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Cognitive Analytic Therapy: A Sympathetic Critique

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ABSTRACT *Cognitive analytic therapy (CAT) is an increasingly popular form of time-limited therapeutic intervention in the UK, which claims success with a variety of psychological problems such as depression, trauma, eating disorders, anxiety related disorders, borderline personality disorder and histrionic personality disorder. This paper begins by outlining the theoretical origins of CAT as well as its main conceptual tools. Cognitive analytic therapy has its roots in the synthesis of cognitive psychology, personal construct theory and psychoanalytic object relations. However, I would suggest what is most promising in CAT is the (relatively) recent import of Vygotskian and Bakhtinian ideas such as the 'zone of proximal development' (ZPD) and 'dialogic interaction'. Further ideas from critical psychology/psychotherapy are used to interrogate some of the limitations of CAT. I will be asking if CAT is a genuine gain for the contemporary worker who has to deal with greater psychic tension than before under a crisis-ridden capitalist regime. The paper ends with an assessment of CAT's future influence and the two principle trajectories available to it: 'therapy as an expert system' or 'therapy as social critique' (Totton, 2005, 86).*

Key words: Cognitive Analytic Therapy, Vygotsky, Bakhtin, Critical Psychology, Capitalism

INTRODUCTION

Since capitalism transformed into a hyphenated entity variously prefixed as *post-modern* (Lyotard, 1984), *late* (Mandel, 1975), *neoliberal* (Rüstow, 1980), *post-industrial* (Bell, 1973) or *post-Fordist* (Negri, 1988), a corresponding subject has been taking shape. This new subject is a more fluid and knowledgeable worker who seems at the same time to be more vulnerable and atomized than her earlier incarnations. Moreover, the needs, desires and anxieties of this new worker have also multiplied thus requiring a more nuanced psychotherapeutic service to repair the damage done to its multi-faceted labour power. At the same time, an increasingly radicalized generation of therapists has attempted new projects using the equalizing paradigm to ensure equality along class, race, age, power and gender variables (Chaplin, 2005). One product of these transformations has been the development of cognitive analytic therapy and it is the purpose of this paper to assess its credentials to heal damaged labour power.

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Since the subject matter of this paper is a dialogic form of therapy, I feel a brief self-reflexive confessional would be an appropriate place to start. I began what turned out to be a rather inauspicious 'career' in psychology many years ago with the firm conviction of qualifying as a clinical psychologist. In the mid 1980s clinical psychology was still a very small profession (approximately 1100 UK practitioners in 1982), living in the shadow of its more illustrious cousins – psychiatry, psychoanalysis and psychotherapy.

Clinical psychology's fate was from the outset inexorably linked with 'behaviour therapy' and later on with 'cognitive behavioural therapy' (Reavley, 1982, 26). It is precisely this uncritical relationship that compelled me to re-evaluate my initial sympathies toward clinical psychology. On closer examination, the assessment part of clinical psychology seemed a recipe for stigmatization, the therapy element proved haphazard at best and reductionist at worst, and the research agenda became disconcertingly self-serving. To paraphrase Joel Kovel, 'I began to wonder then whether [clinical psychology] had not been created in order to trivialize history' (Kovel, 1981, 19). I thus said my goodbyes to a career within clinical psychology and embarked on a different route that finally ended in the stupor of academia.

What has kept me going within this vacuous and conservative field of intellectual endeavour has been the occasional spark of brilliance discovered in the works of Lev Vygotsky, Michael Bakhtin and, more generally, critical psychology. Through these critical currents I have once again become acquainted with radical forms of therapy and counselling, which contextualize the individual within his/her social environment and promote emancipation. One such current *may* prove to be cognitive analytic therapy (CAT). The present work is an attempt to assess whether CAT is a genuinely novel form of radical therapy or a pseudo-radical intervention aimed at the rapid repair and return of the subject to the workplace and the joys of wage-slavery!

FIRST CONTACT

I first came across CAT during a weekend training course at Birkbeck College, University of London, which ran on 30–31 January 2009 (supervised by two qualified CAT trainers, Steve Potter and Annalee Curran). The aim was to provide a group of participant counsellors, psychiatric nurses, social workers, clinical psychologists and the odd non-practising mole (me!) the opportunity to evaluate the principles and practice of CAT.

The initial sales' pitch was rather low-key and dignified. We were informed how CAT was developed over the past 30 years through the work of Anthony Ryle and his associates. Their aim was to 'create a brief, focused and effective psychotherapy that could be delivered by front-line staff to large numbers of patients in the public sector' (Llewelyn, 2003, 502). In the process, they worked on transforming the monologic discourse of psychoanalysis *about* the patient to a dialogic (and simplified) discourse created in collaboration *with* the patient. Initially CAT was employed with 'neurotic' problems within an out-patient psychiatric context although more recently it has been applied to a wide variety of 'psychotic' issues including major mental illness (Kerr, 2001).

There was no attempt to aggrandise Ryle's role in CAT's developmental story, which is a refreshing change from other forms of psychodynamic or humanistic psychotherapy still reliant on the aura of the bourgeois-progenitor. The conceptual tools of CAT were described

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through a brief talk and a video depicting a fictional therapy session. Two further tools (the *diagram* and the *letter* which will be discussed below) were then introduced for the *reformulation* of the client's life-story.

The second day focused on seminal pressure points during the therapeutic process, various 'difficult' and 'breakthrough' moments. The *good-bye letter,* which traditionally ends the therapeutic relationship was elaborated and the programme came to a close with a discussion of multidisciplinary work with the client and community mental health teams (CMHT). In fact, working with CMHTs seems to be a conscious strategy on the part of advocates of cognitive analytic therapy in an effort to gain a foothold within the world of psychotherapy. Community mental health teams consisting of social workers, psychiatric nurses, clinical psychologists, counsellors and therapists are increasingly used in the UK to provide a consistent and long-term service for people with complex difficulties, especially those with childhood trauma who manifest a high level of distress and self-harm. Cognitive analytic therapy's emphasis on relations and communication with significant others, it is claimed, places it in a superior position to help these patients compared to either cognitive or psychoanalytic models (Thompson et al., 2008, 132). Furthermore, CAT can provide members of CMHTs with a 'shared common language' and a coherent ideological framework of analysis (Thompson et al., 2008, 131).

THE LANGUAGE OF CAT

In line with any novel treatment, CAT promotes its own discursive practice, which on closer inspection turns out to be influenced by three imperatives: (1) a rejection of previous discourse, especially the 'archaic and confusing language of' classical psychoanalysis (Llewelyn, 2003, 502); (2) a re-accentuation of older modes of expressing mental illness, especially those connected with object relations; and (3) a new vocabulary for capturing the nuances missed by other therapeutic models.

Like so many practitioners before them, cognitive analytic therapists began by rejecting and/or de-emphasizing certain dimensions of Freudianism. As Bateman et al. (2007, 51) inform us, 'CAT originated in part from the attempt to restate key psychoanalytic object relations ideas in an essentially cognitive language and in the extensive use of repertory grid techniques to investigate psychodynamic therapy.' The early emphasis on object relations was part of the move away from the Freudian notion of universal unconscious conflicts. However, when object relations itself proved inadequate to the healing task, a major rethink was prompted, leading to the import of Vygotskian and Bakhtinian concepts.

Throughout these changes, some key aspects of CAT have remained constant. For example, CAT insists on conceptualizing 'the patient in non-static, systemic terms whereby actions and relationships are understood as both causal and caused by each other' (Llewelyn, 2003, 503). Moreover, the interaction between therapist and patient is from the outset collaborative and mindful of asymmetries of power. All this gives CAT a theoretical flexibility and relational dynamism that more bureaucratised forms of therapy have forsaken over the course of their co-option.

The notion of a series of symptoms constituting a 'disorder' is replaced by the *procedure*. The original definition of a procedure was close to schema. If Fredrick Bartlett saw schema

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as an active organization of the past in order to give people orientation for future behaviour (Bartlett, 1932), then Ryle described the procedure as a 'linked chain of mental processes and actions involved in the execution of aim-directed acts' (Ryle, 1985, quoted in Llewelyn, 2003, 503). Procedures, however, are more than schemas since they 'include external and mental phenomena and unite cognitive, affective and behavioural components and communication' (Bateman et al. 2007, 53). Most of us use procedures effectively most of the time in our endeavour to function in the world. However, people with psychological distress become tangled up in a cycle of dysfunctional and distressing procedures.

It is crucial to view procedures relationally. 'Our early experience in reciprocation with our all-powerful carers invites a number of … *reciprocal role procedures* (RRP)' where *roles* describe how we interpret others or the internalized voices within (McCormick, 2008, 33). Role procedures aim for a response from others but also regulate the individual once they become internalized voices. The influence of Trevarthen who studied early post-natal experience through infant-carer engagement, D. W. Winnicott who believed 'there's no such thing as a bad baby' (i.e., baby grows with others), Bowlby's attachment theory with its focus on 'the shared world outside rather than the private world inside' (Moghaddam, 2007, 162), George Kelly's insistence on getting to know the client's life story in order to empathize more easily (Bannister et al., 1994, 74), and, finally, Bakhtin's dialogism are evident in the notion of reciprocal role procedures.

In healthy individuals there is a wide range of dichotomous role procedures, such as care-dependency or control-submission or demand-striving, which are internalized. These internalized patterns help to maintain the self in the social world. In individuals suffering from psychological disorders, therapists identify a narrow repertoire of role procedures and/or exaggeration in one of the poles of the RRP. For instance, one could discover deficiencies of care in the care-dependency RRP, excess of control in the control-dependency RRP or excess of demand in the demand-striving RRP (Bateman et al, 2007, 54). A borderline personality who is trapped in an abused-abuser pattern can come to play both roles of this RRP. Sometimes just remembering or talking about past traumatic experiences can provoke state switch. So in CAT the emphasis is not so much on the cause of the original trauma and the cathartic re-living of it (Miltenburg and Singer, 1999a, 1). According to Ryle and Fawkes (2007, 166) and in a nod to Vygotsky, '[i]nterpersonal and intrapersonal patterns are often parallel, as when a childhood experience of *striving to please* parents who are *critical* is repeated both in self-criticism and in criticalness of others'.

Faulty or maladaptive procedures are classified into three main types: traps, dilemmas and snags. Briefly put, *traps* are repetitive cycles of behaviour with a loop-back mechanism where consequences feed back into their perpetuation. For example, a depressed patient acts in ways that 'make failure and defeat more likely', leading to more depression (Denman, 2001, 244). *Dilemmas* refer to false choices or unduly narrow options, which lead to self-despised behaviour on the part of the patient who then becomes cross with himself and switches to an opposite procedure. For instance, an individual who initially acts by placating people around her, may become angry with herself, and switch to being overaggressive towards everyone. Finally, *snags* are 'anticipations of future consequences of action … so negative that they are capable of halting a procedure before it ever runs' (Denman, 2001, 244). Denman gives the example of a gay man so frightened of coming out that he prefers to live a lie.

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Cognitive analytic therapy supersedes existential forms of therapy such as logotherapy where 'choice' is sometimes elevated to an idealistic principle as a determinant of individual behaviour (cf. Frankl, 2004). In contrast, CAT recognizes the limitations imposed on individuals by social, economic and cultural factors. The narrowing of procedural repertoires discussed above may be caused alternatively by 'impoverished environmental opportunities', 'deliberate attempts by caregivers to restrict procedural repertoires', or previous faulty learning (Denman, 2001, 245).

STAGES OF THERAPY

Cognitive analytic therapy proposes that neurosis is characterized by *diminished* or *dysfunctional multiplicity* whereas in more extreme cases of childhood abuse this becomes a psychotic dissociation represented by *pathological multiplicity*. The therapeutic process aims to 'support the patient's capacity for self-reflection' by overcoming diminished and pathological RRPs (Ryle and Fawkes, 2007, 166). Change depends on the extent of this self-reflective process and the control of difficult memories/feelings. Unhelpful procedures are identified and alternatives explored. Here the therapist helps by becoming 'a new internal voice' and by avoiding reciprocation of dysfunctional RRPs (Ryle and Fawkes, 2007, 167). In line with Bakhtinian therapy, CAT acknowledges multiplicity while maintaining the essential unity of 'the self'.

Therapy is divided into three overlapping phases, namely, reformulation, active therapy, and termination. The whole process usually lasts between 16–24 sessions. This time limit is not absolute. Ryle acknowledges that for some clients, long-term therapy and more intensive care may be of value (1997, 160). However, it is also worth pointing out that time-limited therapies can in fact be more intensive than extensive long-term therapies (Ryle and Kerr, 2002, xvi). For those interested in the origins of CAT's interest in time-limited therapy see James Mann (1973).

During the *reformulation* phase the patient's difficulties are collaboratively located within a model of the self. The patient is asked to carry out 'homework' in the form of reading the Psychotherapy File which describes traps, dilemmas and snags. The homework is intended to help patients recognize patterns of thinking, feeling and acting and how to control their dysfunctional elements. The patient is assured that through changing dysfunctional patterns, they can also change the way other people behave towards them. The last part of the File is a questionnaire that aims to discover difficult and unstable states of mind. Usually by the fourth session a reformulation letter and a sequential diagram are collaboratively worked out and discussed.

The active part of the therapy begins by encouraging the use of the reformulation letter and sequential diagram to recognize dysfunctional RRPs. Hopefully the safety of the environment will encourage previously denied and avoided memories to be discussed openly. Cognitive analytic therapists believe that the mere naming and accepting of these negative expressions have a major therapeutic effect. This is a common belief amongst most schools of therapy and the cynic may seek to trace its roots to the ancients' belief that naming a plague was half-way to battling its ills.

The therapist spends a considerable amount of time preparing the patient for the end of therapy, which 'is seldom accepted without some disappointment or anger' (Ryle and

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Fawkes, 2007, 168). The experience of losing the therapeutic bond can bring back painful feelings of betrayal and loss. 'Good-bye letters' are one form of mitigating the negative effects of these feeling but also an accurate appraisal of the gains and failures of therapy. Unlike psychoanalytic and some forms of humanistic therapy, CAT 'does not seek to make major characterological changes, but rather, attempts to un-stick a stuck system' (Llewelyn, 2003, 504). To my mind, this is an affirmative feature of CAT which distinguishes it from fluffier forms of therapy that attempt to engineer 'clean closures'.

VYGOTSKY AND BAKHTIN ADD THEORETICAL COHERENCE

An outsider may get the impression that CAT has been subjected to major theoretical overhaul at seminal junctions during its development, usually in response to pragmatic concerns. For example, at its outset, CAT deliberately distanced itself first from Freudian defence mechanisms in symptom formation and later from Klein/Bion's explanation of borderline personality disorder as psychic disintegration (Denman, 2001, 249).

Then there was a temporary move towards Kelly's personal construct theory, whose traces can still be detected in CAT's predilection for scientific problem solving (e.g., setting homework for patients). However, more recently the focus on individual processes, so privileged by cognitive psychology, has been supplanted by the ideas of Vygotsky and Bakhtin. In fact, the Patient File Questionnaire could be viewed as a Bakhtinian-influenced version of Kelly's repertory grid.

Jerome Bruner's work on 'scaffolding' (an extension of Vygotsky's learning techniques) was an early influence on the development of CAT (Ryle, 1994). The educational scaffolding that occurs in the classroom acts as a model for the handing over of control and conceptual thinking that takes place within therapy. Bruner has also described two forms of knowledge, namely 'narrative' and 'paradigmatic', arguing that both can be used to persuade. Critical psychologists would recognize these as falling within the domain of narrative therapy (cf. Law, 1999) and rhetorical psychology (cf. Billig, 1996) respectively. Cognitive analytic psychology uses both narrative and paradigmatic discourses to shift the balance of discussion from a restrictive Freudian past to a retelling of the patient's experiences from alternative perspectives. The reformulation letter discussed above is based on narrative discourse whilst the RRPs and diagram are examples of paradigmatic thinking, since they employ abstract, verifiable descriptions (Ryle, 1994). Both modes of discourse help create a 'zone of proximal development' (ZPD) where therapist and patient can jointly create conceptual tools for enhancing self-knowledge (Ryle, 1994).

Following the import of Bruner's ideas, CAT also benefited from the pioneering work of Leiman (1997, 2002), who employs Vygotskian and Bakhtinian ideas in therapy. In fact, the relationship between Leiman and Ryle is best described as reciprocal, since Leiman has derived his *dialogical sequence analysis* from RRP. This is a technique intended to describe the moment-by-moment details of the therapeutic process and the 'interpersonal patterns that clients repeatedly enact in life' (Leiman and Stiles, 2001, 314). Crucially it incorporates therapist utterances as well as client utterances in identifying issues of concern.

Leiman has shown through his case studies how clients can in joint reflection within the zone of proximal development 'advance more than one level within a single session' (Leiman and Stiles, 2001, 315). Once trust is established within the ZPD, partly hidden and

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painful signs/words can be gradually rediscovered. Likewise new, jointly created signs/words will emerge facilitating comprehension (Leiman, 2002, 228).

UNDERUTILIZED IDEAS FROM VYGOTSKY AND BAKHTIN

If the section above signposted the deliberate and direct utilization of Vygotsky and Bakhtin by Ryle and co-thinkers, there is also an untapped reservoir of Vygotskian and Bakhtinian ideas with, at best, a tangential relationship to CAT. This section attempts to foreground these potential links in the hope of a richer engagement.

De-classification

We can begin by mentioning Seikkula (2003) who as a clinical psychologist and family therapist influenced by Bakhtin is keen to get away from the limitations of clinical diagnosis. He suggests that for most orthodox practitioners the labelling of a patient as 'schizophrenic' means 'an end to the interest of this research problem' but for those engaged in a dialogic interaction this definition triggers an avalanche of new meaning (Seikkula, 2003, 88). This is sensible counsel for a faction within the CAT movement who seem to have developed an uncritical stance towards diagnostic classification. In the assessment part of their seminal book for example, Ryle and Kerr express the mildest form of concern when they concede the 'state-trait' distinction is 'not always clear' (Ryle and Kerr, 2002, 72). It is true that they criticize labelling as, at times, 'arbitrary and reductive' (Ryle and Kerr, 2002, 132) but, by and large, the existence of mental illness and the distinction between Axis I and Axis II in DSM are taken for granted with undue haste.

We must constantly remind ourselves that 'the original DSM [Diagnostic and Statistical Manual: Mental Disorders] listed about 60 disorders, while the latest has about five times as many' (Singer, 2006, 6). The focus on the more bizarre attempts to create illness (e.g., *accidie* which was believed to arise from a failure to do one's duty to God in medieval England or the stigmatization of *homosexuality* as deviance) serves to detract attention from the sheer ubiquity of classification. Cognitive analytical therapy does not reject classification so much as *re-accentuate* it through introducing a dialogic element (Bakhtin, 2000, 423). This is a valid tactic for resistance, when used as part of a wider repertoire, but I would argue quite inadequate on its own.

Therapy as teaching

Therapy as education and self-development has a long history. Erich Fromm urged the analyst to ask herself constantly, 'What is new that the person learned this hour or this week?' (Thomson, 2009, 82). He also believed, 'the teacher is taught by his students, the actor is stimulated by his audience, the psychoanalyst is cured by his patients: provided they do not treat each other as objects, but are related to each other genuinely and productively' (quoted in Thomson, 2009, 90). What was in Fromm a vague humanistic technique of interaction has more recently found a coherent theoretical expression in neo-Vygotskian therapy. Roland Tharp suggests '[p]ychotherapy-as-education is a concept that has been slowly rooting for some decades, but its ripening has awaited the application of analytic tools with the explanatory and guiding power of sociocultural/activity theory' (Tharp, 1999,

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18). Cognitive analytic therapy has wisely decided to hitch its wagon to this movement. Both Vygotskian and CAT practitioners would agree that therapist and client should negotiate the *meaning* and *sense* of words in the course of therapy and interpret events jointly. Unlike phenomenology, *epoché* is not elevated to a fetishized ideal and in contradistinction to Freudianism *insight* alone is not credited with breakthroughs. Unlike phenomenology, which is rooted in the here and now, CAT uses language historically. Whether it does do with the same depth as psychodynamic therapy is an issue beyond the scope of this text.

Family and group therapy

In line with Seikkula above, Tharp has also extended Vygotskian techniques into family therapy. If Vygotsky was correct in suggesting that the task of development is the dialectical synthesis of everyday/informal knowledge with abstract/formal concepts, then the role of family and 'community' becomes indispensable. This is especially true 'for members of cultures of which the therapist is not thoroughly knowledgeable' (Tharp, 1999, 22). This manoeuvre from Freud's 'stuffy consulting office through to group, family and network therapies' is *by and large* a positive expansion of psychological problems into wider social relations. There are significant exceptions to this rule when the inclusion of family members and larger network members would be counterproductive. For instance, issues involving child abuse, insoluble family antagonisms and some forms of eating disorders. Part of the therapist's task is to ascertain which family member would enhance the therapeutic process and when to retain a one-to-one relationship with the client. Related to this issue is CAT's uneasy relationship with the 'unconscious'. Is it really appropriate for CAT practitioners to refuse interpreting the unconscious and merely focus on 'what can be seen or has been reported' (Ryle and Kerr, 2002, 11–12)? Does this attitude include ignoring 'invisible' capitalist social relations? Do we have to downplay them too because they may have their roots in the past and be concealed from view most of the time?

Jones and Skaife (2009) have even shown how the political and personal can be fused within a masters' degree course in art therapy. They explain the aims of their course at Goldsmiths College as follows:

> The purpose of the art therapy large group is to teach students about art therapy processes, which become magnified in the large group context, and to consider the existential, political and social issues that are raised in becoming a professional art therapist (Jones and Skaife, 2009, 23). [They argue that even within the present constraints of neoliberal capitalism, this approach] 'helped students gain a new understanding of their political agency and about the power of acting collectively to represent their interest … (Jones and Skaife, 2009, 25) [my additions]

It would be ironic if CAT became complicit in reversing this trend. In this context the current minimal group interventions of CAT seems to be a limitation that time will overcome (cf. Ryle and Kerr, 2002, 174).

Dealing with trauma

An excellent example of overlap in therapeutic conceptualization between neo-Vygotskians and CAT is the work of Miltenburg and Singer (1999b), who question the orthodox therapeutic practice of forcing the client to relive traumatic experiences. They believe this could

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reinforce dissociation, reify clients, and 'destroy the client's spontaneous compensatory system' (Miltenburg and Singer, 1999b, 541). Moreover, 'not every client needs or is willing to relive these experiences, nor is equal to the task' (Miltenburg and Singer, 1999b, 541). Moreover, 'survivors cannot afford to give up their survival strategies as long as there are no alternatives available' (Miltenburg and Singer, 1999a, 2). The behaviours and feelings that the client wishes to change are not always 'dysfunctional'. They may at the same time be necessary for client survival.

It would also be sensible to ensure CAT's focus on 'states' remains dialogic and flexible. Concepts like 'states' are not usually suitable for demonstrating development and interaction. They also tend to treat 'psychic processes as reified entities, *things*' (Miltenburg and Singer, 1999b, 545). That is why Vygotsky put so much emphasis on 'human plasticity' and understanding the 'internal logic' of subjects (Miltenburg and Singer, 1999a, 8). Has CAT taken sufficient precaution to avoid these errors? I believe it has but the potential for reification exists whilst 'states' remain a crucial part of CAT's discourse.

Perhaps what is really making me uneasy regarding CAT's treatment of trauma is the apolitical stance adopted. In line with a great deal of trauma research, 'the role of capitalism in promoting [. . .] sexual abuse is conspicuous [. . .] by its total absence. Terms such as *post-traumatic stress* disorder and *identity* are employed uncritically throughout' (Fozooni, 2008, 147). As I have commented in the same text, 'I would like to see research on trauma to benefit from the writings of Vygotsky and Bakhtin in the future. For example, Weine (1999) has ably used Bakhtin's notion of *speech genre* to discover the *Forgotten History* of traumatic events during psychotherapy … And Zittoun (2004) has used a Vygotsky-inspired semiotic interpretation to investigate the relationship between trauma, memorials and politics' (Fozooni, 2008, 147).

Dialogic self

The next idea that could benefit CAT comes courtesy of Hermans and Kempen (1993). They understand the self as a multiplicity of positions, called a Personal Position Repertoire (PPR) which brings to mind Ryle's reciprocal role procedures (RRP). In Hermans and Kempen's account the self comprises various social roles incorporated by an individual ('internal positions'), together with representations of significant others ('external positions'). The positions are endowed with a 'voice' through which they engage in dialogues (Geiser, 2006, 444). The dialogic self should be seen as a network of power with power relationships as catalysts for change (Valsiner, 2002, 262). Geiser in applying this model to shape-shifters from Sierra Leone touches on a vital issue. What is the link between the 'healthy' losing of self during shape-shifting or shamanistic trances on the one hand and dissociations experienced during 'psychotic' episodes? Is this 'losing of the self' a skill that can be developed? Or perhaps a 're-awakening of skills we all had as children' (Geiser, 2006, 447)? Is the changing body-image experienced by Wiccan witches during a state of 'losing of self' similar to perceptual distortions associated with most forms of eating disorders? Is multiple personality disorder an extreme form of the kind of shape-shifting most of us employ in everyday life? If so then the task of the therapist is to mobilize the 'adult' part of the client to develop communication tools for contacting the 'angry' part of the dialogic self (Miltenburg and Singer, 1999a, 11). Instead of dismissing the 'angry' part of self as

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'dysfunctional', or 'maladaptive', the therapist comes to appreciate its survival functionality and gradually reassures the self to do without it or employ it more wisely.

Cross-cultural contributions

Ultimately what is interesting about Geiser's work is twofold: firstly, this and similar projects could act as a cross-cultural contribution to the burgeoning research being carried out on CAT, thus enforcing its self-reflexive dimension. As Rogoff and Morelli (1989) have pointed out '[a]n important function of cross-cultural research has been to allow [Western] investigators to look at their own belief systems (folk psychology) on scientific theories and research paradigm' (Rogoff and Morelli, 1989, cited in Messer and Dockrell, 1998, 310). Secondly, such Bakhtinian approaches can interpret client's religious beliefs sympathetically without colluding with what the therapist may strongly disagree with.

Of course it is perfectly legitimate to point out that in today's complex and dynamic world cultural variations within a society may prove as significant as cross-cultural variation. In that case, I would suggest Bakhtin's distinction between *official* and *unofficial* cultures should become a more integral part of CAT's interpretative repertoire.

Polyphonic travelling and chronotopes

If Geiser uses Bakhtin's notion of polyphony to address the 'surplus of visions' experienced by shape-shifters, the related work of Peter Good (2001) employs Bakhtin's concept of a *polyphonic traveller* to reinterpret the psychiatric landscape. In this outstanding contribution, Good argues that to 'engage with the voices that play on the [psychiatric] landscape requires more than a simple intellectual shift … Polyphony demands a physical change to one's own bodily standing' (Good, 2001, x). Good rails against the separation between healer and sufferer institutionalized by official psychiatry. He identifies two principle *chronotopes* (time-space bonds) that populate the psychiatric landscape: the care chronotope and the patient chronotope. The care chronotope is distinguished 'by the sheer speed of its time flow' (Good, 2001, 25). It represents psychiatry's vision and is always addressed to an idealized future 'capable of dealing with the inevitable disappointments of the present and the shame of the past' (Good, 2001, 26). Time, in the patient chronotope, has a 'much more unstable quality … given to sudden accelerations or alarming tangents' (Good, 2001, 27). The most common feature of time in this chronotope is its 'slowed-down almost viscous quality' (Good, 2001, 27). Good expands on this basic antagonism between the two chronotopes to reinterpret psychiatry – its mode of surveillance and regulation as well as moments of resistance and autonomy exerted by patients. This is an approach that can enhance CAT's rather perfunctory critique of institutionalized psychiatry and add a new dimension to the collaborative dialogue at the heart of CAT.

The antagonism between care and patient chronotopes should conclude in synthesis rather than mere negation of the former. Paré and Lysack (2004) pose a similar problem: how to balance client knowledge with therapist knowledge? How can clients feel free to express themselves, and at times 'adopt certain ways of making meaning around problems' without feeling overwhelmed and hemmed in by therapeutic discourse? The issue is not a simple case of ensuring an even wicket or empowering the client to withstand monologic discourse.

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The process should aim for a dialectical synthesis of scientific (therapist) and everyday (client) discourses, whilst minimizing the harmful effects of official discourse. The process must also be cognizant of moments of client vulnerability when empowerment is willingly handed over to the therapist in return for peace of mind.

Power relations

According to Paré and Lysack (2004, 10) the 'intention is to disrupt and disempower the taken-for-granted *truths* or constraints, so that more empowering and open *voices* may enter into the conversation'. Following Bruner, they use scaffolding to manoeuvre the therapeutic discourse from monologue to dialogue. Talk, and problems, are externalised during scaffolding or to use Bruner's terminology a 'loan of consciousness' takes place (Bruner, 1986, 74). Of course, I am aware of the problems with this approach: firstly, the post-structuralist reader may rightly object to the structuralist taste of such metaphors, and secondly, externalising problems may not be applicable in certain cultures (e.g., Japanese culture), which prefers compromise to confrontation (Paré and Lysack, 2004, 15). Finally, one indicator of resistance and disengagement could be non-verbal communication. This is an aspect of therapy usually consigned to intuition, whereas ideas from Bakhtin can sensitize us to the subtle nuances of non-verbals within a coherent theoretical framework.

Activity and performance

Whilst wary of imposing the Leninist political philosophy of Fred Newman and Lois Holzman (1997) on the reader, there are certain parallels between *Social Therapy* and CAT that need to be drawn out. To quote: 'Basic to social therapy (and to building community) are two human capacities that engage alienation: *activity* and *performance*' (LaCerva et al., 2002). Activity is defined as 'revolutionary, practical-critical activity' (Marx, 1974, 121), the relevant ontological unit for psychotherapy. Performance is a particular form of this general activity, 'the human capacity to … be both *who we are* and *who we are becoming/ who we are not*' (LaCerva et al., 2002, 31).

In a departure from CAT, the focus in social therapy is not to solve individual problems but 'rather … to help groups of people create environments for getting better' (LaCerva et al., 2002, 32). This group approach, and a genuine desire to avoid victimology, are two positive aspects of social therapy that could strengthen CAT. It may even be worthwhile pointing out that both CAT and social therapy's usage of performance can be improved if they take on board Bakhtin's notion of the 'emancipatory laughter' – a sadly neglected aspect of therapy even within Bakhtinian circles.

RAISING CONCERNS WITH CRITICAL PSYCHOLOGY/ PSYCHOTHERAPY

The final section of my paper attempts to use the substantial, and growing, resources of critical psychology/psychotherapy/counselling to raise issues that have caused concern as I delved deeper into CAT. I hasten to add that I view these issues as deficiencies that could be overcome in time. Given the fact that I am neither a CAT insider nor a qualified therapist, it is perfectly conceivable that the list below is more a manifestation of my ignorance than

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an accurate picture of the state of play. I trust my criticisms will be received as positive and constructive rather than an exercise in nitpicking.

Capitalism and class

We live in a capitalist world which gorges itself on the entrails of the overwhelming majority in the interest of a tiny minority. This, for me, is the most basic, fundamental truth of our times which no amount of modernist humanism or postmodernist relativism can conceal (Fozooni, 2006). Any therapeutic intervention, aiming to ease suffering until the social relations propping up the system have been superseded, must take onboard this elemental truth.

There is very little in CAT writing that can be described as the political economy of psychotherapy or a class analysis of psychological illness. As Walkerdine (2007, 24) has suggested regarding psychoanalytic psychotherapy, it is conceivable that '[t]here is, in a Foucauldian sense, not an absence of clinical engagement with class, but a very specific engagement with the working class as an object of a surveillant social-work gaze.' In other words, class may be present in CAT discourse *implicitly*. I accept this possibility. Actual clinical work, especially carried out by therapists from a working-class background, may be far more responsive to class issues. However, my reading so far suggests this is a low-priority topic for CAT.

Whether this absence is by accident or design I cannot say but I do view it as a major deficiency. Unless therapy gives class emancipation centrality, and that means dealing with the issue *explicitly*, it will fail to help the sufferer or subvert bourgeois social relations. Psychotherapy is a commodity that, like any other, contains both a use-value and an exchange value. Singer's analysis of the political economy of psychotherapy in the US, for instance, has ably demonstrated how 'huge insurance companies call the shots in the mental health field' (Singer, 2006, 1). Medication 'therapy' becomes the treatment of choice for insurance companies. This has engendered a cosy relationship between them and pharmaceutical companies leading to a situation when, in 2002, 'the combined profits of the ten drug companies in the Fortune 500 were more than the profits of all the other 490 firms put together' (Singer, 2006, 3). The promotion of 'disease' and 'illness' to fit new drugs (Angell, 2004) is a relatively new phenomenon that any radical psychotherapy has to challenge if its efforts are not to be institutionalized. At present I see little sign, and perhaps more worryingly little desire, of that in CAT.

As Totton has observed, all psychotherapists have a political *agenda*, whether this is admitted to or not: 'all psychotherapy rests on a theory – explicit or implicit, conscious or unconscious – of *how people should be*' (Totton, 2006, xiv). And as Parker rightly adds, it is not a question of finding the right 'balance' between psychotherapy and politics in some sort of false homage to the ancient Greek notion of 'equilibrium' but the realization that every action, discourse and desire is already saturated by politics (Parker, 2008, 96).

In practice this should amount to an open discussion with the client regarding the bourgeois origins of the 'psy-complex' (Rose, 1985). It is not sufficient to carry out a 'dialogic interaction' (Bakhtin, 2000) without the historical tool of therapy being jointly demystified (Vygotsky, 1978). For instance, if it is true that the bourgeois and petty-bourgeois background of most therapists hinders the therapeutic relationship (Hannon et al., 2001, 142),

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should not this be a topic for discussion between therapist and client? If Hannon et al. (2001, 143) are correct in asserting that '[c]lassism is institutionalized in counsellor education programmes' (and I believe if anything they are understating their case) then isn't CAT's refusal to discuss class tantamount to collaboration with capitalism?

What makes the issue of class even more urgent is the fact that 'much of what is frequently discussed under the rubric of race or ethnicity [and I would add gender, sexual orientation and disability] may be better explained by social class' (Davis and Proctor, 1989, cited in Hannon et al, 2001, 140). Anne Kearney, herself both a counsellor and a trainer, has put it well: '… class is far more important an influence on counselling than any other social grouping, and that each of the other groupings is mediated by class' (Kearney, 1996, 47).

We are witnessing massive transformations in psychotherapy and counselling. Part of this shift is intellectual as more and more practitioners become influenced by critical, constructionist and Vygotskian currents. However, there are two negative factors worthy of consideration: professionalization and regulation. Ehrenreich (1989) has shown how the 'professionalization' of therapy/counselling has been used as a cloak to buttress petty-bourgeois interest and exclude working-class candidates. And Parker argues that 'the British government is preparing to regulate the activity of counsellors and psychotherapists through the Health Professions Council.' This he speculates is about normalizing a set of principles and practices that will reduce therapy to 'procedures, techniques and targets to roll through as many people as quickly as possible' (Parker, 2009). It would be unfortunate if CAT's desire for professional recognition from official bodies and its preference for short-term therapy were to make it a convenient cost-cutting measure for the state.

Poverty and depression

John Cromby (2004) demonstrates convincingly that depression and social inequality are associated. This poses an immediate challenge to all those forms of therapy that view depression as maladaptive behaviour or a disorder with organic roots. It also challenges therapies to explain why the effects of social inequality do not impact uniformly upon individuals. CAT is capable of dealing with the latter problem but tends to ignore the social aspects of depression. Occasionally lip-service is paid to external realities such as unemployment and poverty and their adverse impact on self-esteem but one feels these issues play an insignificant part in the course of cognitive analytic therapy (cf. Ryle and Kerr, 2002, 57). Where, for example, is CAT's critique of medicine and the pharmaceutical industries, or for that matter the impact of alienation on depression? McCormick, for in stance, encourages the severely depressed to trust 'medical or psychiatric advice' (2008, 23). Her depiction of the 'depressed thinking trap' seems only marginally superior to agony-column homilies (McCormick, 2008, 76–79). There is little or no political interrogation of science, medicine or the notion of progress. In its desire to make friends with everyone, CAT ceases to question power relations and the financial advantage accruing to certain segments of psychiatry as a result of drugs like Prozac (cf. Lewis, 2003). In this context CAT's humanistic philosophy can seem inadequate to the task at hand: '[CAT therapists] seek to remove the *roadblocks* which have maintained restrictions and distress and have

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prevented the patient's further growth and we assist in the development of more adequate route maps' (Ryle and Kerr, 2002, 14).

The trend is worrisome, especially since a great deal of positive work has been done in recent years to get away from 'outcome research'. For example, John Marzillier (2004, 392) has warned us '… psychotherapists, anxious to prove that what they do works, have bought into a medicalised way of defining psychological experience. They act as though it is correct to state that people have depression or anxiety or schizophrenia like they *have* measles or diabetes or heart disease.' It is also worrisome because it has parallels with CAT's non-resistance to bourgeois morality. In what I consider a distortion of Vygotsky, CAT has a tendency to fetishize early caregiver-child dyadic relationships and downplay formal bourgeois cultural restrictions imposed on us throughout life: 'Formal rules of conduct and explicit social norms have a small and late impact compared to the indirect transmission of values and assumptions about the world and self through the child's joint activities with others in the early years' (Ryle and Kerr, 2002, 42). This leads to the unfortunate paraphrasing of Vygotsky, which strikes me as flawed as well as dogmatic: 'what the child does not do or say with the adult today she will not do or say on her own tomorrow' (Ryle and Kerr, 2002, 43).

Temperament and neurobiology

The de-emphasising of politics and class antagonisms in society by CAT is made worse by its predilection for notions of 'temperament' and its uncritical import of behavioural genetics and developmental neurobiology (cf. Ryle and Kerr, 2002, 26–8). It is noteworthy that the only criticism of Jung's conception of the self alluded to is the neglect of the social dimension of self (Ryle and Kerr, 2002, 37). Having presented certain clichéd positions regarding genetics and biology as uncontroversial 'facts', Ryle and Kerr go on to make this astonishing concession:

> … a certain amount of what may be described as personality may be the effects of temperament rather than of developmental experience. As such they may be relatively immutable, raising the question of whether, in that case, the task of psychotherapy may be, in part, to help an individual to live with and manage their particular temperamental characteristics as well as to make sense of their consequences. (Ryle and Kerr, 2002, 26)

Although sold to us as pragmatism and realism, this, in fact, is a pre-emptive admission of defeat, which imposes self-limiting boundaries on the therapeutic process.

CONCLUDING REMARKS: TWO PATHS AVAILABLE TO CAT

Totton (2005) makes a distinction between two positions within therapy; one he calls *therapy as an expert system* and the other *therapy as a social critique*. The former 'tends to operate from a cure or adjustment model' (Totton, 2005, 86). It is concerned with establishing its credentials as a profession by finding a niche, erecting an enclosure around it and claiming the knowledge generated inside the enclosure as its private property. The enclosure is then further parcelled out according to a technical division of labour that aims to increase production. It has its own seminal texts, lodge masters and bureaucrats. This is, of course, therapy as exchange value.

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Therapy as social critique or social resistance aims instead to demystify the relations (economic, cultural, political and personal) that perpetuate exploitation and alienation. If a therapy cannot politically interrogate capitalism its usefulness must be seriously curtailed. Vygotsky, and to a greater extent Bakhtin, would refute the notion of a body of expert knowledge that therapists could lay claim to (Pollard, 2008, 209). The problem with CAT's import of political figures such as Vygotsky and Bakhtin is that ultimately they have been tamed and sanitised and perhaps even used instrumentally. Their radicalism has been transformed into woolly humanism and liberal sentimentalism. I believe Pollard makes a similar point in her excellent study of Bakhtin and psychotherapy (Pollard, 2008, 1). Which position would CAT have the greatest affinity with: therapy as an expert system or therapy as social critique/resistance? I suspect different practitioners in this field would respond to the question differently and I also suspect that most practise a kind of therapy that borrows elements from both poles.

Related to this is the substance of socio-economic factors influencing individuals, a dimension usually neglected by CAT. Despite Vygotskian influences, one feels CAT lacks an activity theory for navigating the wider issues of concern that may fall within the extra-psychological domain but are nonetheless crucial for successful intervention in psychotherapy. There is little attempt to connect personal distress and the structures of a system based on capitalist exploitation, patriarchy and racism (cf. Jacoby, 1997; Kovel, 1987; Ralph, 1983). In this sense CAT is a regression from the gains of the 1970s and 1980s. On the other hand, in its incorporation of Vygotsky and Bakhtin, its innovative treatment of 'neurotic' and 'psychotic' patients and its desire to open up its methods and practice to inspection by all and sundry, CAT is justifiably winning admirers in the therapeutic community.

In assessing CAT I have had to overcome my own deep-seated scepticism about the efficacy of therapeutic treatment. I have come to accept CAT as a genuinely integrative approach, which is still expanding and finding its feet. There is a great deal in CAT worthy of serious consideration: I like the way its time-limited nature reduces dangers of over-dependence; I like its Vygotskian and Bakhtinian elements and would prefer it to develop further along these lines; I like CAT's ambition in helping the most 'difficult' clients (although on the other hand CAT selects its clientele very carefully, filtering out those with suicidal or extreme self-harm tendencies, who are referred to psychiatry, as well as those deemed not sufficiently motivated to benefit from therapy, e.g., addicts); its attempt to base itself on sound, coherent theory instead of settling for a convenient eclecticism; its preference for anti-Cartesian dialogism and its collaborative approach. Finally, I am impressed by CAT's scope and ambition. I believe that if in the future CAT chooses to become a fully fledged therapy as critique/resistance/education rather than therapy as an expert system, its status amongst radical psychologists will be guaranteed.

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