funds has profound, if unintended consequences for our field: the closer a therapy can resemble the medical model the more likely research funding will be given. Invariably, a new therapy can be shown to be effective against a placebo or treatment as usual condition, so then the therapy calls itself evidence-based (or empirically-supported). In turn, this particular type of evidence determines the content of clinical guidelines as there is an established hierarchy of evidence with meta-analysis of large RCTs at the top. Moreover, the research that is funded usually focuses on tightly defined research diagnostic categories further reinforcing a single diagnosis as the norm rather than the common mixed clinical pictures seen in non-research practice. This generates a self-perpetuating cycle further consolidating the grip of the medical model.

> 'The *de facto* requirements of clinical trials advantage treatments that are

> readily manualised, time-limited, and focused on symptoms' (*op cit*. p 273).

Despite the inevitable limitations of the evidence base derived from these processes, however, we can note some important gains that have implications for our practice:

- A key medical research design – *the meta-analysis* – was driven, in fact, by a seminal early psychotherapy paper by Smith and Glass, (1977), who aggregated the results of studies that compared a psychotherapeutic approach to some type of comparison or control group (*op ci.t.* p.24). The positive finding was that psychotherapies have clinically relevant 'effect sizes', comparable in most cases to the effects of psychiatric medication. Indeed, more refined recent re-analyses show *better* overall results for psychotherapy than were described in the original paper, whereas critics had predicted the effect sizes would melt away with more rigorous analyses (*op cit*. pps. 91-92). So, we are reassured by the book that psychotherapy generally shows respectable 'effect sizes' when it is treated as a medical treatment, so we can hold our heads high, before going on to criticise the assumptions behind meta-analysis.
- Various research designs have been used to test whether it is the *techniques* that differentiate therapies which are responsible for positive therapeutic outcomes. In general, this book summarises the evidence that 'techniques' at this level of abstraction are only weak predictors at best. In any case in complex therapies, such as CAT, it is almost impossible to isolate one technique, as though it were a specific drug, and test its efficacy (using strategies like'dismantling' the therapy). So, the book encourages us to adopt a more holistic view of change in psychotherapy research with attention to aspects such as the therapeutic relationship as key to the change process.
- As an alternative to technique-defined therapies, there was a trend starting around thirty years ago to look at heuristics or 'clinical strategies' that are applicable across models of psychotherapy. For example, the two clinical strategies identified by Goldfried (1980) as generally common to all psychotherapeutic approaches are *providing corrective experiences and offering direct feedback*. (*op cit*. p.45). These approaches cross traditional therapeutic boundaries and provide a framework for eclectic practice within a generally relational framework. (See Society for Exploration of Psychotherapy Integration [SEPI] for fuller discussion (SEPI, 2021))
- Rather than focus on medically defined outcomes, Jerome Frank, who developed the idea of 'common therapeutic factors', called for a redefinition of what psychotherapy intends to do:

> 'The aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby

transforming the meanings of experiences to more favorable ones' (Frank and Frank, 1991, cited on p. 30).

- Despite the dominance of the 'medical model' there has been great interest in understanding these 'common factors' as can be seen, for example, in the way that therapies that are not primarily relational have incorporated strategies for maintaining a positive therapeutic bond (Castonguay, *et al*, 2010).

Adherence versus alliance

As part of the homogenisation of psychotherapy the authors comment on some of the problems associated with 'Psychotherapy Treatment Manuals' (*op cit*. p25), and other ways of reducing variability between different therapies purporting to deliver the same 'dose' of the same 'treatment'. One of the most interesting aspects of the book is in disentangling the very complex interplay between 'adherence' to a manual, therapeutic alliance, and outcome. For example,

> 'Barber *et al* (2006) found that when the alliance was high, adherence was irrelevant [to outcome], but when it was low, moderate levels of adherence were most effective.'

This book puts the interplay between therapist and client at the centre of the psychotherapy process. The authors suggest that the medical model would predict that *adherence* to a well-defined, empirically sound therapy is more important in predicting outcome than the *alliance*, and show that adherence in fact has a complex but relatively weak link with outcome, whereas alliance, however measured, seems to be reliably associated with outcome. However, the picture is more nuanced than that. When a client 'resists' treatment efforts (in alliance terms having low agreement about the goals and tasks of therapy) therapists often increase their attempts to adhere to the protocol as though persuading the client to comply. But, this is shown to be detrimental, suggesting that adherence needs to be in the Goldilocks zone – not *too much* adherence and equally not *too little*.

Comparatively little scrutiny is given to a similar 'Goldilocks zone' paradox concerning the alliance, however. Whichever school of therapy we may be from, it is important to recognise a breach or failure to develop the alliance, but it is equally important to spot an *over*-positive (idealising) alliance as this can also lead to decidedly poor outcomes and treatment failure (as noted in the psychodynamic literature for well over a hundred years) (Hall, 1995).

Adherence and Competence

Adherence and competence are components of the medical model that are used to interpret the results of clinical trials. Adherence measures the extent that therapists do *what* the model predicts they should do, whereas competence specifies that it is done *to an agreed standard.* The argument is that to draw any conclusions about the

effectiveness of a treatment, the therapy must first be delivered as specified in the protocol (adherent) as otherwise you are not actually testing what you say you are testing, and it must be delivered skilfully (competently). Together, these two aspects are referred to as the *integrity* (or fidelity) of the treatment, using tools like the CCAT (Parry *et al*, 2021)

> 'It is now virtually required that clinical trials of psychotherapy assess and report adherence and competence' (*op cit*. p.232).

This mainly focuses on the treatment being evaluated, but it is important that the comparison treatment is delivered as effectively as possible too. Comparing a well-supervised treatment where researchers, supervisors and therapists are enthusiastic (i.e show an 'allegiance bias') against so-called 'treatment as usual' [TAU] hardly makes for a fair comparison. Nevertheless, there are many published studies where TAU is hardly specified at all. So, it is important to minimise false positive results for new treatments by carefully supporting and nurturing treatment as usual, with agreed structure and supervision to allow a fair comparison. This is sometimes referred to as *Optimised* Treatment As Usual [OTAU], (e.g.Zipfel *et al*, 2014) but the ways in which standard treatment is quality-controlled must be specified.

Even when control conditions are optimised, there is an even more questionable assumption being made

> '. . . that adherence and competence are therapist characteristics. When Waltz *et al*. (1993) rigorously defined adherence and competence, they realized that the *context of therapy* – characteristics of the client and what was happening in therapy – were important: '*When clients like their therapist and improve substantially, it is easier for therapists to look competent'*. (Waltz *et al* 1993, p. 624 cited *op cit*. p. 236)

This problem is well recognised when assessing a therapist's competence in a teaching setting – and equally it is hard to look competent when a therapy is going badly (unless observable skills to address an alliance rupture are used skilfully), but when things are going well there is a 'halo effect' that is hard for an observer to discount. Hence, adherence and competence may also be a *consequence* of a good therapy rather just a cause.

For all its faults, assessment of treatment integrity must retain some utility, however, otherwise we end in a very strange world where words are not anchored to their common meanings:

> 'When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean – neither more nor less.'
>
> 'The question is,' said Alice, 'whether you can make words mean so many different things.'
>
> 'The question is,' said Humpty Dumpty, 'which is to be master – that's all.'
>
> Lewis Carroll:
> Through the Looking-Glass

Quality improvement

The implication from traditional 'Medical Model' outcome research is that to improve the outcomes of care we should disseminate evidence-based treatments into routine psychotherapy practice.

> 'According to this perspective, therapists are achieving relatively poor outcomes because they are not using faithfully evidence-based treatments, and if these therapists began to use such treatments, outcomes would improve'. (*op cit.* p268)

Wampold and Imel (2015) are right to be sceptical about this over-simple account: therapists are unlikely to engage as fully if they and the clients do not have some expectation that what they are discussing is helpful, and to force therapists to adopt a model that they feel is alien is likely to be counterproductive.

In contrast, the Contextual Model focuses more on the therapist actively engaging the client – so the focus should be on therapists choosing the appropriate approach for each client and using ongoing measurement of progress to optimise outcomes:

> 'According to the Contextual Model, a variety of different treatments will produce benefits as long as the treatments are given by effective therapists. . . [with] each therapist responsible for achieving commendable outcomes, regardless of the treatment they choose to use. This perspective leads to the use of 'practice-based evidence', which uses data about the progress of clients in practice to improve the quality of care (*op cit*. p.270 for fuller discussion and references).

Lambert and colleagues demonstrated that giving feedback about progress to a therapist *during the therapy* improved outcome as it helped the therapist to know when things were not going well and helped a therapist to engage in a discussion about when to end the therapy (Lambert, 2010).

Treatment Choice

The book concludes with some points to consider about treatment choice, commenting there is insufficient evidence to privilege one approach over any other. However, they still impose some exacting standards:

> 'therapists must deliver a treatment that is coherent, explanatory, and facilitates the patient's engagement in making desirable changes in their lives . . . [rather than] incoherent eclecticism. . . [Secondly], therapists are responsible for the outcomes achieved by their patients. Of course, some patients will have poorer prognoses than others, due to a number of factors outside of the control of the therapist, but overall therapists should achieve reasonable benchmarks for the types of patients being treated. . . [and thirdly] there should be]. . . a limit to the range of therapies that should be provided. . . which should have a reasonable and reasonably defensible psychological basis' (*op cit*. p.273)

This raises some important issues that are not fully explored in the book.

The authors do examine integrative therapies, firstly focused on integration between two distinct models (e.g., Wachtel,1997), and, secondly, on other integrative approaches derived from a common factors approach (e.g., Garfield, 1995), before moving on to their Contextual Model. However, they do not give full weight to the growing category of therapies that have inbuilt methods for integrating different approaches through structured reformulation in the initial stage of therapy, as is the case with CAT but also other formulation-based approaches.

Regarding supervision, the book raises some apparently troubling issues:

> 'To help the supervisee progress, the supervisor assesses the present skill level of the supervisee and compares that to the ideal or desired skill level, keeping in mind of course the developmental level of the trainee. Using the discrepancy between present and ideal skill level assumes that the supervisor's ideal skill level will result in better outcomes for clients than the current level. [However], we presented evidence that adherence and competence ratings were not [well] correlated with outcomes. This suggests that the supervisor's assessment of the competence of the supervisee may have little to do with the supervisee's actual effectiveness and much to do with the supervisor's own implicit model of competence. (p.276)

This raises important conceptual issues about the nature of psychotherapy supervision. Pedder cites Fleming in his description of supervision as 'jug, potter, or gardener' models: Is the supervisor's task to fill the jug of the supervisee's mind with knowledge; being a potter shaping the supervisee in the supervisor's idealised image; or a gardener cultivating and promoting the growth and maturity of the therapist? (Pedder, 1986, citing Fleming, 1967). I suspect most relational therapists will favour the gardener analogy but might also think that it is going too far to think we have *no* valid knowledge to impart. But, there is clearly a risk of a supervisor simply imposing their *'own implicit model of competence'*.

Having contrasted The Medical Model with The Contextual Model, and predictably favoured the latter, it is unfortunate that there is not more of an attempt to see how the two models can co-exist. I think the medical model, for all its failings, has focused on real concerns about what is effective, and how to make those treatments more widely available, and how we can faithfully describe commonalities between disparate presentations. But following that approach without being aware of the contextual factors would also be a serious disservice.

The book is both readable and broad in scope and I recommend it for beginners in research who need a good overview of the psychotherapy debate over the last forty years. For experienced researchers it is a salutary reminder of the enormous breadth of approaches that have already been taken to the questions why and how psychotherapy works.

How does CAT fit with the analysis of Wampold and Imel (2015)?

In this final section we can reflect where CAT research fits into the overall picture presented in *'The Great Psychotherapy Debate'* with particular attention to the CAT recent special issue.

Taylor and Hartley (2021, p. 1) comment in the Editorial:

> 'A notable characteristic of CAT research to date is that it has largely consisted of practice-based evidence (PBE), small-scale evaluations taking place in real-world clinical practice, often led by clinicians.'

They address many of the key issues raised in 'The Great Psychotherapy Debate' commenting as below:

> 'This focus is perhaps reflective of CAT's origins as a pragmatic model developed primarily through clinical practice. Research of this nature comes with advantages and disadvantages. The small samples limit the generalizability of the results, and the lack of randomization and control or comparison groups limits the ability to attribute outcomes to the therapy itself. Nonetheless, such small-scale clinical work is important. Case series and small-scale pilot trials represent an essential step in determining the acceptability and safety of novel interventions, and the feasibility of larger-scale evaluations' (Taylor & Hartley, 2021, p.1).

The special issue demonstrates that CAT research uses a wide range of methods, and this plurality enriches our field. Papers in the recent special issue are embracing psychotherapy research in all its diversity and often address issues of the client-therapist relationship.

The *client perspective* is central when Balmain and colleagues, (2021a) focus on a service user perspective using systematic review and a qualitative approach, and in a separate paper service user experience of CAT in complex secondary care is reviewed (Balmain *et al* 2021b).

There is also a *qualitative study* on mapping using the 'Torchlight' method (Jefferis, Fantarrow and Johnston, 2021). In contrast, other papers are *quantitative and outcome-focused*. There is a variant of *single case design* for borderline personality with an innovative twist: the response to the therapist withdrawal during the period where psychotherapy is not occurring is used to test a theory-specific outcome variable of resilience to separation (Kellett, Gausden and Gaskell, 2021). In addition, there is *pilot service evaluation* of a CAT-derived approach to self harm (Taylor *et al*, 2021).

CAT is now used in diverse contexts and settings, and examples here are an *exploration of group CAT* for anxiety and depression, (Martin *et al*, 2021), and a report on a new *hybrid approach* using CAT with a digital support tool (Easton *et al*, 2021). Just prior to the publication of the special issue the context of perinatal mental health problems was the subject of a pilot study (Hamilton *et al*, 2020) again showing that CAT is an acceptable and potentially effective approach in a wide range of contexts, and there is a

further recent *single mixed methods case study* on obsessive morbid jealousy (Kellett & Stockton, 2021), that demonstrates the usefulness of this approach as a way of developing a research base with modest funding.

Finally, when *adherence and competence* need to be assessed, whether in a teaching or a research context, there is a well-developed competence framework reported (see Parry *et al*, 2021). This examines the key issue that

> 'an adherent but incompetent CAT therapist could produce a narrative reformulation that was outside the patient's zone of proximal development, so rendering it meaningless to them',

and describes the elements that constitute competence as a CAT therapist. As discussed earlier, *The Great Psychotherapy Debate* suggests that adherence, competence and treatment integrity are outdated concepts, but for all the problems of reification of concepts having these measures available adds something of long-term value as treatments develop over time.

The Contextual Model approach shows a healthy approach to understanding the client perspective, resolving barriers to care, and developing CAT in a range of naturalistic settings. However, from the 'medical model' perspective there is an important meta-analysis by Hallam, Simmonds-Buckley, and colleagues (2021) that summarises the state of the art in *quantitative* research. They looked at the acceptability, effectiveness, and durability of change with CAT. They found twenty-eight relevant studies of reasonable quality of which 25 were analysed in the end. Just over a third of the 28 studies (10 [36%]) were *randomised control trials* .

The remaining eighteen (64%) looked at *change over time* but not in an RCT setting and where there was no comparison to another treatment. The latter point is technical but important as comparing the same individuals pre- and post-therapy gives much larger effect sizes than comparisons between one therapy and another or against a control (where the effect size can be conceptualised as the *additional* benefit derived from CAT). Nevertheless, the studies showed moderate to large effects sizes measured pre-post in global functioning, interpersonal problems, and depression and this is a small but important step in making a case for CAT as part of the funding of a larger RCT.

The studies showed that CAT is being offered to clients with complex problems, for example, long-standing and complex trauma, and most studies were in a public setting such as the NHS.

A fair summary of the state of play would be that there is still a clear focus on outcomes, using a variety of appropriate measures and respectable pre-post change demonstrated with CAT, but with relatively few RCTs being conducted. However, one of the main points from *The Great Psychotherapy Debate* was that we are at risk of idealising RCTs and need to keep a broad base of research methods

to support the Contextual Model.

However, the Contextual Model itself is not beyond criticism: it is no better than standard models in making refutable predictions; and at times there is a conceptual confusion. In criticising the use of adherence and competence measures the book overlooks the issue that one of the key competences in any relational therapy is to have the skills to repair a problematic therapeutic alliance, and to date there have not been large-scale research projects looking at the impact of recognising alliance breaches and repairing them on the eventual outcome.

When relational outcomes are individually agreed as relevant to a particular client the link between alliance and outcome may be mediated through specific skills in place in relational therapies (see for example Bennett *et al*, 2006 in CAT and Agnew *et al* (1994) in Psychodynamic Interpersonal therapy [PIT] on recognition and repair of alliance breaches.

Reflection

CAT research has a good range of strengths but some areas that are less strong, and one of the main 'weaknesses' is driven by structural factors in allocating research funding. There is no simple solution either through adopting the route of excessive preoccupation with RCTs, or by denying their importance, in the *realpolitik* of psychotherapy provision. CAT has so far managed to keep a questioning and at times critical conversation about our practice, and a varied research perspective is an important ingredient of that rich, dialectical dialogue.

So, rather than pose research questions as if 'winner takes all' we can look at establishing strength in diversity. We know that the main monoculture of CBT has absorbed ideas from many different approaches that started as distinct models (e.g., mentalisation, compassion-focused therapy, emotional regulation). So, rather than an existential threat we can take a broader view of developing psychotherapy as a sustainable culture within a complex ecosystem.

To gain large research grants researchers are pressured to move towards a unified way of doing CAT (in order to be replicable), and currently have to focus on diagnostically homogeneous groups (at the expense of real-life complexity). In doing so researchers risk becoming separate from practitioners. It is possible to negotiate through these two pressures, for example in the large scale RCT seen in the work of Chanen and colleagues (2021) in Melbourne, Australia, but in general it has proved difficult to develop large-scale outcome studies as fundable psychotherapy research becomes more narrowly defined.

It is hard to move from a simplistic diagnostic model where problems arise 'in the person's head' to a fully biopsychosocial model, open to change within a therapeutic relationship. Our

current research methods are not equipped to resolve questions at this level of clinical sophistication, even though case discussion and supervision can take in the whole picture.

The recent special issue shows that CAT research is certainly healthy in the sense of being methodologically diverse using pluralistic methods within manageable studies that can be conducted by small research groups. There are studies taking place outside major research centres and they ask questions that arise from the richness of everyday practice. The researchers are recognisably still clinicians and teachers, and the CAT being studied takes place in a wide range of settings, with a small number of larger scale RCTs complementing the range of approaches.

Earlier, we looked back twenty years to a placeholder editorial (Margison, 2000) commenting on the need for more systematic research. This in turn looked back a further twenty years to Anthony Ryle formulating the new CAT model as a way of integrating two apparently disparate approaches to psychotherapy. This position was summarised succinctly by Ryle and Kerr in a quote from *Introducing Cognitive Analytic Therapy* (Ryle & Kerr, 2020, p1):

> 'CAT evolved as an integration of cognitive, psychoanalytic and, more recently, Vygotskian and Bakhtinian ideas. It is characterized by a predominantly relational understanding of the origins of patients' problems. . . From the beginning it has emphasized genuine therapist-patient collaboration [offering] a respectful, whole-person, 'transdiagnostic' approach. . . The model arose from a continuing commitment to research into effective therapies and therapy integration, and from a concern with offering appropriate, time-limited treatment in the public sector.'

The special issue on CAT demonstrates that CAT researchers are still consistent with those values. In some ways CAT researchers have tried to adopt a transdiagnostic approach, less wedded to systems such as ICD and DSM. Moreover, the Wampold book takes each piece of research as frozen in time at the point of publication, for understandable reasons. But, in practice, research is an integral part of an evolving approach. Research questions are prompted by real dilemmas in the therapy room, and in turn, CAT as a model of therapy transmutes almost imperceptibly into a new version. Those of us working in psychotherapy around forty years ago hearing the first iterations of CAT would hardly recognise the model as currently described – the core values are unchanged, but the tools, length of therapy, range of formats and clients seen have changed hugely. Research is always shooting at a moving target with therapies evolving over time, and CAT focuses on reformulation rather than fixed diagnostic categories

The special issue shows both the health of CAT research but also some of the limitations of research being carried out on a relatively small scale. If we look ahead another twenty years from now we may see further development of this

hybrid model of small-scale research supporting and enriched by larger projects. Or, we might see further amalgamation of models along more generic lines with all the relational therapies working from a shared set of values to sustain a larger research programme. If we look at the history of psychotherapy, there are strong forces keeping us within tribal boundaries, and even splitting us into smaller subgroups. But reviewing this book is a good reminder that CAT is one of a range of relational therapies drawing on expertise across psychodynamic, cognitive-behavioural, and procedural approaches enriched by a growing research base. It is here that the Contextual Model has its main strength – in providing a point on the way to developing 'a genuinely multidimensional and integrative biospsychosocial approach' for relational therapies (Kerr, personal communication). □

REFERENCES

Agnew, RM, Harper,H, Shaoiro, DA, Barkham, M (1994) Resolving a challenge to the therapeutic relationship: A single case-study. *British Journal of Medical Psychology* Vol 67 Pp155-70

Balmain, N, Melia, Y, Dent, H and Smith, K (2021a): A systematic review of service users' experience of cognitive analytic therapy (CAT),'*Psychology Psychotherapy Theory Research and Practi*ce, Vol. 94, (S1), Pp36-63.

Balmain, N, Melia, Y, John, C, Dent, H and Smith, K (2021b): Experiences of receiving cognitive analytic therapy for those with complex secondary care mental health difficulties, *Psychology Psychotherapy Theory Research and Practice,* Vol. 94, (S1), Pp120-136

Barber, J.P, Gallop, R, Crits-Christoph, P, *et al* (2006): The role of therapist adherence, therapist competence, and alliance in predicting outcome of individual drug counselling: Results from the National Institute drug Abuse Collaborative Cocaine Treatment Study, *Psychotherapy Research,* Vol. 16, Pp229-240.

Barkham, M, Margison, F (2007): Practice-based evidence as a complement to Evidence-based practice: From dichotomy to chiasmus. In: C. Freeman & M. Power (Eds) *Handbook of Evidence-based therapies: A guide for research and practice.* Chichester: Wiley (Pp433-476).

Bennett, D, Parry, G, Ryle, A. (2006) Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: a task analysis *Psychol. Psychother*. Vol 79 (3) Pp 395-418

Castonguay, LG, Constantino, MJ., McAleavy, AA, Goldfried, MJ (2010): The Therapeutic Alliance in Cognitive-behavioral Therapy. In: J.C. Muran & J.P. Barber. (Eds) *The Therapeutic Alliance: An evidence-based guide to practice*, New York: Guilford (Pp150-171)

Chanen, A (2021): A Comparison of Adolescent versus Young Adult Outpatients with First-Presentation Borderline Personality Disorder: Findings from the MOBY Randomized Controlled Trial *The Canadian Journal of Psychiatry /La Revue Canadienne de Psychiatrie* (26 Feb) 1-13 Published online ahead of print DOI: 10.1177/0706743721992677

Fleming, J (1967): Teaching the basic skills of psychotherapy, *Archives of General Psychiatry*, Vol. 16, Pp416–426.

Frank, JD, Frank, JB (1991): *Persuasion and Healing: A comparative study of psychotherapy* (3rd Ed.) Baltimore: Johns Hopkins University Press.

Garfield, SL (1995): *Psychotherapy: An Eclectic-Integrative Approach*. New York: Wiley

Goldfried, MR (1980): Towards the delineation of therapeutic change principles, *American Psychologist*, Vol. 35, Pp991-999.

Hall, JM (1995): Idealizing Transference: Disruption and repairs. In: I.M. Goldberg (Ed) *Progress in Self Psychology* Vol 1. New York: Routledge Pp109-146

Hallam, C, Simmonds-Buckley, M, Kellett, S, Greenhill, B, and Jones, A (2021): The acceptability, effectiveness, and durability of cognitive analytic therapy: Systematic review and meta analysis. *Psychology Psychotherapy Theory Research and Practice* Vol. 94 (S1), Pp8-35.

Hamilton, J, Saxon, D, Best, E, Glover V, Walters SJ, Kerr IB. (2020) A randomized, controlled pilot study of cognitive analytic therapy for stressed pregnant women with underlying anxiety and depression in a routine health service setting. Clin Psychol Psychother. 2020;1–15 DOI: 10.1002/cpp.2520

Hucklenbroich, P (2014): 'Disease Entity' as the Key Theoretical Concept of Medicine *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, Vol 39 (6), Pp609–633,

Jefferis, S, Fantarrow, Z. and Johnston, L (2021): The torchlight model of mapping in cognitive analytic therapy (CAT) reformulation: A qualitative investigation, *Psychology Psychotherapy Theory Research and Practice*, Vol. 94, (S1), Pp137-151

Kellett, S, Gausden, J and Gaskell, C (2021): The effectiveness of cognitive analytic therapy for borderline personality disorder: Utilizing a withdrawal experimental design to improve sensitivity to abandonment, *Psychology Psychotherapy Theory Research and Practice*, Vol. 94, (S1), Pp96-119.

Kellett K, & Stockton, D (2021): Treatment of obsessive morbid jealousy with cognitive analytic therapy: a mixed-methods quasi-experimental case study, *British Journal of Guidance & Counselling*,

DOI: 10.108003069885.2021.1929834

Lambert, MJ (2004): *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change (Fifth Edition)*, New York: Wiley

Lambert, MJ (2010): *Prevention of treatment failure: The use of measuring, monitoring and feedback in clinical practice*. Washington D.C: American Psychological Association

Margison, F (2000): Cognitive analytic therapy: a case study in treatment development (Editorial) *British Journal of Medical Psychology* Vol. 73 (Pt 2), Pp145-50.

Martin, E, Byrne, G, Connon, G and Power, L (2021): An exploration of group cognitive analytic therapy for anxiety and depression. *Psychology Psychotherapy Theory Research and Practice*, Vol. 94, (S1), Pp79-95.

Merzhvynska, M, Simmonds Buckley, M, Delgadillo, J and Kellett, S(2021), Trajectories of change in the therapeutic alliance during Cognitive Analytic Therapy for depression. Psychology Psychotherapy Theory Research and Practice, Vol. 94 (3) Pp464-480.

Parry, G, Bennett, D, Roth, AD and Kellett, S (2021): Developing a competence framework for cognitive analytic therapy, *Psychology Psychotherapy Theory Research and Practice*, Vol. 94, (S1), Pp151-170.

Pedder, J R (1986): Reflections on the theory and practice of supervision, *Psychoanalytic Psychotherapy*, Vol. 2, Pp1–12.

Ryle, A, Kerr, IB (2002): *Introducing Cognitive Analytic Therapy 2nd Edition*, Chichester: Wiley (p.1).

Ryle, A (1980): Some measures of goal attainment in focused, integrative, active psychotherapy: a study of fifteen cases, *British Journal of Psychiatry* Vol. 137, Pp475-486

Sackett, DL, Strauss, SE, Richardson, WS *et al* (2000): *Evidence-Based Medicine: How to practice and teach EBM* (2nd Ed.), London: Churchill-Livingstone

SEPI (2021) Journal of Psychotherapy Integration – Society for the Exploration of Psychotherapy Integration (sepiweb.org) [Accessed 08/10/21]

Smith, ML, Glass, GV, (1977): Meta-analysis of Psychotherapy Outcome Studies, *American Psychologist*, Vol. 32, Pp752-760.

Taylor, PJ, Fien, K, Mulholland, H, Duarte, R, *et al* (2021): Pilot service evaluation of a brief psychological therapy for self harm in an emergency department: Hospital Outpatient Psychotherapy Engagement Service, *Psychology Psychotherapy Theory Research and Practice*, Vol. 94, (S1), Pp64-78.

Taylor, PJ, Hartley, S (2021): Reformulating the relationship between cognitive analytic therapy and research: Navigating the

landscape and exploring new directions, *Psychology Psychotherapy Theory Research and Practice*, Vol. 94: (S1), Pp1-7.

Taylor, PJ and Hartley, S (2021): Special Issue: Cognitive Analytic Therapy: Research Developments and Insights. Psychology Psychotherapy Theory Research and Practice, Vol. 94: (S1) Ppi-iv, 1-170.

Wachtel, P (1977): *Psychoanalysis and Behavior Therapy: Towards and Integration,* New York: Basic Books.

Wampold, BE, Imel, ZE (2015): *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work (Second Edition),* London: Routledge

Zipfel, S *et al* (2014) Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial *Lancet* Vol 383 Pp 127–37

Charting the Territory of Trauma

●**The Reckoning** Mary Trump (2021) New York: St Martin's Press

Steve Potter

Mary Trump's book *The Reckoning* details her analysis of the cruel psychology of her uncle in combination with the traumatising and divisive ideologies of racism, sexism, white exceptionalism and rugged individualism that lie unresolved among the founding narratives of the United States.

The Reckoning came out in May 2021; President Biden had just served his first 100 days and the second impeachment trial of ex-president Trump had floundered in the Senate. Previously Mary Trump has written one book *Too Much and Never Enough* about her uncle halfway through his presidency. Its subtitle: '*How My Family Created the World's Most Dangerous Man'* is further evidenced in the opening paragraph of her new book:

> 'The insurrection on January 6th, 2021, shouldn't have come as a surprise – my uncle Donald had been sowing the seeds of discontent for two months and promoting division and grievance for four years. It was a watershed moment – deliberate, planned, incited, yet another assault aimed squarely at everything I had always thought this country stood for. America is a deeply imperfect

country – a country that has never actually been democracy for all of its people, just for a privileged majority – but it always had the potential to become that hoped-for, more perfect union.'

The subtitle to *The Reckoning* reads *America's trauma and finding a way to heal.*

In CAT terms it offers a reformulation that looks inward and outward at the same time offering a personal and social perspective. Mary Trump is well placed to do this as a clinical psychologist and as a specialist in trauma work. Her starting point is her own trauma. She checked into a PTSD clinic shortly after her uncle was elected. In processing past and present personal wounds arising from her family across several generations, she extends her healing narrative to facing the trauma built into the deep structure of American society.

> '. . . this book couldn't simply address the trauma caused by the intersecting crises caused by COVID; it also had to address the trauma caused by the political crisis that exposed the long-standing fragility of our democracy.'

Mary Trump speaks clearly as she sees it. 'We are a traumatised society.' Cruelty is cruelty: for example, in separating refugee children from their parents. Fascism is fascism: the collusion with her uncle by the Republican Party is a courting of fascism. The cruelty incites violence and division.

> 'For four years the performative cruelty of the Trump administration and its message that we need to be tough and vindictive and punitive wore away at the fabric of our society We were pitted against one another and forced to choose sides.' p166

She links his political indifference to the tragedy of COVID to the family ideology.

> 'On August 3, 2020, a day before the United States surpassed 150,000 deaths from COVID Donald's interview with Axios reporter Jonathan Swan aired on HBO. "It is what it is," he said after Swan pointed out that 1000 Americans are dying a day. That was a popular expression in my family, and hearing it sent a chill through my body.' p81

Mary Trump berates her uncle for denigration of good authority, science and expertise and government and painfully notes it in a personal way when seeing her uncle triumphantly pulling the mask away from his face on returning to the White House from his hospital treatment for COVID.

> 'He clenched his teeth and jutted out his jaw, just as my grandmother did when she was biting back anger or clamping down on her pain. In Donald, I saw the latter.'

There are some startling and painful statistics and a call for healing the trauma in part through the payment of reparation to the descendants of those traumatised.

> 'By the time slavery was abolished in 1865 the numbers of people living in bondage in the United States had grown to four million. Every generation since has been shut out of the economic and educational benefits that were regularly bestowed on whites. There is no way to

> compensate for the loss of life or the destroyed potential or the fallout from the resulting trauma, but reparations will, as far as possible, return what has been stolen.'

Mary Trump links the cruelty of her uncle across a common narrative of contemptuous treatment of women, cruelty towards refugees, aligning with white supremacists, attacking climate change awareness and science and common sense in relation to COVID.

She gives a coherent account of how racism works to draw in the poor white migrant populations into an identification with the American dream. Mary Trump generously acknowledges her sources and those who have helped with the book. Anyone who wants to look America in the cold eye of its crisis through a personal and insider account will find the book a challenging but informative read.

What might we take from the book from the perspective of a relational view of mental health? That therapists need to also be historians and step outside of nationalism and be as careful in reformulating the workings of the society around them as they would be with the complex needs of a client. Whereas we have a language for not getting entangled in our own transference dynamics with the client, it is a different challenge to not be entangled with the society that partitions, positions and genders us with privileges in some cases and abuses and harm in other cases. I read Mary Trump's book at the same time as reading *Active Hope: how to face the mess we're in without going crazy* by Joanna Macy and Chris Johnstone. It was a book recommended by members of the ICATA climate crisis special interest group www.internationalcat/events and whilst it was written before the Trump era, it is equally part of a call to change the agenda. As Mary Trump stresses her uncle is only the symptom or presenting problem of a deeper structural crisis.

The focus of *Active Hope* is on a broad and activist relational awareness of the climate crisis and how changes comes from within us as well as around us joining together and doing things. Where Mary Trump looks the social structure and internalisation of trauma in the eye there is less on the pathways to change which is at the heart of the *Active Hope* book.

> 'We will have moments when the penny really drops that our world is in grave danger. When facing a challenge far beyond what we might normally think ourselves capable of dealing with, we need to move beyond the familiar and learn the art of seeing with new eyes. The next section of this book introduces four empowering shifts in perception. We like to think of these as the four discoveries: a wider sense of self, a different kind of power, a richer experience of community and larger view of time.'

What both books do is seek common cause to change the conversation, or rather initiate a thousand conversations about change.

Can CAT help? Can its capacity to use maps to hold in mind the complexity of

an individual client's attempts to change the conversations about themselves and re-work deeply embedded narratives be used to examine the societal narratives that oppress or free us? Well yes, we have more chance of being able to chart the push and pull of the political in the personal with a map making conversation than without one. Mary Trump says as much about her time at the trauma clinic in the Arizona desert.

> 'So, in the desert, I attempted to chart the territory of my trauma; I was a shoddy cartographer, and often lost my way, forced to detour by my desperate need to avoid the very thing that would help me get home – but facing the trauma was the only way to deal with it, so during the weeks in the desert, that is what I did.' □

Steve Potter is a CAT Psychotherapist, East London

REFERENCES

Joanna Macy & Chris Johnstone (2012) *Active Hope* California: New World Library

Recent published and forthcoming books on CAT

Potter, S. (2020)
Therapy with a Map:
a cognitive analytic approach to helping relationships
https://www.pavpub.com/mental-health/therapy-with-a-map

An overview of CAT therapy from the point of an active, relational, and conversational approach using the tools and methods of CAT co-creatively with the client

Marshall, J. Kirkland, J. (2021)
Reflective Practice in Forensic Settings:
a Cognitive Analytic Approach to Developing Shared Thinking

https://www.pavpub.com/mental-health/reflective-practice-in-forensic-settings

A collection of practitioners accounts of using CAT methods to develop reflective practice and teamwork in Forensic setting but with applications more widely

Brummer, L. Cavieres, M. Tan, R. (editors) (2022)
The Handbook of CAT Theory and Practice OUP

A multi-author compendium of the developments in and applications of Cognitive Analytic Therapy