Author's response

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It is gratifying to find both analytical and cognitive therapists engaging with and responding to cognitive–analytic therapy (CAT), even if it is unsurprising to find them taking it to task for being insufficiently analytical or cognitive respectively. Some points made by Dr Whewell and Professor Kingdon do need a response.

Dr Whewell is supportive of CAT, but criticises the therapist's "busyness" in building an alliance, which he claims "reduces the space for reflection". This space, he says, is one of "viewing without memory or desire". From a CAT perspective, therapy involves two active people in a mutual interpersonal engagement, and the withdrawal of one into "his or her own internal world" is not felt to be conducive to that engagement. CAT therapists are fiercely critical of analytical pretentions to an independent viewpoint obtained by distancing (often literal) and the interpretation of theorised internal structures, which are thought to be in principle unknowable by the patient. A measure of CAT's critique of analytical thought of this kind is that, for CAT, a person who strove to be without memory (of others) and desire (in relation to others) would be striving to cease to exist.

Dr Whewell's comments on the case vignettes are perceptive. Obviously, the patients may take from discussions of the ending of the therapy messages of disappointment and deprivation. However, by the same token, long-term treatment must not be idealised. The indefinite open-ended offer of long-term therapy may provoke fantasies of ideal care and of omnipotence. Furthermore, in this setting, a major side-effect of long-term treatment in patients with borderline personality disorder is malignant regression, in which over-idealised hopes turn to angry dependent disappointment and regressed demand.

Many trainee therapists, particularly those from analytical backgrounds, are terrified of the fixity they suppose will ensue from a reformulation letter. But their terror is not justified, and they soon discover that the letter, which both when it is given and throughout therapy remains a negotiable document, is one of the most powerful aspects of the therapy. From a CAT perspective treatments that do not have an early stress, it is unvoiced and acknowledged theoretical assumptions which may inform treatments which do not have an early stress on clear formulation often contain unacknowledged assumptions which are prejudicial to a patient's treatment and to clear thinking.

Professor Kingdon rightly identifies outcome research as a key need for CAT and he is unimpressed by accounts of difficulty in obtaining funding. He argues that small-scale unfunded pilots make the case for definitive research funding, implying that CAT has not done such pilots. In fact, Ryle's failed bid for funding was based on just such a pilot. Professor Kingdon's call for such pilots also, in my view, fails to take into account the differential difficulty of doing research with patients whose main problems are personality difficulties as against those who have Axis I conditions.

Professor Kingdon also questions what CAT will add to CBT practised in an empathic and flexible manner. This and other elements of his comments tend to suggest that CAT is fundamentally warmed up and a bit woolly CBT. Such a reading of CAT theory and practice ignores major areas of differential theoretical emphasis. CAT is far more interpersonal in its theorising than CBT, and its theory of learning and procedural revision is derived from Vygotsky and stresses social processes rather than from the behaviourist or cognitivist views of learning, which are more individualistic. CAT therapists believe these theoretical differences are important and allow CAT to describe interpersonal processes more accurately even than close CBT neighbours such as schema-focused therapy.

I agree that evidence of effectiveness is crucial for CAT's future. For me though, CAT has powerful appeal as a psychology that allows me to understand the phenomena patients describe with more clarity than the psychodynamic model and more inclusiveness than CBT.

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