A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation of Psycho-Diagnostic Categories, 'Psychopathology' and Counselling Psychology: A Discourse Analytic Study of Chartered Counselling Psychologists' Talk.

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Introduction

Year One: Counselling Psychology - Critical Psychology in a Postmodern Age? Challenging and Reconstructing Traditional notions of Psychopathology, Psychiatric Categories and Psycho-Diagnosis

Year Two: Psycho-Diagnostic Categories, Psychopathology and Counselling Psychology. A Discourse Analytic Study of Counselling Psychologist’s Talk.

Year Three: Between the Real and the not Real: 'Knowledge', 'Truth', 'Power' and the Creation of Clinical Realities. A Discourse Analytic Study of Psychotherapeutic Practice.

Publications

This portfolio contains work submitted in partial fulfilment of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. It incorporates three dossiers: Academic, Therapeutic Practice and Research. Whilst the dossiers and the individual pieces of work contained within them cover a wide range of material and aim to demonstrate a range of abilities and competencies, I believe that it is the ethically and critically orientated threads running throughout, which binds them into a meaningful whole, i.e., the overall development of my professional identity/position and approach to practice. Though I acknowledge that the representation of my work is necessarily partial and is open to elaboration, revision and critique, it nonetheless symbolises my own unique 'rite of passage' into the culture of counselling psychology and a professional community of practitioners. This 'rite of passage', i.e., the process of constructing and performing my own identity as a counselling psychologist, has been conflict ridden, not in a negative or urgent sense (though it felt that way at times) but rather as in a transitional period to be negotiated. My struggle to claim or resist certain images, modes of practice and ways of being made available to me during the course of my training, have gained expression throughout the portfolio most clearly in my preference for and use of social constructionist and critical approaches to psychological theory, research and practice. As a means of orientating the reader to the contexts and conditions giving rise to the work in this portfolio, I will introduce relevant aspects of my own experience, including my motivation for undertaking a professional training in counselling psychology and my personal and professional experiences prior to and during the course.

The ongoing negotiation of my professional identity and reasons for pursuing a career in counselling psychology are inseparable from my experiences of personal, familial, social and cultural uncertainty. I grew up in a rural farming community, which provided a stable and tightly defined community. However, I never felt comfortable with this particular way of life or the subject positions and statuses that it offered to me. Consequently my
experience of growing up was largely characterised by a sense of opposition, difference and not belonging.

At eight years of age, what I now know in diagnostic terms is referred to as 'obsessive-compulsive disorder' entered my life and held me prisoner until well into early adulthood. Thus I experienced first hand what it was like to be afraid, to suffer in silence, to feel 'abnormal' and to feel ashamed. These experiences were perpetuated during my schooling where I was subject to negative evaluations and descriptions, e.g. 'slow learner', 'not academically gifted' and so on, which I found to be quite capturing of my identity (I later found out that I have a different style of learning, i.e., dyslexia). Though my sporting ability provided a necessary foil and allowed me to construct a sense of self worth and positive identity, my aspirations of becoming a professional cricketer were cut short during my adolescence by a bone infection. I subsequently qualified as a personal trainer and aerobics instructor and had a successful career in the health industry. During this time, through my own intimate and professional relationships, further uncertainty arose in relation to my relatively privileged position and cultural location as a white middle class heterosexual man subject to living in male orientated culture. I became disillusioned with the health industry's promotion of the 'body beautiful' through the 'male gaze' and my own unwitting complicity in the reproduction of stereotypically gendered images of 'normality' and 'beauty'.

Trying to make sense and create meaning amidst a sea of confusion and uncertainty was a key factor that drew me towards the discipline of psychology. I also was drawn to a career in psychology because a great deal of my work as a health professional had taken on a 'therapeutic' quality. The people I worked with frequently experienced all manner of life related difficulties and used our sessions as a safe conversational space in order to discuss matters of importance to them. The level of contact I experienced personally and within the context of my professional role was something that I found rewarding and enriching of my own life and identity. At this point I felt that I wanted to find a career
that would allow me to work specifically in a therapeutically and psychologically orientated way.

I left the health industry and undertook a practitioner training in Neuro-Linguistic Programming (NLP), a diploma in Clinical Hypnosis and a Social Sciences module with the Open University in order to develop as a person, reconnect with my own learning abilities and to get a taste of more psychologically and therapeutically orientated ways of being. I realised that the key to my own learning and development was largely dependent upon being motivated and passionate about what I was learning/doing. I felt passionate about my own and others experiences of life and relationships and psychology seemed to provide a structured way forward. I researched different professional pathways, which included reading the Handbook of Counselling Psychology (Woolfe & Dryden, 1996) and decided that I wanted to embark on a career in counselling psychology. At this point I decided to do an undergraduate degree in psychology and counselling with a view to going on to postgraduate training. My first degree gave me further insight into the discipline of counselling psychology. Not only was I introduced to the major theorists and models of psychotherapeutic practice but also to social constructionism, which I immediately felt a kinship towards. Participation in an experiential group and experiential exercises further developed my own reflective and relational capacities and helped to cement my desire to become a therapeutic practitioner.

I opted to study and develop a career specifically in counselling psychology as opposed to say clinical psychology or training as a psychotherapist for many reasons. In a very concrete sense I saw it as providing a professional home and identity along with the privileges that entails, e.g. recognition, status, livelihood etc. However, my ultimate motivation was of a much more personal nature. My own experiences of life led me to abhor unequal and discriminatory practices and the objectification / pathologisation of people, which I found to be disrespectful and abusive. This resulted in me developing preferred values and ways of being that emphasise equality, mutuality and respect for difference. As such I felt a certain affinity with the ethos underpinning counselling
psychology. The emphasis placed on context, non-pathologising and anti-discriminatory practices, the acknowledgement of the co-creation of meaning within relationship and a critically reflexive stance, seemed to hold a great deal of creative potential for both individual and social life. Perhaps above all else, I was drawn to counselling psychology because I understood it to be a site through which meaningful conversation and change could take place.

During the course of my training I came to view the discipline as an ethical activity, which emphasises concern for one's fellow person/humanity. That said I do not believe that either the discipline of counselling psychology or myself as a counselling psychologist exist statically in a cultural vacuum or are immune from the possibility of reproducing potentially oppressive or pathologising practices. That is why I have consistently adopted a deconstructive and critical approach throughout my training, as I believe it is only through ongoing critical reflection at the level of self, discipline, and culture that such abusive practices and unequal relations can be minimised and the ethos and aims of counselling psychology can increasingly be realised as a lived reality and not just a philosophical or disciplinary ideal.

This critical stance in no way means that I am 'anti' counselling psychology. On the contrary, it matters because counselling psychology and my position as a counselling psychologist has a direct bearing on my own life and identity as well as others. My critical position means that I care and that I am willing to take a stand. I do not view clients' difficulties in terms of 'pathology', with me as a therapist providing a 'cure'. Rather I look to our shared humanity and see my own liberation and the creation of a better world as being bound up with those 'others' who seek help. It is an attempt to appreciate the constitutive and relational nature of lived experience, along with the mutual negotiation of difference that lays at the heart of my personal-professional journey and which hopefully finds expression and an audience through the work in this portfolio.
Academic Dossier

The academic dossier contains four essays. Each essay adopts a critical and exploratory approach to the phenomena being investigated and represents an interplay between my experience of learning on a taught course and how I made these learning experiences personally relevant and meaningful by forging links with and incorporating what I felt interested and passionate about into my academic writing.

The first essay I have presented is entitled 'Constructionist based therapies challenge to modernist models of therapy: The importance of narrative'. This essay looks at the ways in which modernist forms of psychodynamic and cognitive therapy use clients' stories or narrative as a means of accessing supposedly more 'foundational' aspects of psychological reality, such as 'personality structures' or 'schemas'. This is contrasted with social constructionist or narrative based therapies, which place the clients' process of narration at the centre of their work. Some of the potential limitations of modernist models are highlighted, and attention is given to the implications these contrasting approaches to narrative hold in terms of the relations of power engendered in the therapeutic relationship.

The second essay: 'Empathy - psychotherapeutic interpersonal understanding and the therapeutic relationship', considers psychotherapeutic empathy as an aspect of the therapeutic relationship with reference to psychodynamic theorising and my own clinical observations. By taking a wider view of psychotherapeutic empathy as a relational and dialogical phenomenon, I was able to reconcile some of my misgivings about what I perceived as the subject/object dualism inherent in traditional forms of psychodynamic practice. This in turn helped me to engage with and become more open to the potentially useful aspects of psychodynamic work in my clinical practice.

The third essay: 'In cognitive therapy, how would a therapist understand and work with difficulties arising in the therapeutic relationship. Illustrate with examples from clinical
practice', looks at some of the historical and conceptual factors pertinent to the areas of cognitive therapy and the therapeutic relationship per se before forwarding an account of the interdependence of the therapeutic relationship and cognitive therapy. This is achieved through reference to relevant literature and my own clinical experiences of working with difficulties in the therapeutic relationship.

The final essay included in the academic dossier: 'The therapeutic relationship: An integrative aid', was written during my final year of training. It is a result of having been encouraged to actively consider the issue of integration in relation to our own personal approach to practice. Written to a shorter word count, this essay takes the view that human meaning making is constituted through relationship. The therapeutic relationship is considered as a framework for integration at the theoretical level and as a personal aid to integration at the level of practice, which is illustrated through a brief reflexive example. Within the overall context of my training, this essay reflects my sustained engagement with the significance of relationship at the level of theory, research and practice.

Therapeutic Practice Dossier

This dossier relates to clinical practice and provides the reader with a brief overview of my placements and the client populations I have worked with. It also contains a 'Final Clinical Paper', which discusses the ongoing evolution of my personal style and approach to practice.

Research Dossier

This dossier presents my research, which developed organically in conjunction with my personal and academic interests and clinical experiences. A statement on the 'use of self' in the research follows each study, which is designed to alert the reader to my motivations for exploring specific topics and my experiences of conducting research
itself. Each piece adopts a social constructionist and critical framework in order to explore issues that I believe are central to the discipline of counselling psychology and have a direct bearing on psychotherapeutic practice.

The Year One literature review is entitled: 'Counselling Psychology - Critical Psychology in a Postmodern Age? Challenging and Reconstructing Traditional Notions of Psychopathology, Psychiatric Categories and Psycho-Diagnosis'. Having embarked upon a career in counselling psychology largely because it rejects the medical model's view of mental 'illness', I was keen to explore traditional conceptualisations of 'psychopathology' and the use of diagnostic classification systems in contrast with the applied discipline of counselling psychology. This review helped me to gain a broader historical perspective on the discipline of which I was now a part. This was particularly useful for my own development because it helped me to maintain a critical stance whilst managing the tensions I experienced working clinically as a trainee-counselling psychologist in contexts where bio-medical views of 'psychopathology' were dominant.

As my literature review had been at a relatively abstract level, I decided to conduct a qualitative study in my second year entitled: 'Psycho-Diagnostic Categories, Psychopathology and Counselling Psychology. A Discourse Analytic Study of Chartered Counselling Psychologist's Talk', in order to look, within the context of a research interview, at local instances of how counselling psychologists spoke about and accounted for 'psychopathology' and their use or non use of diagnostic categories in their own practice. The discourse analytic methodology employed enabled me to explore the personal, interpersonal and professional functions served by speakers' accounts in relation to the tensions and dilemmas identified in the literature review.

The final piece of research entitled: 'Between the Real and the not Real: 'Knowledge', 'Truth' and 'Power' and the Creation of Clinical Realities: A Discourse Analytic Study of Psychotherapeutic Practice', builds upon the social constructionist frameworks employed in the first and second years. It examines the discursive relationship between 'knowledge',
'truth' and 'power' in the context of psychotherapeutic practice and pays attention to the implications and effects particular discourses have on therapist/client subjectivities and the relations of power made available to them. This piece of research was particularly meaningful for me as it reflected issues that I was facing and attempting to work through in relation to my own position and preferred approach to practice.

The research dossier also includes a published article entitled: On 'mundane heterosexism' (Craven, 2002), which featured in the 'Research in brief' section of *Lesbian & Gay Psychology Review, 3*(2), 62-63. Written during my first year of training, the article reviews a research report conducted by Elizabeth Peel (2001) who combined discourse analysis with lesbian feminist politics in order to explore what she refers to as 'mundane heterosexism', i.e., subtle forms of heterosexism in language. The process of reviewing and writing about somebody else's work gave me further insight into the potentials, as well as drawbacks, of discourse analytic research methods and helped me to develop my own research interests during the course of my training.

N.B. The details of individual clients have been changed and pseudonyms have been employed throughout this portfolio in order to protect client and research participants' confidentiality.
References


ACADEMIC DOSSIER
Introduction

This dossier presents four selected essays that were submitted during the Psych.D course. The first essay is concerned with the importance of narrative and considers psychodynamic and cognitive therapies' traditional use of narrative in contrast to constructionist or more explicitly narrative based approaches. The second essay discusses the notion of psychotherapeutic empathy as an aspect of the therapeutic relationship, with reference to psychodynamic theory/concepts and reflections on my own clinical practice. The third essay forwards an account that argues for the interdependence of the therapeutic relationship and cognitive therapy. Finally, the fourth essay considers how the therapeutic relationship can be usefully viewed as an aid to integration at both theoretical and personal levels.
Constructionist based therapies challenge to modernist models of therapy: The importance of narrative.

The last several decades of the Twentieth Century saw narrative become the subject of numerous new investigations. The increasing interest in the study of narrative suggests the emergence of another strand to the "new paradigm" movement and a further refinement of postpositivist scientific method. What has been called the discursive and narrative turn in psychology and other human sciences can be seen as part of larger tectonic shifts in the cultural architecture of knowledge following the crisis of the modern episteme (Brockmeier & Harre, 1997). The new interest evolves around an acknowledgment that the story form, both oral or written, constitutes a fundamental linguistic, psychological, cultural, and philosophical framework for our attempts to come to terms with our nature and the conditions of existence (e.g. Bakhtin, 1981; Bruner, 1986; Polkinghome, 1987; Sarbin, 1986). It can be argued that this turn to narrative reflects similar developments within philosophy and the social sciences in general and that such developments are having a significant impact in the therapeutic field (see McNamee & Gergen, 1992).

This paper aims to consider the importance of narrative and the implications it holds specifically in relation to clinical practice. In order to achieve this, traditional modernist models of therapy shall be set against and contrasted with recent postmodern, constructionist informed narrative therapy (e.g. White & Epston, 1990). Harnessing the tension between modern and postmodern approaches to therapy serves to provide an organising framework in which to consider the respective views of, importance accorded to, and ways of working with narrative in clinical practice. With narrative firmly in the spotlight this paper aims to provide a snapshot of the impact of postmodernism on therapy and the challenge it levels at modernist models of therapy. In doing so a cogent...
argument that views the core of therapy as an arena for the telling of personal stories shall be forwarded.

A useful point at which to start is consideration of how the ways and ideas about narrative and stories have been employed in therapy. Many theorists, to help make sense of therapeutic work, have used the concept of narrative and story; for example, Berne (1972) developed the idea of the life script of the client in his model of transactional analysis. Gustafson (1992) identified three types of life stories, which he viewed as underlying problems and anxieties clients experience. Due to limitations of space, only two schools of thought shall be considered, which can be located within the modernist tradition, namely, psychodynamic and cognitive models.

The psychodynamic and cognitive schools of therapy can be described as foundationalist, in that they each utilise narrative (i.e., the stories clients tell) in order to gain access to supposedly more ‘foundational’ levels of psychological reality (McLeod, 1997). In the psychodynamic tradition therapists do not typically work with the clients' story in its own right, but instead use narrative to gain access to 'underlying' psychic and emotional structures. Although within the psychodynamic tradition a therapist may start by asking to hear the client's story, the story is not recorded in story form, rather the therapist gathers information that is subsequently reduced into conceptual categories, which are deemed of particular interest. McLeod (1997) notes how such categories are shaped in line with psychodynamic theory, focusing for example on transferential themes, developmental issues or triangular relationships. Consequently the client's narrative is treated as a source of evidence that supposedly corresponds to underlying 'personality' structures that are being expressed directly through their story.

In general terms, psychodynamic theory holds to the notion that there is an underlying unity to the stories that people tell. Deriving from Freud's original ideas, therapeutic work aims to unearth the client's core 'life story' (McLeod, 1997). Freud assumed that clients' life stories could be understood in terms of the template provided by the Greek story of
Oedipus Rex. The theme of assuming the existence of a core, repetitive life-story that is evident in psychodynamic theory has not gone unchallenged. For example, Spence (1987) notes how this framework can only work if certain elements of what the client says are downplayed so that their situation can be fitted to the guiding template or theory. Omer (1993) draws our attention to further potentially dangerous implications of this approach, stressing how the reduction of a client's life to a core narrative theme may reduce, oversimplify and ultimately result in marginalising the complexity and richness of the client's lived experience. Within psychodynamic work we find the use of story to be viewed as a means to an end with the story itself being deemed of relatively little interest to the therapist.

In the cognitive tradition the concept of narrative is typically viewed as a form of representation. Cognitive therapists regard stories as a means of gaining access to, and facilitating change in, fundamental underlying "scripts" or "schemas". Once again, as with psychodynamic theory, we find the goal of therapy to be the attainment of a coherent, singular life story. The prescriptive nature of cognitive therapy raises concern over the extent to which the client's story is implicitly replaced by the therapist's theoretically led story. The client's reality, as expressed through their narrative, is understood as an individual, cognitive product; in other words, the social and relational dimension is pushed to the periphery. The cause of difficulties, and responsibility for change, remains solely with the individual client. Subsequently, the therapist stands removed from the client, evaluating and diagnosing their crisis or difficulties by general culturally significant criteria. For example, the cognitive approach of Albert Ellis (1962) is steeped in the modernist notion of the rational individual, as such therapy evolves around the replacement of the clients 'faulty' or 'dysfunctional' life story with a more functional one provided by the therapist, where the difference between a good (rational) and a dysfunctional (irrational) story is quite explicit. Arguably again, the therapist working within a modernist model of therapy may fall into the position of 'expert', imposing their theoretically driven understanding onto the client's situation.
Having briefly outlined some of the key features of psychodynamic and cognitive models approach and orientation towards working with narrative, we find that both traditions rely upon a blueprint or metanarrative (Omer & Strenger 1992). They write that:

...clients come to therapists with their broken narratives, which therapists offer to mend... included among the therapist's bench tools are: A metanarrative that serves as a template into which the client's life narrative is fitted and newly cut to size. (Omer & Strenger, 1992, p.256)

When we consider the use of stories in a modernist context, narratives are viewed essentially as structures of language. For the modern therapist narratives can function as conveyors of objective knowledge. The psychodynamic and cognitive models of therapy can be viewed as products of the modern era, and as such, share deeply in the assumptions of modernism. Perhaps one of the most central beliefs resulting from the modernist context is that the professional therapist should ideally function as a scientist. The client's narrative is considered of relatively little value in the understanding of their lives, and is viewed as less preferable to the empirically based account of the trained scientist. The theories underlying the aforementioned models each contain assumptions stemming from their modernist orientation regarding the underlying cause of the problem or pathology, which can be understood as being intimately bound and situated within the wider medico-scientific narrative of pathology and cure. Secondly, there is an assumption that the cause of the problem can be located within the individual. Thirdly, assumptions are made concerning the means by which the problem or pathology can be eradicated or fixed (see Gergen & Kaye, 1992; Kaye, 1999).

It is this backdrop that establishes the modern therapists posture towards the stories their clients tell. Though the client may initially get to tell their story it is the therapist's scientific narrative that maintains a privileged position due to its professional endorsement. Thus the trained professional enters into work with a client with an existing narrative that is not only well-developed but has support within their community of
fellow practitioners and scientific peers (Gergen & Kaye, 1992). Arguably this makes for a skewed imbalance of power in favour of the therapist as they define themselves apart from the client with whom they are working. This, in turn, upholds the belief that they are the ‘expert’ holding special knowledge that allows them to observe, assess, diagnose, and treat the client without being subject to the same processes as the person they are interacting with (Weingarten, 1998). In a similar vein Keeney (1983) notes how the modern therapist is seen as the observer, that is, as distinct from the client who is the observed. From this vantage point it is assumed that the therapist knows and understands the client better than they know and understand themselves. Consequently, the therapeutic process, regardless of the focus, entails the replacement of the client's story with that of the therapist.

The metanarratives employed in these theories essentially provide an image of how the person should be, and how they have become the way they are, i.e. ‘faulty’ or pathological. It is the perceived image of the fully functioning or good individual that guides the therapeutic outcome. Whilst the replacement procedures of modern therapies undoubtedly do have some therapeutic benefits it is the potentially injurious consequences that are of concern in this paper. Firstly, we find that the therapeutic procedure virtually guarantees that the therapist's narrative will not be threatened but rather be vindicated as being correct. Spence (1982) has noted how the search space, as defined by the therapist, can be continually expanded until the "correct" answer is found. In other words, the therapeutic deck is stacked in the therapist's favour, with any potential challenges being muted, due to the power accorded by their socially sanctioned status and scientifically endorsed narrative.

Lyotard (1984) views the modern search for overarching theories as containing the seeds of terror and totalitarianism. The metanarratives employed in the modern models of therapy reviewed, at best may replace the problematic narrative with an alternative clinical reality, which if accepted may prove beneficial; at worst, the metanarrative can demand consensus and conformity. To this extent, they can be viewed as powerful
ideological systems serving to legitimate the dominant interests of differing therapeutic factions, thus maintaining the therapeutic status quo.

It has been noted that modernist approaches to therapy begin with an a priori narrative that is justified by its claims to a scientific base. Gergen and Kaye (1992) point out that because it is sanctioned as scientific, this narrative is relatively closed to alteration. They argue that the therapeutic procedure furnishes the client with a lesson in inferiority wherein the client is indirectly informed that they are ignorant and incapable of comprehending reality. Clearly then, on this account we see the modern therapist positioned as superior to the client, with the subsequent therapeutic interaction being a unidirectional one-way flow, as the therapist imposes their theory upon the client's situation. To this extent modernist narratives are practically content free as the therapist's narrative is an abstract formalisation cut away from the context and circumstance in which the client lives. This feature of modernist models of therapy is highly problematic as the decontextualised nature of modern narratives, which attempt to help clients by replacing their stories with the fixed narrative of the therapist, fail to give due attention to the particularities of the context in which the client's experience is embedded.

As we turn now to narrative therapy, as informed by social constructionist thinking, we find therapeutic practice is based on postmodern premises. Despite modernist therapies finding increasing theoretical value in the concept of narrative, it is only constructionist, narrative therapies that fully acknowledge the significance of storytelling by placing the client's process of narration centrally in their work (McLeod, 1997). From this perspective, there are no "true" stories, no fixed "truths", no master narratives, (Parry & Doan, 1994).

Instead, social constructionists and narrative therapists reject the idea of an external reality and "grand metanarratives", in favor of 'local knowledges' and the intersubjective influences of language, culture and discourse. Rather than the modernist representational-referential view of language, this position holds language to be constitutive, as such; the
problems clients bring to therapy are understood as being constructed in, and through, language.

The goal of therapy is to play with different ways of thinking about difficulties clients experience, as one kind of story will work in some contexts, or relationships, but not at all in others. The form of therapy advocated from this position aims to open clients up to a multiplicity of possible personal narratives about the self, their life situations, and to free them from the limiting constructions imposed on them in their past (Gergen & Kaye, 1992). The potentially dangerous power imbalance that is evident in modernist models is minimised due to the therapist adopting a position of genuine curiosity, what Anderson and Goolishian (1992) call a "not-knowing" approach, towards the client's difficulties. The collaborative nature of the therapeutic relationship is further emphasised as the therapist attempts to join forces with the client against the problem. This particular view and approach towards practice and therapist client relations is embodied in the maxim: 'The person isn't the problem: The problem is the problem' (Epston, 1989, p.26). Thus the therapist is positioned as a 'co-author' rather than an 'expert authority' and therapeutic change is construed as the dialogical process of re-authoring the 'dominant' or 'problem' story in which alternative knowledges, meanings and counter-plots can be resurrected and performed. Anderson and Goolishian, (1987) consider therapeutic change not to be merely problem resolution or problem solving, but rather problem dissipation, which they see as occurring in the process of "languaging" about a problem. Basically, for them, change is the co-evolution of new meaning and this takes place through conversation or communicative exchange.

From a narrative vantage point this is best encapsulated in the notion of polyvocal collaborations. This is more of an overriding aim and orientation rather than a specific technique. Polyvocality emphasizes expanding the number of voices bearing on a particular problem. Narrative therapists aim to resist internalising discourses and practices, which locate problems within the individual. Instead the aim is to bring many voices into the dialogical mix thereby generating new options and possible actions.
Certainly there are many liberating benefits for the client, most notably; polyvocality may enable the client to find plausible alternatives to the situation they find themselves in when they present themselves for therapy. In this sense, they become more flexible and better able to see alternative ways of going on. From a postmodern viewpoint, it is difficult to find fault with such an approach, however, modernist therapists may argue that bringing "non-expert voices" to bare on the situation may have negative and potentially damaging consequences for the client.

Having outlined modernist models of therapy's general orientation towards and use of narrative, this paper has proceeded to detail the constructionist, narrative approach. Attention has been drawn to the potentially injurious consequences of modern approaches and their reliance on guiding metanarratives. In particular, their modern heritage has been noted and the implications this position holds for the therapeutic relationship. Following this, the social constructionist informed narrative approach has been highlighted as offering an alternative account of the human condition in which narrative is placed centrally in therapeutic work. Finally, in keeping with the postmodern position adopted in this paper, I shall refrain from extolling the final word on which approach is best or holds the "truth". However, it is hoped that a case has been made for viewing therapy as an arena for the telling of personal stories and the potential benefits this position holds.


Empathy - psychotherapeutic interpersonal understanding and the therapeutic relationship

Introduction

The notion of psychotherapeutic empathy is a well-established concept that has been long cherished within the therapeutic community. Empathy has been conceived in a number of different ways, for example; as a trait, a state of being, an attitude, a form of communication, a way of knowing, an awareness, a special kind of relationship, a behavioural readiness, and a physiological condition (see Bohart & Greenberg, 1997). Though the notion of empathy can be traced to Theodore Lipzi, who in 1897 introduced the concept of *einfühlung*, which literally means ‘feeling into’, it was Titchener (1909) who coined the term empathy, referring to it as a ‘process of humanizing objects, of reading or feeling ourselves into them’. More recently, Carl Rogers (1975) is credited with placing empathy at centre stage in the therapeutic process. It is Roger's powerful and often quoted definition of empathy that has frequently served as the basis for psychotherapeutic practice. He defines empathy as "entering the private, perceptual world of another and becoming thoroughly at home in it" (p.2). However, Sexton and Whiston (1994) in reviewing the plethora of literature and research regarding empathy, state, "the definition and mechanism of empathy seem unclear" (p.26). Moore, (1990) highlights that research has generated little agreement among investigators, and Gladstein (1983) concludes that there have been few conclusive research findings. As such, there is continued debate regarding the intra-psychic or interpersonal location of empathy and its categorisation as a skill, attitude and/or a form of understanding.

One notable distinction that has arisen amongst almost all past and current contributors to the extensive literature on psychotherapeutic empathy is between *empathy* and *understanding*. Some theorists posit a clear separation between empathy and understanding, for example, Shlien (1997) views empathy as a form of pre-conceptual perceptual attunement with an other that is important for adaptation and survival, but
different from conceptual understanding or communicating. However, most theorists seem to be more ambivalent regarding the distinction between experiencing and understanding when conceptualising empathy. For example, Roger's (1959) view of empathy includes perceiving both 'emotional components and meanings' (p.210) related to the client's conceptions of reality. Similarly, Kohut (1984) regards empathy as a 'capacity to think and feel oneself into the inner life of another person' (p.82). Greenberg and Elliot (1997) draw a distinction between empathy and interpretation, viewing the former as 'an affective form of understanding that...differs from conceptual understanding...in that it is something that therapists feel rather than just understand intellectually' (p.169).

Other psychoanalytically orientated writers, like Eagle and Wolitzky (1997), consider empathy to be the internal experience of sharing in and comprehending the momentary psychological state of another person; while interpersonal theorists, such as Stolorow (1994), provide a directly methodological focus by portraying empathy as 'a method of investigating and illustrating principles that unconsciously organise a patient's experience' (p.45).

Bohart and Greenberg (1997) have provided a comprehensive survey of the relevant theoretical formulations and empirical studies associated with the various conceptions of psychotherapeutic empathy that evolved during the twentieth century. In attempting to integrate various conceptions of psychotherapeutic empathy drawn from differing schools of therapy, Bohart and Greenberg (1997) include both experience and attempts to understand in their consideration of psychotherapeutic empathy. They make a distinction between experience and understanding, extending the latter to include 'more affective, perceptual, experiential, or tacit kinds of understanding' (p.420) and argue that

A key therapist skill here is the ability to temporarily suspend one's own frame of reference in service of taking the role of the other, as well as being able to go beyond this to be able to empathically grasp the larger context in
which the experience of both therapist and client in interaction is taking place. (Bohart & Greenberg, 1997, p.420)

Bearing the aforementioned distinction between experience and understanding in mind the central aim of this paper is to critically consider psychotherapeutic empathy as an aspect of the therapeutic relationship in relation to psychodynamic theorising and my own clinical observations. By contrasting traditional uses of psychotherapeutic empathy, i.e., classical analysis, with more recent relationally orientated psychodynamic approaches, I shall attempt to critically appraise the impact each position holds in relation to the therapeutic relationship. A second aim is to position psychotherapeutic empathy within a broader conceptualisation of interpersonal understanding

**Empathy and Psychoanalysis**

Within the psychoanalytic literature empathy has been referred to as a developmental need, as a mode of listening, as a form of communication, as a curative agent and as a method of observation and data gathering (Eagle & Wolitzky, 1997). For Freud, empathy was a way for the therapist to know the mind of the client. In classical psychoanalysis the primary function of empathic listening was to provide clues about the patient's unconscious dynamics, which in turn helped facilitate effective interpretations. As the therapist's empathic understanding was not shared with the analysand there was no attempt, for example, to use empathy to help establish a relationship in which a corrective emotional experience could take place. Consequently, empathy is viewed as a prerequisite for the therapeutic relationship rather than a direct "curative" agent in psychoanalytic treatment. It appears that Freud never intended empathy to be a central instrument of analysis. Clearly for traditional psychoanalysts, therapeutic empathy is understood to be a method of observation and data gathering. This stance towards psychotherapeutic empathy is perhaps more understandable when viewed within the context of Freud's (1912/1958) attitude towards the analytic relationship wherein he frequently advocated the "blank screen" approach, and, on occasion, that of a surgeon
who takes an entirely objective attitude towards the patient. Such a therapeutic stance is theoretically contingent and positions the therapist as an 'objective' knower or 'expert'. This in turn affects the therapist's posture towards empathy and the therapeutic encounter more generally. It should be noted that this traditional view of psychoanalysis reflects a split between the observing subject and the observed object. In short, the "experience-distant" or external perspective characteristic of traditional psychoanalysis leads to the client being treated as a behaving object rather than an active subject. Arguably Freud's drive theory embodies an outdated nineteenth century philosophy of science, predicated upon the possibility of having access to an 'objective truth'.

Historically, the notion of empathy was thrust to the centre of the psychodynamic stage with the development of Heinz Kohut's (1971) self-psychology. Kohut argued that the "experience distant" detached way in which classical analysts understood their patients was not helpful. Rather, he emphasised the importance of the therapist trying to comprehend what was going on in an "experience near" way. This means that the analyst should try to place him/herself, through the process of "vicarious introspection" into the experience of the client. Kohut's formulations (1971, 1977, 1984) attempt to replace the drive as the basic constituent of mind with factors derived from the earliest relationships between the child and his/her object world. His depiction of the analytic process wherein the therapist actively works with the client rather than imposing their theory on the client is consistent with the relational premises underlying his theoretical position. The general increase in emphasis on relationships and their role in the development and remediation of psychopathology (e.g. Luborsky, 1984; Mitchell, 1988; Watchel, 1993), has led to empathy or its lack being seen as an important component in both development and psychotherapy. Subsequently, relational theorists (e.g. Stolorow & Atwood, 1992) define the therapeutic relationship in terms of an interpersonal field wherein the participation of the analyst is essential as opposed to the traditional view of the therapist as a neutral observer who interprets drive and defence mechanisms within the client. This directs the clinician's attention to ways in which he/she and the client are mutually influencing each other.
Despite the modern emphasis on the importance of therapeutic empathy in psychoanalysis, and the implications each perspective holds in terms of the location and role of therapeutic empathy, there remain many unresolved questions regarding its role in theory and practice, such as, to what extent is it necessary for the therapist to experientially identify with the subjective world of the client in order for understanding to occur? In what follows, the relationship between the psychodynamic concept of projective identification and therapeutic empathy will be used as a platform from which to launch a more general inquiry into psychotherapeutic understanding in the analytic situation.

Empathy and Projective Identification

Tansey and Burke (1989) assert, "When empathy occurs, projective identification is always involved. The experience of empathy on the therapist's part always involves the reception and processing of a projective identification transmitted by the patient" (p.195). Projective identification according to these authors is an interactional phenomenon whereby one person projects an aspect of the self or internal objects "into" another individual, and through interactional pressure,

...unconsciously elicits thoughts, feelings, and experiences within [this other] individual which in some way resemble his own...the projector may stir up within the therapist an experiential state that to some degree matches or compliments the projector's immediate self experience. (Tansey & Burke, 1989, p.45)

The basic claim is that projective identification and empathy are inextricably linked. If so, then what does projective identification have to do with the process of empathy? Tansey and Burke (1989) answer this question as such: "an awareness and examination of one's own experiential state - insofar as it is closely related to the projected aspects of the patient's inner world (i.e. aspects of the self or internal objects) and has been induced by
the patient through interactional pressure - becomes the primary "tool" for empathic understanding of the patient" (p.201). They argue that the best means of achieving empathic understanding is by being aware of and examining one's own experiential state. This involves not so much putting oneself in another's place as being in another's place by virtue of the other's projection and interactional pressure (i.e., projective identification).

However, there does appear to be the possibility that the therapist's experiential state reflects to a large extent his or her own pre-understanding, theoretical preoccupations, and so on, and may not, therefore be a direct product of the patient's projections and interactional pressures. Critically, I agree from a psychodynamic perspective that the therapist's experiential state is, in part, indicative of what is going on in the patient but is not necessarily a consequence of projective identification. In my own clinical practice I recall a session when I had an impulse to cry in response to a client's expression of sadness. I believe empathic resonance and understanding were achieved responsively in relation to one another and that my empathic understanding of the client did not necessarily involve the client's projections "into" and interactional pressures on to me.

This conceptualisation of empathy always involving projective identification fits with the traditional view of empathy as one separate self trying to infer or intuit itself across the gulf separating it from another. Highlighted are wider concerns and dilemmas posed by traditional psychoanalytic uses of empathy. The therapist may either intentionally or unintentionally impose their theory upon the client's situation. There is a skewed power imbalance in favour of the therapist because in classical analysis, the therapist, via their detached, neutral therapeutic stance, withdraws themselves from genuine communication, whereas the client must probe the details of their psychological history ever more thoroughly and radically. As such, there is a monological character to psychoanalysis that is problematic. The flow of influence becomes unidirectional and therapeutic empathy runs the risk of becoming a form of mind reading or second-guessing the client's experience, that is, the therapist operates on the client rather than with the client in accordance with a predetermined theoretical model. Consequently, understanding the
meaning of the client's experience is ascribed by the therapist rather than being jointly negotiated. Questions surrounding abuse of power in the therapeutic encounter arise forcibly as the concept of therapeutic empathy may become little more than an excuse and justification for forcing interpretations onto clients' experiences. Though this view and critique of traditional forms of psychoanalysis and its use of empathy may be oversimplified, there remains a cogent argument that embodied empathic attunement and its validation in the critical dialogical encounter with the client may actually be blocked.

Contrastingly, recent relational psychodynamic models are part of a wider shift in understanding that highlights empathy as a situated and process orientated activity. As such, therapeutic empathy becomes liberated from egocentric images of two separate individuals wherein one - the therapist - attempts to discern something happening within the skin of the other - the client. From the outset, static conceptions of empathy, and concerns over its "true" nature take a back seat in favour of working with and understanding it as an emergent property of the therapeutic relationship.

I have found this stance honours the multi-dimensional nature of the construct, which in turn opens up greater space for shared or jointly negotiated meaning between therapist and client. One implication of such a move is that power in the therapeutic encounter is more evenly distributed and the therapeutic relationship becomes a collaborative and co-constructive process. Empathy is no longer a state in which I as the therapist can simply 'be', without reference to another person, namely, the client. It is not possible to actually experience what the client experiences, indeed the implication of actually experiencing what the client experiences may lead the therapist into the same debilitated state that led the client to seek help in the first place. In practice, I experience as I listen to, and interact with, the client and attempt to experientially respond in an empathically complementary manner. The empathic message that is conveyed is 'I understand what you are feeling and experiencing', not 'I am feeling what you are feeling'. It appears to be the understanding component of the empathic process that carries the therapeutic gain. Thus, the two-way nature of therapeutic empathy is highlighted, as, what the therapist feels or understands
irrelevant unless the client also believes and feels his or herself to be understood. In my opinion, therapeutic empathy does not emerge or exist, and genuine therapeutic gain does not occur without such shared or joint understanding (see Shotter, 1993).

From this perspective, therapeutic empathy is intimately interwoven with action and communication, and serves as a basis for therapeutic action. I have found it important to actively attempt to pick up and resonate with the client's experience and to communicate such empathic involvement to the client. This involves a willingness to be open, vulnerable, and present to the client. As has been noted, the goal of therapy is not to experience, but to understand experience. Therefore it is meaning and not feeling per se that fuels understanding. Such interpersonal understanding that characterizes therapeutic empathy more widely emerges when the therapist works with attitudes of self-criticalness, curiosity, and respectful openness towards their lived encounters with clients. In practice I have found that this requires the full dialogic collaboration of therapist and client and moves both towards the heightened awareness of previously unconscious, unspoken or unconceptualised meaning. The increased sense of reflexivity that is produced in the client can only be achieved when the therapist is also reflexively aware and concerned. As such, therapeutic empathy and the interpersonal understanding that it fosters, functions as an integral part of a collaborative and cooperative relationship. It is crucial because it is the process by which the therapist and client dialogue, co-discover, and co-create new meaning. Viewed in this respect therapeutic empathy is seen as the gradual flow of emergent dialogical understanding between therapist and client. Importantly, this includes a contextual appreciation of how an individual client's lived experiences relate to the particular socio-cultural, political and interpersonal contexts in which they are embedded and evolve as human beings.

The aforementioned contexts, in which both participants are embedded, draw our attention to the necessarily perspectival nature of both therapist and client's pre-understandings and knowledge. It is through the ongoing dialogical journey that both come to understand one another. The therapist, that is seriously trying to understand is
required to attempt a critical penetration of their own pre-understanding, whilst simultaneously remaining open to the understandings of the client. When a therapist makes an interpretation they are simultaneously engaging in an interpersonal exchange with the client. A "correct" interpretation (i.e., one that is meaningful for the client) therefore implies a deep and empathic form of relatedness. Thus, meaningful interpretation and deep relationship imply one another. Genuine therapeutic empathy and the interpersonal or joint understanding (Shotter, 1993) that it creates can thus be equated with dialogical consensus between both participants. The "truth" and subsequent agreement or disagreement of any interpretive act is necessarily perspectival and subject to ongoing revision within the therapeutic relationship. Acknowledging and becoming aware of the perspectival nature of participants' understandings in the psychotherapeutic encounter through critical dialogue is a primary function of therapeutic empathy. Conceived of this way the analytic situation becomes a dynamic process of co-exploration, constant checking and re-checking, which can allow both therapist and client to sharpen understanding and converge towards co-constructed new meanings.

Conclusion

Based upon recent developments with the psychodynamic tradition and my own clinical experience an account has been forwarded that has argued for understanding psychotherapeutic empathy as something that occurs relationally between people, and that the therapeutic relationship is the therapy, forming a kind of gestalt that includes both parties involved. Furthermore, attending to the distinction and close connection between experiencing and understanding at the level of theory and practice, relationally orientated psychodynamic models appear congruent with Bohart and Greenberg (1997) who identify the most defining feature of empathic understanding in psychotherapy as the ability to somehow step outside of one's usual way of perceiving and comprehending, combined with the ability of somehow adopting something of the role of the other, in further combination with a heightened understanding of the larger contexts within which all of this takes place.
More generally, this shift in focus, from the intrapsychic towards the interpersonal realm, fits with recent postmodern thought, which emphasises the primacy of relatedness and the multiplicity of different ways humans can construct reality (Mahoney, 1991). Because there is no one "objective reality", the therapist's ability to empathise becomes particularly important. If reality is multiple and socially constructed then empathy becomes the fundamental way of knowing across diverse personal realities.
References


In cognitive therapy, how would a therapist understand and work with difficulties arising in the therapeutic relationship?

Illustrate with examples from own clinical practice.

Introduction

The principal aim of this paper is to present an informed (albeit selective and interested) account of how a therapist would understand and work with difficulties arising in the therapeutic relationship whilst conducting cognitive therapy. In order to do this, the paper starts by providing a brief excursion through historical and conceptual factors pertinent to the areas of cognitive therapy and the therapeutic relationship per se. The intention is to broadly situate the areas under consideration in order to elaborate a more detailed account of the importance and interdependence of the therapeutic relationship and cognitive therapy. This will be achieved through reflection upon relevant literature and reference to my own clinical practice and development as a trainee counselling psychologist, currently practising from a cognitive perspective. More specifically, how I have conceptualised and worked with (utilised) difficulties in the therapeutic relationship. Due to space limitations the focus is narrowed to one particular type of 'difficulty' frequently arising in the therapeutic relationship, namely, 'ruptures' in the alliance. An argument is forwarded that stresses the centrality of the therapeutic relationship as the primary medium through which the techniques of cognitive therapy gain maximum impact, thus highlighting the therapeutic relationship as a potent site and vehicle for therapeutic change.

Cognitive therapy

Disenchantment with the behavioural tradition is a salient factor that gave rise to cognitive therapy in the late 1960's. Aaron T. Beck, who is often regarded as its originator, developed cognitive therapy as a relatively short-term and structured
psychotherapy for depression, which explicitly focused on modifying 'patient's' current dysfunctional thoughts and behaviours (Beck, 1967). At the present moment in time it features firmly as a mainstream psychotherapeutic model, which according to Smith (1982) is widely accepted as one of the most popular intervention formats amongst clinical practitioners. In western culture the present socio-political climate is increasingly infused by the ideology of professionalisation (House, 1999), which emphasises a scientific 'treatment' mentality and being accountable in terms of demonstrating outcomes and effectiveness. As such, it is not surprising that the cognitive therapy model, with a strong empirical emphasis that lends itself to quantification through its manualised - protocol based approach, has become the psychological treatment of choice for many Axis I conditions (Roth & Fonagy, 1996).

The theory, practice and focus of cognitive therapy have evolved during the years since its inception with some theorists (e.g. Perris, 2000; Vallis, 1998) making a distinction between first and second-generation approaches. First generation or "traditional" approaches are said to be characterised by a focus on 'surface' level structures (e.g. automatic thoughts and basic assumptions) and work therapeutically at the level of content and symptomology. Contrastingly, more recent second-generation approaches emphasise 'schemas' or core beliefs with the therapeutic focus being geared towards 'deeper' levels of cognition. The development of schema-focused approaches (e.g. Padesky, 1994; Young, 1994) partially arose in response to the difficulties encountered in working with people experiencing Axis II disorders, i.e., complex personality disorders. In spite of there being little evidence to suggest that schema focused work is more effective than non-schema focused work, as Jacobson and Gortner (2000) contend, its popularity has grown to the point that it is frequently thought of synonymously with cognitive therapy and it is increasingly employed in work with Axis I disorders such as anxiety and depression.
In the beginning is the relation.

Martin Buber

Clarkson (1996) reviews five different kinds of therapeutic relationship of possible benefit to the psychotherapeutic venture. These are, the working alliance, the transferential / counter-transferential relationship, the reparative / developmentally needed relationship, the I-Thou relationship and the transpersonal relationship. Though it is not within the scope of this paper to individually review each type of relationship, where relevant, elements of these types of relationships will be highlighted when considering the therapeutic relationship specifically in relation to cognitive therapy. Of key importance at the present moment is that Clarkson's (1996) paper draws our attention to the fact that the therapeutic relationship has repeatedly emerged from research as a significant factor in therapy. For example, she cites Frank (1979) and Hynan (1981) as two researchers, amongst many, who found that the relationship between the client and therapist is repeatedly more closely related to outcome than whatever technique has been used. As such, it is empirically and anecdotally justified to say that there is somewhat of a consensus regarding the crucial importance of the therapeutic relationship, which is thought to be common across different types of therapy. From Clarkson's (1996) observation that "relationship is the first condition of being human" (p.29) to Kahn's (1991) radical statement "the relationship is the therapy" (p.1), the importance of the therapeutic relationship cannot be overemphasised.

Cognitive therapy and the therapeutic relationship

Traditionally, it has been within the domain of psychoanalytic theory and practice that the transformative potential of the therapeutic relationship has been paid most attention - only recently gaining a foothold in the cognitive literature (Jacobson, 1989). However, more recently, Clark (1995) notes that a major criticism levelled towards cognitive therapy is that, comparatively, the role of the therapeutic relationship in cognitive therapy remains poorly defined and researched. Safran and Segal's (1990) stark conclusion is that
the lack of focus on the therapeutic relationship in cognitive therapy "has had a seriously detrimental impact on practice". Historically speaking, it appears that such criticism is largely directed towards first generation approaches of cognitive therapy, which were goal orientated and consequently paid little attention to the therapeutic alliance. A central feature of what has been written about the therapeutic relationship in cognitive therapy has been its conceptualisation of therapy as a process of social influence. Traditionally such a stance has emphasised the psychology of the client - a "one-person psychology" (Kahn, 1996), that is to say, what occurs within the client has been privileged over what occurs between the client and therapist.

Whilst not focussing in great detail on the role of the therapeutic relationship in cognitive therapy, first generation approaches, such as the one developed by Beck et al (1979), do nonetheless stress the importance of "collaborative empiricism", i.e. the requirement of therapists to develop collaborative relationships with clients in the spirit of investigation in order to test their perceptions and cognitions against 'reality'. Clients are encouraged to treat their perceptions as hypotheses, which should be confirmed or disconfirmed in accordance with relevant evidence. Broadly speaking, a good therapeutic relationship is conceptualised as necessary but not sufficient for good outcome in cognitive therapy. The nature or quality of the therapeutic relationship is deemed important, but not central, to the treatment or its outcome (Beck et al., 1979). In summary, traditional cognitive approaches tend to view the therapeutic relationship as something that is a prerequisite for the change process, rather than an integral part of it (Safran & Segal, 1996).

The arrival of second-generation schema-based approaches heralded greater emphasis being placed on the therapeutic relationship as an active mediator of change. Given the significance placed on clients' past developmental experiences, the necessity for therapists to foster a "secure base" (Bowlby, 1988), in the context of the therapeutic alliance, has increasingly been emphasised. A prominent theme in recent years has been the interest in the therapeutic relationship as an arena in its own right for the exploration and modification of client's behaviours and beliefs. Such developments and interest into
relational intelligibilities possibly parallels wider historical and cultural transformations that have seen a tectonic shift from cultural modernism to postmodern culture (see Gergen, 1994, 1999; Holzman, 1999; Kvale, 1992) Notions such as 'rationality', 'objectivity', 'expertise' and the 'self-contained individual' - central to modernist models of therapy, such as traditional cognitive therapy, have been challenged by social constructionist scholars (e.g. Burr & Butt, 2000; McNamee & Gergen, 1992) and the emergence of systemic, narrative and constructionist modes of therapy. These developments have seen the concern shift from what occurs within the client (one-person psychology) to an emphasis on what occurs between people (therapist and client), an intersubjective psychology where the therapist's perspective is acknowledged to impact on the client's experience of therapy (Strawbridge, 1992; Wilkinson et al., 1997).

In the domain of cognitive therapy, the work of Safran and Segal (1990) provides one example of an increased focus on the role of interpersonal context and environmental variables in the formation and maintenance of emotional disorders. They utilise elements of interpersonal theory (e.g. Sullivan, 1953) in order to move towards a cognitive-interpersonal perspective on how change takes place in therapy, thereby bypassing the debate over cognitive versus interpersonal factors. Their stance eschews theoretical separation of these two elements preferring to view them as completely interdependent. At the heart of their work lies the notion of the interpersonal schema, which is defined by Safran (1990) as "a generic cognitive representation of interpersonal events" (p.89). Interpersonal exchanges are considered to be governed by Kiesler's (1982) principle of "complementarity". That is, people respond accordingly to other's behaviour and are "pulled" to act in a complementary manner. For example, when faced by an other's hostility or dominance, the interpersonal pull is to act in a submissive fashion. Such interpersonal relations are believed to operate in a way that confirms and reinforces already constituted schemas.

Safran and Segal's (1990) work is particularly relevant in relation to the present paper for a number of reasons. Firstly, their work explicitly views the therapeutic relationship as
central to effective and lasting change. Secondly, in noting the impossibility of the therapist capturing a 'neutral' or 'objective' position they emphasise a social constructionist, rather than realist, epistemology. What takes place in therapy thus comes to be understood in terms of the contributions of both therapist and client with therapeutic change taking place through the dialectical engagement between the two. Thirdly, they emphasise, in relation to the client, the need for the therapist to track changes in their own inner experience in order to gain important clues and insights into the client's phenomenological experience. By incorporating elements of interpersonal theory Safran and Segal (1990) provoke an expansion of traditional cognitive therapy towards a two-person psychology. Such an emphasis promotes more egalitarian or mutual relationships as attempts are made to understand clients' psychological distress within the context of the therapeutic relationship. This emphasis on the therapeutic relationship, coupled with its conceptual integration of cognitive and interpersonal theory, makes it highly consistent with the fundamental principles and integrationist focus evident in counselling psychology. As such, the cognitive-interpersonal perspective is used as a conceptual framework for reflecting upon how the therapist understands and works with difficulties arising in the therapeutic relationship.

**Difficulties arising in the therapeutic relationship**

For the present purposes, the working alliance is viewed as the client's willingness to engage in a therapeutic relationship, whereas the therapeutic alliance denotes the continually fluctuating quality of the therapeutic relationship. The primary difficulty to be addressed in this paper concerns those moments when ruptures occur in the therapeutic relationship. Ranging from straightforward misunderstandings to more complex or chronic problems, ruptures signal the point in the interaction between the therapist and client when the quality of the alliance becomes strained or impaired (Safran & Segal, 1990).
An example of a rupture in the therapeutic alliance occurred with Mrs Y a 53-year-old woman who presented with chronic anxiety. From the assessment session I had made the initial tentative formulation that her core schema was possibly "I'm unlovable" and that one of her central (tacit) assumptions was that she needed to subjugate her own needs in the service of others in order to maintain interpersonal relatedness, i.e., to ward off the possibility of being rejected. Our previous sessions centred on her sense of frustration that "people walk all over me", continually feeling responsible for other's happiness and that nobody is on her side. In each session Mrs Y appeared anxious speaking rapidly and at great length in a high pitched nasally tone of voice. Her general style gave the impression of desperation and an intense yearning to be liked. I found it difficult to get a word in edgeways and Mrs Y appeared to either dismiss what I had to say or immediately start talking over me. I had tried with limited success to empathise with Mrs Y's feelings and we had made little progress in terms of looking at the connection between her thoughts and feelings. I had felt confused and disappointed that we were unable to establish a focus for our sessions. My interventions became increasingly challenging. I was aware that in spite of the basic rapport we had established and the client's willingness to engage in a therapeutic relationship that the quality of the alliance had become increasingly strained. The rupture became explicit and the process of its resolution was instigated during our sixth session together. Mrs Y became increasingly irate as I challenged (tentatively) the extent to which she had to take responsibility for looking after her parents (though elderly they were fit and well). Her voice became louder and faster as she gave a list of reasons why she had to do so and demanded an explanation of how I could question her before falling silent. In the following moments of silence as I tried to compose myself and work out how best to respond I noticed that Mrs Y appeared to have visibly shrunken, her anger seemed to have evaporated and she looked upset and remorseful. As I asked her what her experience was at the present moment she replied that she felt criticised and misunderstood.

This information relating directly to the therapeutic relationship and our interaction was of great significance. Following this exchange I was able to conceptualise the rupture in a
number of ways. It alerted me to the fact that my interventions had been theory rather than experience driven. As such I had been 'hooked' by Mrs Y's interpersonal pull and was participating unwittingly in the interaction (Safran & Segal, 1996). The rupture provided an opportunity for me to re-establish the stance of participant-observer, become aware of my own feelings and the responses (action tendencies) Mrs Y elicited in me. This in turn enabled me to generate hypotheses about the kinds of potential responses she might evoke in other people. Having not successfully 'unhooked' from Mrs Y's interpersonal pull up until this point I had some theoretical understanding of the cognitive process she was engaging in, thus my interventions were based in logical reasoning and had failed to connect in an emotionally grounded and alive way that gave her a tangible experience of observing her own constructive and interpretive processes. During the sessions it had perhaps been easier for me to do this (focus on her cognitions in isolation) rather than acknowledge the feelings of anger and frustration that had been evoked in me. Having not 'unhooked' I had unwittingly responded in a complementary manner i.e. my challenging may have come across as hostile and critical leading her to feel "walked over" by me. This may have served to confirm and reinforce her core belief that she is unlovable and that if she doesn't subjugate her own needs to others she will be rejected.

This rupture in the therapeutic relationship was beneficial on several counts in terms of subsequent progress made. Firstly it provided a window into Mrs Y's subjective world and role-relationship model. This created an emotionally live opportunity for me to further understand her particular sensitivities and interpersonal schema. Having gained a better conceptual understanding of how we were interacting and the feelings being invoked in me, I was able to work with this by meta-communicating in a tentative and exploratory manner about the dysfunctional interactional cycle we had become locked in. The aim was to help Mrs Y become more aware of the impact she has on others and what she is contributing to our interaction. As I spoke to Mrs Y in a non-judgemental way she appeared to become more able to explore her internal experience in a more psychologically engaged way. This shift seemed to lead to an improvement in the therapeutic alliance. I was able to respond more openly and empathically and we were
able to collaborate in establishing a clearer focus for the therapy. We agreed to look at her automatic thoughts, assumptions, emotional responses and underlying beliefs in the context of the therapy and her everyday relationships. Central to the rupture and subsequent process of repair seemed to be that we had entered into more of an I-Thou relationship (Buber, 1923/1970). My initial over-reliance on theory, technique and lack of attention to my own feelings and responses had momentarily blinded me to what was happening in the moment for Mrs Y in the context of the therapeutic relationship. What had seemed clinically sterile had taken on a more authentic, emotionally alive and genuinely collaborative quality born out of our mutual relationship.

My own experience of trying to make sense of, and work with, difficulties arising in the therapeutic relationship is aligned with Safran and Segal's (1996) view that ruptures can usefully be viewed as opportunities rather than as something to be avoided. Such experiences also warrant the conclusion that the therapeutic relationship provides the primary means for attaining effective change. One also becomes aware that the technical interventions possible when working from a cognitive therapy perspective have an impact on the therapeutic alliance and relationship. Emphasising the context of, and working with, the therapeutic relationship appears to ensure that therapy does not become overly mechanistic as the human nature of the therapeutic encounter and process of change is acknowledged. This leads to a position where the utility of any particular intervention comes to be judged in terms of its relational impact and the meaning it generates for the client. On a final (personal) note, as a trainee counselling psychologist the therapeutic relationship has also provided an overarching context for learning about the practice for cognitive therapy. I have found it to be within the situated nature of therapeutic practice i.e. within the context of the therapeutic relationship, that conceptual understanding of the principles and techniques of cognitive therapy gain their meaning.
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The Therapeutic Relationship: An Integrative Aid.

Introduction

One of the defining features of psychology and the psychotherapeutic professions since their inception has been conflict between competing schools and their associated views and practices. Traditionally characterised by rhetorical exercises in one-upmanship, disparate psychotherapeutic schools and models have emphasised their differences in the attempt to demonstrate why their particular approach is 'better' than others (Gergen, 2000). Such conflict between approaches is evident within the domain of counselling psychology, which owes much of its theoretical development (as reflected in practice) to three contradictory schools of thought beginning in the early 20th century, namely, the psychodynamic, behaviourist (cognitive-behavioural) and the humanistic / existential-phenomenological traditions (Clarkson, 1996). Nonetheless, as evidenced by the emergence of integrationist and eclectic views in the 1980's (Beutler, Harwood & Caldwell, 2001), there appears to be increasing convergence among such contrasting therapeutic schools and broad recognition of at least one fundamental way in which differing schools and models are similar.

The aim of this paper is two-fold. Firstly, a brief discursive travelogue is forwarded, locating the integrationist movement as a response to changes and development within the psychotherapeutic professions as well as to broader transformations taking place at cultural levels. Secondly, given that it can be cogently argued that the 'integration' or synthesis of different approaches at the level of practice is an individual endeavour (see Clarkson, 1996; Horton, 2000; Skovholt & Ronnestad, 1995), a brief reflective account of what has been of assistance in my own efforts to work integratively as a trainee counselling psychologist is outlined. In order to position myself responsively in relation to the increasing cross fertilisation between different orientations, the therapeutic relationship is utilised as a framework for considering integration at a theoretical level given that it can be viewed as a common denominator bridging orientations. The view of human meaning being constituted through relationships also fits my own view of the
therapeutic enterprise and epistemological commitments. As such, the therapeutic relationship is also used as an aid to personal integration. Clarkson's (1995) 'five relationship' model provides a pre-existing conceptual resource and anchor point for the present account.

Focusing on the therapeutic relationship and the notion of integration appears particularly germane to the field of counselling psychology on two counts. Firstly, the therapeutic relationship pulses at the heart of counselling psychology practice. Secondly, the need to acknowledge and respect differences is recognised in the requirements of The British Psychological Society - counselling psychology's professional body. As such, counselling psychology training is not exclusionary; rather it incorporates awareness of a broad range of orientations and requires a working knowledge of at least two different models, or approaches to therapy, from which trainees are encouraged to develop their own 'unique' approach or personal philosophy of practice.

Whilst the primary thrust of this paper is to consider the therapeutic relationship as a potent vehicle for integration within and between different models of therapy, it is recognised that such analysis cannot stand independent of its context of production. As such, the movement towards integration, and the focus on relationship, can be viewed as reflecting and being embedded within changes related to large-scale cultural process, which are linked to living in late modern or post-modern society.

Integration - making sense of multiplicity

Perhaps the most significant impetus for interest in psychotherapy integration flows from the conclusion in a growing body of research that no single school of psychotherapy is able to demonstrate consistent superiority over the others (e.g. Seligman, 1995). Additionally, the sheer volume of different theories and approaches available for therapeutic consumption has led to the conclusion that there is no single 'truth' about psychological distress and how to treat it. Whilst additional mutually reinforcing factors
have been identified as fostering the development of integration (see Norcross & Goldfried, 1992) and four systematic views (common factors approach, theoretical integrationism, technical eclecticism and strategic eclecticism) have been identified within the integrationist movement, as evident in contemporary psychotherapeutic practice (Beutler et al., 2001). This paper views psychotherapy integration as a 'work in progress' rather than an end product or fixed position. From this perspective Clarkson (1996), argues that 'it is likely that any good, competent or growing counselling psychologist is always integrating themselves whether between or within 'schools', their professional and life experiences or between themselves and the learning they forge in the relationship with their clients' (p.260). In a claim somewhat akin to the literary notion of 'intertextuality' (the idea that an individual text only gains its meaning in relation to other texts), Clarkson (1996) also notes that the integration of therapies is far from being a new phenomenon; rather analysis of any particular psychology inevitably reveals some borrowed theory, concept or techniques from another model or discipline.

Clearly, from this standpoint psychotherapy integration appears somewhat inimical to finite definitions or descriptions, as it takes on different meanings depending on its context of usage at various points in history. However, what does seem to be clear is that, in spite of the confusion surrounding the different terms used (often interchangeably), 'integration' is a growing tendency both within and between psychological schools. For example, research conducted by Dryden and Norcross (1990) demonstrates that more and more practitioners are explicitly identifying with integrative practices and apply brand-name psychotherapies in a flexible fashion. More specifically in Britain, a recent survey conducted by Hollanders and McLeod (1999) indicated that 87% of the counsellors and therapists interviewed regarded their practice as based on a combination of methods and approaches, i.e. as being integrative or eclectic, rather than being grounded in a single 'pure' model. It seems that the use of integrative and eclectic approaches at a grass roots level, i.e. the actual situated behaviours of therapists, more accurately reflects a postmodern epistemology of practice (see Polkinghorne, 1992) thus strengthening claims for a more flexible, practice-led approach to theorising. Such a position sits favourably with
Samuels' (1989) contention that psychotherapeutic pluralism compliments the psychological diversity of human beings.

Arguably as the various psychotherapeutic orientations have developed across time, there has been a substantial shift away from the intra-psychic realm toward the interpersonal domain. It is this movement towards understanding human distress and meaning as a product of relationship where contrasting schools and models begin to converge. More specifically, the therapeutic relationship has become a common ground for different perspectives from which mutual acceptance, cross fertilisation and integration have begun to occur. This shift has been accelerated by research, which indicates that it is the relationship between therapist and client, more than any other factor that determines the effectiveness of psychological therapy (e.g. Frank, 1979; Hynan, 1981; O'Malley et al., 1983; Orlinsky et al., 1994).

**On the road to relationship**

It is not within the scope of this paper to review in detail how the therapeutic relationship is conceptualised and used by the major therapeutic orientations, however, a brief review illustrates the increasing emphasis being placed on relationship.

Within the theory of psychoanalysis there has been a clear move away from the hegemony of a 'one-person' psychology to a 'two-person' psychology. This is evident, for example, in the development of object relational models (e.g. Greenberg & Mitchell, 1983) and the intersubjective approach (Stolorow et al., 1987). The particular kind of therapeutic relationship advocated, is the transference relationship. What occurs between the therapist and client is viewed as containing information about the client's normal ways of relating in their current life, and as bearing clues about the origins of such patterns of relating.

Existential-humanistic thinking (e.g. Buber, 1970; Rogers, 1957) has long emphasised the centrality of relationship. The therapeutic relationship is often referred to as the person-
to-person or I-Thou relationship and is characterised by 'being with' rather than 'doing to' the client. Importantly, Rogers' (1957) formulation of the hypothesis that there are certain necessary and sufficient conditions (genuineness, empathy, and unconditional positive regard) for therapeutic change, can be viewed as a statement that reaches beyond the confines of client-centred therapy. As Bozarth (1997) contends, Rogers' (1957) statement is an integrative one, 'referring to conditions which are qualities for all therapists in all therapies and for all helpers in all situations...' (p.17).

Cognitive-behavioural therapy has also taken significant strides towards the interpersonal domain. Though previously conceptualising a good therapeutic relationship as necessary but not sufficient for a positive therapeutic outcome, contemporary developments have seen interest develop in the therapeutic relationship as an arena in its own right for the exploration and modification of clients' behaviours and beliefs. For example, Sanders and Wills (1999) have pointed out that cognitive therapists, such as Safran and Segal (1990) and Young (1994), have developed cognitive interpersonal models of therapeutic processes, which focus on 'how to use the relationship as an active ingredient of therapy' (p.120).

**Encounters of a relational kind**

My own experience of the clinical situation is that theory rarely translates neatly into practice. I have found that unless the relationship between the client and myself is attended to then the rest of the therapeutic work struggles to get off the ground. Furthermore, it is within situated practice that cross fertilisation seems to occur in a relatively fluid manner. Being relationally responsive within a context of mutuality and negotiation has made it possible to move between 'being' and more active 'doing' with clients. For example, whilst working with a client who was experiencing chronic anxiety from a cognitive-behavioural perspective, it was possible to move between different types of therapeutic relationship within the course of therapy. Utilising Rogers' (1957) core conditions at the start of therapy created an atmosphere of trust and a sense of genuine
contact and recognition between the two of us. This sense of togetherness fostered hope and a shared appreciation and understanding of the meaning of anxiety to the client. As the therapeutic dialogue developed, the client increasingly spoke of both past and present interpersonal topics. Awareness of the transference relationship enabled interventions, such as interpretations, questions and reflections more typically associated with exploratory psychodynamic work, to be incorporated into the sessions. Finally, the collaborative nature of the therapeutic relationship also made it possible to negotiate space for active 'doing' where more manualised cognitive interventions were carried out in relation to the client's presenting difficulty.

This brief illustration highlights how the therapeutic relationship can promote an integrative posture and allow flexible use of theoretical knowledge and technical skills. A key feature of this integrative process has been developing an ability to reflect in action as well as on action (Schon, 1983).

Conclusion

By taking into account that the current cultural reality is multiple and diverse, it seems possible that integration (conceived of in its broadest terms) is able to avoid presenting itself as an absolute or superordinate theory. The argument that 'knowledge' and human meaning is a product of relationship, constituted through discourse and the daily interactions between people in the course of social life (Burr, 1995) has had a significant impact on the field of therapy (see McNamee & Gergen, 1992). The consciousness of construction and appreciation of the multiple 'truths' ushered in by social constructionist dialogues, provides a useful lens through which to view the existence of so many therapeutic approaches, i.e. as paralleling the pluralism observable in various social and cultural movements and the value of difference, particularly as recognised in post-modern texts (Feltham, 2000). Gergen (2000) has noted that the move towards pluralism and collaboration takes us away from a logic of separate and demarcated domains and promotes increased enthusiasm for a both *and* position wherein 'therapists will
increasingly feel free to create unique confluences, practices that combine and integrate elements that have traditionally been separate' (p.368).

The therapeutic relationship has been presented as one possible means to integration within a plurality. As the common thread running across different therapeutic orientations, the therapeutic relationship stands out as a distinct and durable feature of the process. As such, it may go some way towards fulfilling Norcross and Newman's (1992) hope that the integration movement will 'engender an open system of informed pluralism, deepening rapprochement, and empirically grounded practice' (p.32).
References


THERAPEUTIC PRACTICE DOSSIER
Introduction

The therapeutic practice dossier provides a context to my therapeutic practice and experience throughout the course. It contains brief descriptions of each of my placements including the client populations that I worked with. It also includes the 'Final Clinical Paper', which provides an account of some of the factors that I consider influential in the evolution of my own therapeutic style and approach towards clinical practice.

As specified in the introduction to the portfolio, all potentially identifying information related to clients, including details about placements and supervisors, have been changed or omitted in order to maintain confidentiality.
My first year placement was within an Employee Assistance Program (EAP), which operated as part of a major transportation company's occupational health department situated in the South East of England. The EAP provided short-term (typically six sessions) psychological assistance and support to employees (clients) who had either sought assistance for themselves, or who had been referred to the program via their manager and/or the occupational health department's medical doctors. The program was available to all employees within the company; however, internal auditing indicated that it was primarily used by "ground level" workers rather than people employed in managerial or senior positions.

The EAP was managed by a senior counsellor and included a clinical psychologist, six therapists/counsellors (both full and part time) working from a variety of theoretical orientations, several trainees on placement and a research psychologist. The client group attending the program was predominantly male, and varied in terms of age and ethnicity. Generally, presenting difficulties were of low to moderate severity and related to issues such as, anxiety, depression, relationship difficulties and stress arising from work based conflicts. Additionally, a smaller percentage of employees had been involved in work based traumatic incidents or had drug/alcohol related problems. Members of the team who specialised in trauma or substance misuse attended to these clients wherein long-term individual and group work was carried out.

My primary responsibilities were to conduct short-term individual therapy sessions with selected clients from the waiting list, and to utilise weekly individual supervisory sessions (primarily influenced by humanist, solution-focused and psychodynamic models).
This placement was within a primary care setting (G.P. surgery) situated in the South East of England. The service provided psychological therapy to adults who had been primarily referred by their G.P.s. The client group was predominantly female and was varied in terms of age, ethnic background and socio-economic status. Clients presented with a variety of generic mental health issues, such as, depression, anxiety, interpersonal difficulties and issues arising from life events such as bereavement, divorce, redundancy etc. Following referral, clients were seen for assessment and then were placed on a waiting list for approximately 2-3 months. If clients were judged to have severe or / and enduring mental health issues they were referred on to the appropriate secondary psychiatric service for further assessment and treatment. Typically, clients whose difficulties were deemed appropriate to be managed within a primary care service were offered a contract of ten to fifteen fifty-minute sessions of psychological therapy that was psychodynamic in orientation.

My primary responsibility was to conduct individual psychodynamic therapy with selected clients from the waiting list, liaise with clients' G.P.s or other health professionals were appropriate and utilise weekly supervision. This placement was terminated prematurely due to a break down in the supervisory relationship.
The second placement was split between primary and secondary care settings. I spent one day a week working for a primary care counselling service that was part of an NHS trusts psychology department situated in the South East of England, which employed clinical and counselling psychologists, psychotherapists and counsellors within G.P. surgeries. The client group was primarily female and was varied in terms of age, ethnic background and socio-economic status. Clients were referred by their G.P.s. and presented with various mental health issues, for example, depression, anxiety, panic attacks, bereavement and interpersonal difficulties. My role was to offer short-term psychodynamic therapy (usually twelve weekly sessions) to clients on the waiting list.

The second day was spent working as part of a community mental health team for the same NHS trust. The mental health unit was comprised of psychiatrists, social workers, clinical psychologists, community psychiatric nurses and three part time psychotherapists. The client group was mixed in terms of gender, age, ethnicity, socio-economic status, and presenting difficulties were usually of a more severe and enduring nature. The service provided both short-term cognitive-behavioural therapy and longer-term psychodynamic therapy. Given the short duration of this placement, I worked with individual clients who were selected on the basis that they could benefit from relatively short-term psychodynamic therapy that might lead on to a referral for either long-term individual or group therapy.
Third-year Clinical Placements: An NHS Community Mental Health Team

October 2002 - August 2003

The first clinical placement during my third-year was within a Community Mental Health Team (CMHT) situated in a large NHS trust in the South East of England. The team was multidisciplinary in nature and was comprised of psychiatrists, approved social workers, clinical and counselling psychologists, community psychiatric nurses and support workers and had close links with a number of specialist services. The client population was mixed in terms of gender, ethnicity, age and socio-economic status. Presenting difficulties were usually of a severe and enduring nature, which included chronic depression (including suicidal behaviour), anxiety, panic disorder, social anxiety, phobias, posttraumatic disorders, eating disorders, obsessive-compulsive disorders, somatic complaints and personality disorders. The CMHT was medically led and clients' difficulties were managed through a combination of pharmacological and psychotherapeutic interventions.

Referrals to the psychology service came from G.P.s. and other members of the team involved in clients care. Individual cases were reviewed during weekly interdisciplinary meetings in order for service provision decisions to be made. Clients were usually seen for assessment within two weeks of referral and were then placed on a waiting list for about three months. My responsibilities were to deliver both short and long term cognitive-behavioural/integrative therapy to individual clients selected from the waiting list, attend monthly psychology meetings and weekly case discussion meetings, and utilise weekly individual supervision (integrative focus).
In the final part of my training I undertook a clinical placement within a psychological treatment service that was attached to an NHS hospital in the South East of England, taking referrals from G.P. practices, the Community Mental health Team and specialist services within the Trust. The team was managed by a consultant clinical psychologist and included clinical and counselling psychologists (both full and part time), trainee clinical and counselling psychologists, and assistant psychologists. The team comprised both an adult mental health department and a family therapy service, some working in multi-disciplinary teams and others providing therapeutic services directly from the waiting list. There was a strong interest and emphasis on narrative and systemic approaches within the department, though individual practitioners worked according to a variety of psychotherapeutic models (e.g. psychodynamic, cognitive-behavioural, humanistic etc). The client group for psychological therapies was mixed in terms of gender and socio-economic status and generally had complex difficulties of moderate severity. Referrals to the CMHT or specialist services were made if these became necessary.

Most therapeutic work was individual, though I was involved in doing some joint family work with a senior clinician, and I often conducted individual therapy with other members of the client's family or support network present. My main responsibilities were to carry out individual therapy sessions with selected clients, who had been referred directly by their G.P.s., attend fortnightly departmental meetings, utilise weekly individual supervision (narrative/integrative focus) and attend a fortnightly narrative/systemic group supervision.
Final Clinical Paper: The uncertain path to Dialogue.

The explicit intention of this paper is to tell the story of my professional evolution as a counselling psychologist. In describing and accounting for how my 'position' has developed over time, attention will be given to the ways in which theory, research, context and experience have influenced and informed my clinical work with individual clients. I also consider it necessary, where possible, to map the ways in which my participation in institutional and broader socio-political contexts impacts on my actions, in order to give a situated account of this development.

Faced with the task of 'putting it all together' in a single written account, has brought me face-to-face with many of the leading protagonists that I have engaged with during the course of training. The idea or concepts of 'science', 'psychology', 'rationality', 'objectivity', 'theory', 'method', 'research', 'evidence', 'knowledge', 'truth', 'self' 'subject', 'object', 'human nature/development', 'psychopathology', 'expertise', 'therapy' and so on, central as they are to the discipline of modern academic and applied psychology, have necessarily had a substantial bearing on my development as a counselling psychologist. Crucially, from the initial stages of training, I have been encouraged to reflect upon, and question, the 'natural' taken-for-granted status of such notions and the possibilities for action they represent. As such, adopting a 'critical' and reflective orientation becomes the starting point for the telling of my professional story. This does not mean finding an 'objectively true' or 'correct' standpoint; rather I view it as the ongoing process of understanding how we come to stand where we are (e.g. Griffith & Griffith, 1992; Parker, 1999). Thus, what follows is my own particular 'truth', based on, and mediated through, my experience of academic, institutional, and applied contexts whilst training. It is unavoidably 'local' as it reflects not only my cultural location as a white British middle class heterosexual male, but also my personal and political development and proclivities.

Making explicit the 'local' and interested nature of my own account accords with a view of 'truth' as being relative (see Gergen, 1994). However, I am not suggesting that simply
'anything goes' or that I abandon learned skills, theory and research. Rather, I consider the ongoing process of reflecting upon my own position, i.e., my epistemological commitments, actions, relationships, values, biases and so on, to be a principled activity vital to ethical practice.

Having come to view the discipline of psychology as a thoroughly situated and performative activity, concerned with socio-moral relations (see Shotter, 1993), rather than as a decontextualised body of thought, I accept that power, interests, values and context affect what I do as a counselling psychologist. Rejecting the premise that research is 'neutral' or that our interventions are unaffected by politics, has enabled me to accentuate 'practice' as the site in which psychological theory and research gain their intelligibility. Being 'practice-led' enables me to confront the burgeoning array of theories and approaches available for therapeutic consumption in a flexible manner, attaining pragmatic coherence without losing sight of the psychological diversity of the individuals I work with. I also consider that engaging in ongoing 'practical deconstruction' (Parker, 1999) actively encourages connection between the personal, professional and political domains and provides a critical lens through which I am able to describe, account for, question and evaluate what I do as a counselling psychologist.

Clearly there is a large part of me that believes in the value of psychological therapy and the role of the counselling psychologist in the amelioration of human suffering. However, having adopted a 'critical' orientation, I no longer take it for granted that psychology simply pursues human welfare in a manner that is just and fair (Prilleltensky & Nelson, 2002; Rose, 1990, 1996). During the course of my training I have often felt internal disquiet in regard to subtle and overt abuses of power and the potentially pathologising and normalising effects of traditional conceptions of psychological inquiry and practice (see Parker et al., 1995; Pilgrim, 1992). Similarly, in relation to my own practice I have felt uneasy with the structural 'power' and 'expert' status I am given in relation to clients who come to therapy for help with distress, and worried about how my position could
easily be abused. ¹ Thus it is not possible for me to automatically take a benign view of my clinical work and practices with clients. Consequently in my endeavours to develop my own position, a large part of my training has been spent trying to find ways of working with which I feel comfortable personally, professionally and politically.

The advancement of my 'critical' stance has been facilitated by an awareness of post-modern, post-structural and social constructionist perspectives. The impact of these perspectives on the discipline of psychology and the field of therapy are well-documented (e.g. Burr, 1995; Fee, 2000; Gergen, 1994, 1999, 2001; Henriques et al., 1984; Holzman & Morris, 2000; Kvale, 1992; McNamee & Gergen, 1992, 1999; Nightingale & Cromby, 1999; Parker et al., 1995; Parker, 1997 1999; Prilleltensky & Nelson, 2002; Proctor, 2002; Riikonen & Smith, 1997; Shotter, 1993; White & Epston, 1990). Acquainting myself with these perspectives destabilised my personal world, and prompted radical shifts in my understanding and approach towards psychological theory, research and practice. Though no single description adequately captures the different lines of thought and practice identified with these perspectives, Burr (1995) has described social constructionism as a critical and counter intuitive approach, that renders problematic that which we usually take for granted. Appreciating the significance of the 'turn to language' (Parker, 1992), i.e., the social constructionist view that language actively constructs social and clinical realities rather than reflecting an independent reality, led me to jettison the idea of a knowable external reality and grand meta-narratives in favour of 'local knowledges' and the intersubjective influences of language, culture and discourse. From this constructionist informed vantage point, relationship takes priority over the individual. Consequently, I view clients' expressions of life and identity and the problems for which they seek help with, as being constituted between people in the realm of social discourse rather than within the person, as is the often the case in many traditional ways theorising, researching and practising psychology.

¹ My position has developed in conjunction with my research interests where I have qualitatively explored the use of use of diagnostic categories in counselling psychology practice and 'power-relations' in the therapeutic relationship.
Viewing psychological theories and models of therapeutic practice as discourses that systematically form the objects of which they speak (Foucault, 1980) on the one hand, and structure subjectivity on the other, has reinforced my view that there is no single 'truth' about psychological distress and how to treat it. Nonetheless, as discourses can be both enabling and constraining (Martin & Sugarman, 1999), I try to avoid listening and acting in exclusionary terms with clients. Instead, I attempt to maintain a curious stance (Anderson & Goolishian, 1992), and to hear and speak from within different discourses in order to join with clients in resourceful dialogue. The move to a relational intelligibility and focus on action and its sense (meaning-making) rather than behaviour and its determinants, has led my work increasingly to be informed by the narrative metaphor. To this end I attempt to facilitate a safe space and atmosphere through being open and present. I see my role as one of 'co-author' and attempt to provide a conversational context that contributes to clients' explorations of alternative narratives of identity and preferred ways of living, thinking, and being.

The development of my personal position and approach to practice was greatly facilitated by two contrasting experiences during my training. Firstly, I found that my own personal therapy helped me to learn about and experience the struggles and dilemmas encountered on the uncertain road to dialogue, within the context of a therapeutic relationship. Though I sometimes felt that my therapist did not understand where I was 'coming from', I was moved by her acceptance of me as a person of value in my own right, and her willingness to 'talk' with me as a fellow human being, which included her disclosing her own thoughts, feelings and experiences of therapy and life. This sense of equality, and the two-way nature of therapy, was something that I experienced positively as we mutually recognised and negotiated our difference and generated meaning between us.

Contrastingly, I had a clinical supervisory experience at the beginning of my second year where I experienced first hand what it was like to be negatively positioned and evaluated and to have my motives pathologised. This was a very distressing and anxiety provoking experience, which was resolved by prematurely terminating this particular placement.
Though I am aware that this was a supervisory and not a therapeutic relationship, the power differential between my supervisor and myself meant that I found it difficult to resist such enforced positioning. The one-way nature of this relationship led me to feel dis-empowered and question my own knowledgeableness and identity. Combined, these experiences helped to reinforce my personal and professional values and have moved me to work as transparently as possible in order to form strong working alliances with clients, rooted in our shared humanity.

Though my preferred position has often felt 'at odds' with mainstream psychology, the pluralism and diversity of the theoretical, research and practice base of counselling psychology, which has moved beyond the narrow constraints of a positivist philosophy of science, provides a means of holding and working with the tensions between mainstream scientific and critical perspectives. Whilst there remain areas of conflict, it has helped me to work towards inhabiting a 'both/and' position where modernist models of therapy and my preferred social constructionist approach can co-exist and compliment each other, as evident in my work synthesising cognitive and narrative approaches. The ongoing challenge, as I see it, is to develop further ways of synthesising empirically supported psychological models and techniques with critical perspectives in the context of lived human experience in which clinical practice occurs (Lamer, 2001).

Having described some of the key areas and experiences that have influenced my preferred position and approach towards theory, research and practice, I will now offer an account of my therapeutic work with clients during the course of the training. The aim is to provide the reader with an account of the development of my practice, which reflects on the learnings, implications, consequences and effects of working in particular ways. Central to this account is the process of learning through experience, including the dilemmas and struggles I have faced attempting to honour and develop my own preferred approach, whilst engaging with the mainstream models of therapy taught on the course. Though this continues to be a demanding task, I believe my exposure to these models has
been a necessary and ultimately rewarding experience, that has enriched my personal and professional life.

For the sake of clarity, I have adopted a chronological structure to describe how my exposure to, and experience of, practicing from within different models has influenced and shaped my preferred approach to practice. In order to protect client confidentiality details of individual clients have been changed and pseudonyms have been employed throughout.

**Year One: Core model - Humanistic**

Woolfe (1996) has drawn attention to the humanistic value base, i.e., a focus on well-being and potential rather than sickness and cure, underpinning the discipline of counselling psychology. Carl Rogers' (1951) implicit statement of person-centred values, which emphasises respect for the person as an individual having dignity and worth in their own right, has been influential and largely matches my own developing approach to practice. However, whilst I agree with Rogers' emphasis on warmth and respect for the individual, I do not hold the person-centred view that there exists a permanent essential self and an objective entity called human nature (Mearns & Thorne, 1999). Rather I see the 'self' and 'human nature' as socially constructed and believe that agency, values and goals (what Rogers refers to as 'self direction') are culturally and relationally contingent. Thus, whilst maintaining respect for the individual client, I nonetheless view what occurs in therapy as being co-constructed between the client and myself.

In spite of diverging from the essentialism inherent in traditional models of humanistic therapy concerning the nature of the 'self', I have nonetheless found the 'core conditions' (i.e., warmth, empathy, 'unconditional' positive regard and congruence), along with the primacy accorded to the client-therapist relationship, to be of up most importance.
During my first years practice I worked in an organisational setting (Employee Assistance Program), which operated a short-term policy (maximum six sessions). This provided a suitable context for me to put into practice my interest in constructionist approaches (in this instance a solution-focused approach) whilst developing core humanistic skills. Though not aware of it at the time, this represented an early foray or attempt at synthesis, as pragmatically the work I conducted incorporated cognitive, humanistic, experiential and behavioural elements. Furthermore, attempting to help clients reconnect with their own resources in order to build a firm sense of personal agency and the solution-focused question, "how can I best help this particular client?" (O'Connell, 1998), resonates with Rogers' hypothesis, "how can I provide a relationship which this person may use for [his/her] own personal growth?" (Rogers, 1961, p.32).

Perhaps most significantly, the efficacy of the humanist approach and value of the therapeutic relationship 'hit home' as a result of actually 'doing' therapy and noticing that it was the quality of the relationship between myself and the client, rather than my ability to apply a particular theory or technique, that appeared to be meaningful and which led to a positive therapeutic outcome. The value of this approach became increasingly apparent to me when working with Mr C, a 32-year-old man who presented with a long history of anxiety and symptoms of depression following the death of his father a few months prior to his referral. The dilemma I experienced centred on my level of input or directiveness within therapy, i.e., between a more theoretically led 'doing to' as opposed to a more non-directive 'being with' the client. Though I don't believe it is possible to not be directive as a therapist, as all ways of acting in the context of therapy (regardless of theoretical orientation) value and invite certain ways of being over others, I nonetheless gained a palpable sense of the value in trying not to 'get ahead' of the client, i.e., staying a 'step behind', creating space for the client to think and speak, remaining curious about their 'lived experience' and allowing meaning to emerge conversationally. Thus, I found that when I was technically less 'active' and embodied the core relational conditions of empathy, positive regard and congruence through being open and transparent about therapy, and myself that Mr C was able to explore and give meaning to his experience in
a more engaged manner. The discursive practices of asking questions conversationally and responsively, reflecting back, summarising, clarifying, along with conveying warmth and respect, helped to establish an atmosphere in which he could give voice to an increasing range of his thoughts and feelings without fear of being shamed or humiliated.

As I attempted to 'direct' process rather than content (Greenberg, et al., 1993) and to hear and validate the client's subjective experience and perceptions, he was able to gain a heightened awareness of the incongruence between his sense of who he is ('self'), including his current actions and ways of being, and the person he believes himself to capable of being ('ideal self'). Further to this, the sense of genuine contact and working together against the problem helped Mr C to feel understood. This in turn had the desirable effect of facilitating his sense of agency. Having made it explicit that therapy was dependent on feedback from Mr C, I intermittently checked out how he was experiencing therapy. Consequently he was able to take an active stance and say what was relevant to him and what he was finding helpful or unhelpful.

In my experience there is a good degree of fit between solution-focused and humanistic models. Both approaches emphasise respect for the individual and the importance of relational and emotional aspects of therapy. As a naïve therapist the solution focused approach provided a structure and direction to the therapy, which was enhanced through an appreciation of the humanistic conception of the therapeutic relationship as being empowering and healing in its own right (McLeod, 1996). Also of note, the solution-focused use of scaling questions lent itself to explicit forms of evaluation, which complemented the CORE pre and post therapy questionnaires used in this setting.

**Year Two: Core model - Psychodynamic**

I approached the second year training with some trepidation. The challenge I faced, in terms of practice, was to set aside my theoretical reservations and biases and to engage with the model openly and sensitively in order to experience and learn about working within this approach. I was mindful that no discourse is inherently liberating or
oppressive (Sawicki, 1991) and felt I could relate to psychodynamic theory and practice as a linguistic discipline concerned with meaning and interpretation rather than mechanism and explanation (e.g. Rycroft, 1985; Spence, 1982). Given that my preferred social constructionist approach foregrounds a relational rather than individual ontology, I found myself drawn to attachment theory (e.g. Bowlby, 1988; Holmes 2001) and object relational theorists (e.g. Balint, 1957; Bion, 1962; Fairbairn, 1952; Guntrip, 1961; Klein, 1952; Winnicott, 1965, 1971) who emphasise the vicissitudes of early development, and the role of parenting, in the formation of a sense of self and others. Though still acknowledging the role intra-psychic conflicts, I found the attention given to interpersonal aspects of psychological functioning, along with attempts to understand the individual as embedded within social and relational contexts, fitted more closely my own preferred movement away from a biologically deterministic viewpoint. However, rather than rigid adherence to any one psychodynamic approach, I aimed to work in a pragmatic fashion resisting dogmatic certainty with the aim of understanding theory through experience.

During my second year I had two clinical placements in primary care settings, one of which incorporated one day working in a mental health unit. As was the case in my first year of training, the therapeutic relationship became the site where 'meaning making' occurred and theory came to life. Given the constraints of the setting (therapeutic contracts were limited to between ten and fifteen sessions), I aimed to achieve a balance between supportive work and more exploratory interventions. I found Mann's (1973) approach emphasising the importance of time and issues of loss and separation as central features of short-term clinical work, helped to provide a framework for thinking about, and working with, clients in this these particular settings.

My work with Mrs M, a 39-year-old married Portuguese woman who was referred for panic attacks, provides an example of how I engaged with some of the discursive, relational and knowledge practices associated with the psychodynamic approach. Having been left with her grandparents in Portugal at the age of six for a period of one year
whilst her parents came to England to find work and a new home, themes of separation and abandonment made up a substantial part of Mrs M's narrative. Her sense of being abandoned was repeated in her adult life when her parents returned to live in Portugal whilst she was pregnant with her third child. The onset of her panic attacks coincided with her return to England having holidayed at her parent's home in Portugal the previous summer.

In consultation with my supervisor I had hypothesised that Mrs M's experiences of feeling abandoned and rejected had created an insecure attachment style and that her current difficulties could be understood in terms of the conflict between her longing for the love and attention of her parents, and 'repressed' feelings of anger and pain associated with the rejecting aspect of her relationship with them. In light of her experiences, Mrs M appeared to use 'splitting' (Klein, 1952) and 'denial' as defensive mechanisms in order to regulate internal states, and avoid painful or unmanageable aspects of her experience.

With this dynamic story in mind, a crucial part of therapy was establishing a sense of trust and a secure enough base in order for Mrs M to address what Hinshelwood (1995) refers to as the 'maximum point of pain', i.e., her experience of feeling abandoned and rejected by her parents. As with other clients, this involved building a working alliance through the use of active listening, reflecting and empathy. I also engaged in practices of interpretation in order to draw attention to, and make links between, her past and present experiences. This appeared to have some effect as she increasingly became able to acknowledge and give voice to her anger towards her parents for having left her.

As we moved towards the 'ending' phase of therapy Mrs M became increasingly disillusioned and angry with me. I had experienced her as alternatively clinging to, then rejecting me. This seemed to represent her fear of ambivalence and separation, which was being enacted between us. In terms of 'transference' I appeared to have been positioned as the abandoning parent. Though I experienced concordant feelings of guilt, I was mindful of Bion (1962), who suggested that rather than trying to make up for what the
client has suffered in the past we should offer to repeat the failure to love them enough and then share with and help them to work through feelings about this failure. In order to assist Mrs M to re-work abandonment issues and negotiate a 'new ending' in the context of therapy, I was careful to try and provide a 'holding environment' (Winnicott, 1965) for her anxiety and anger without becoming defensive or rejecting in response to the interactional pressure she placed me under. This helped her to begin to verbalise the anger that had been 'split off' and 'denied' and we were able to work towards separation in a good relationship wherein she could see the mother (me in the transference) as a separate object of love and hate (Winnicot, 1971). By the last session, Mrs M's anger towards me had subsided and she reported feeling "sad" that therapy was ending. She also indicated that therapy had helped her to "make sense" of the "panics", which had reduced in frequency and intensity, and that she no longer felt overwhelmed by the anger and pain around the rejecting aspects of her relationship with her parents.

Year 3: Core model - Cognitive-behavioural

My final year of training represents a more purposeful development of my own position and preferred approach to practice. Whilst attending to the course requirement that third year placements have a cognitive-behavioural focus, the setting (community mental health team) and my supervisor, allowed considerable flexibility for me to work integratively. I was also presented with the opportunity to gain experience of long-term work (up to ten months) with more complex and enduring cases. My practice and professional communication was further enhanced through working alongside, and collaborating with, other mental health professionals.

Theoretically I found contemporary developments such as Safran and Segal's (1996) refinement of cognitive therapy in light of interpersonal theory, the use of attachment perspectives (e.g. Bowlby, 1988) and Young's (1994) Schema-focused approach, helped to redress traditional CBT models' (e.g. Beck, 1976) lack of attention to the developmental origins of clients' difficulties. Though these developments place greater
emphasis on the therapeutic relationship (in keeping with the evidence base and the ethos of counselling psychology), I still found the language practices, for example, the rhetoric of 'collaboration' and 'equality', to be muddled with the idea of compliance (see Proctor, 2002), thus largely obscuring the power differential between client and therapist. Likewise the internal focus on cognitions and schemas (viewed as the property of individual minds) seemed to mask the socio-political conditions and contexts that are constitutive of clients' identities and experience of psychological distress.

Without disputing that certain approaches such as cognitive-behavioural therapy are efficacious with certain clinical presentations of anxiety and depression (see Gilbert, 2000; Roth & Fonagy, 1996), I nonetheless found that incorporating narrative ideas and practices (e.g. White & Epston, 1990) helped me to achieve a higher degree of congruence in my work through attaining a greater sense of integration between my personal, professional and political selves. I used narrative practices to deconstruct 'therapy' and the medicalised context in which it was taking place. I found this helped to strengthen the working alliance, particularly with clients I worked with who had been in the mental health system for a long time and who reported feeling de-humanised through having been labelled.

My work with Mr A, a 58-year-old man, who was referred with chronic anxiety and an "inability to cope" following a "breakdown" at work, provides an illustration of how paying attention to prevalent cultural discourses along with the interpersonal and structural power relations (both inside and outside of the mental health service and therapeutic context) enriched cognitive-behavioural therapy.

From the outset of therapy Mr A had difficulty in expressing thoughts, emotions and needs in an open or direct manner and seemed suspicious of my role. Though we established a rational for cognitive-behavioural work and a tentative working alliance through talking openly about the structure and process of 'therapy', it quickly became apparent, on account of his ambivalent stance towards his difficulties and me, that
therapy was unlikely to be straightforward. Initial attempts aimed at identifying and modifying self-defeating patterns of thinking and behaviour were unsuccessful. In supervision I hypothesised that a great deal of Mr A's psychological distress related to his interpersonal schema i.e., a generic cognitive representation of interpersonal events (Safran, 1990). This included engaging in actions linked to the belief that he has to suppress or defer his own opinions, thoughts, feelings, emotions and needs to others (initially his father and subsequently to other authority figures, e.g. teacher, employer, therapist etc) in order to maintain interpersonal relatedness.

My own reading and research interests had alerted me to the potential for modernist forms of therapy to reproduce the subject/object dualism that is so pervasive in the structuring of power relations in Western society. Given that a substantial part of Mr A's difficulties related to the conflict he experiences between complying with authority figures on the one hand and a more assertive position where he is able to get his own needs met on the other, I made the decision to conceptualise his experience and current symptoms within a discourse of power. This seemed particularly relevant given his historical experiences of power relations and the inevitable structural inequality in roles between therapist (helper) and client (helped). Also, I had noticed that Mr A appeared to be experiencing 'transference' in relation to me. Whilst it might have been viable to work with the 'transference relationship' in order for Mr A to work though issues of personal authority, I had become sensitised, through my ongoing discomfort with traditional psychodynamic conceptions of the therapeutic relationship, that what is termed 'transference' is usually experienced most strongly by people in hierarchical situations where they are in junior or subject positions (White, 2000). Without disregarding the significance of, or link between, Mr A's past/current relationships and the therapeutic relationship, reading what was occurring between us as a trace of very present power-relations was pivotal in the therapy. As we began to attend to and deconstruct the interactional politics that were generative of such phenomena, I made a concerted effort to situate my comments, thoughts and interventions in the context of my own experiences, training, intentional states and theoretical allegiances - what White (1997)
terms the condition of 'transparency'. Though this did not 'do away with' power, I believe it helped to minimise the structural hierarchy between us. Not only did this call into question the idea that I had all the answers and would decide what was best for him but also it seemed to offer a different experience of power-relations. This led to a more two-way process, one that invited reciprocity and mutual exchange rather than a sense of indebtedness.

Having acknowledged the reality of Mr A's experiences of such inequality (including the structural inequality between us), he began to exercise more choice (personal power) and responsibility. Whereas initially any form of challenge or empathic confrontation on my part had been met with suspicion and hostility, Mr A began to act more openly and congruently as the 'expert' on his own life rather than feeling he had to defer to a perceived authority figure. For example, he began to openly voice his opinions and negotiate the direction of the sessions. Though there remained upsets and ruptures in our relationship we seemed to have entered into what Clarkson (1995) refers to as a 'person to person' or 'real' relationship. From this position Mr A was able to take an active stance and made an informed decision to engage with cognitive-behavioural work, notably looking at and challenging the distorted aspects of his cognitive and interpretive processes.

Mr A's self-report indicated that he had felt competent and honoured by this approach. By the end of therapy he had gained an increased awareness of the historical and relational contexts and conditions that had shaped his taken-for-granted beliefs, thinking and behaviours, and he indicated that he was more in control and able to manage his emotions and mood. It was the focus on the meaning of his lived experience in the everyday context of his life and not just cognition or behaviour that was the variable of focus. The therapeutic relationship appeared to provide experiential disconfirmation of his interpersonal schema and opened a space for him to generate alternative beliefs and ways of relating to himself and others that reflected his preferred identity.
By the end of my third year placement I had not gained the required 450 clinical contact hours due to not finding a suitable placement straight away in the first year and through clinical hours lost following the breakdown of my first placement during the second year. As such, I seized the opportunity to undertake a further six-month placement working with primary care referrals explicitly from a narrative perspective. Along with gaining experience of individual and group narrative supervision, this placement provided freedom to further develop my preferred position in an environment where the narrative metaphor and approach to therapy held the same status as more mainstream models. In particular, I developed the narrative attitude of viewing the problems that clients bring to therapy as being something affecting the person, rather than as characteristics or qualities intrinsic to them. Overall, I found the experience of working in this setting from this particular approach was sustaining and invigorating of my identity and helped to augment the existing resources and skills I had developed in other models.

In summary, this paper has attempted to demonstrate how I practice as a counselling psychologist. I am keenly aware that a paper such as this can only provide a fleeting glimpse of my work. I hope that what I have included has demonstrated ethical and effective practice whilst persevering the richness and complexity of the stories clients' have shared with me. My training has provided a solid foundation and has facilitated the development of my professional story, which continues to unfold and thicken as I gain further experience.
References


RESEARCH DOSSIER
Introduction to research dossier

This dossier consists of a literature review, two qualitative pieces of research and a published article. The literature review explores traditional conceptualisations of 'psychopathology' and the use of diagnostic classification systems in contrast with the applied discipline of counselling psychology. The second paper explores Chartered Counselling Psychologists talk about psycho-diagnostic categories, 'psychopathology' and counselling psychology practice. The third paper examines the discursive relationship between 'knowledge', 'truth' and 'power' in the context of psychotherapeutic practice. The published article is in the form of a review of a research article.

Reflective commentary on the 'use of self' during the research process is included at the end of each piece of research.
Counselling Psychology - Critical Psychology in a Postmodern Age? Challenging and Reconstructing Traditional Notions of Psychopathology, Psychiatric Categories and Psycho-Diagnosis.

Abstract

This paper reviews how mainstream psychology traditionally conceptualises and accounts for 'psychopathology' as evident in selected abnormal psychology textbooks. Present day understandings of 'psychopathology' were located historically within modernism and its particular view of science. The primary theme uniting the reviewed literature was a common search for the causes of 'psychopathology', which evolved around competing organic and psychological explanations. A deconstructive stance was adopted in order to examine the assumptions underpinning mainstream psychology's view of 'psychopathology' and its approach to categorising and diagnosing it as the correct point for treatment. The implications of mainstream psychology's view of psychopathology in regard to modern therapeutic practice were noted and contrasted with the applied discipline of counselling psychology. Two dimensions were used to differentiate counselling psychology from traditional psychology and therapeutic practice, i.e., attention to 'little narratives' or local meanings and understandings and a relational focus. These dimensions were used to compare the traditional use of psycho-diagnosis and psychiatric categories with counselling psychology's contextual use of psychological formulation in applied practice. Counselling psychology's potential to challenge the status quo and offset some of the potentially normalising and pathologising effects associated with modern forms of therapy were discussed.
Introduction

In contemporary Western society, terms such as 'psychopathology', 'abnormal' functioning, mental illness/disorder, schizophrenia, anorexia, therapy, diagnosis etc, abound within the abnormal psychology literature and have become part and parcel of everyday discourse. The daily usage of such terms is evident in the ways in which some people become marked out as not 'normal' or different. Alongside the increasing "discovery" and categorisation of these problems / disorders is the parallel increase in the provision of counselling and therapy. The proliferation of named syndromes and pathologies, it is argued, is part of the more general phenomenon of the pathologisation of everyday life (Burr and Butt, 2000).

Arguably, this is a time when biomedical and reductionist explanations and understandings of psychopathology are dominant in both scientific and applied psychotherapeutic worldviews and practices (Fee, 2000). The terms and the means of classification that have penetrated our culture and the mental health profession in so many ways stem most recently from science's attempt to provide a system that can 'objectively' identify and thereby classify the different types of disorders which fall under the rubric of 'abnormality'. This present position highlights how we have inherited the legacy of the eighteenth century when madness became an "object", a thing-in-itself, discoverable by dispassionate positivist inquiry (Foucault, 1965). As such, this viewpoint holds that the only way 'psychopathology' can be recognised as 'real' and thus worthy of rigorous study and funded research, is when it is rooted in the medicalised language of bio-physiology or some other deep-seated individual factor (Fee, 2000).

The current review can be located as part of the "gathering storm" of movements that are confronting expert knowledge in the mental sciences (McNamee & Gergen, 1992). It is indebted to and derived in part from the efforts of the anti-psychiatry movement of the 1960s and 70s, where the likes of Thomas Szasz and R.D. Laing contested psychiatric authority. However, following the 'turn to language' (Parker, 1992) in the social sciences
and humanities, attention is directed towards the discursive or textual underpinnings of mental life and their role in the study of psychopathology (e.g. Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995; Rose, 1989; Shotter, 1992).

The wellspring of unrest that questions the concept and utility of scientific psychology as developed during the modern age is associated with the wave of critical thought and philosophy that seeks to "deconstruct or question modernist beliefs about truth, knowledge, power, individualism and language...Postmodern philosophers challenge the assumption that reason alone can provide an objective and universal foundation for knowledge or that a knowledge based on reason will be socially beneficial and ensure progress", (Collier, Minton & Reynolds, 1991, p.87). Instead, psychopathology and psychological knowledge are re-cast as being constructed socially and linguistically via the negotiated socio-cultural meanings that are historically prevalent.

Whilst there exists no single or unified postmodern philosophy, there is nonetheless a range of thinkers who focus on different aspects of the postmodern condition, for example, Lyotard's (1984) suspicion of self-justified meta-narratives, especially those viewed as scientific; Derrida's (1974) view of language as unstable, partial and anti-metaphysical; and Foucault's (1977, 1980) work that paid attention to the relationship between power, knowledge and the self in his historical analyses.

So that the first aim of critically examining the notion of 'psychopathology' can be fulfilled, nine major US and UK abnormal psychology textbooks aimed at undergraduate and postgraduates were reviewed as a starting point to gain a ‘flavour’ of how mainstream psychology accounts for psychopathology. The texts reviewed are Bootzin and Acocella (1993), Comer (1992), Davison and Neal (1996), Halgin and Whitbourne (1993), Holmes (1998), Kendall and Hammen (1998), Olmans and Emery (1998), Rosenhan and Seligman (1995) and Sarason and Sarason (1993). Each text was readily available in a British university library; as such, they are considered to give a reasonable representation of both British and American approaches to abnormal psychology. Texts
are considered that were published during the 1990s so as to give a relatively up-to-date view. Whilst it is acknowledged from the outset that a variety of different accounts and explanations of psychopathology could be offered, consideration of these texts allows us to see how psychopathology is being spoken about and constructed in mainstream psychological discourse, whilst taking into account and questioning the extent to which it overlaps with psychiatric discourse. Equally, it affords us the raw materials from which a critical and deconstructive analysis can be built.

Whilst reviewing this literature, attention will be given to, and an attempt made to locate, contemporary understandings of 'psychopathology' within the modern world-view generally, and within the context of abnormal psychology more locally. Following this, the postmodern strategy of undermining "totalising" knowledges shall be evoked in relation to the Diagnostic and Statistical Manual of Mental Disorder, fourth edition, the primary text for classifying Psychiatric disorders (American Psychiatric Association, 1994) by highlighting the modernist assumptions underpinning its use and their implications. Our concern is with how these assumptions shape current understandings and makes it possible for mental health professionals to diagnose and locate people in psychiatric categories by reducing experiential and behavioural variations to fixed pre-emptive constructs.

In essence, the first aim of the review is to employ postmodern thinking in order to highlight what has been taken for granted in the traditional literature concerning psychopathology and mainstream psychology's approach to categorising / diagnosing it as the correct starting point for treatment.

Whilst deconstructive critique at the abstract level of theory is not in itself particularly new or radical, it is deemed necessary as the second part of the review aims to move towards the applied arena thereby considering the interplay between theory and practice. The reason for this stems from the contention that there is a strong tension between academic and professional/applied psychology, in part due to the entrenchment of
psychological theory in modernity, whereas professional practice, on the other hand, has to face human life in a postmodern age (Polkinghorne, 1992).

The review shall start by presenting a brief and selective overview of the explanations of ‘psychopathology’ that have prevailed historically.

**Historical overview**

Each of the nine texts reviewed (Bootzin & Acocella 1993; Comer 1992; Davison & Neal 1996; Halgin & Whitbourne 1993; Holmes 1998, Kendall & Hammen 1998; Oltmans & Emery 1998; Rosenhan & Seligman 1995; Sarason & Sarason 1993) considers the changing historical views of psychopathology or psychological abnormality. Each text refers to demonology as the earliest explanation for psychopathology - that is, a belief in possession by evil spirits or demons as the cause of mental disturbance.

The focus then shifts towards the mythological writings of the Greeks, which are considered to be a rich source of descriptions as to what was looked upon as mental disorder in very early times. There is consensus amongst the reviewed texts that it was during the classical era in Greek history that we began to see the evolution of a naturalistic approach to abnormal behaviour. Each text makes reference to Hippocrates who considered psychological abnormality a disease caused in some ways as other bodily illness. His greatest contribution is considered to be his insistence that all illness or mental disorder should be explained on the basis of natural causes. The Greek era is also considered to have been a time when curiosity developed about physical and psychological functioning. The use of ‘scientific method’ i.e., the application of rationality to what they observed, was a clear break away from earlier beliefs that evil spirits caused psychopathology. It is notable in the texts reviewed that current Western views of psychopathology trace their heritage to classical Greek and Roman origins. The notable exception is Kendal and Hammen (1998) who acknowledge the contribution of Asian and African cultures to our current views.
The next historical period is referred to as the middle or "dark" ages wherein no scientific or medical advances were deemed to have occurred beyond those made earlier by Hippocrates and Galen. This period is also widely associated with the resurgence of primitive beliefs regarding spiritual possession. It is argued, that following the fall of the Roman Empire, people were grasping desperately for security, with a great number finding it in supernatural explanations of phenomena that were distressing or difficult to comprehend rationally. This crystallised around a religious sect, Christianity, which had grown rapidly from a persecuted minority to the official Empire religion by the fourth century A.D. The church's position was one of belief in the supernatural. As such, their position ran against the grain of rationalism that was essential to science. The legacy of rationality that the middle ages had inherited from the Greek philosophers was soon abandoned as demonology, and superstition gained renewed importance, becoming the "psychiatry" of the day.

The seventeenth and eighteenth centuries are referred to as the age of reason and the Enlightenment because reason and scientific method came to replace religious faith and dogma as ways of understanding the natural world. Two primary views were competing at the time that mirror current debates in the field, namely, organic versus psychological explanations of psychopathology. Despite the tension between the two, consensus was reached in the rejection of supernatural forces as the cause of abnormal behaviour. By the end of the eighteenth century superstition had been replaced with a commitment to rationality and scientific observation.

The beginnings of modern thought and practice are attributed to the nineteenth century physician William Griesinger (1817-1868) who revised Hippocrates' theory of mental diseases advocating that every mental illness has a physical cause. Following this, Emil Kraepelin furnished a classification of mental diseases in terms of their organic bases in 1883. The enduring nature of Kraepelin's scheme can still be seen as it forms the basis of present day classification schemes. The reviewed material comes up to date by acknowledging the continued dominance of the medical model into the twentieth century.
This is set against the psychological approach where leading figures such as Anton Mesmer (1733-1815), Jean Charcot (1825-1893), Pierre Janet (1859-1947), Joseph Breuer (1842-1925) and Sigmund Freud (1856-1939) were considering psychological factors in the explanation and treatment of psychopathology. This tension between organic and psychological explanations of psychopathology continues in the present day.

Modernism and the rise of science

The deconstructive stance taken in this review prohibits us from accepting these historical accounts at face value as 'objective' or 'true'. Instead it helps us to examine and locate current understandings and explanations of psychopathology with the parallel development and rise of modern science. The eighteenth and nineteenth centuries were highlighted historically as being particularly important periods of development. The intellectual movement of the eighteenth century known as the "Enlightenment" gave definition to the idea of "modernity" and birth to a range of disciplines, including those we now call the social sciences that have shaped the modern conception of "knowledge". Enlightenment thinkers engaged in energetic critique of all forms of traditional and religious authority - for example, superstitious or magical beliefs. In their place was substituted a belief in progress, reason and science. What has become known as the "project" of modernity and of the Enlightenment proposed a vision of the world that valued material progress, prosperity, individual freedom and social justice founded on rational rather than religious or magical principles (Billington, Hockey & Strawbridge, 1998). This fits with Foucault's (1965) contention that it was during the Enlightenment that "madness" became an "object", a thing-in-itself, discoverable by dispassionate positivist inquiry.

Psychology - "Child of Modernity"

Psychology is one of the academic disciplines that has its beginnings in the last half of the nineteenth century when the principles of modern science were applied to the study of
human beings (Giorgi, 1986). Modern science had effectively developed descriptions of the regularities that held in the natural realm. As such, it was believed that application of naturalistic methods to the human realm would produce a body of knowledge that would make possible the prediction and control of human behaviour. Danziger (1979) notes modernism's emancipatory intentions, assuming that gathering such information would allow for the efficient education of children, the reform of prisoners and most importantly for the purposes of the current review - to *cure* 'mental illness'. Clearly then by this account the discipline of psychology adopted the modernist notion or belief in underlying fundamentals or *basic essences*. For Gergen (1992) who views there to be four overarching presumptions from modernism giving rise to the discipline of psychology, at the heart of the modern enterprise lies the belief in a knowable world. From this belief stems the general premise that there is a basic subject matter to be elucidated. He argues that by presuming a knowable subject, modern psychology is shaped by a belief in universal properties. Abnormal psychology exemplifies these beliefs as it attempts to study psychopathology by *categorising* it, thereby gaining principles and possibly laws that can be discovered and generalised to other instances across time, situations and persons. Additionally, the logical empiricist philosophy driving modern psychology and abnormal psychology is dedicated to a belief in 'truth through method'. It is here we find the belief that through the scientific method obdurate truths can be discovered about what 'psychopathology' is and what causes it. There is continued faith in the increasingly contested belief that such methods are impersonal and prohibit the entry of ideology and values when describing and explaining psychopathology. Finally, there is a belief in the progressive nature of the research enterprise. The application of empirical methods to the subject matter of psychology is believed to illuminate its *fundamental* character increasingly: the goal being to establish reliable, value-neutral "truths" (Gergen, 1992, 1994).

The primary theme uniting the reviewed literature is a common search for the causes of psychopathology. The advent of modern science shifted theories of cause from mythical or supernatural to organic and psychological explanations. Scientifically accounting for
psychopathology as in evidence in the reviewed literature shows a clear commitment to the explanatory as the primary mode of human understanding. Newman (2000) notes how during the modern era the scientific model has been of unprecedented value in helping us to understand the nature of so-called "physical reality". However, he goes on to argue that this particular scientific story, wherein the scientific model is a key feature, has come to be more than just a means to understanding the physical world but also has achieved paramount status as the universal definition of understanding itself. Importantly, he highlights how the efforts of twentieth-century positivism have led to the scientising of history and all human understanding by attempting to make it fully explanatory.

The explanatory and/or predictive mode of understanding, which has come to dominate science and is rooted in the capacity to derive deductively a characterisation or a definite description of a specific phenomenon, is clearly in evidence in the reviewed texts and their focus on explaining what psychopathology is and what causes it. When we consider how abnormal psychology is defined in the reviewed texts their wholesale allegiance to this modernist derived view of science becomes clear. For example, Comer (1992) defines abnormal psychology as a field devoted to the scientific study of abnormal behaviour wherein scientists and clinicians systematically gather information so that they may describe, predict, explain and exert some control over the phenomena they study. Similarly, Oltmans and Emery (1998) define abnormal psychology as the application of psychological science to the study of mental disorders, and Davison and Neale (1996) refer to abnormal psychology as an area of scientific study, where the goal is to observe, systematically acquire and evaluate information, and then develop general theories that explain the information.

To date, this review has located present day understandings of psychopathology more widely within modernism and its particular view of science, and more locally within the current context of abnormal psychology. The focus will now shift to a more detailed examination of some of the central assumptions underpinning current conceptualisations of psychopathology and their implications.
Throughout the reviewed texts the influence of modernism is at its clearest in the united assumption that psychopathology / mental illness exists as the starting point for both theory and practice. Distilled to its basest element, this assumption holds that there is something - a discrete entity - that actually exists (ontological surety) and that through the correct method (i.e., the scientific method) can be discovered, observed and described. As the historical periods are constructed as being characterised by uniformity and homogeneity we can read this as an attempt to classify and categorise psychopathology. As such, the notion of categorisation as exemplified by the starring role given to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in all the reviewed texts shall be focused upon and critically examined.

Describing and categorising behaviour and experience

*The power of psychology lay in its promise to provide inscription devices that would individualise such troublesome subjects, rendering the human soul into thought in the form of calculable traces. Its contribution lay in the invention of diagnostic categories, evaluations, assessments and tests that constructed the subjective in a form in which it could be represented in classifications, in figures and quotients. The psychological test was the first such device.* (Rose, 1990, p.109)

As was noted earlier, the historical development of classification systems includes Hippocrates' development of a medical model of madness in ancient Greece during the fourth century B.C., and Emil Kraepelin's organically based classification system of mental disease in the nineteenth century. These approaches rejected the dominant notion that illness was of sacred or divine origin. Thus science triumphed over religion and it was thought that psychopathology could be classified alongside physical illness. What is of importance, within the context of this investigation, is that the rise of the scientific tradition in Western society led inexorably, it seems, to the systematic categorisation of
forms of mental illness or disorder, and that all ensuing developments drew upon the medical model.

Psychiatric taxonomy has evolved currently into the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, commonly referred to as (DSM-IV) published by the American Psychiatric Association (1994). One perspective on the DSM-IV classification system is that it provides a convenient and scientific shorthand for describing clinical issues faced by mental health professionals. Schwartz and Wiggins (1986) note that from a modernist perspective, in which empirical science is capable of providing 'objective' truths, the DSM approach to understanding, explaining and treating mental problems that human beings face makes compelling sense. Establishing its initial credibility as an outgrowth of medicine, the DSM-IV has developed in the same manner as other biological classification systems. As with diagnosis in medicine, the assumption is that a DSM diagnosis should provide an established reference point from which standardised modalities of treatment could begin. By logical extension, conferring a DSM diagnosis should confer the same sense of understanding and sense of deliverance from disease that occurs in medical diagnosis.

However, unlike other biomedical classifications of pathology, psychiatric explanations of the aetiologies of "psychopathology / mental disorders" have been a constant source of conflict (e.g. Grob, 1985; Klerman, Valliant, Spitzer & Michels, 1984). Consequently, the DSM-IV has adopted a descriptive and apparently non-aetiologically based approach to classifying psychopathology. In spite of this stance, it is still based on the presupposition that such disorders are inherently biomedical in their aetiology (see American Psychiatric Association, 1987), and that eventually the cause and course of such disorders will be scientifically discovered. Bound with the hegemony of discovery, of knowing, of science and modern epistemology, the DSM-IV is underpinned with the *a priori* demand that it be part of a scientific explanatory system wherein mental problems can be classified and treated as scientifically agreed upon mental disorders.
As noted earlier the case for the importance of classification makes sense when viewed from within the dominant or received view. However, once we begin to unpack and deconstruct its underlying assumptions and concepts we find that it is both problematic and resting upon shaky foundations. At the base of this foundation lies the modernist view of science within which diagnostic classification finds itself situated. Such a view holds that there is a 'knowable' world and that through progressive scientific rational discovery we can uncover the nature of the external world and the interior of individual people's minds. A general issue then with classification systems like the DSM-IV (1994) is the underlying assumption that each disorder that is classified is a distinct entity, i.e., that psychopathology is a "thing in itself". This realist assumption is challenged by the alternative notion that 'abnormal' functioning or any mental illnesses (however defined by the DSM-IV, 1994) are social constructions rather than actual "things" (McNamee & Gergen, 1992).

Furthermore, the DSM-IV's concern is with 'abnormal' functioning. We have seen how this is central to the field of abnormal psychology, yet in order for us to make sense of it, the notion of 'abnormal' requires a description of what is 'normal' to make sense. In essence, one pole is dependent on the other for its meaning - it could not exist without the opposite that defines it. Within the context of abnormal psychology, definitions of psychopathology are based on the assumption that a "norm" exists. For example Oltmans and Emery (1998) and Haigin and Whitbourne (1993) use the criteria of statistical deviation from the norm to define abnormality. Similarly, Bootzin and Acocella (1993), Davison and Neale (1996) and Rosenham and Seligman (1995) use the criteria of violation of norms to define abnormality.

Looking at the 'normal/abnormal' opposition, which is central to mainstream abnormal psychology, in a wider historical frame, we find that this category simply reconstitutes the opposition between 'sane' and 'insane' or between 'healthy' and 'sick' (Parker et al., 1995). The uses of the DSM-IV (1994) to classify categories of 'normal' and 'abnormal' functioning therefore define ideals of behaviour. It reflects and reinforces the current
ideologies and cultural themes. In this sense the dominant meanings that are associated with what it is to be ‘normal’ or ‘abnormal’ not only constrain and influence people’s behaviour, but also, as Hare-Mustin and Marecek, (1990) note, serve to maintain the status quo and justify existing hierarchies of power and status. For example, until its revision in 1980, homosexuality was included in the DSM as a category of mental disorder, which served to reaffirm the moral and cultural sanctions against non-heterosexual behaviour. The declassification of homosexuality as a disorder resulted from the emergence of the gay liberation movement and political activism. Kutchins and Kirk (1997) argue that science was not the key factor in deciding whether or not to include or exclude a particular diagnosis in the DSM; the dispute over the inclusion of homosexuality was not about research findings or scientific ‘fact’ - it was a 20-year debate about beliefs and values. This adds weight to social constructionist claims that classification systems such as the DSM-IV (1994) and their use to classify ‘abnormal’ functioning are products of their time and place. The decision to regard any set of behaviours or experience (e.g. homosexuality) as ‘abnormal’ is not then, a scientifically ‘objective’ fact; rather it is a political and moral decision that is grounded culturally in which types of behaviour are deemed acceptable or unacceptable at a particular historical point.

Although the DSM-IV holds each category to be a pure pathology, it runs into further problems when we consider the huge gap between theory and practice. The clinician or practitioner who attempts interventions with a person who has been classified as ‘abnormal’, that is, someone who behaves outside of the culturally constrained ‘norms’, is often confronted with problems which instead of being neat, orderly and scientific as in the DSM-IV, are messy and ambiguous in the everyday world. It would seem then that the search for generalized, abstract rules and the use of the DSM-IV to classify ‘abnormal’ functioning, in spite of its constant revision and improvements (see Kutchins & Kirk, 1997) in practice might not be appropriate to human difficulties.
The role of language - discourse creating its object of inquiry.

Understanding the role of language, and the institutions in which it is used, becomes crucial to a critical and evaluative account of the use of the DSM-IV to classify 'psychopathology' and 'abnormal' functioning. As the DSM-IV is located within psychiatric discourse, aspiring to mimic the natural sciences, it appears to have succumbed to the belief that in order to help a complaint, you have to describe it and name it. As the DSM-IV adopts the medical model as its frame of reference and seeks to understand psychological disorders in the same way that medicine understands physical disorders, both the style and the language of the manual have therefore become more medicalised.

Arguably then, the language and modernist use of the DSM-IV have played a significant role in shaping both professional and lay conceptions of "clinical reality" with respect to the problems brought before mental health professionals. Gergen (1990) in his provocatively entitled article "therapeutic professions and the diffusion of deficit" warned of the danger of reifying a language of mental states:

The mental health professions operate largely so as to objectify a language of mental deficit. In spite of their humane intentions, by constructing a reality of mental deficit the professions contribute to hierarchies of privilege, reducing natural interdependencies within the culture, and lend themselves to self-enfeeblement. This infirming of the culture is progressive, such that when common actions are translated into a professionalized language of mental deficit, and this language is disseminated, the culture comes to construct itself in these terms. (Gergen, 1990, p.353)

Repudiating the notion of correspondence between language and "reality", as postmodern constructionist intelligibilities do, renders problematic the discursive repertoire of 'objective' and decontextualised assessment, diagnosis and intervention, the use of
classificatory systems, and the very status of theory informed by the metaphor of scientific discovery (Lowe, 1999). If we replace the representational-referential view of language associated with the DSM-IV with a relationally and rhetorically responsive view (e.g. Shotter, 1993), the realities created by diagnostic classifications are no longer seen as actual states of being, but instead as historically situated ways of talking that have constitutive effects. To this end the DSM-IV (1994) can be regarded as a system of statements about the world that creates lived realities. This paves the way for us to see diagnostic categories as discursive complexes, that through a set of statements are able to construct objects and a variety of subject positions.

Having taken a critical look at the notion of categorisation and the DSM-IV classification system, suspicion has been levelled at the modernist presumption that there are universals of behaviour that transcend history, culture and context. In addition to highlighting classification as being central to and derived from modernist beliefs, the constitutive, as opposed to merely descriptive, nature of language and how this is inextricably linked to the attribution of meaning and practices of power, has also been brought into view.

The review will now take forward some of the considerations that have arisen regarding how psychopathology is conceptualised and understood traditionally alongside its use of diagnostic classification systems, and consider this explicitly in relation to the applied discipline of counselling psychology. The guiding question for this part of the review is what is counselling psychology's relationship with ‘psychopathology’, i.e. how does it view (conceptualise) and work with (treat) it? Whilst hoping to answer this question, albeit tentatively, given the new and evolving nature of counselling psychology, greater emphasis is placed upon exploring its potential for challenging the status quo and for formulating new knowledge and improved practices, thus contributing towards, and widening, constructive dialogue. This exploratory stance allows us to question whether counselling psychology's underlying philosophy; value base, status and epistemology mark it out as a potential postmodern response to the difficulties associated with
modernism. And if so, is it able to offer increasingly more appropriate ways of viewing and working with the psychological 'abnormality' clients bring to therapy?

In order to examine this relationship the primary source of literature to be reviewed comes from Woolfe and Dryden's (1996) *Handbook of Counselling Psychology*, the most recent British textbook available to date, which offers a detailed portrait of the history, philosophy, theory, methodology and practice of counselling psychology in Britain. Counselling psychology will be considered as it has developed and been defined within the British Psychological Society, which established a Counselling Psychology Section in 1982, which gained Divisional status in 1994. Additional material relating to counselling psychology's ongoing evolution in the United Kingdom will come from *Counselling Psychology Review*, the academic journal published by the British Psychological Society's Division of Counselling Psychology.

**Counselling Psychology**

Counselling psychology is a relatively new and innovative branch of applied professional psychology concerned with the integration of psychological theory and research with therapeutic practice. Woolfe (1996) defines counselling psychology as the application of psychological knowledge to the practice of counselling. Although the empiricist paradigm has always been the dominant or influential discourse within mental health (see Parker et al., 1995) counselling psychology can be viewed as a departure from this traditional position. Most notably, this departure and difference stems from its phenomenological base and humanistic value system (Clarkson, 1998; Woolfe, 1996), which views human beings as free and autonomous individuals. This value system is reflected in reactions against the medical model of professional-client relationships and a move towards focussing on facilitating well-being rather than on responding to sickness and pathology. In turn, Woolfe (1996) locates counselling psychology "in a pivotal position between narrow scientism on the one hand and a failure to take sufficient account of any scientific method on the other" (p.11). Considering this position in terms
of the modern/postmodern divide that has been evoked to date, Woolfe's conceptualisation of counselling psychology seems similar to House's depiction of what a postmodern practice should be like:

Perhaps postmodernism is a kind of "reaction formation" against the excesses of soulless scientism of modernity; and it seems to me that the fields of counselling and psychotherapy are in a unique position to develop an embodied, humanistic approach to research that transcends the ideology of objectivism and which honours both our need for communicable intersubjective knowledge about the world and core humanistic principles, which elevate the values of holism and human meaning above those of mechanism and quantifiability. (House, 1997 p.59)

Whilst the criticisms that have been levelled at the notion of psychopathology and the use of classifications systems cannot easily be discarded, neither can the "reality" of the pain nor suffering that clients present to mental health professionals with. Ussher (1991) aptly noted that the critics of psychiatry "can become captivated by their own mesmerising arguments, moved or thrilled by the shocking horror of the extremes they portray, forgetting the essential reality and unglamorous actuality of madness as it is for the majority" (p.221). Clearly, the palpable signs of pain and suffering in practice cannot be dismissed purely as social constructions.

The remainder of the review will start by outlining traditional modernist approaches to therapeutic practice and some of their normalising and pathologising implications. By contrasting explicitly with counselling psychology, some preliminary responses will be offered regarding the use of psychiatric diagnostic categories; a question that is currently being considered by the discipline (see Strawbridge & James 2001). In order to achieve this, two dimensions will be used to differentiate counselling psychology from traditional psychology and practice; namely: 'little narratives' - local meanings and understandings; and 'from within to between' - a relational focus. More specifically, these dimensions
will be used to compare the traditional use of psycho-diagnosis, and psychiatric categories, with counselling psychology's use of psychological formulation in applied practice.

Traditional applied practice

Kaye (1999) notes how modernist models of applied therapeutic practice both treat the individual as the locus of pathology (thereby diverting attention from the role played by socio-cultural factors in the genesis of psychological distress) and are informed by assumptions of: 1) An underlying cause or basis of pathology 2) The location of this cause within the individual 3) The ability to diagnose the problem 4) Treatability via a specifically designed set of techniques. Implicit in these suppositions are the concepts of normality and abnormality, the normatively good or bad and the presumption of a "true" root cause, which can be objectively established, known and remediated. Thus, when practitioners are confronted with a client who is experiencing psychological distress and they use diagnostic categories like those found in the DSM-IV, they are (often unwittingly) entering a medical discourse. As Pilgrim (2000) notes: "Diagnosis is a medical task which creates a simple dichotomy between the sick and the well" (p. 302). From this viewpoint, therapy can be seen as an instrumental practice consisting of the treatment of what is judged to be psychopathology and abnormal or dysfunctional behaviour. Practitioners working within these parameters attempt to bring about a restructuring or reprogramming of behaviour in individuals against some criterion of the 'normal'. Therefore, modernist therapy is concerned with altering behaviour patterns and belief systems with the establishment of alternative, more functional, or more socially normative patterns.

In the first part of the review we saw how the DSM-IV (1994) is used to classify categories of "normal" and "abnormal" functioning, which define ideals of behaviour and reinforce current ideologies. Modernist models of applied practice appear to extend this stance. The act of helping becomes problematic as modernist models incorporate a theory
of function and dysfunction as well as an associated set of activities whereby it is assumed that change can be induced in another by the specially trained and accredited. This conceptualisation perpetuates the concept of the therapist as having privileged knowledge, a socially accredited expert who can provide a diagnosis, an authoritative and "true" version of a problem and act according to a set of prescribed activities to correct it (Kaye, 1996).

As such, modernist conceptualisations of therapy, in punctuating therapists as objective knowers or experts, ensure that the modern therapist enters the therapeutic arena with a well developed narrative (culturally dominant narrative of pathology/cure) for which there is abundant support within the community of scientific peers. It is this background that establishes the therapist's posture towards the client's difficulties. A clear demarcation can be seen between the client's narrative, which is viewed as made up of the insubstantial stuff of daily life - replete with distorted memories and wishful thinking. Contrastingly, the scientific narrative has the seal of professional approval. Consequently, the client's narrative is either incorporated or is replaced by the professional account (Gergen & Kaye, 1992). This process of replacing the client's story with the therapists metanarrative is in evidence in psychoanalysis where the client's account is transformed by the therapist into a tale of family romance (i.e., the Freudian Oedipal story). In Rogerian therapy, the humanist odyssey of self-fulfilment encourages the client to accept their 'real self' and become more whole. The cognitive-behavioural story centres on reason and educates clients in more 'correct' or 'rational' ways of thinking and acting. Thus, the therapeutic metanarrative provided by therapists serve as organising frameworks, which simultaneously provide inbuilt solutions to clients problems (see Omer & Strenger, 1992).

However, such modernist derived therapeutic metanarratives suffer from a rigidity of narrative formulations and are relatively closed to alteration. Despite all the different possible modes of acting in the world, the client is set on a course that emphasises; ego autonomy, self-actualisation, rational appraisal etc., depending on the type of therapy.
selected. As an abstract formalisation the therapist's narrative is cut away from particular cultural and historical circumstances. That is to say, modernist narratives are non-specific, by attempting to diagnose and categorise they aspire towards universality, consequently they are left with very little to say about particular circumstances. In this sense they are insensitive, and arguably fail to register the particularities of the client's life engagements.

As such, traditional modernist approaches have major shortcomings: when people are approached as objects about which therapist's know truths, their experience is often one of being de-humanised. The 'objectivity' of the modernist worldview often ignores the specific, localised meanings of individual people. When people are treated as objects they are invited into a relationship in which they are passive, powerless recipients of the knowledge and expertise of the therapist. It favours a form of person blame and is often blind to the social conditions in which problems develop. Practitioners working from a modern perspective overlook their inevitably reflexive role in creating, via their questioning, the version they think they perceive. At best, these versions fit for the client, or draw distinctions, which help them to generate new, less problematic, possibilities for themselves; at their worst, they represent a circular activity in which the therapist finds the 'disorder' that they hypothesise to be there and attempts to impose these on the client - a form of intellectual colonialism (Hoffman, 1993; McCarthy & Byrne, 1988). One major consequence of modern therapists' strict adherence to, and reliance upon, psychodiagnosis and psychiatric categories, is that it may lead to a fixity or stereotype of thinking and discourse that may potentially limit the client's opportunity to forge alternative meanings, solutions and narratives in relation to their psychological distress.
"Little Narratives" - local meanings and understandings.

Lyotard (1984) refers to all overarching theories and belief systems, including those of the social science, as "grand or meta-narratives" and describes the postmodern condition as one that abandons the search for these. He argues that in social science as well as everyday life, it is the small-scale theories and accounts that should claim our attention, "the little narrative remains the quintessential form of imaginative invention" (p.60). In contrast to the modern search for such overarching theories, counselling psychology seeks local understandings of people, informed by their subjective accounts of the world and experience (Woolfe, 1996, p.7) it points to the significance of what Lyotard calls "little narratives" that steer us away from potentially dangerous conformity and consensus and introduces greater fluidity and appreciation of context and difference. Rather than the pursuit of an "objectively discoverable truth" (Strawbridge & Woolfe, 1996, p.619), its discipline gives primacy to exploring the ways in which individuals perceive and attribute particular meanings to their phenomenological realities (Van Deurzen-Smith, 1990).

McLeod (1996), for example, considers that attempts to impose diagnostic labels on clients, risk obscuring the inevitable ambiguities that compromise individuals' unique perspectives. Counselling psychology's use of client and context specific formulation minimises this risk as it emphasises evaluating emotional and mental health with respect to a person's position in the life cycle, along with their lifestyle and relationships (Woolfe, 1996, p. 8). Rather than attempting to categorise clients and their distress, counselling psychology pays attention to the particular, i.e. the "little narratives" which locate clients' behaviour and experience in its biographical and social context.

"From within to between" - a relational focus.

Counselling psychologists' use of psychological formulation in contrast to relying upon diagnosis and psychiatric categories also goes some way towards addressing and
redistributing power within the therapeutic relationship. Rather than attempting to "objectively" diagnose from a privileged and expert position thus attempting to answer the psychiatric question "is this person suffering from a mental disorder or not?" The helping relationship, which forms an integral part of counselling psychology's practice-led discipline (see Woolfe, 1996) is characterised by its system of "cooperative inquiry". This involves developing a shared understanding between client and therapist to address the client's concerns. This approach is characteristically postmodern in that it represents a move away from emphasising the psychology of the client - a "one-person psychology" (Kahn, 1996), to a focus on what occurs between people, i.e. an intersubjective psychology, where the therapist's perspective is acknowledged to impact on the client's experience of therapy (Strawbridge, 1992; Wilkinson, Campbell, Coyle, Jordan & Milton, 1997). Indeed The British Psychological Society now formally recognises the values of practice-led counselling psychology, of phenomenological practice and inquiry, including respect for subjectivity and intersubjectivity (BPS, 1998). This stance appears to be a move beyond the technical rationality inherent in modernist approaches attempts to objectify clients, and their psychological distress, towards what Schon (1983) refers to as "reflective practice" whereby the subjective horizons of both client and therapist can meet.

Earlier it was noted that traditional approaches adopt a medical knowledge base and assume a direct correspondence between language and 'reality' wherein the mental health professional acts as an 'expert' and is able to diagnose a 'true' account of the problem in accordance with descriptive categories. However, Rogers and Pilgrim (1997) note that psychiatric classification systems hold no definitive advantage over ordinary or lay descriptions of psychopathology. They argue that ordinary people know that these aspects of experience come in all shapes and sizes, and that they can offer a rich range of lay theories about their development and amelioration. Instead of using supposedly "objective" categorical descriptions, which are more reductionist, impersonal and stigmatising, counselling psychologists' use of psychological formulation works with, rather than on, the client. It is more responsive to clients' own descriptions and
understandings of their difficulties. As such it is more sensitive to the psychosocial context of everyday behaviour, experience and language thus avoiding technicalising and pathologising ordinary judgments.

Such context-specific formulations are at odds with the notion of diagnosis and entail what Kaye (1993) refers to as a "receptive stance" toward the therapeutic encounter. Rather than buying into objectivist truth discourses that focus on pathology, the receptive stance views the individual as an *agent* rather than an object; as such, it implies a receptiveness and curiosity about the client's construction of experience, together with an active search for negotiated meanings, rather than a reductive reframing of the others presenting concerns in accordance with predetermined psychiatric diagnostic categories.

The primacy afforded to the therapeutic relationship in counselling psychology is congruent with postmodern practices. Resting on a form of relational practice between therapist and client, counselling psychology seeks to reach "joint understanding" (Shotter, 1993) wherein local meanings and understandings are collaboratively reached, rather than imposed or prescribed as in modern models of applied practice. This approach helps ensure that ordinary human distress e.g. developmental difficulties, traumatic experiences, context related stress and so on, are not turned into pathology or sickness akin to physical disease. This relational focus attends to situational factors thereby bypassing the notion of "disorder" which locates the difficulty within the person. Additionally, formulation remains tentative in contrast to using descriptive categories that can be presented as scientific and objective. In line with its phenomenological and humanistic value system, "healing" can be seen to occur as a result of "being with" the client rather than "doing" a diagnosis and/or fixing what traditionally would be objectified as "the disorder/problem". This relational focus and use of context-specific formulation creates therapeutic space for the exploration, negotiation and transformation of local meanings - i.e. the little narratives.
Conclusion

In this paper, I have sought to deconstruct traditional understandings of psychopathology by unearthing their modernist assumptions and orientation. Particular attention has been given to the notion of categorisation and how this binds psychological theory and explanations of psychopathology to the modern world-view. Having questioned the impact of this traditional stance, the focus shifted towards applied practice. Counselling psychology's general approach and orientation towards psychopathology was considered. More specifically, counselling psychology's use of psychological formulation was contrasted with the traditional use of psycho-diagnosis. Whilst the aim has not been to reach any definitive answers (a modernist endeavour), this paper has attempted to address and contribute towards furthering constructive dialogue regarding the issue of understanding and working with psychological difference. Whilst not explicitly constructionist in its epistemology and orientation, it is my own contention that counselling psychology is a vital part of the "gathering storm" challenging traditional knowledge in the mental sciences.

Strawbridge and Woolfe's (1996) contention that "counselling psychology is not just a psychological activity but is also a cultural enterprise" (p. 606) reflexively questioning its relevance to society and role in maintaining and/or challenging the existing social structure, mark it out as a critical form of psychology with the potential to challenge the existing status quo, formulate new knowledges and improve practice. Wide scale, this is exemplified in counselling psychology's phenomenological and humanistic value base, its reaction against the medical model of professional-client relationships and its emphasis on well-being rather than pathology. More specifically this has been illustrated by counselling psychology's use of psychological formulation, which brings into question the traditional use of the diagnostic approaches, and at the same time forwards a non-pathology orientated means of assessing and working with psychological difference and abnormality. Most notably, it provides a mode of practice that collaboratively negotiates between therapist and client the meaning of psychological 'abnormality' and
psychological distress. Thus, contrary to traditional psychology which tends to
decontextualise clients' distress, viewing psychopathology as internal or within the client,
counselling psychologists encourage clients to distinguish between internal/psychological
and external/social aspects of the issues they are dealing with and find appropriate
strategies for both. In this way, the client is not blamed but recognised and validated in
their struggle, and thus empowered to find social and personal solutions to their
psychological distress.

Whilst having to address and acknowledge the fact that counselling psychology draws its
roots from modernist approaches and models that essentially began a century ago, it
nonetheless appears to be evolving and modifying itself in light of the changing cultural
context within which it is situated. It has developed models of practice and inquiry that
are at odds with the dominant view of science within the discipline (Strawbridge &
Woolfe, 1996) and according to Clarkson (1995) is uniquely placed to "evaluate and
implement theories which are used as tools, as metaphors as Wittgensteinian ladders
rather than as laws set in tablets of stone, unresponsive to changing conditions, unaware
of the interrelatedness of all our explanatory theoretical nets." Its "methodological
pluralism" (Barkham, 1990) and eclectic approach to practice seems open to diversity
(Gelso et al, 1988) and 'confluence' (Clarkson, 1996) of theories and techniques to
generate understanding and acceptance among the innumerable 'local' meanings and
interactions of human activity. Arguably, embracing a pluralistic outlook bodes well for
its ongoing development as a discipline.

Finally, this paper has used the modernist / postmodernist dichotomy to clarify and
critique modernity's influence in regards to the notion of psychopathology and associated
applied practices. However, perhaps the most revolutionary and exciting aspect of
counselling psychology is that it replaces this binary either/or logic with a both/and
position. Counselling psychology is not part of the postmodern reaction that radically
rejects the possibility of knowledge, celebrating the diverse and ephemeral; rather it
represents a critical recognition of the limits and excesses of modernism, yet a
willingness to continue to seek understanding without the certainties of modernist assumptions. As a corollary, the counselling psychologist is invited to conjoin the personal, professional and the political. It is to be hoped that mental health professionals will be stimulated to enter the debate by considering their own responsibility to challenge and expose the shortcomings of traditional modernist forms of psychological inquiry and practice, and their potentially normalising and pathologising influence, whilst continually developing more liberatory notions of psychological difference and emancipatory forms of applied practice.
Many different experiences, both personal and professional have motivated me to explore the psychological literature on 'psychopathology' and the use of diagnostic classification systems. Having personally lived with 'obsessive compulsive disorder' (undiagnosed) for a large part of my life and also having witnessed the dehumanising effects of diagnostic categories on somebody close to me when they were 'diagnosed' with a psychological 'disorder', I felt both interested and duty bound to become more informed about the discipline of psychology's conceptualisation and approach towards psychological 'abnormality' and distress. Also, having specifically opted to study counselling psychology largely on account of its reaction against the medical model I wanted to see where it stood and what its relationship was with 'psychopathology'. This felt particularly important, as I was becoming increasingly aware of the tension between theory and practice in my own training. I liked the critical focus and conceptual tools provided by social constructionist perspectives, which I felt were vital for reflective and ethical practice. At the same time I was looking to explore and find ways of making theory meaningful at the level of practice, which was my primary concern given that I had started working clinically with people who were experiencing very 'real' psychological distress that could not be simply dismissed as a 'social construction'.

The process of conducting the review was a challenging task. The complexity of the area and level of debate surrounding the issue of 'psychopathology' and the use of diagnostic classification systems was difficult to hold in mind. It was especially difficult trying not to privilege one account over another, which included trying not to privilege a social constructionist account. As I found the areas being reviewed were so emotive, impacting on me personally as well as professionally, I recognised that it was not possible to forward an account that wasn't interested. As such the challenge I faced was to try and say something that I believed in, without just dismissing others' views on purely personal grounds, i.e., taking the view that whilst 'psychopathology' and psychological 'abnormality' are socially constructed and that the 'truth' of different perspectives is...
relative, our ways of conceptualising 'psychopathology' nonetheless have 'real' effects and consequences, some of which are preferable to others. This tension was a large part of the process and helped me to make further sense of my own personal and professional relationship with the areas being reviewed. One of the positive effects of having conducted the review was that it helped to ensure that my developing position and preferred approach towards conceptualising and working with 'psychological abnormality' was an informed one. Engaging with the areas under review during my first year was also relevant given the context (Employee Assistance Program) I was working in during my first year clinical placement. Here, there was an implicit tension between practitioners, many of whom were opposed to the use of diagnostic categories, and the service providers, who required practitioners to use diagnostic categories in order to make decisions about employees work status. Having conducted the review and experienced first hand some of the ongoing tensions and debate at the level of theory and practice, I became aware that there weren't any easy or definite answers. Nonetheless it affirmed my belief that it is important to keep asking questions about the consequences and effects of what is often taken-for-granted.

I very much enjoyed exploring this topic, which has been brought to life through my experience of working clinically with people who are experiencing psychological distress. Having engaged with the literature I am now looking forward to conducting research aligned with these areas.
References


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Psycho-Diagnostic Categories, 'Psychopathology' and Counselling Psychology: A Discourse Analytic Study of Chartered Counselling Psychologists' Talk.

Abstract

This study set out to examine talk about 'psychopathology', diagnostic categories, and counselling psychology practice from a social constructionist perspective and used a discourse analytic methodology. A total of eight Chartered Counselling Psychologists were interviewed. The interviews were audio taped and transcribed in detail in order to attend to both micro and macro discursive features. The constructions offered were situated within two interpretive repertoires ('empiricist' and 'contingent'). Particular attention was paid to the rhetorical effects and functions of their discursive practices. Analysis suggested that speakers used the available discursive resources flexibly in their accounts to achieve a variety of personal, interpersonal and professional functions. The oppositional nature of the available discourses meant that speakers were positioned in dilemmatic ways in relation to their professional identity. The way in which they deal with such dilemmas via agentive positioning in practice is considered. The potential application of these finding are discussed.
Introduction

This discursive study is intended as a piece of sustained critical engagement with (and a contribution to) ongoing transdisciplinary dialogues and challenges stemming from various quarters of the humanities and sciences. Such dialogues have served to locate psychological science as a by-product of what Gergen (1994) has been termed "cultural modernism" and have questioned and challenged modernist concepts pivotal to the common practices of psychology such as 'truth', 'rationality', 'objectivity', 'expertise' and 'scientific progress'. The present research can therefore be located as part of the wider historical and cultural transformations that have created what Curt (1994) refers to as a "climate of problematisation" where there is a 'disenchantment' with the established view that it is possible to gain direct access to the 'truth' through the correct (scientific) method and thus 'solutions' to the 'problems' (e.g. to 'cure' mental 'illness') that beset society and individuals.

Traditionally, at the level of theory and research biomedical and reductionist explanations have dominated scientific and psychotherapeutic worldviews with regard to 'psychopathology' (Fee, 2000). Psychological disorders and distress have been conceptualised as residing in individuals who are seen as pathological or irrational in some way. The ontological and epistemological basis for traditional conceptualisations differs from discursive approaches in being 'realist'. A representational view of language holds precedence so that terms such as 'psychopathology', mental 'illness' and 'schizophrenia' are assumed to 'represent' or denote actual distinct mental entities or states as things-in-themselves, which can be identified, measured, categorised and treated. As such, theory and research findings are taken to express 'facts' that have been 'discovered' about certain phenomena independent of ideology, values, context or interpretation, i.e. stand independent from processes of social construction. However following the 'turn to language' (Parker, 1992) in the social sciences and humanities, attention has been directed towards the discursive or textual underpinnings of mental life and their role in the study of psychopathology (see Parker et al. 1995; Rose, 1989; Shotter, 1993). A
constructionist informed intelligibility gives primacy to a view of language as constructive and constitutive of reality rather than merely as a representational medium (Burman & Parker, 1993; Gergen, 1994; Potter & Wetherell, 1987). 'Psychopathology' (however defined and categorised) and psychological knowledge are recast as social constructions rather than 'actual things' (McNamee & Gergen, 1992), which are linguistically negotiated via the socio-cultural meanings that are historically prevalent (see Gergen, 1985, 1994).

Burr (1995) notes that the idea of language being structured into a number of discourses has been taken up by a variety of writers (e.g. Foucault, 1972, 1976; Hollway, 1984; Parker, 1992) along with the notion that the meaning of a 'signifier' (for example, 'psychopathology') is dependent upon the context of the discourse in which it is used. This brings into focus the role of discourses in wider social processes since they make possible and credible particular ways of seeing and acting in the world. As such, the ways in which discourses are interwoven with institutional structures and practices highlights their role in the process of legitimation and the exercise of power. However, whilst a particular discourse may come to dominate or become the 'common sense' of the time, it is the nature of discourses that they are always being implicitly contested by other discourses. That is to say, alternative constructions or counter-discourses can and do emerge (Willig, 2001). Central to the current investigation is Foucault's (1979) view that power-knowledge and power-resistance are always operating together. In Curt's (1994) terms, "human science knowledge is not an ideologically neutral telling-it-how-it-is, rather, it is the use of knowledge to monger power - the power to construct particular versions of events". Billig et al's (1988) discursive approach is useful here as it stresses the 'dilemmatic' aspects of ideology and of thinking generally. Participants are seen to possess contrary linguistic repertoires (ideologically infused discourses) for talking about their professional worlds and practices. The oppositional nature of the themes allow participants to discuss, deliberate, conform, resist and argue over such issues as 'psychopathology', diagnostic categories and counselling psychology practice.
In addition to constructing objects, discourses also construct subjects. They make available positions within networks of meaning (e.g. professional communities of practice) that speakers can take up as well as resist. A subject position within discourse identifies 'a location for persons within the structure of rights and duties for those who use that repertoire' (Davies & Harre, 1990). The concept of 'positioning' is useful in the context of the present study, as it provides a useful way to characterise the shifting responsibilities and interactive involvements of members of a community of practice as it encompasses the emergence of the actor and an institutional order. Embedded within historically and ideologically constituted discourses participants' understandings of their communities of practice may have deterministic effects with regard to their actions and conduct. However, this is not absolute as the existence of quandaries and contradictory options in dynamic interactions enables the possibility of acting agentically when faced with particular dilemmas (Linehan & McCarthy, 2000).

The result of this constructionist approach is that the dilemmatic and rhetorical nature of accounts, along with issues of the 'good' and the 'real' and personal, professional (institutional) accountability and responsibility take centre stage. Analysis therefore attends to the discursive practices of particular participants, i.e. the situated and interested nature of discursive constructions and action orientation of talk, and also to the discursive resources, i.e. the wider cultural and institutional frameworks of meanings and practices, within which they are produced. This eclectic approach advocated by Wetherell (1998), pays attention to both micro and macro levels of analysis. Such a 'twin focus' has the potential to examine the interrelationship between the production of knowledge, the exercise of power and situated discursive practices - by considering how, and to what ends, 'psychopathology', diagnostic categories and counselling psychology practice are constructed by speakers in and through discourse. Furthermore, the construction and management of 'professional identity' becomes a site of great discursive interest, in that it highlights the dilemmatic nature of the relationship between 'psychopathology', diagnostic categories and counselling psychology practice. Such research seems timely given the ideological push towards professionalisation (House, 1999), current debates
within the discipline of counselling psychology regarding the use of diagnostic categories (see Strawbridge & James, 2001), and more general debates between traditional (realist) and constructionist conceptions of psychological science and the nature of 'psychopathology'. Thus, a discursive approach enters the fray by conjoining the professional and the political. By highlighting the textual and interested nature of psychological theory and practice, the 'objective' existence of modernist terms such as 'psychopathology' and 'schizophrenia' are challenged along with the taken for granted and potentially harmful (e.g. pathologising / normalising) aspects of their use. Problematising the modernist foundations underpinning counselling psychology's use of diagnostic categories moves us to reflexively ask questions regarding its relevance to society and its role in maintaining and / or challenging existing social-institutional structures and practices.

Method

Participants

Ethical approval was gained from the University of Surrey's Advisory Committee on Ethics before recruiting participants (see Appendix A). In order to allow for diversity within and across the accounts to emerge, data was collected through individual interviews with eight Chartered Counselling Psychologists. Four had recently qualified (within the past five years), whilst the other four had achieved chartered status via the 'grand-parenting' scheme. They had a range of clinical experience in private, primary, secondary, and tertiary settings and are identified by pseudonyms only.

Interviews

Interviews were conducted either in the participants' own home, at their place of work or within a University in the South of England. Each participant was given an information sheet and informed consent form that outlined the study and what their involvement
entailed (see Appendix B and C). In order not to overly constrain participants' accounts I followed a semi-structured format during the interviews covering three broad themes: 1) their personal / professional view or understanding of 'psychopathology', 2) counselling psychology practice and, 3) use of psychiatric diagnostic categories (see Appendix D for interview schedule). Open-ended questions were supplemented by reflections upon the content of their responses and requests for elaboration of points made. Potter and Wetherell (1987) have noted that interviewees' responses are shaped responsively by their expectations of the interview. This was present during the interviews as I appeared to be placed in a number of different positions, for example, as an interested student / colleague as participants were aware that I am a trainee counselling psychologist.

Method of Analysis

Each interview was audiotaped and transcribed (see Appendix F for a copy of a transcript) by the researcher using a basic version of the notation scheme proposed by Atkinson and Heritage (1984), (see Appendix E). The data was analysed largely following Potter and Wetherell's (1987) guidelines and adapted by Coyle (2000). Interviews were read line by line at least two times to identify and note recurring themes whilst attending to the questions "why is this particular utterance here?" "what are the possible functions of this particular utterance?" and "what discourses are being invoked in this utterance?" The coding procedure was a preliminary to analysis itself and entailed finding analytically interesting and relevant portions of text (Henwood & Pidgeon, 1992). These extracts were then coded in accordance to their relevance to a set of inclusive categories, i.e. 'psychopathology', counselling psychology practice and the use of diagnostic categories.

The analytic process involved a sustained engagement between the researcher and text, which entailed further reading and rereading of extracts in order to formulate hypotheses or interpretations. The analytic focus moved recursively between on the one hand, micro level discursive practices wherein attention was paid to the rhetorical functions, and
action orientation of talk, and on the other hand, a macro level consideration of the
discursive resources within which these discursive practices were produced.

The choice of material and resulting analysis reflects the theoretical commitments and
interests of the researcher. Given the social constructionist (non-realist) epistemology
underpinning this research, traditional criteria used to evaluate quantitative research (e.g.
validity and reliability) are inappropriate as it is openly acknowledged that the analyst
cannot stand independent of the text they are analysing. As such, no claim is made that
the analysis is 'objective' in the traditional sense. Letting go of the hand-rail of 'truth' and
external validation, the aim was to illuminate local and contingent 'truths' rather than
engaging in meta-theoretical 'truth games'. No claim is made other than to make a
particular 'reading' available, which is open to further interpretations or 're-writing'.
Nonetheless, the particular narrative or reading that has been constructed aims to forward
a purposeful interpretation of the texts. Interpretations have been linked to quotations;
therefore the reader is allowed to determine how persuasive, and well supported by the
texts, the analysis is and what the utility of its insights are (see Elliot et al. 1999 for
evolving guidelines).

Analysis

Discoursing Distress

Two opposing accounts / constructions predominated in participants' talk about
'psychopathology', diagnostic categories and counselling psychology practice. These
themes have been termed the 'empiricist' and 'contingent' repertoires respectively1. They
are understood as providing the 'conditions of discursivity' (Curt, 1994) or background
discourses that allow participants, within their professional communities, to sustain what

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1 Given that I distinguished in the data set strong and consistent resonance's of these repertoires that I had
encountered in my reading before starting the analysis (see Gilbert & Mulkay, 1984; Harper, 1994), it
seemed more sensible to invoke these terms rather than trying to produce new terms for the same discursive
phenomena with the aim of laying claim to spurious originality.
Wittgenstein (1953) called its "form of life". That is to say that traditional institutions, their discourses and practices invite particular ways of life and meaningful practices (for professionals and their clients), and discourage, silence or repel others.

With a twin focus the present study aims to take into account the availability of these interpretive repertoires within a particular cultural and professional formation - the discipline and practice of counselling psychology - alongside individual participants' local concerns and their realisation through discourse within a specific context. As a starting point, I have chosen to present several extracts in order to illustrate what appeared to be salient features of the repertoires. My aim is not to pit one against the other and attempt to determine which account is 'true or 'best' in any 'objective' sense (a modernist endeavour) but rather to reflect critically on the discursive systems (global and local) that participants are embedded within, along with the linguistic resources they utilise, in order to achieve certain ends, i.e. to 'make sense' and speak as 'rational' agents (psychologists).

**Empiricist Repertoire**

What is referred to in this paper as the 'empiricist repertoire' is used to signify modernist notions and assumptions regarding such basic issues as 'reality', 'knowledge', 'science', psychological 'disorders' and their 'cure', along with the principles of modern science implicit in contemporary psychology. It is often referred to synonymously as 'objectivism', 'positivism', 'naïve realism' or the 'received view' and provides the ground in which the empiricist repertoire is rooted.

Throughout the texts participants are seen implicitly and explicitly to make use of an empiricist discourse as they describe, explain and make attributions about the 'objects' they are orientating towards. This appears to serve many functions, the most salient of which being to construct a version of events wherein 'psychopathology' is granted ontological status as a 'thing' that 'exists' independently in the world. This particular
construction appears to be intimately bound up with legitimating the use of diagnostic categories.

P = Participant
R= Researcher

Extract One (Interview 3 - Diana)

112 P: I suppose you're looking for things that would (4) yeah (.) I haven't thought about this like this before but er (.) but that would (.) differentiate them from how anybody might react in a particular situation for instance or if they have (1) if they're thinking in ways that wouldn't be within what you'd think to be the normal range (.) so (.) you know (.) if they think that they (.) as I had a client (.) who before she saw me

118 R: [right]

119 P: when she had a psychotic depression and was (.) erm (.) in hospital (.)

120 R: [Mmm] [mm]

121 P: she believed that she had caused BSC (.) you know (.) now the

122 R: [right]

123 P: medical model is (.) probably very useful when it comes to dealing with somebody with that level of pathology that's so disabling (.) er (.) that is (.) well (.) that is so outside the norm (.) er (.) or people

126 R: [right]

127 P: who think they're Jesus Christ.

Extract Two (Interview 4 - Nathan)

30 P: She's a paranoid-schizophrenic (1.5) with CLEAR EVIDENCE of that (.) auditory and visual hallucinations (.) many-many symptoms (1)
Initially in the first extract (line 112) the construction of 'psychopathology' is offered cautiously ('I suppose') with an additional qualifier to minimise the extent of the claim ('I haven't thought about this like this before'). This can be seen as a form of 'stake inoculation' (Potter, 1996) and appears to perform important work in terms of managing stake, i.e. it functions to reduce personal accountability for any claims that follow. Potter (1996) notes that the empiricist repertoire is a standard device for constructing the 'out-there-ness' of a particular phenomenon. In both extracts, the 'reality' of 'psychopathology' is achieved by working up a construction that portrays it as something that exists independently as a thing-in-itself 'out there' in the world. This is partially achieved by using the metaphor of scientific discovery and visual, observational and legal terms, for example, "looking for things" (extract 1 line 112) and "CLEAR EVIDENCE" (extract 2 line 30). Crucially the use of this metaphor constructs a version of events whereby the discoverer (psychologist) is portrayed as merely revealing something that has been there all along. A notable feature of this type of accounting is that it constructs a logical (rational) argument: i.e. 'psychopathology' exists so therefore it can be dis-covered. The rhetorical pay off appears to be that the conclusion, i.e. presence of 'psychopathology', is warranted by the impersonal operation of logic, rather than the motivated inference of the speaker, thus providing a reassuring sense of 'objectivity' or rationality.

This sense of 'objectivity' is made intelligible through recourse to an empiricist discourse, which operates in dualistic terms by creating a clear separation between subject and object, or between the knower and the known. This duality is evident in the second extract, "She's a paranoid-schizophrenic" (line 30), which is bolstered by the specific use of a diagnostic category and associated professional vocabulary, for example, 'auditory and visual hallucinations', which gains added legitimacy through its grounding in medico-scientific frameworks of understanding. It is also evident in extract 1 when Diana says, "if they're thinking in ways that wouldn't be within what you'd think to be the normal range" (line 115-16) The implication that such a construction allows is that the speaker (psychologist) or the listener is positioned as the 'knower', an 'expert' who holds a privileged position in relation to the experiences of the client. Implicitly this makes it
possible for clients to be positioned as 'passive objects' whose behaviour and thinking can be 'observed' and thus classified.

By constructing their claims in a logical fashion, weight is added to the notion that speakers are merely observing and reflecting upon an 'object' (psychopathology) that has a pre-existing character. The implication of this discursive form is that an atmosphere is created that allows speakers to account for and legitimate the diagnostic venture (and use of diagnostic categories) as a logical process of 'objectively' discovering the 'facts' of 'psychopathology'. In the present accounts, the 'facts' of 'psychopathology' come in the form of 'evidence', which is constituted by the identification of 'symptoms'. In the first extract, such 'evidence' takes the shape of behavioural reactions and particular forms of thinking that are either present or absent and which differentiate the client from 'normal' thinking and behaviour (lines 114-16). Initially, however, what the 'norm' is and exactly what kinds of behaviours or forms of thinking that constitute such deviation from this 'norm' are not specified. Such non-specificity is also evident in the second extract. Though a categorical description (paranoid schizophrenia) is provided mentioning particular symptoms, i.e. auditory and visual hallucinations, the emphasis and stress is placed on there being "CLEAR EVIDENCE" and "many-many symptoms" (lines 30-31). Rather than providing detailed descriptions that situate behaviour and experience in their biographical and social contexts, it seems that vague global formulations are preferred. A possible function of this type of construction is that it erects a rhetorical barrier making the 'obviousness' of its claims difficult to challenge or undermine by providing just enough information to infer the presence of 'psychopathology. Another rhetorical device is used in the first extract that serves to further externalise the 'out-there-ness' of 'psychopathology'. The description of a client who thought she had caused BSC or people who think they are Jesus Christ (extract 1 lines 117-27) functions to make the report more effective by drawing on extremes of relevant dimensions of judgement with regard to non-normative activities. As an example of what Edwards and Potter (1992) refer to as 'extreme case formulations', it appears to achieve the rhetorical effect of rendering 'self-
evident' the 'objective' presence of 'psychopathology', thus increasing the 'facticity' of the account.

The features of an empiricist discourse highlighted in extracts one and two were common throughout the texts. For example, "you're the one with (.) the experience and knowledge (.) the expertise (.) you know (.) to make offers of treatment" (Annabel Interview 6: lines 43-5.), Kate in relation to 'anorexia', "you can see it (.) no doubt about it"( Interview 8: line 145), "I try to seek understanding in observable behaviour" (Nathan, Interview 4: lines 360-1),"you get people (.) a lot of clinically depressed patients in primary care" (Sue Interview 7: lines 303-4), "someone presenting with a clear panic disorder" (Janine Interview 5: line 412).

Contingent Repertoire

Though the empiricist repertoire appeared to be central to participants' accounts they also drew upon a contingent repertoire during the interviews. I am using the contingent repertoire to denote the conditional and interested nature of specific accounting practices. Whereas the empiricist repertoire appeared to provide a means of talking about 'psychopathology' and diagnostic categories at a more impersonal, theoretical and 'objective' level, the contingent repertoire constructed the use of diagnostic categories as a less than straightforward endeavour that was influenced and shaped by a number of factors, for example, "client understanding and desired outcome" (Diana, Interview 3: lines 379-80), "personality factors" (Nick, Interview 2: line 159), "individual experiences" (Charlotte, Interview 1: line 336), "training" (Sue, Interview 7: line 251), "therapeutic orientation" (Janine, Interview 5: line 254), and "philosophical viewpoint" (Nathan, Interview 4: lines 83-4). As is evident, rather than having access to or only using an empiricist or contingent repertoire, both repertoires frequently occurred within accounts from the same participants. Nonetheless, a dominant feature that came up repeatedly throughout the interviews was that the contingent repertoire appeared to act in contrast to the empiricist account.
Extract 3 (Interview 2 -Nick)

P: You know in the context of where I work now (1.5) you know (.) the
diagnosis of schizophrenia is not helpful because I can get a client or I
can go to assess a client and I (.) now his diagnosis is paranoid-
schizophrenia (1) but I have (.) you know (.) the diagnostic (.) erm (.)
criteria for that is so broad and so meaningless that it (.) it is meaningless
because I have no idea what to expect (.) it could be someone who's very
disturbed and very unwell and very unable to communicate yet it could
be someone who (1) has no problem communicating their symptoms (.)

R: [right]

P: yet (.) you know still had auditory hallucinations and can be quite flat
but coping okay. I think it depends (.) you know some criteria or some
labels are quite useful some really aren't=

R: =right

P: so I guess I take it with a pinch of salt really (.) so at the end of the
day it's what it means to the client (.) it's what concerns the clients (.)
erm (.) what they're expressing or able to express which I find most
important rather (.) that I go on (.) rather than whatever diagnosis they've
received.

R: When you say (.) "that you go on" (.) you mean?

P: That informs my formulation or informs (.) you know (.) whatever
therapeutic rationale that I'll try and consider (1) and I won't say (.) you
know (.) if I'm referred a client and it says "this person (.) has a diagnosis
of borderline personality disorder" (.) I wouldn't read that and think "oh
right so I'm going to do..." you know-you know (.) "evidence based
practice with this client is DBT [dialectical behaviour therapy] or
schema-focused therapy" (.) rather I'll wait until I see the person (.) let's
see what they come with (.) you know (.) they might (.) they could
describe symptoms that are consistent with anxiety or depression which I’m thinking (.) you know (.) formulate in a different way.

As has been noted, the empiricist repertoire functions as a reifying discourse turning something abstract ('psychopathology') into a thing. One way in which this particular construction was put to use was to portray the psychologist as having 'objective' knowledge about 'psychopathology' independent from context or any form of interpretation. In the above extract, we find that the speaker forwards a more personal and interested account wherein the 'reality' of 'psychopathology' and the utility of diagnostic categories are constructed as contentious issues contingent upon a number of factors. This alternate and contrasting version of events emphasises the local and particular over universal categorisations, and works potentially to subvert or problematise the empiricist account. Given that speakers actively gain certain rights and privileges (category entitlements) through use of an empiricist repertoire that constructs the psychologist as being in some way 'scientific' and 'objective, any break away from this position poses a dilemma for the speaker in terms of how they manage their own interest and stake, i.e. their culturally sanctioned position as 'professional helper'.

From the start of this extract Nick appears to be building an alternative account (situating psychotherapeutic practice) that contrasts with an empiricist one, whilst carefully managing his own stake or interest. In the opening sequence he starts by orientating to a specific context, i.e. his current place of work, which is followed by the claim that a diagnosis of schizophrenia is not helpful in this context (lines 248-9). This is not presented as a stand-alone statement; rather it is something that requires justification. Interestingly, even whilst working up an alternative contingent account, he still makes flexible use of empiricist forms of reporting. For example, he accounts for the claim that the diagnosis of schizophrenia is not helpful by presenting the reasons in the form of a list, i.e. 1) the speaker does not know what to expect because the criteria are so broad they are meaningless, II) the client may be disturbed and unable to communicate their symptoms, III) the client may be coping and able to communicate their symptoms (lines
251-56). The list works to indicate that these are more than individual instances on their own, but instances standing for a more general state of affairs. By appealing to the generality of the situation, this particular presentation helps to work up the veracity of the account, which makes it more difficult to challenge on the grounds that it is a one off situation or just his personal view.

Significant use is made of 'context', which appears to be central to the account and serves several different functions. For example, 'you know in the context of where I work now' (line 248), can be seen to act potentially as an inoculation or disclaimer against challenges or counter claims that he is not doing his job responsibly. This is achieved by developing the account in the narrative of a role player, which positions the speaker as being pushed and pulled by the exigencies of context. For example, line 249 Nick says, 'I can get a client' and later in line 253 'I have no idea what to expect', which works to manage the accountability of his actions. Additionally, it characterises what follows, i.e. the speaker's interaction with clients and his stance towards and use of diagnostic categories to inform psychotherapeutic practice, as happening routinely - is 'normal' - in this particular setting.

As the account develops, the initial claim, i.e. that the diagnosis of schizophrenia is not helpful (lines 248-9) is followed by an additional claim, 'I think it depends (.) you know some criteria or some labels are quite useful some really aren't...' (lines 258-9). This possibly functions to deflect attention away from the initial claim, which could be undermined on the grounds that it is just his personal view. Further rhetorical work helps to neutralise the initial claim further: '...I take it with a pinch of salt really (.) so at the end of the day it's what it means to the client...' (lines 261-2). The implication of this construction is that the speaker is positioned as being somewhat ambivalent towards the possibility of achieving any fixed or 'objective' truths regarding 'psychopathology' and the utility of diagnostic categories. This subtly redirects the conversational focus towards the speaker's actual concerned involvement and interaction with clients and helps to work up and legitimate a contrasting account where the diagnostic venture and the utility of
diagnostic categories only 'make sense' in relation to a context of usage. As such, 'understanding' can be interpreted as being discursively linked to action and conduct. This is partly achieved by foregrounding the personal and involved position of the psychologist and the dynamic interplay with clients. For example, "...it's what it means to the client (...) it's what concerns the client (...) erm (...) what they're expressing or able to express which I find most important rather that I go on (...) rather than whatever diagnosis they've received" (lines 262-65). Additionally, there is significant use of personal pronouns where Nick refers to himself as 'I' to index the various actions he performs. For example, 'I work' (line 248), 'I think' (line 258), 'I find' (line 263), and 'I'll try', (line 268). A vital way that Nick warrants his actions, making them appear reasonable and justifiable, is by presenting different kinds of self, appropriately. As the speaker accounts for how his own personal understanding and stance inform his actual practice, he presents himself as considerate, thoughtful, reflective, open-minded, and acting tentatively with the client's best interests in mind. This positioning is achieved by accounting for how he would work with somebody who had received a diagnosis of borderline personality disorder. Referring to this diagnosis, use is made of reported speech, e.g. "oh right so I'm going to do ..." (...) you know-you know (...) "evidence based practice with this client is DBT [dialectical behaviour therapy] or schema focused therapy"...(lines 270-73). Even though this is presented hypothetically, it nonetheless indicates to the listener or reader that this report is in some way typical of 'standard' psychotherapeutic practice. In it the psychologist is portrayed implicitly as a detached impassionate empirical being who goes about 'objectively' applying the appropriate psychological intervention according to the 'evidence' or specific diagnosis with little or no regard for the person. As such, any interaction is downplayed and the psychologist's interestedness is heavily obscured. This construction allows the speaker to position himself as being, and acting, in opposition to this. For example, '...rather I'll wait until I see the person (...) let's see what they come with (...) they might...' (lines 273-74). The implication of this is that the psychologist is positioned favourably as aiming to work collaboratively with the client rather than acting upon them. In contrast to the empiricist account, this particular construction casts the
categorisation of behaviour and experience as being contingent upon an interaction between the therapist and client.

*Dilemmatic Dances*

So far it has been highlighted that participants possess contrary, i.e. empiricist and contingent, linguistic repertoires. The persistently oppositional nature of the views forwarded were often explicitly presented as being problematical or as positioning the speaker in a dilemma, for example, 'that's where the problems start' (Charlotte Interview 1: line 29), 'so you know the-friction or tension between psychology and psychiatry' (Nick Interview 2: line 105), 'so you're automatically in a funny position' (Diana Interview 3: line 647), 'it was a huge dilemma' (Janine Interview 5: line 195), 'there are radically opposing philosophical views' (Sue Interview 7: line 390) and only make sense against a background of historical, cultural, institutional and ideological assumptions about the nature of reality and knowledge. The analysis proceeds by focusing specifically on the dilemmatic nature of participants' accounts as they orientate to the issues of psychopathology, diagnostic categories and counselling psychology practice. There were several pervasive themes evident across the texts relating to the dilemmatic aspects of ideology (Billig et al. 1988). They centred upon tensions between the notions of authority and equality, theory and practice and between categorisation and particularisation. Due to space limitation, the analysis will focus on the tension between authority and equality.

In the following extract, as Charlotte orientates to the use of diagnostic categories we find ambivalence between authoritarian expertise one the one hand and democratic egalitarianism on the other, as she manages her identity as a counselling psychologist.
P: I mean not in the sense that I think that diagnostic categories are absolutely necessary and that's what we should use and that's how (...) we should think (...) you know (...) how we should formulate client problems or whatever but (...) in terms of the necessity of (1.5) erm not necessarily the necessity but (...) yeah in terms of the necessity me to have an understanding of the DSM (...) and be able to use it (...) and be able to you know speak this language (2) but this doesn't necessarily (...) affect me (...) my practice when I am with a client on a one to one basis

I: right

P: I wouldn't you know call anybody borderline or something or I wouldn't you know do you see what I mean?

I: Yeah I'm trying to sort of (...) it seems as though there are different levels to it in a way you're saying that it's different in your clinical work

P: [yeah] [yeah] [hmm]

I: so I was just wondering can you maybe expand on what those differences are or possibly how come that it's like that?

P: Well erm say for example I have this client who has been diagnosed as borderline personality and she has a severe personality problem erm the way I would speak with other professionals is going to be different than when I'm with her you know (...) I'm not going to perhaps say to her (...) you have borderline or given your borderline personality disorder this is what is best for you I would probably say something to her like

R: [Mmm]

P: (...) you know we're here together to think together what your needs are (...) and you know how can we best (...) erm help you.

R: Right (1) so okay so the right okay yeah

P: and perhaps I might have in mind what might be helpful or best for her but I won't necessarily (...) I will not say to her well I think because
Within a cultural context imbued with liberalist and democratic norms, the position of counselling psychologist, i.e. an authority or 'expert' in the psychological domain, is constructed as being less than straightforward. They are the constituted authority with greater 'power' than the client due to 'expertise' and knowledge gained through professional training. However, despite this cultural and institutional positioning, a pervasive feature throughout the texts was the presence of democratic and egalitarian motivations within participants' constructions of counselling psychology practice that seemed to indicate an embarrassment with 'power' and the position of expert authority. One dilemma that appeared charged with ambivalence evolved around the speakers' discursive use and management of an empiricist repertoire on the one hand, i.e. the category entitlements afforded by the pathology-focused yet culturally-sanctioned position of 'expert' who is supposed to be able, scientifically and 'objectively', to identify, categorise and treat 'psychopathology', and on the other hand, a position that values liberalist notions of equality and respect for the individual meaning of clients' distress, emphasising the local and contingent nature of understanding created in the therapeutic encounter (contingent repertoire). As such, speakers expended considerable discursive energy in order to maintain their status as an authority in a liberal or anti-authoritarian fashion.

In extract 4, the speaker manages the conflicting values and dilemmatic aspects of authority and equality in a number of ways, achieving particular effects as she attends to the issues of psychopathology and diagnostic categories in counselling psychology practice.
The sequence starts with Charlotte distancing herself from the authoritarian view of diagnostic categories that is embedded within an empiricist repertoire. Her narrative essentially functions at an implicit level to challenge the 'correctness' of the dominant view that diagnostic categories provide the 'appropriate' (scientific and objective) or only means for understanding 'psychopathology' from which treatment can proceed. Initially this claim is personalised through the use of personal pronouns, for example, 'I mean not in the sense that I think that diagnostic categories are absolutely necessary' (lines 368-9), which works to position the speaker in opposition to this view. What immediately follows - 'and that's how we (. ) we should think (. ) you know (. ) how we should formulate client problems or whatever' (lines 369 - 71) - makes the inference available that this is precisely what the view she is opposing advocates. However, possibly in order to manage her institutional accountability, it is done without explicitly stating this and is therefore deniable. The use of 'we' possibly functions to further manage the accountability of the speaker's views by providing a line of insulation against rebuttals or the criticism that solely personal interests motivate the account. A further rhetorical device is deployed in managing the dilemma of stake. The use of 'or whatever' (line 371) works to achieve a 'disinterested' account of interest by mobilising indifference precisely at the point where it could become an issue or be called into question.

As the account develops, the speaker shows some hesitation and ambivalence before positioning herself as being held to account institutionally. For example, 'in terms of the necessity of (1.5) erm not necessarily the necessity but (. ) yeah in terms of the necessity' (lines 371-2) constructs the speaker as having no 'real' choice in the matter. The speaker thus positions herself at the professional and institutional level as being required or obligated to work within a particular professional framework of understanding and associated vocabulary. Though this is presented as a concrete reality, the speaker nonetheless partially resists this forced positioning by constructing her own therapeutic practice with clients on a one-to-one basis as not necessarily being affected (line 374-5). One possible conclusion that can be drawn from this construction is that the speaker's ambivalence indicates an awareness of the politicised nature of her work and the dilemma
of her position as a counselling psychologist - a liberal expert who simultaneously accepts and rejects authority.

This dilemma highlights that the speaker is positioned within an already constituted discourse (empiricist) and institutional framework of understanding, that makes possible and privileges certain practices. However, in spite of this, the speaker is able to construct a sense of choice and agency within this particular (and dominant) discourse. A contrast is constructed that is dependent on the addressee, i.e. between talk with other experts (professionals) and with non-experts (clients), that allows the speaker to position herself as an agent who selectively uses the technical vocabulary and diagnostic language grounded in the expertise of professional authority (empiricist repertoire) depending on its context of usage. For example, referring to a client diagnosed with borderline personality disorder she states, 'the way I would speak with other professionals is going to be different than when I'm with her' (line 386-7).

Talking about therapeutic practice provides the speaker with a context for rejecting an authoritative expert position in favour of a more egalitarian one. Two resources in particular are employed by the speaker to construct a position of equality. Firstly, in lines 387-9, '... (. ) I'm not going to perhaps say to her (. ) you have borderline personality or given your borderline personality disorder this is what is best for you...' infers that this is what an expert authority would do and thus enables the speaker to work up the difference between this position and their own. Secondly, there is significant use of democratic semantics, i.e. 'we' statements. For example, '...you know we're here to think together what your needs are (. ) and you know how can we best (. ) erm help you. (line 391-2). The discursive form is one of polite invitation rather than imperious command. The ethos is one that expresses democratic aspirations and utilises the language of free and equal exchange. This works to construct the therapeutic encounter within counselling psychology practice as a joint venture wherein 'we' (counselling psychologist and client) discover and create meaning together rather than 'I' (the expert) tell 'you' (the client) the 'objective' facts. This construction allows the speaker implicitly to resist the
authoritarianism of their expert position, thereby re-positioning their self in a softer more egalitarian light. However, this position appears to be charged with ambivalence, as authority has not been totally abandoned. The speaker still contains the therapeutic maps e.g. 'I might have in mind what might be helpful or best for her' (lines 394-5) and therefore directs the client, but does so without appearing overly directive, which is achieved by using tentative words like 'perhaps' and 'might'. Wetherell, Striven and Potter (1987) have termed this particular pattern of discourse and behaviour as 'unequal egalitarianism' or a 'non-authoritarian authoritarianism'.

Overview

The analysis has suggested that the constructions offered by these Chartered Counselling Psychologists were achieved through a number of discursive practices and were situated within empiricist and contingent repertoires. Depending on the discursive context in which they were evoked, the identified repertoires appeared to work in conjunction with and in contrast to one another and functioned to construct particular versions of events. In the first section of the analysis, the empiricist repertoire was seen to act as a powerful linguistic resource that enabled speakers to perform attributional actions, i.e. the attribution of 'psychopathology' through use of an ostensibly dis-interested and descriptive discourse. At the micro level, the various strategies employed served particular rhetorical functions, such as, the managing of stake or interest, creating a sense of 'objectivity' by making accounts to appear factual, and the dynamic positioning of self and others.

More broadly, at the institutional level, it seemed to provide the discursive conditions from which the diagnostic venture (application of diagnostic categories) could be legitimated as a process of 'objectively' dis-covering the 'facts' of 'psychopathology' independent of ideology, values or context. The pervasiveness of this repertoire and its effects can be interpreted as serving a socio-political function as certain 'non-normative' activities are brought into an arena requiring professional 'expert' interest. The accounts
offered can be viewed as asserting professional legitimacy, as credence was given to the notion that the work of counselling psychologists was in some way 'objective', 'scientific' and thus worthy of its culturally sanctioned status.

Contrastingly, a contingent repertoire was used to emphasise the situated nature of therapeutic practice and use of diagnostic categories. Standing in opposition to the empiricist repertoire, which produced a version of events wherein the 'true' nature of people's distress could be determined, the contingent repertoire functioned to reinsert both the therapist and client as active agents (not objects) back into the discussion. What appears to be a monologue of reason about mental illness in the empiricist repertoire is transformed into a dialogue between mental illness and human experience in the contingent account.

In order to consider the conflict and tension evident between the two repertoires and the issues participants were orientating towards, the second part of the analysis examined the dilemmatic nature of the accounts, which was most evident in relation to the management of professional identity. A notable finding was that the process of constructing and negotiating identity was riddled with conflict (e.g. between the positions of authority and equality), as speakers claimed or resisted the images available to them through the opposing repertoires. A central feature of the accounts was that speakers constructed themselves as conforming to institutional requirements (e.g. the use of diagnostic categories) whilst simultaneously resisting dominant institutional storylines through agentive positionings in practice. As Linehan and McCarthy (2000) have noted, 'we define ourselves with respect to communities of practice and that 'identity' is constructed through the negotiation of meanings of our experience of membership in communities' (p.438). As such, participants' talk about professional 'practices' (both discursive and material) was seen to only make sense against a background of ideological assumptions. The historically constituted social and institutional structures (e.g. National Health Service, British Psychological Society, judicial, economic etc) thus contextualised the ways participants accounted for their understanding of 'psychopathology', diagnostic
categories, counselling psychology practice and dealt with dilemmatic quandaries arising from these particular conditions. Participants' talk demonstrated a reflexive awareness of being embedded within institutional storylines, a moral order and local contexts, for example, working within (and therefore being held to account) in a range of medical contexts (NHS settings) that afforded certain rights, responsibilities, duties and obligations. It was in between such macro and micro contexts that particular dilemmas were played out. For example, in extract four, if the speaker was too democratic, then their position, institutional authority and potentially their job as culturally sanctioned 'expert' becomes untenable or endangered, whereas with too much technical expertise the equality (and quality) of the therapeutic relationship becomes threatened. Rather than invalidating their accounts, the inconsistencies resulting from speakers being positioned in dilemmatic ways can be viewed as the 'nodes' of tension that enable the construction of creative and flexible accounts (Billig, 1988).

What this study has perhaps most saliently illustrated, is that participants actively use a variety of discursive practices embedded within historically and culturally available interpretive repertoires, in order to actively constitute notions of 'psychopathology', diagnostic categories and counselling psychology practice, and do so to achieve particular effects. This discursive view is a substantial departure from traditional conceptualisations and 'cognitivist' approaches to such notions as 'psychopathology'. The difference lies in the fact that discourse analysis has no need to posit the existence of mental entities or operations residing within the individual. As such, one advantage over more traditional 'cognitive' approaches to researching psychological phenomena is that it allows such phenomena to remain as discursive events and does not treat them as reports of underlying cognitive states or events. It follows that words are always far more than merely 'labels for objective things' (Riikonen & Smith, 1997).

In relation to counselling psychology, the current findings indicate that there may be a gap between the 'ideal' and the 'real', i.e. between theory and situated practice. The principles and values as expressed in counselling psychology theory, such as, a
phenomenological and humanistic value base, a reaction against the medical model of professional-client relationships and an emphasis on well-being rather than pathology (Woolfe, 1996), stand in opposition to the discourses (empiricist, bio-medical) prevalent in the applied contexts counselling psychologists find themselves working in. Given that current practices are culturally sanctioned and increasingly reinforced by an ideological framework of professionalisation (scientific 'treatment' mentality, evidence based practice etc) creates ongoing dilemmas for individual practitioners at a local level and more general dilemmas for the status, identity and development of the discipline.

If counselling psychology is to be a cultural enterprise reflexively questioning its relevance to society and its role in maintaining and / or challenging existing social structures and oppressive (pathologising / normalising) practices, as well as being a psychological activity, as Strawbridge and Woolfe (1996) contend, then it may be worthwhile for counselling psychologists to take a critical and deconstructive posture towards their theories and practices. Given these observations, the discursive register and range of possible positions and options available to practitioners may be expanded if future research continues to situate the theories and practices of counselling psychologists in their historical and political contexts. Such a focus may allow for power relations intrinsic to the therapeutic venture as a modern ideological and strategic discourse to be attended to.
Use of Self

I find the topic of mental illness inescapably personal. In attempting to understand and make sense of my own embodied experiences I have found myself asking the question, "am I normal or abnormal?" As a teenager somebody I was close to was categorised as being mentally ill. This was a frightening experience that gave me first hand experience of some of the negative, pathologising and dehumanising effects of defining somebody as 'mentally ill'. The diagnostic category that was applied did not help me to understand their experience and seemed to create distance between us making relating to each other more difficult. These factors meant that for a long time I had lots of questions and no framework or way to understand and make sense of my own or others experiences. My decision to study counselling psychology was partly in response to these experiences. Perhaps naively I thought that it could provide the 'ultimate' answers. However, I quickly found both in theory and practice that it raised further questions. Early on in my training I was introduced to social constructionist and postmodernism dialogues. The inquisitive and critical postures appealed to me and seemed to ask different questions in relation to mental illness. In my own personal and professional development this has helped me to move in, around and through some of the dilemmas and contradictory options that I continually find myself facing both at a theoretical level and in my situated and embodied personal / professional practices. My decision to study 'psychopathology', diagnostic categories and counselling psychology practice reflects an intertwining of professional and personal interests and my own sense of personal, moral, professional and ethical responsibility to continually reflect, question and challenge my own position and practices as a trainee counselling psychologist. It is my belief that whether my experiences and interests are similar and provide echoes for other practitioners or are radically different to them, that we nonetheless mutually define ourselves through each other. In this respect it was my hope that this research could make a contribution to an area that is at the heart of the field by stimulating further conversations amongst its practitioners.
I found the interview process challenging. Perhaps what was most difficult was trying not privilege one version of events over another. On the one hand, I felt part of the interview and what was being generated, but on the other hand I felt constrained or uncertain about my role as a facilitator. I wasn’t prepared for the way that I would be positioned in the interviews and how that would constrain my own responses and interactions. This centred on the fact that the participants knew I was a trainee counselling psychologist. Furthermore, some of the participants had graduated from the course where I am training or had some involvement in a professional capacity with the course. A great deal seemed to be being taken for granted during the interviews. Given that personally, this was exactly what I wanted to question, might have impinged on my ability to interview with a view to generating data in relation to my research questions. At times it seemed as though it was being implied that "we are the same so you must know what I mean". This led to the feeling that I was colluding with their particular ‘take’ on the areas under discussion and that I couldn’t challenge or question their views in any depth because of my 'trainee' status. As such, I found myself deferring to their authority (chartered status) and how they saw the areas under discussion and the nature of the research project. I also had the sense that participants' felt that there was a definite agenda and were trying to provide responses to fit with what they thought I wanted. Though in hindsight these factors were providing rich analytic material, it was difficult to see this and get a critical purchase on the events because I was also part of them. Additionally, given the complexity of the areas under investigation and the difficulty I had experienced in trying to maintain a tightly defined research question (it seemed to change all the time) meant it was difficult to feel in control of the interviews or to keep to the interview schedule.

Doing the analysis whilst trying to meet additional clinical, academic requirements and also attend to life events and personal circumstances, meant that at times it was a difficult and lonely process. Though I have a long standing interest in discourse analysis this was the first time that I had attempted to conduct an analysis in any detail. Connecting my general understandings of the constructive nature of language to particular instances of talk was not easy. Learning through the doing was quite different to my previous
conceptual understanding of discourse analysis. It seemed that a paragraph, a sentence or even a single word, were open to multiple interpretations. I often found myself spending several hours just looking at one piece of data and becoming very confused as to how to related to my research questions. It was difficult to make decisions and trust my own interpretations. Measuring my own efforts against the sophistication of analytic work I had read frequently led to a feeling of paralysis and not knowing how to move forward with my own work. Also the richness and volume of data, combined with a desire to include everything, meant that I experienced difficulty in knowing what to include. This was especially difficult when I had spent so long transcribing and trawling through the data - I didn’t want to let anything go! I also felt that the complexity and my own struggle and sense of confusion in relation to the areas under investigation led me to feel that my views or understandings were in some way unqualified or not clearly enough defined for the purposes of a research report.
References


Dear Mr Craven,

**Psycho-diagnostic categories, psychopathology and counselling psychology: A discourse analytic study of counselling psychologists' talk (ACE/2001/102/Psych)**

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at [http://www.surrey.ac.uk/Surrey/ACE/](http://www.surrey.ac.uk/Surrey/ACE/).

This letter of approval relates only to the study specified in your research protocol (ACE/2001/102/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 18 February 2002
Date of expiry of approval by the Advisory Committee on Ethics: 17 February 2007

Please inform me when the research has been completed.

Yours sincerely,

Catherine Ashbee (Mm)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr A Coyle, Supervisor, Dept of Psychology
APPENDIX B

Participant Information Sheet

I am currently undertaking a three year Doctoral training in Psychotherapeutic and Counselling Psychology at the University of Surrey. During my training I have developed an interest in the disciplines relationship with psychopathology, i.e. how it views and works with psychological distress / disorder. In particular I am interested in the prevalent use of DSM psychiatric categories as the primary means of categorising mental disorders.

As a chartered counselling psychologist you may have found yourself working with diagnostic categories of psychopathology or opposing their use. In the research element of my training I have decided to explore chartered counselling psychologists' personal and professional views about the use of diagnostic categories in counselling psychology practice. As this is currently a prominent area of debate being addressed within the discipline I feel that this is a valuable area for research and would therefore be grateful if you would consider taking part in this study.

Participation would involve taking part in an interview with myself lasting approximately one hour. During the interview I will be introducing topics related to counselling psychology practice and the use of diagnostic categories of psychopathology. The interview will be audio taped and later transcribed by myself. Confidentiality will be respected in accordance with the Data Protection Act 1998. Your name and any identifying information will not appear on the transcript and the audio tape recording will be destroyed. Some of your responses may be reproduced in the final study but at no time will your name or organisation be identifiable. You retain the right to withdraw from the study at any point without having to give a reason.

Please do not hesitate to contact me if you would like further information. I can be contacted by telephone (01483 879176 or 07786 298 945) or in writing. The address is Department of Psychology, University of Surrey, Guildford GU2 7XH.
Thank you

Mark Craven
APPENDIX C

Consent Form for Participants

I am a trainee Counselling Psychologist who would like to do some research into Chartered Counselling Psychologists' views on the use psycho-diagnostic categories in Counselling Psychology practice. I have written an information sheet to explain it in more detail. If, once you have read the information sheet, you would like to be involved please sign this form and return it to me in the stamped addressed envelope.

If you have any questions please 'phone me (Mark Craven) on 01483 879176 or 07786 298 945. Alternatively, you can write to me at the Department of Psychology, School of Human Sciences, University of Surrey, Guildford, GU2 7XH.

If you do agree to be involved in the research and then change your mind you can withdraw from the study, despite signing the consent form, at any time without having to give a reason. There are no penalties if you decide to withdraw from the study.

Please read the following paragraph, if you are in agreement, sign where indicated

I agree that the purposes of this research and what my participation in it would entail have been clearly explained to me in a manner that I understand. I therefore consent to participate in an audio taped interview regarding the use of psycho-diagnostic categories in Counselling Psychology practice. I also consent to all parts of the recording being transcribed for the purpose of research.

NAME OF VOLUNTEER (PLEASE PRINT): ..........................................................

SIGNATURE: ...........................................................................................................

DATE: .....................................................
NAME OF WITNESS (PLEASE PRINT): .............................................

SIGNATURE: ...........................................................................

DATE: ...................................................................................
APPENDIX D
Interview Schedule

(Introduce self and basic outline of study to participants and ensure have gained informed written consent)

My research is concerned with Chartered Counselling Psychologists' views (both professional and personal) of the use of diagnostic categories of psychopathology in counselling psychology practise. I am interested in giving you the opportunity to talk about and express your views and experiences of the practice of counselling psychology in relation to the notion of psychopathology and the use / non-use of diagnostic categories.

If you have any questions at any time during the interview, please do not hesitate to ask.

(Turn on tape)

Constructions of Psychopathology

The notion of mental illness or psychopathology continues to receive widespread attention and generate debate within the discipline of psychology. I would like to start by exploring what your own view of 'psychopathology' is.

- How do you personally define or understand the notion of psychopathology / mental illness?
  (Follow up - what ideas / issues come to mind?)

- What factor and experiences do you consider to have been formative in the development of your view?
- (Follow up - how have these factors shaped your views?)
Counselling Psychology Practice

The field of counselling psychology is still a relatively new branch of applied psychology. There is continued development in terms of the identity and practices of the profession and individual counselling psychologists who are encouraged to develop their own distinctive philosophy and approach to practice. I am interested in your own understandings, views and experiences of counselling psychology practice.

- Can you tell me what comes to mind when you think about counselling psychology?

- There are different opinions regarding counselling psychology's view of psychopathology. What are your views in relation to this?

Diagnostic Categories of Psychopathology

Counselling psychologists utilise various methods of assessment in order to inform their work with clients. One method available is to use diagnostic categories to classify mental disorders.

- There are a variety of different views or stances towards the use of diagnostic categories within counselling psychology practice. Can you tell me what your own views are?

- When practising as a counselling psychologist in what ways, if at all, are diagnostic categories of psychopathology useful in understanding and helping clients. Can you give any examples?
That is all the questions that I would like to ask

- Is there anything else on the subject that you would like to talk about which I have not covered?
- How did you feel talking about this subject?

(Prompts to use throughout the interview to help encourage participants to explore their responses further)

Could you say more about that?
Can you give me an example of that? What you mean? How do you feel about that?
Why do you think that?
What makes you say that?
How useful do you find that?
APPENDIX E

Transcription Notation

The form of notation used is based in the system developed by Jefferson (1985), a complete description of which can be found in Atkinson and Heritage (1984). Some of the basic features are outlined.

1. Square brackets mark an overlap between utterances. - [ 

2. An equals sign at the end of one speakers turn and at the start of another's indicates no discernable pause - =

3. A full stop in brackets indicates within a speakers utterance - (.)

4. Underlining indicates those words are said with particular emphasis, whilst words in UPPER case characters were said louder than the surrounding speech.

5. Empty square brackets [ ] indicate that some of the transcript has been omitted.

6. Round brackets ( ) indicate that the speech they contain was inaudible or doubt regarding its accuracy.

7. Italicised material refers to contextual information.
APPENDIX F

Transcription of Third Research Interview

R = researcher
P = participant

R: okay (.) erm to start off with the notion of mental illness or psychopathology receives widespread attention and generates debate within the discipline of psychology as a whole (. ) I'd like to start by exploring what your own view of psychopathology is?

P: (2) hmm erm I suppose if you say the word psychopathology then I do start thinking of the diagnostic categories because the word psychopathology to me implies the medical model and gets me

R: u-huh

P: into that area

R: yeah

P: of my thinking er I suppose my practice is grounded in the humanistic approach and therefore I try and face each individual without thinking oh they are a "depressive" or they are a blardy blah

R: yeah

P: just meet them as a person and er see what (. ) try and get an insider perspective of what their experience is

R: yeah

P: er so I suppose I (. ) would have an awareness of the diagnostic categories (. ) existing particularly because I located in a community mental health team

R: yeah

P: which tends to be dominated by the medical model but I would try and bracket those

R: right

P: when I see the clients I'm just meeting them as an individual
R: sure

P: erm (1) and I suppose (.) talking a lot (.) but I suppose in thinking about the
humanistic approach to things and (1) and linking it into erm what Spinelli and existential
(.) later existential framework said (.) was that (.) really in therapy (.) I think it was
Spinelli (.) I'm not sure (.) in therapy erm two people are meeting both with difficulties in
living in the hope that the therapist has slightly less difficulties that the client and that the
focus will be on the client's not the therapists

R: sure yeah

P: so it's about reducing that distance that's there in the medical model about somebody
as an expert

R: right

P: and somebody as not an expert that you're going to give a treatment to (.) so though I
have the medical model bracketed up there

R: right

P: I try and keep it bracketed except when I need it for certain things if you see what I
mean? I relate to it but I try and be in the room not as this expert as a person to work co-
collaboratively with the client.

R: Right so it sounds from what you've just said there that there's something very distinct
or very different I suppose in terms of how you approach psychopathology if you're
coming at it from the medical slant (.) which seems to me from what you've saying that
somebody approaches the client as some form of expert or as opposed to as you approach
them from a humanistic perspective (.) there's a difference or some form of difference
there or?..

P: Yeah I mean (.) in danger of setting up straw persons cause I'm sure not that many
people are that extreme

R: right yeah

P: as that but I think its necessary for clarification purposes you know to set it up as that

R: yeah so you're saying in practice its not actually as clear cut as that?

P: Well in practice most psychiatrists for instance if you think of the medical model and I
have a psychiatrist in my head
R: right yeah

P: in practice most psychiatrists probably don’t go in as you know (.) erm classically the
expert as maybe they used to years ago most people have moved a little bit to saying that
the patient has expertise on their own (.) you know to a more equal (.) but if you think if
R: [right] [yeah] [yeah]
P: it as a continuum they would be more towards the medical end obviously than I would
R: [sure]
P: be (.) also clinical psychologists would tend to be (.) but again you know not always
(.) but tend to be more towards that end of the spectrum continuum than I would be.
R: [yeah] [yeah] Sure so whilst not (.) rather while taking into account that its to some extent its sort of over
generalising or its making a case for it but what's then (.) if there is this association or to
your mind a link between the medical model and a particular view of psychopathology (.)
how do you see that relationship, or how is psychopathology viewed within that
framework?
P: Within the medical model?
R: Yeah it sounds as though that seems to be the main thing that jumps out when you
think of psychopathology you think ah there's a medicalised or...
P: yeah I mean I suppose its also saying there is pathology (.) there is something wrong
with the person (laughs)=
R: = can you maybe give an example of that or what sort of things do you think of?
P: Hmm (.) erm well I suppose at the extreme end of the (.) erm (.) pathology end of the
(.) you know if you had somebody who was psychotic (laughs) erm then most people
would say (.) see them as having something wrong with them erm their not just having
difficulties in living they have a medical problem.
R: Right.
P: But that could be argued (.) I mean you know (.) was it erm (.) I cant remember who it
was that argued (.) was it Lacan or French people anyway (laughs) that argued that it was
R: [okay yeah]
P: with schizophrenia that it was environment that (.) I mean it's difficult to separate out
R: [yeah]
P: everything anyway and I suppose psychopathology you think psychopathology if people have a diagnosis as something that's an illness then-then you tend towards
R: [yeah]
P: thinking about medication
R: right
P: there's a link to that
R: right yeah-yeah
P: so with psychosis you put them on an anti-psychotic erm (1.5) and you might think if they were clinically depressed to put them on anti-depressants erm (2) and I think 'm sometimes that can be (.) you know that is probably the fairest (.) that they (.) I'm not saying I'm against that
R: right
P: you know erm people often do need medication
R: yeah sure but there's something about it that is about an understanding of what psychopathology is that then links to how its treated and you're saying that medication would be associated with that framework that causes would be attributed to presumably...
P: yeah the difficulties are clearly located in the patient
R: right
P: (2) hmm (2)
R: So how-how does it work then (.) you're saying that (.) I mean this is quite over generalised views of how er it is in practice but if people are somewhere in between say if we've got humanistic on one side and-and the strict medical type understanding on the other (.) if people do shift between how do the two (.) do the two come together or what is the interplay?
P: erm I think (.) I think they do when you assess the patient
R: right
P: I suppose you're looking for things that would (4) yeah I haven't thought about this like this before but er but that would (.) differentiate them from how anybody might react
in a particular situation for instance or if they have (1) if they're thinking in ways that
wouldn't be within what you'd think to be the normal range (. ) so (. ) you know if they
R: [right]
P: think that they (. ) as I had a client (. ) who before she saw me when she had a psychotic
depression and was erm in hospital (. ) she believed that had she caused BSC (. ) you know
R: [hmm] [hmm] [right]
P: now I think the medical model is (. ) probably very useful when it comes to somebody
with that level of pathology that's so disabling (. ) that is (. ) well that is also so
outside the norm
R: right yeah
P: er or people who think they're Jesus Christ or...
R: Yeah. So how does (. ) I'm just thinking back to what you said about if there is a view
that we could think of psychopathology or mental illness as problems in living or
something like that as opposed to it being erm biological or some form of illness or
pathology how does=
P: =I think I put it on a continuum erm (5) so one end of the continuum you've got
somebody that's an in patient-needs medication er in order to for their behaviour to be
normal (laughs) within a normal range.
R: [right so] Right so if somebody's behaviour is outside of what
we're talking about this normal range then is it no longer problems in living or?
P: I mean it gets quite philosophical doesn’t it at this point (. ) but it depends on degree
R: [yeah sure sure]
P: doesn’t it (. ) I mean if somebody thinks they've caused BSC and they're going to kill
themselves or-or if they think they need to kill somebody else er that is the extreme end
of the continuum (. ) I suppose where it meets more (1) would be with something like
clinical depression which may be (2) which one could see as possibly arising as in a
reactive way to events in their lives because they want to understand why somebody's
R: [yeah yeah]
P: become depressed but they've (. ) reached a degree of depression where you'd tick all
the boxes for clinical depression and that might imply that they might also need, they
P: might need erm medication in order to lift their mood up enough to respond to therapy sometimes erm (6) can't remember what the yeah...

R: [yeah yeah right]

No that's fine. I was just thinking rather wondering what your experience has been of (.)
you've spoken about a continuum and that there being sort of a norm to some extent and I
guess that's as a practitioner what you're faced with or I the mental health professions
that you're faced with making some kind of (.) I mean judgements are being made and I
guess I was curious about how that sort of fits when we're talking about psychopathology
if its something that is outside of what we are calling a normal range (.) how those kinds
of decisions are made or how (.) how do you get to that understanding or judgment?

P: Right cause there're culture bound aren't they so what's acceptable in one society (.) to
a degree (.) I mean some things wouldn't be acceptable probably anywhere either to the

R: [sure] [yeah]

P: individual or society (.) to a degree their culture bound erm how (.) so sorry (.) how do
I get to-to a judgement of whether its (??)

R: well just what it like for you in practice (.) you know here is somebody who's
behaviours whose what their telling you etcetera and then I guess to some extent you're
trying to make sense of that and make sense of that with them so...

P: I mean I don't see people who are (.) I haven't as yet seen people who are psychotic (.)
so I haven't had that issue in my practice if you see what I mean (.) er I do see people

R: [hmm] [hmm]

P: who are severely clinically depressed and have been inpatients erm (1) but I'm not
thinking this person is oh (laughs) its difficult isn't it because I suppose because I'm
applying (1) I tend to be applying that model (.) its an integrative model but the cognitive
behavioural approach say to a severe depression would be (.) big in there because the

R: [right]

P: outcome studies have shown it to be very effective er so I'm not thinking then (.) in a
medical model way of depression er I'm thinking of the case conceptualisation of that

R: [right]
P: client (2) so you know I'd be (. ) so (. ) in a way that's kind of inde-independent of how
severely depressed they (. ) are as long as they're able to come you know they're
outpatients you know they're able to come and see me (2) and (. ) yeah the severely
[hmm hmm]

P: depressed ones tend to be on medication as well so-I-think-that-side of its taken care
of by the psychiatrist to a degree
R: right right yeah
P: I mean I do have times when I have to write letters to other professionals or when I
would get more into a sort of diagnostic category with (. ) and I do think of people as
depressed or as anxious er (1) but what (. ) I'm not sure about the meanings behind
R: [yeah]
P: psychopathology and it seems to have a label of (2.5) something wrong with them (2)
it could be seen in a derogatory way I suppose psychopathology whereas diagnostic
R: [yeah yeah]
P: categories slightly different (2) erm
R: Hmm (. ) so what sort of things are you thinking of when you say that
psychopathology might have this negative sort of connotation=
P: =(well) I think of the word pathology as being bad (laughs)
R: Right how so?
P: Don't know er (. ) well I suppose people tend to use the word don't they "god that's
really pathological"
R: yeah
P: in language you know (. ) and therefore it has (. ) to me and I'm sure I'm not alone
(laughs) it has got connotations of negativity about that word but (4) its not a word
R: [right]
P: I use a lot (. ) I wouldn't say (2) I don't tend to (. ) that word doesn't tend to come up a
lot in practice erm diagnostic category might if I'm writing to other professionals.
R: [right] [sure] What
are the implications of that then if-if psychopathology or saying that somebody's mentally
ill (. ) the terms that we use (. ) does that make a difference to practice or how it actually is
with a client (. ) how you see a client?
P: If somebody's labelled mentally ill there might be different expectations of outcome
R: [right]
P: I suppose (1) I'm not saying I'd have them but they might be out there erm (1)
R: [hmm hmm]
P: mentally ill it tends to imply something more permanent or something like
schizophrenia or psychosis erm cause of course the other big area is personality disorder
R: [yeah] [hmm]
P: disorder (. ) which is a (1) bit of a nightmare really (laughing) in some ways but er (4)
R: [sure]
P: so (. ) do you want me to say more about when I would use diagnostic criteria? Is that
or...
R: Well I-I certainly will do but I thought maybe if I could just ask I mean we've
mentioned quite a few things about sort of your understanding of psychopathology (. ) I
guess some-of-some of the implications we've touched on those kinds of things but first
of all is there anything else that comes to mind or that you think of when we speak
generally about psychopathology or mental illness?
P: I don't know its just seems to be sometimes associated with a culture of blaming the
individual
R: right
P: erm associated with that (. ) and particularly in the media
R: right
P: you know and it frightens people (. ) it has negative connotations.
R: Right. Are you able to give any examples or are you thinking of anything in particular
when you say that?
P: (1) er well if you look at the recent er governments putting emphasis on in into the
sever and enduring mentally ill erm which seems to be a lot more to do with the response
R: [yeah]
P: to a fear in the public of (.) people erm attacking being not safe with people who are mentally ill than to do with the actual needs out there (.) erm because I mean very small (.) the risk from people who are mentally ill is so small and also (.) its often (.) the other

R: [hmm hmm]

P: thing is they want to (.) there's a government dictum to reduce the suicide rate particularly in young men (.) well their not the severe and enduring (.) the people (.) a lot of people who commit suicide are not the severe and enduring mentally ill (.) they are more neurotic than psychotic (.) you know more reactive depression (.) you know highest suicide rates doctors (.) dentists (.) vets (.) farmers that sort of group of young men has gone up not in (.) paranoid schizophrenics=

R: [right]

P: so its like they want to bring down the suicide rate but they're putting the money into that area instead (laughs) or not that that area doesn't need money but (.) and it's a [yeah]

R: [right]

P: skew in what the public seem to think of as mentally ill people (.) they seem to think of the mentally ill as dangerous, that's the presentation often given in the media.

R: [yeah] Right so

I'm just thinking that's (.) I mean this is a quite different view really to what we've just spoken about when we've talked about psychopathology and er what goes with that

P: (laughs) [right]

R: and then this seems to incorporate a much broader picture (.) I was just wondering how that sort of (.) if that feeds back into...(2)

P: I think what the public believe and what is generally out there; I mean not all the public obviously but tends to be (.) very different to what mental health professionals believe.

R: Right.

P: (2) Because what's presented in the media is what sells newspapers and that tends to be to do with (1.5) with the dramas.

R: Right. So there seems to be two very different understandings or its in (.) and again to-to you know generalise (.) I'm sure its not as clear cut as that (.) but there seems to be a
very different level of awareness or thinking around psychopathology and what it means from the general population as opposed to the professionals who work with people.

P: Hmm, yeah
R: And=
P: =LIKE people who are severely mentally ill would tend to be more risk to themselves than others on the whole (.) you know
R: Yeah-yeah
P: erm (1) but the few cases that have happened were mentally ill people have (1.5) or murdered somebody have been highly publicised so it's a false picture.
R: Right.
P: But I (.) I'm very interested in how things are represented in society.
R: Yeah-yeah (.) so...well (.) what (.) from what you've said then what's the representation in society of psychopathology or mental illness?
P: AS DANGEROUS (.) as a threat (.) as scary (.) as (.) something to be controlled erm
R: [right] [right]
P: (2) I mean you know (.) at the extreme end obviously (.) I suppose certain newspapers
R: [yeah] [yeah]
P: will tend to be more measured than others (laughs).
R: Yeah-yeah. Do you think that sort (.) the media or the political element is that present in practice or does that, is there interplay between these factors?
P: Yes because politicians respond to public - they want votes (laughs)
R: Right
P: MAYBE they're not totally doing that (.) you know (.) I guess they also have think tanks and research groups that feed back to them but they are a lot of the time responding
R: [yeh] [yeh] [yeh]
P: to public (.) feeling because they want (.) because they're elected.
R: Right
P: Erm
R: (2) so what as a practitioner then are you responding to in your role within=
P: well I don’t see majority of people with severe mental illness as as dangerous.
R: Yeah
P: erm but then tend not to see the very severe end anyway so it’s not (.) you know (.) but
I don’t see them as dangerous and I don’t see them as making up the majority of the
population who have (.) a problem with living or a mental (laughing) illness, I mean there
is a continuum erm (1.5) there isn’t anyone that doesn’t have issues but I guess its when
R: [yeah]
P: those issues you have begin to interfere with everyday living to a degree that you
R: [right]
P: have to seek help.
R: Right.
P: Which will be in primary or secondary care according to where you’re placed and how
severe you are and what the provisions are.
R: Okay-okay
P: but...(2)
R: I wanted to ask (.) when we’ve spoken about erm what your view of psychopathology
is or speaking about it generally and your own views as well(.) but what’s been sort of
formative in the development of your own views (.) are there any sort of factors or
experiences that have really (.) contributed towards how your view has developed-where
your view has come from?
P: I suppose just my experience in (.) training on different placements (.) one of my (.)
and since qualifying (.) I suppose since qualifying (.) worked in (.) and for the year before
(.) in community mental health teams (.) erm (.) but I’ve also worked in an inpatient unit
some of the time running a group (.) helping run a group on a men’s inpatient unit AND I
think that helped to make me less-less nervous of people who are (.) who look very odd
and I guess that’s the other thing that often (.) the severely mentally ill can look very
R: [yeah]
P: odd if they’ve been on the erm the very old fashioned medications.
R: And how’ve you experienced that or when you (.) what’s=
P: So they might have strange gaits and strange habits and ticks that you know until
R: [u-huh]
P: you've learnt about it you don't realise that it's the result of the medication not them or and you know actually when you've experienced them (.) although they can be a bit unpredictable its less scary once-once you've (.) been alongside them for a while.
R: Right. So I mean just linking that back to what you said earlier about the sort of publics view or representation as something being scary and frightening or possibly
P: [hmm]
R: dangerous (.) are you saying in your own experience it changes with contact or there's something about...
P: Yeah yeah
R: Would that (.) is that=
P: =because then you begin to see that actually they're not that (.) you know (you begin) to understand them and see them as people and not just as objects-scary objects (.) I mean
R: [right] [right]
P: the unknown is always (1) is always more scary than the known isn't it or...
R: [yeah] Right yeah.
So the you're actual (.) yeh (.) the actual placement experience that's been-that's been formative or how else has that actually (.) what has that meant for the development of your views or how (.) can (.) are you able to say?
P: (2) (gosh) erm (4) er just that (.) oh dear (.) most of the time their ordinary (.) you know with very difficult (.) severe problems in living (.) but ordinary people really erm
P: (1) hmm
R: and how is (.) I guess=
P: =I'm wondering whether I should be talking more about (1) whether you want me to be talking about the severe end all the time or whether we should be talking more about (.) I suppose I associate pathology (.) but I know strictly speaking depression is (.) could be seen as psychopathology (.) anxiety and you know (.) I suppose I don't like that label
R: [sure]
P: for it cause I don’t like that word because the connotations of that word.
R: Right (. ) so if someone is talking about depression or anxiety you wouldn't view that
as psychopathology?
P: No I know it is but I don't think of it in that way though.
R: Right-right
P: I know it's a label isn't it
R: yeah
P: but I don't think (. ) I don't have anything on any of my little notes that says
"psychopathology" (laughs) you know erm (2.5) I have books I suppose that I (2) the
R: [yeah]
P: other thing was my training was therapy led rather than diagnostic category led (. ) so
most of the literature I was reading was to do with how to do therapy with people not
"this is depression and this is how you work with depression" for a long time coming
from the (. ) you know (. ) initially psychodynamic was my (. ) before I did the course I
had some experience of that and then erm and then it was client-centred and
psychodynamic coming together
R: right
P: so that wasn't coming from a medical model I came from the therapy
R: yeah
P: and it was only later then (. ) I suppose when I started doing cognitive-behavioural
particularly when I started doing the cognitive-behavioural erm (. ) model that you started
having protocols for depression and protocols for anxiety that you started thinking more
R: [right] [right]
P: in terms of those boxes (2) and I suppose clinical psychologists tend to be more in (. )
tend to be more that way because their placement experience is dictated by experience
with client groups (. ) rather than with (. ) its not quite the same thing but do you see what
R: [yeah] [right]
P: I mean (. ) rather than with therapeutic er milieu.
R: So what (. ) what's sort of the difference there then coming at it form a therapy point of
view as opposed to a=
P: =okay. So if somebody presents to me erm (.) what I'm asking them is why they're here and (1) what they hope (.) to achieve by coming here erm (3) and so I go from that and

R: [yeah]

P: work with that rather than this (.) label "oh yes I've got to take PTSD off the shelf" you know (.) although with PTSD I do tend to do that more but erm but I go from their experience and what-what they want to do and make a case conceptualisation which is individual (.) then I may bring in things according to what they've got in that case conceptualisation (.) I know its quite (.) so difficult to be clear on because its very

R: [right] [hmm] [hmm]

P: complex (.) erm

R: I mean do you see there as being pro's or con's to that approach, you're saying that, it sounds as though there's an awareness that there's this way of understanding or using these labels etcetera but that your choice is to (.) to go about it in a different way and I'm just wondering what the pro's and con's are?

P: Yeah (.) erm (.) I think if you go in and think "right I've got a depressive here's the treatment" you're in danger of missing out things (.) your in danger of going in with

R: [yeah]

P: assumptions and not really seeing what they're presenting with (.) erm (2)...

R: So what are (.) so would they be really presenting with if its not depression or etcetera etcetera if its not one of those things?

P: (laughs) well it could be things labelled other things couldn't it (.) but it could be things like environmental (.) you know (.) you could be taking in the broader context of their life erm (.) which may involve looking at things (.) using the psychosocial-bler-bler-bler-bler-biological whatever that long word is (laughs) approach to things (.) so your taking a more holistic view erm you might (.) you know they're allowed to speak about what's important to them (.) they might start talking about something that might be better addressed by (.) some other way or complimentary to it you know (.) you might get a community support worker to go in and give them advice on there erm (.) how to sort out their bills and get there lives in order in that way (.) which might have more effect than

R: [right]
P110: you know (.) of therapy you know,(2) erm also you take in account of where their
located socially because (1) you know (.) looking at it from a feminist perspective, if
somebody' s living in a deprived erm (2) I always think North Peckham estate you know
(laughs) cause I did work there once erm, well you know wouldn't it be normal to be
depressed under certain

R: [okay]

P111: circumstances (1) and its I mean (.). YEAH BYE (says goodbye to her children)

R: [right]

P: (5) erm (2) there can be political arguments as well, I very great difficulty in not
(going) down to the political (laughs) for some reason but you know (.). if your blaming
the person (.) locating the problem in the person then your never looking at what the
societal problems are you're always blaming the person erm when you look at the suicide
rate in farmers for instance if you say "oh they're depressed" you might out on the fact
that a lot of it is EEC legislation or the way the newspapers talk about farmers or the way
new people don't like the mud on the roads. Its about taking a more holistic approach and

R: [yeah yeah]

P: and taking more things in and different levels of analysis erm=

R: =this=

P: =not that I'm doing social research all the time (both laugh)

R: this sounds as though from how you've described it, it poses quite a dilemma to the
individual practitioner or that it sounds quite a difficult task in a way.

P: [well I think] Yeah I mean you
can say to a client you know if this this and this is going on you can normalise their
experience for instance and say like (.). you know "I'm not surprised you're feeling bad (.)
so would I" you know.

R: Yeah-yeah

P: So you're immediately coming down (.). not coming down to their level but it's
equalising.

R: Right, and what do you think is the=

P: =benefit of that?
R: Yeah *(both laugh)*

P: Erm well its **normalising** they think "oh well maybe I'm not mad".

R: Right.

P: Cause they come to you and they come to a community mental health team and they -
they have feelings about that (. ) people have **seen them** as having a mental health

R: [yeah]

P: problem maybe (. ) they're coming with that (. ) already (. ) a lot of the time erm (1.5)

R: [right]

P: and they feel **relieved** if you say "well look, this is a normal response (. ) I can
understand why you're responding in that way" and then I guess you might not be able to
change the world *(laughs)* so (. ) but that in itself (. ) that normalisation (. ) that recognition
that (can bring) incredible **relief** to people (. ) just yeah (. ) you know I'd be like (. ) I'd feel
like that in (. ) or **anyone** would feel like that in that situation.

R: Right.

P: That in itself is so therapeutic erm (. ) I keep going off on tangents.

R: It moves around (. ) it's a big area.

P: It is a big area its quite complex isn't it.

R: Just to (. ) sorry (. ) just to try and come back to the development of your views and I
appreciate there's so much there (. ) but you've mentioned your own experience of
working and practicing er I think you mentioned training as well as somehow being
formative in the development of your own views (. ) is there anything else around that (. )
any other experiences or factors that sort have-have gone into that? I mean you've
mentioned this awareness about...

P: I mean I do use DSM-IV for instance (. ) I don't know if you're coming on to that in a
bit but or (. ) can I talk about it now?

R: Of course.

P: Erm there are times when its very useful to have the diagnostic categories and (. ) and
to use them (. ) in the aid of the client erm (. ) you might get (. ) they might have an
**insurance claim** you know (. ) there might be times when you do use quite a traditional
P: medical approach erm (.) psychopathological if you like approach to it because they suffered as a result of something and they need the label in order to go through the legal process of what they're doing (.) for instance and the medical model fits more with
R: [right]
P: the legal process than an existential one (laughs) you know wouldn't be very useful in that-in that (1) so it's pragmatic erm (.) also I suppose (.) it can be helpful to a client sometimes to have labels too you know (would say) you're depressed because it can be helpful to have an explanation. to have label. "what's wrong with me" you know,
R: [yeah] [yeah]
P: and if they say "oh I've got this, I've got post..." sometimes that helps to do that too (.) I wouldn't say I'd that I wouldn't (.) not acknowledge someone's depressed or someone who's anxious or (1) erm (.)or suffering from Post Traumatic Stress. I've used
R: [yeah yeah]
P: it more with PTSD than other things because that's often the thing that involves er,
R: [right]
P: they've been referred for by their company or something or they've got time of work to come for that or there're legal implications er (.) I'm just trying to think what other
R: [yeah] [yeah]
P: things (2.5) well sexual abuse but that's not a diagnostic criteria but er one tends to think about (.) things that might arise from (.) if someone's been abused you have in your mind (.) what things might be difficult for them you have (.) I always have bracketed off the things research has shown with those sort of things that (.) you know happen because
R: [right]
P: it would be stupid not to because it might help to be (.) aware of them (.) to be (.) er not on guard but (3.5) well to be aware that for certain client's certain things might be particularly sensitive or erm (1) you might look for certain things a bit in certain client's because its (.) well it saves time and you know (.) erm yeah helps the therapy.
R: Right
P: So it's not that I don't think of them but I don't necessarily think of it as psychopathology but just as (.) what goes with that presentation.
R: Right. So there is a benefit to **you** in a sense as well? I mean you've said that it

P: [yeah]

R: benefits the client in a way=

P: =Yeah=

R: =and it sounds as though that aids you in your conceptualisation your...

P: =Yeah you might think "ah yes (.) de-de-de, ah yes, ur-ur-ur" seen that seen that.

R: I was just thinking how do you actually, how do you arrive at those decisions, or how

does that process sort of work, it sounds difficult in a sense?

P: (3) erm (.) I don't know which bit of this to get at it from erm (6) well again talking

about CBT if somebody is presenting with depressive symptoms then working in certain

ways (.) have been found to help with depression. There will be certain CBT techniques

that will go across the board  erm what Pedesky calls "cognitive therapy unplugged",

things that you might use for (.) across the board (.) but there are particular (2) erm you

know (.) like thought record keeping and that sort of thing that (.) erm activity scheduling

(.) all the things that come from the protocol research on CBT.

R: Right.

P: So then I might (.) say "oh yes that's been helpful" (.) you know so (.) or for anxiety,

erm panic attacks you'd bring down the protocol on panic attacks and get them to draw up

a (.) do a hierarchy of the anxiety provoking situations and work your way through them

and it really works.

R: Right.

P: BUT you might not just be doing that (.) you know but...

R: But there's something about there are things in place that are of use to you...

P: Erm yeah yeah and that's I suppose the benefit of an integrative approach (.) in that

you can do that (.) you can take (.) you can take the things that are useful from (.) which

ever (.) camp as it were

R: Right

P: IT makes it more complex yes (.) it is more complex but then people are (.) you know

R: [yeah] [yeah yeah] [yeah right]
P: and I suppose it-it all comes together in the case conceptualisation erm, (3) which is not always overtly stated to the client (. . . ) you know I won't always be working (. . . ) I work much more obviously CBT with certain clients that other clients erm (. . . ) if somebody is presenting with a history of (. . . ) abuse for instance (. . . ) er and they just feel its impacting on their life I might be much more (1) much more humanistic much more erm exploratory than someone presenting with a clear panic disorder you know (. . . ) and I'd be thinking probably of seeing them for longer and (1) perhaps have to pay more attention to certain things (. . . ) certain aspects of the therapeutic relationship (. . . ) you know different things come in (. . . ) sometimes I think about in terms of the five therapeutic relationships framework of Clarkson's erm you know what am I working in now (. . . ) and Pedesky does a similar thing

R: [yeah yeah]

P: er (. . . ) what do you need to be with this client if they are being very emotional do you need to be more structured or do they need to let that out or you know (. . . ) what's happening in the room (2) and I might not necessarily go (. . . ) yeah (. . . ) AND whether you focus on the present or the past or (. . . ) but this is going away from the point isn't it.

R: That's fine. I was just (. . . ) it just popped into my head (. . . ) I was just thinking about (. . . ) wondering about how (. . . ) you know you mentioned a complexity and that there are so many different sort of ways that you can approach things (. . . ) people are complex and we've got all these complex procedures and different (. . . ) you know things in place (. . . ) you know to try and help people and everything. Is there something about the context that does sort of shape practice or what are the effects of the context or the system that you are working in?

P: Sure er I think there is pressure, there is a pressure at the moment to work more cognitive behaviourally (2) erm because the G.P.'s have got it-got it in their heads (. . . ) everybody's got it in their heads (. . . ) its really trendy (laughs) there's been (. . . ) I mean there's been loads of outcome studies on it (. . . ) it lends itself to outcome studies (. . . ) its sort of research based all the way along its evolution and erm (2.5) and yeah it lends itself more to outcome research than perhaps psychodynamic for instance approach would do
although the psychodynamic has improved recently in measuring things but the very
nature of what its talking about its more difficult to look at unconscious by its very
R: [hmm]
P: definition erm (3.5) but there's a lot there's also as I said earlier with the erm more recent conceptualisations of cognitive-behavioural therapy particularly with schema
focused approach there's an awful lot of overlap in ideas erm or (1) yeah there is a
R: [yeah]
P: tendency towards movement towards integration in practices anyway and of course
experienced practitioners tend to be integrative the research shows doesn't it erm but you
were saying context Yeah in the CMHT there's the influence of the medical model
there you know I'm sharing a corridor with two psychiatrists and an SHO (laughs) so
er (1) I-I will be more aware of diagnostic criteria's and so forth than I was when I was
working in-in a student services department in an art college and I suppose I feel perhaps
a slight more pressure to be more like that the whole milieu is more like that.
R: Right so how-how does that pressure sort of manifest itself?
P: Well I suppose writing to G.P.'s writing to consultant's talking to consultants if
you're talking to people like that then you're tending to use their language or you need to
communicate so you use some things erm I-I tend not to talk about existential
cconcerns a great deal or sort of...
R: Can I ask I mean it seems or why or what's the...
P: I suppose people would for one thing its quite difficult to get into that in the short...
you know in the short times we have er (2) it somehow doesn't quite fit.
R: Right
P: Erm so (1) but you know I do deal with clients who do have existential anxieties erm,
particularly people who have anxiety generally you know...
R: Yeah-yah so is that what's that like in practice for you you're saying that the
ccontext the language the way of talking that you're involved in it sounds as
though it doesn't necessarily fit with your own actual stance or understanding of things?
P: I was just thinking about it now I would tend to be talking to those other
professionals about the clients that they would tend to be coming into contact with
R: Right.

P: They tend to be (. ) I'm using tend a lot (. ) at they erm at the less (. ) erad pathological end
of the spectrum (laughs)

R: Right.

P: The ones who have difficulties in living that the psychologist's would see but not the
CPN (laughs)

R: Right.

P: The CPNs see clients (. ) usually see clients that the psychiatrist gives them to see (1.5)
that need a more team approach erm that might be more likely to be on medication and so
forth.

R: Right (. ) I'm trying to get that clear in my own head is there (. ) is it different for
psychologists or different types of workers?...

R: Yeah sure but your experience is?

P: That I tend to get the client's that are perhaps-not all my clients but I have a proportion
of clients that I think of as sort of luxury clients (laughing)

R: What are luxury clients? (laughing)

P: Erm clients who are (. ) oh dear (. ) erm perhaps very intelligent (. ) very middle-class
(. ) have the luxury of being worried about (. ) are they being fulfilled in life (. ) but are not
maybe (1) severely depressed bit I suppose what people would call the worried well.

R: Right.

P: Erm I see a few of them (. ) not many erm and often they do present with something
that can be a diagnostic category (. ) you now mild obsessive-compulsive disorder is quite
common in that group (. ) I've found in my experience, erm (1) existential anxiety
certainly (. ) you know if you're struggling to live from day to day your not worried really
about whether or not you're being fulfilled because you haven't got time (. ) you know
you have clients who are living on thirty pounds a week with their kids (.) they haven't
got time to worry about the meaning of life.
R: Right.
P: Sometimes (.) well okay sometimes they might but you know its kind of a luxury isn't
it er (2) but there's I suppose one is tending to see less of those luxury clients because of
the pressures on services (.) I mean I've got a waiting list of one year (.) so I can't see
them for long anyway.
R: Sure-sure
P: those ones anyway.
R: I was just thinking moving into try and talk a little bit more specifically about
counselling psychology practice ern I think what you're saying lead into that and I was
just wondering about how does the counselling psychologist (.) again in the context
you've been talking about (.) how does that fit in (.) you're saying that you might get (.)
you see certain clients or what's your experience of=
P: =Well I see primary and secondary client referrals (1) so I'm lucky that I can do both
so I get a mixture. Now in some CMHT's you cant. In the CMHT were I was working
before l-I could only see the secondary referrals so I got more of the severe end.
R: Yeah.
P: I get a cross-section now in fact you know (.) it depends how you define primary and
secondary care that's another issue ern, but I see a mixture of suffering levels.
R: Right-right.
P: A mixture of (.) what (.) yeah (.) if you want to call pathology (.) degree of
pathology.
R: Right. How does what we've been talking about and I mean your own experience (.)
your own (.) the context that you practice in (.) how does that fit into counselling
psychology practice?
P: Oh right (.) as opposed to clinical you mean?
R: You're a counselling psychologist aren't you?
P: Yeah
R: Yes
P: My job was advertised for a clinical psychologist.

R: Right.

P: A lot of them are.

R: Yeah.

P: So you're automatically in a funny position.

R: So what's the...

P: Well they might have expectations that you'll be like a clinical psychologist and often times yeah (.) I mean as I said to set up straw persons (.) is dangerous erm in some of the CHMT's I've worked with you know (.) I can say that the person who was a clinical psychologist was for instance (.) more psychodynamic than I was (.) were as traditionally clinical psychologists have been seen as more cognitive-behavioural erm and counselling psychology (.) psychologists has taken in (1.5) more of the psychodynamic approach but that is a generalisation erm (2) I probably have moved partly more towards cognitive-behavioural through being influenced by clinical psychologists that I work with as well (.) although my department's probably fifty-fifty now (.) er (1) I mentioned training differences so there are difference in underlying philosophies.

R: Right.

P: Er (.) I don't do testing you know (.) I haven't been trained in it (.) erm I might be less inclined to use testing materials (.) you know less forms (.) BDI (.) less of that measurement stuff than your traditional clinical psychologist.

R: Right.

P: I might be (.) I don't know if I am erm, yeah I feel a bit resistant to using things like that but I'm required to use them to a certain degree (I mean there's pressure)

R: [the resistance is?]  

P: Oh well I don't know if that's personal or philosophical I hate forms (laughing) you know I hate having to put things in boxes.

R: Right.

P: Er at the same time we've got to show clinical effectiveness (.) we've got to show outcomes (.) so that=

R: =right (.) so you mentioned (.) there is a pressure there is a context related pressure.
P: Yeah yes, which I wouldn’t have say in private practice to the same degree it
would be slightly different. I’d still have pressure to be effective but maybe not to
be demonstrating it in that way.
R: Right.
P: So you know there’s a twenty, there’s a thirty-three and there’s a twenty-two
(joking) (laughs) sorry I’m being very...
R: No-no-no
P: erm so yeah there is context pressure.
R: And you mentioned about differences in training and perhaps some of the
differences perhaps between a clinical and a counselling and your experience of not
doing as much testing and that kind of things.
P: Traditionally although...
R: traditionally
P: yeah
R: Although?
P: Although some counselling psychologists are very clinical in a traditional way do a
lot of testing you know but traditionally its generally felt that clinical psychologists
tend to be more cognitive-behavioural do more of the testing stuff come-from a behavioural you know have evolved from a behavioural basis haven’t they
R: 
P: clinical psychology evolved from that background counselling psychology didn’t
(2) it came from the humanistic.
R: Okay so=
P: =but it still you’re still scientist-practitioner but (2), I can get so-so you know
into what you mean by science and so on at this point.
R: Sure well feel free to but what I did want to ask though was given those
differences that you’ve mentioned there. What do you think counselling psychology’s
view of psychopathology is?
P: As compared to clinical psychology’s (laughs)
R: Well no, if you want to make that comparison?

P: I think they're less inclined, I think they're less inclined traditionally, maybe I shouldn't, you know they're less inclined you can have a continuum, maybe with psychiatrists, clinical psychologists, counselling psychologists, counsellors, so a counsellor or psychotherapist maybe, although hmm erm would be at one end of the continuum and a psychiatrist would be at the other end, but you know there's individuals are different but that would be er (1) you know that could be a broad brush or (.) god I'm mixing my metaphors wonderfully, I laugh, erm (4) yeah what, its interesting that where I work I've been responsible for supervising, five counsellors in a (managed) counselling service, cause your seen (that) the counselling psychologists within the department are more appropriately trained to supervise counsellors, because of our training in therapeutic models and its felt that the clinical psychologists aren't (2)

R: [right]

P: as appropriately trained for that because they come more from the diagnostic, erm you know different types of, haven't had personal therapy you know, and those things impact and I'm probably thinking of loads of stuff I could have said about that (laughs) but you know the fact that you've personal therapy yourself has an impact erm might make you less defended therefore you might be less inclined to want to put people in boxes. I don't know

R: Right. So what would be the inclination there the distinction between somebody who possibly has had psychological personal therapy and as opposed to not and something about categorising or putting people in boxes?

P: Yeah, well if somebody label (and that's them) and they're not just people similar to us with difficulties in certain ways or whatever, then that then that makes you look at your own stuff and if you haven't done personal therapy you might be very defended against it.

R: Right.
P: So you might tend to project (.) you know (.) do all sorts of things around that (.) because you're defended not acknowledging you're own (.) easier to think of people as (.) in boxes you know (.) as mentally ill.

R: Right so I mean you're doing that with your hand as well (pushing away motion)

P: [yeah yeah]

R: pushing away (.) so-so what (.) how do you (.) I don’t know, something seems significant

P: [pushing away]

R: there (.) I not sure what it is about=

P: neither am I (.) I'm sort of evolving the idea myself at the moment (laughs) but...

R: there seems to be (.) I think (?) notion of doing that and how you've described...

P: it causes a separation doesn't it-it's a separation (.) yeah (.) it’s a separation when you

R: [right, some distance]

P: put a diagnosis on somebody.

R: A separation between=

P: =between you and them (.) it can be (.) they have this label you don't erm (1.5) whereas if you're thinking in terms of a case conceptualisation with somebody with a difficulty with (.) a particular sort of thing in their life (.) you know there'd be a lot of echoes with your own life a lot of the time (.) there might be a less of a separation with (3) erm it (.) its something to do with being to acknowledge your own stuff (.) that might

R: [right]

P: be easier to do if you've had therapy, erm, and being defended against that and a feeling that you must always (.) especially when its doctors hence the suicide rate but, (laughs) one of the reasons (.) sorry rambling madly (.) (laughs) erm, de-de-de-de-de (.) yeah so it was felt that counselling psychologists would be more appropriate to supervise the (.) counsellors.

R: Sure.

P: Erm the counsellors would have preferred to have had counsellors (.) they had issues with it being psychologists (.) you know whether there's a hierarchy
R: the-ss (. ) I was thinking I mean its been mentioned throughout but you mentioned then
about the continuum or hierarchy when=
P: =I seem to think in continuums a lot don't I?
R: Yeah erm but the erm there's something about the continuum or hierarchy or the
different sort of terms attached to workers in the field ranging from the psychiatrist right
through (. ) I-I don't know there seems to be some significance to that in terms of what
the psychiatrist is here (. ) the clinical psychologist is there the counselling psychologist
is=
P: =are you talking about status (2) (laughs) I wasn't implying it there but you could (. )
The medical model has a higher status (. ) than (. ) humanistic counselling would-does (. )
erm (2) erm (. ) counselling sometimes has negative (. ) seems to have negative
connotation for some people, they say "oh you're a counsellor, oh you know, you've done
a bit of counselling training".
R: How's that fitted for you as a counselling psychologist in practice?
P: A lot of the time I don't mention I'm a counselling psychologist, I say I'm a
psychologist.
R: Right because?
P: Because some people hear the word counselling and say counsellor and that could
mean (. ) I mean it's a meaningless term you know and its probably (. ) it depends were I
am erm (1.5) but it's a small profession and probably not very well understood as a result
( . ) erm (1.5 )people often hear the word counselling and think of counsellor and that
could mean (. ) a very small training or it could be a massively long wonderful training,
but its meaningless (. ) term (. ) they pick up on (. ) and I'm a psychologist first anyway
R: 
P: you know first degrees in psychology (. ) so I'm grounded in that, grounded in research
blah-blah-blah you know of psychology. Erm (1) what I do is counsel...I prefer (. )
psychotherapeutic and counselling psychology the whole title but you can't say
psychotherapeutic counselling psychologist (said rapidly) can you? And the division is in
counselling psychology though they did think about changing the name at one point (. ) or
having a different name but erm (1) YEAH its clinical implies medical has a, implies in the word higher status.

R: Right.

P: I think, I mean as personal opinion but have heard it expressed elsewhere.

R: Right okay.

P: I happen to have done research in it personally.

R: Alright (.) can I ask you though (.) I mean there are a variety of different views or stances towards the use of diagnostic categories within counselling psychology practice (.) which I think we've touched on that (.) but what are your views on this (.) on the actual use of diagnostic categories?

P: (2) Do you mean by diagnostic categories actually looking at the DSM-IV and saying this person fits the criteria because dum-dum-dum or do you mean calling someone depressed?

R: Erm I think (.) I guess that's a distinction I'm interested in (.) on what that means for you, erm the very fact that I think=

P: =I would use the word depressed because its-its short hand=

R: =would you think of yourself as using a diagnostic category then when you say depressed?

P: (1) erm (1.5) no probably not...

R: right-right.

P: If I said clinically depressed I might because then your implying tick-tick-tick-tick.

R: Right.

P: You've ticked off certain boxes or reached a certain score or hmm

R: Right so there seems to be a I don't know there's...

P: oh I'd better say a reactive depression (.) a different (.) qualify really the term.

R: Right.

P: Erm (2).

R: Okay. In what ways then when you're practicing do you find diagnostic categories useful (.) if you do find them useful (.) in understanding and helping clients (.) and I'm thinking can you give any examples of that?
P: Certain erm, you know examples (. ) well with Post Traumatic Stress for instance, if somebody's saying they've had an accident, the G.P's written they've had an accident and they've got certain things erm that they're experiencing since then I would tend to be thinking oh have they got PTSD and if they have got PTSD one of the things I've learnt about that helps PTSD, and there are certain things that you can do that have been found to be really helpful, and so I would use-use it, erm and you know I'm aware of it if

R: [right]

P: people are saying (. ) if (. ) if they haven't come with that label but they're having nightmares or they're jumpy and I'd say "oh are you also de-de-de-de-de" and they think

R: [right]

P: they'd say "oh I had this accident" and I might say, "well (. ) did you think you were going to die?" or say "what were you thinking" (. ) I'd say "what were you thinking at the time of the accident", look out for whether they, (. ) although that depends which, whether you were using ICD-10 or DSM-IV whether they need that thought (. ) that they are going to die or not (. ) I don't think they do in ICD-10

R: But what are you thinking or what are your thoughts or feelings towards that use of a diagnostic category (. ) when, in that situation?

P: I think it can be useful because it relates to a collection of things you can do and it might take you a long time to get there otherwise erm (. ) well it might also be counter intuitive at times somethings er (1) I didn't like the idea of asking people to recall what had happened in the present tense going from before it happened (. ) talking all the way through, it felt like a really cruel thing to do (. ) you know (. ) but you know having sort of done (. ) having been on courses on PTSD and short ones, er spoken to people who've done lots of research and work in this area seems to be a helpful thing to do (. ) so I've done it (. ) and trusted that research that comes from that diagnostic criteria I suppose associated with it (. ) and used it and its helped the client no end. I had one client whose nightmares (. ) what she'd been having every night for several months went in the minute (. ) now I guess maybe it wasn't just that maybe it was other things but you know erm cause you can't separate out (. ) erm (. ) but she'd have a lot of the other (. ) the sort of friendly (. ) talking from people so forth so.
R: Right. There seems to be something about=

P: So (.) its looking a the literature as well and blending it with what works for who (.) stuff and thinking right what does it say in the literature about somebody presenting with this with these sort of issues

R: Yeah I mean you mentioned what works for whom and I guess I'm thinking in that sense that there's something about a utility or there's a pragmatic aspect.

P: Yes thank you (laughs) yes. Yeah I am very pragmatic you know (.) I always remember reading in (.) schema-focused therapy you don’t need to go hunting for schemas if somebody, if you can just work at the automatic thoughts level with someone for instance.

R: Right.

P: And you don’t have to go digging up people pasts necessarily (.) you know (.) so you

R: [right]

P: might work (.) might work from top down according to...(laughs) According to what is pragmatic

R: right

P: yeah and what they want to do too (.) obviously (.) it would be, you're responding as well to (.) what they present with erm what they feel they can talk about themselves (.) you don’t impose it, it done in the context of the therapeutic relationship

R: right

P: and the person in front of you.

R: Yeah-yeah.

P: But you might at times say, "this has been found to be useful with this (.) I wonder how you feel about this" you know?

R: Yeah

P: Doing this

R: Yeah

P: So you're being open (.) with them

R: Sure. Is there (.) are there any other things?
P: Writing to G.P.s (.) it can be useful to say this person de-de-de is clinically depressed
you know short hand.
R: Right.
P: They don’t want to have a long-winded (.) explanation of this client they want
something precise for their notes.
R: Right.
P: You know? similarly with anything to do with the courts, although I've not actually
had to go to court I might have to this year with somebody who I only saw twice and then
the police came and asked me de-de-de if I could go to court because its an abuse thing.
So that might come up but erm (.) and I've helped a CPN write a report for court.
R: Right.
P: Because we use DSM-IV for that for PTSD
R: Right-right so there's the uses there.
P: Yeah er AND for research purposes I guess
R: Yeah
P: Although chance would be a fine thing but yes...(laughs)
R: Okay...
P: and one is always doing research anyway in practice but not in a formalised way
R: Right-yeah
P: erm so short hand er as well and linking things together (1) in your head (.) it helps to
have categories in your head (.) schemas in your head (.) that you can attach things to
sometimes but that you can also remain open (.) you know to the person in front of you.
R: Yeah I mean just from what you said it sounds as though there's a movement back and
fourth between sort of, I think that's how I've understood how you've spoken about
P: [it is rather]
R: your practice as something about being with somebody but also drawing upon or
using different theoretical understandings or diagnostic systems when its seems relevant.
P: Yeah, yeah yeah, I like the back and fourth yes erm
R: and that all seems to have been shaped by the context that you've mentioned or the
actual situation you work in.
P: Yeah er sometimes in the past I've done joint assessments with (.) CPN's and so fourth
so (.) and also we have forms in (poster form?) that we have to fill in.

R: Right.

P: Which is horrible(.) which actually comes from social services not from health at all
but...

R: Right but again that's part of the context I guess in terms of=

P: =yes you do have to (. ) some things you do because they're useful(.) some things you
do because (. ) you have to do them.

R: Yeah, so and then I-I assume that's sort of a tension or an ongoing...

P: a bit I mean sort of (. ) I've been involved with the NHS in different ways on and off
since 1978 so I'm kind of (. ) I don't get too upset.

R: Okay (both laugh) all right, okay. That's all the sort of direct questions I'd like to ask
is there anything else on the subject that you'd like to talk about or that you think hasn't
been covered that feels important?

P: (3) Hmmm I'm sure there's something that after you've gone I'll think, "oh god why
didn't I say that, that would've been so useful"

R: I think we've identified (. ) and I mean how the conversation we've had what a big area
and how complex it is.

P: Yeah and I think you need the categories to a degree when you're reading the literature
and also to read literature from different places (. ) so its not in the counselling
psychology review but its in (. ) oh I don't know (. ) clinical psychology forum or
something or-or the BABCP (. ) which is a very good thing to join erm (. ) but you need to
have the ideas of these things in your head and how they fit in and communicating,
communicating with other journals (. ) other professionals (. ) other contexts erm and
being useful to the client, being able to link what's useful in the research to the client.

R: Hmm okay, and finally how did you feel about talking about this subject area?

P: Oh I suppose I think quite anxious, I think "golly" will he think that I'm-I'm, you
know, doing my job properly (laughs) er gosh and can I say I hope this is useful?

R: You can say that (. ) you know its been interesting for me to find out somebody's
views really who's actually practicing.
P: Well they tend to be waffly which doesn't help (both laugh)

R: Well I think it's perhaps something we're both found is that it is a very difficult area to
be concise and specific about because there is so much involved (.) I mean that's
something I've found when I've spoken to people about this area (.) there are so many
areas and things...

P: Yeah I guess on the surface you think it's quite straight forward but when you get into
it there's so many levels of analysis and and yeah

R: Yeah okay well thank you very much for your time.

P: That's a pleasure.
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Between the real and the not real: 'knowledge', 'truth', 'power' and the creation of clinical realities. A discourse analytic study of psychotherapeutic practice.

Abstract

This study set out to examine psychotherapeutic discourse from a social constructionist perspective. Discourse analysis was performed on pre-existing textual data in order to examine the discursive relations between 'knowledge', 'truth' and 'power' within the context of therapeutic practice. Analysis suggested that prevalent 'images of the individual' contained within humanist, psychological and psychodynamic discourses constituted the 'self' within therapy as a 'real' object and 'correct' focus of therapeutic inquiry, whilst simultaneously reproducing culturally dominant forms of individuality. Operating in relation to psychodynamic theory and psychological 'truths' concerning human 'nature', therapy was constructed as a process that 'liberated' clients' 'essential self' from the forces of 'repression'. Moreover, the dominant discourses available fashioned speakers' discursive practices and constrained the subject positions and relations of power available to therapists and clients. The possible implications and effects of these discourses and practices are discussed.
Introduction

One popular conception of the modern discipline of psychology is that it is a disembodied yet coherent 'paradigm'. However, rather than being an 'objective' and value-free body of thought, modern psychology can be viewed as a certain form of life distinctive to contemporary times. Rose (2000) recently depicted the social reality of psychology as a "complex and heterogeneous network of agents, sites, practices and techniques for the production, dissemination, legitimation and utilisation of psychological 'truths' " (p.10). Whilst not holding a monopoly, modern psychology and psychotherapeutic practice have gained unprecedented significance in public and private life as Western culture increasingly makes sense of experience through interpreting human action (recast as behaviour) through the highly individualised idiom of psychological and therapeutic discourse (Furedi, 2003). This ascent, which involves an ever-increasing preoccupation with the inner world of the self-contained individual, has been cultivated to the point where problems that were once thought to be political, economic, social or spiritual in nature are today framed from within a psychological perspective (see Burr & Butt, 2000; Moskowitz, 2001)

Generally regarded as having been shaped by the search for the 'true nature of reality' (Burr, 1995), spawned during the Enlightenment era, modern psychology set about the task of 'discovering' the 'truth' about human nature, people and society (Billington et al., 1998). Modelling itself on the natural sciences and adopting the concomitant belief in a 'knowable world' ensured that psychological inquiry, for the large part, has remained wedded to the empirical hand of science. Consequently, the traditional view of 'knowledge' has proceeded from a realist epistemology. From this perspective, the object under discussion has been viewed as a pre-existing entity whose essential nature can be delineated by a perspicuous observer and be captured in a theory or model (John, 1997). Thus the researcher or psychologist is represented as a neutral observer, immune from the influence of values or context. One of the major implications of the realist epistemology and 'scientism' driving modern psychology is that psychological 'knowledge' and theory, viewed as 'objective' reflections of 'reality', come to receive the stamp of 'truth'.
Located within institutional, political, economic, material, discursive and social contexts, psychotherapeutic practice in its current guise can be viewed as an outgrowth of modernism and the scientific worldview (Gergen, 1994). In general terms this is apparent as each of the major theoretical models and theories informing psychotherapeutic practice (e.g. psychodynamic, cognitive, behavioural and humanistic) are either derived from, or have firm links with, the modern discipline of psychology, sharing deeply in its values and assumptions (McLeod, 1999). Furthermore, the subject-object dualism inherent in modern psychology is apparent in contemporary therapeutic models' preoccupation with the individual subject or 'individualism' (Sampson, 1993).

This focus on the self-contained individual largely came into being through the humanist philosophical tradition, which put the 'self' (perceived as an independently functioning entity) at the centre of both study and values (Payne, 2000). Humanism is essentialist; it assumes that there is an essential 'human nature' or 'self' at the core of an individual that in some ways is unique or original. Subsequently, the modern view of the 'self' has been taken up in different ways by the various models of therapeutic practice in terms of their respective theories of personality and motivation, the assessment process, how they conceptualise change, and the nature of the relationship between therapist and client.

Clearly the notion of the 'self' has become a pervasive 'truth' at the heart of modern psychology and psychotherapeutic practice. However, as the scientific status of therapy as a modernist enterprise has been challenged by new paradigm epistemologies and recent attempts to place psychology in a critical historical context (e.g. Cushman, 1990; Danziger, 1997; Gergen, 1985), it has increasingly been acknowledged that the self-contained individual, so central to traditional theorising, research and practice, cannot exist independently of the observer. Such acknowledgement has drawn attention to the potentially hazardous shortcomings of modern forms of psychological inquiry and practice, i.e., their normalising and pathologising effects, (see Fee, 2000; Hook & Eagle, 2002; Parker 1999). One of the principle players involved in this critical project has been social constructionism (e.g. Gergen, 1985, 1994). With post-structural and post-modern
philosophies\(^1\) serving as a cultural backcloth, social constructionists view language as constructive and constitutive of social and clinical realities rather than as a neutral tool that simply reflects an independent 'reality'. Thus psychological knowledge and theory along with the foundational notions underpinning modernist models of therapy, such as, the 'self', 'objectivity', 'truth' and 'expertise', are recast as social constructions rather than 'actual things' (McNamee & Gergen, 1992), which are linguistically negotiated through the socio-cultural meanings that are historically prevalent (see Burman & Parker, 1993; Gergen, 1994; Potter & Wetherell, 1987). As such, attention has been re-directed towards the discursive or textual underpinnings of mental life, 'psychopathology' and psychotherapeutic practice (see Parker, 1999; Parker et al., 1995; Rose, 1989; Shotter, 1993).

Clearly the 'turn to language' (Parker, 1992) has posed considerable ethical and political challenges to modern psychology and traditional therapeutic practice. Central to such challenges is the claim that 'knowledge and social action go together' (Burr, 1995, p.5), i.e. that 'knowledge' is inextricably linked to, and emerges as, a product of discursive activity. Correspondingly, for social constructionist and critical psychologists, claims to 'knowledge' and 'truth' become important issues linked to the operation of 'power'.

White and Epston (1990) have argued that notions of power in therapy have been "much overlooked in the therapy literature generally, and especially in the benign view that we frequently take of our own practices" (p.18). They note that analyses of power in therapy literature "have traditionally represented it in individual terms, such as a biological phenomenon that affects the individual psyche or as individual pathology that is an inevitable outcome of early traumatic personal experiences, or in Marxist terms as a class phenomenon" (pp.18-19). However, from within a Foucauldian-inspired constructionist framework, 'power' is more than a concept mobilised by various interest groups. It is not a 'thing' that individuals can gain, possess and then lose; rather 'power' is viewed as an

\(^1\) Often termed 'anti-humanist' precisely because they deny the 'self' as being the essential core of identity.
interlocking series of relations, which are played out in discourse and our uses of language. Furthermore, according to Foucault (1980), the analysis of 'power-knowledge' relations becomes central to the analysis of 'power-relations', because 'power' and 'knowledge' are inseparable and implicate and determine each other. Following the thesis that 'knowledge' and 'power' directly imply one another, what is deemed to be 'truth' comes to be viewed as a product of 'relations of power'.

Directing the focus towards the relational patterns in which language is employed and the interrelation of 'power' and 'knowledge' becomes essential to the examination of 'relations of power' within psychotherapeutic practice. By viewing psychological knowledge / theory and psychotherapeutic models as discourses that systematically form the objects of which they speak (Foucault, 1980), including the 'self', the present study aims to attend to the ways in which 'claims to knowledge' and 'truth' contained within dominant discourses both reproduce culturally dominant forms of subjectivity and specify particular 'power relations' between therapist and client.

This study aims to examine psychotherapeutic discourse from a social constructionist perspective. The discursive relations between 'knowledge', 'truth' and 'power' are examined by focusing on the constructions (and their implications and effects) of psychological knowledge / theory, and psychotherapeutic models evident during therapeutic exchanges between therapists and clients. More specifically, the prevalent discourses and epistemological foundations of contemporary psychotherapeutic practice are deconstructed and critically questioned by focusing on 'power relations', i.e. the ways of acting and relating made possible by particular versions of events, between therapists and their clients within the micro context of the therapeutic relationship.
Method

Data

This study utilises pre-existing textual data (transcribed audio-recordings of therapy sessions) obtained from an archived data set that was originally collected for the second Sheffield Psychotherapy Project (Shapiro, Barkham, Hardy & Morrison, 1990). The project involved a programmatic series of quantitative investigations, which crossed treatment with duration in comparing the effectiveness of prescriptive (cognitive-behavioural) and exploratory (psychodynamic-interpersonal) therapy. The material contained in the archive was deemed appropriate as it provided a source of 'naturally' occurring psychotherapeutic discourse and practice as opposed to interview data. Clients and therapists whose interactions feature in the archived data consented to their therapy sessions being recorded and transcribed for use in the Sheffield Psychotherapy Project and in subsequent analyses undertaken by other researchers. Ethical approval for using the data was gained from the University of Surrey's Advisory Committee on Ethics (see Appendix A).

As the availability of data was limited and I was unable to view the materials contained within the archive in person, it was not possible to specify detailed inclusion criteria other than that the transcribed data should be of individual therapeutic sessions between therapists and clients. In order to simplify this process, I requested that a total of between twelve and twenty transcripts be selected randomly from four or five therapists, so as to allow a variety of discursive practices within and across the accounts to emerge.

The data set obtained consisted of twelve transcripts in total, selected randomly from four different therapists, each conducting three sessions of psychodynamic-interpersonal therapy with an individual client. The therapists, all of whom were male, were qualified

2 Psychodynamic-interpersonal therapy is based on Hobson's (1985) Conversational model. Using psychodynamic, interpersonal and humanistic principles, it focuses on the therapist-client relationship as a
clinical psychologists who had been trained in the United Kingdom and had received post qualification experience in psychodynamic-interpersonal methods. Clients were white males drawn from a target population of professional, managerial and white-collar workers from the United Kingdom. Their mean age was 49.5 years and all had presented with clinical symptoms of depression.

Though the quality of the transcription was quite basic (see Appendix B), as it did not follow the kind of notation scheme (e.g. Atkinson & Heritage, 1984) usually used for discourse analytic studies, it does include basic features such as, timed pauses in the talk and words said with particular emphasis or stress are underlined.

**Method of Analysis**

Discourse analysis is an umbrella term for a number of different interpretive and reflexive approaches to conducting research, united by a common attention to the constitutive nature of language and role of discourse in the construction of social and psychological realities. The form of discourse analysis utilised in the present study is influenced by the poststructuralist tradition, which draws on the work of Michel Foucault (e.g. Hollway, 1984; Marks, 1993). Within this perspective, discourses may be defined as 'sets of statements that construct objects and an array of subject positions' (Parker, 1994, p.245). As discourse is viewed as being implicated in the process by which 'human beings are made subjects' (Foucault, 1982, p.208), attention is given to the ways in which discourse both facilitates and limits, enables and constrains what can be said, by whom and when (see Parker, 1992). The concept of positioning (see Harré & Van Langenhove, 1999) is employed to help identify subject positions, which provide, 'a location for persons within the structure of rights and duties for those who use that repertoire [discourse]' (Davies & Harré, 1999, p.35). The socio-political concern with the assignment of subject positions through discourse means that Foucauldian-inspired vehicle for 'revealing' and 'resolving' interpersonal difficulties, which are viewed as primary in the origins of depression.
discourse analysis attempts to move beyond the situated and occasioned nature of spoken interaction in interpersonal communication, i.e., the action orientation of talk (e.g. Edwards & Potter, 1992), in order to say something about the relationship between discourse, power, human subjectivity and social relations. Its deconstructive potential, i.e., its ability to problematize and question what is usually taken-for-granted, is politically appealing in the context of the present study, as it allows us to mount a critical account of the functions and effects of psychotherapeutic practice, through examining the interrelationship between 'knowledge' and power in the production of psychological 'truths'.

Analysis of the data did not operate according to a set formula but broadly observed the following process. To start with, the transcribed data set was read line by line several times in order to identify and highlight the discursive objects that were being constructed, for example, the 'self', human 'nature' etc. For this purpose Parker's (1992, p.5) definition of a discourse as 'system of statements which constructs an object' was utilised. All references (no matter how oblique) were then taken out of the text and organised using relevant themes. The second stage of the analysis aimed to locate the various discursive constructions of the object within the specific discourses of psychology, psychodynamic theory and wider discourses of the individual prevalent in contemporary Western society. The guiding principle was to determine the functions and effects of the prevalent discourses within the texts. That is to say, I was concerned with the ways in which claims to 'knowledge' and 'truth', contained within these discourses, shaped therapists' and clients' discursive practices and produced particular forms of subjectivity. Thus a great deal of time was spent rereading texts and formulating hypotheses about how the available discourses, specified particular relations of power between therapists and clients, and circumscribed the subject positions and opportunities for action available to them.

Although the study was approached with a clear theoretical and analytic focus, influenced by my (the researcher's) interest in critical approaches to psychology, and experience of
entering and practising within the culture of psychotherapy, the various themes and analysis of discourse arose from the detailed examination of the texts. Once interpretations of the data had been formed, the extracts were examined further for evidence that either supported, modified or countered them. In the final stages of the analysis, care was taken to ground all interpretations and analytic claims empirically using quotations from the text as linguistic evidence. Though qualitative research, in contrast to quantitative (positivist) research, is relativistic, it is by no means a solipsistic form of relativism. Nonetheless, the non-realist epistemology underpinning poststructuralist and social constructionist perspectives precludes recourse to the objectivity assumed by the criteria (validity and reliability) traditionally used to evaluate quantitative research. As such, the present study should be evaluated according to the extent to which the material being studied has been rendered coherent, how well the interpretations are supported by and grounded in the texts and the utility of the insights provided (see Yardley, 2000).

Analysis

Throughout the texts, speakers make a number of claims to 'knowledge' and 'truth' relating to the nature and development of the 'self', problem formation and problem resolution, which are routinely expressed in naturalistic accounts of life and identity.

The extracts that follow have been selected in order to render more visible the ways in which speakers' discursive practices are influenced by the prevailing 'images of the individual' contained within humanist, psychological and psychodynamic discourses. In establishing a sense of what is 'real' and 'true', speakers' 'claims to knowledge' structure therapy as a context that is both constituting of the modern subject and reproducing of dominant cultural notions of what it means to be a 'real' person, e.g. 'self-contained', 'individuated', 'autonomous', 'self-actualised' and so on. The discernments made in their accounts implicate, or are dependent for, their meaning upon taken-for-granted psychological 'truths' concerning the presumed existence of an essential human 'nature' or
'self'. As such, speakers' 'knowledge' practices work to 'naturalise', and hinder a consciousness of the constitution of life through such 'truths'. Arguably this has a 'normalising effect' that largely obscures the operation of power in determining what is deemed to be 'true'.

Whilst there are numerous aspects of the texts that could be attended to, in terms of how participants use and manipulate discourse to achieve certain ends, my concern at this stage centres more upon the ways in which speakers are products of, and are spoken through, dominant discourses. This in turn will enable a more situated deconstruction of the specific professional discourses, 'knowledge' practices and 'power-relations' on show in the texts and the implications and effects these hold with regard to psychotherapeutic practice.

T = Therapist
C = Client

Extract 1: (Transcript 11)

46 T: It feels to me as if, I mean it's not so much digging in the past as kind of just bringing..bringing things together (C: yes) putting the pieces of your life together in a way
47 C: Mm. Things that I've just sort of tended to push away on one side and forget.
48 T: Push away and forget, yeah and...
49 C: Yeah, and I ought to bring them in, sort, sort of line them all up and say well look, "There they all are."
50 T: This is me.
51 C: This is me, this is what happened, yes, yeah.
52 T: This is..is all part of me and it's important and..and..and that my tendency to..to shut things off and run away from things is may be not..not the best thing for me now. (C: mm) Maybe now's the time to put the pieces together a bit.
C: Mm, mm. Yeah, yes. I...I can see a certain amount of sense in it, because it's sort of almost as though I'm sort of building up a base or I'm trying to sort of reconstruct my life (T: mm hm) on top of it. Er..
T: Reconstruct yourself.
C: Myself, sorry, yes, myself.
T: To know who you are. (C: yeah, yeah)

Extract 2: (Transcript 4)

T: It feels to me it's something about, something deeper than that. It feels to me it's something about not [3] not having a depth inside. [9] Somehow not having, not having anything inside you to give, it seems (C: mm, mm) empty and hollow, I don't know whether that's actually the words..
C: Well I do feel empty and hollow (T: yes) there's no doubt, yeah I feel there's nothing there. (T: nothing there) Dead right (T: mm) dead right. (T: mm) Um...
T: [3] And I reckon if you're feeling there's nothing there, it may be because there are things there that you're not able to say. (C: mm) And that, there's like...we've talked about the frustration (C: yes) OK (C: yeah) it's...and there's...with Q. you get, you know, you get angry and you don't (C: mm) you don't really come out with it. I, you know what I mean (C: yeah) there are feelings that you're not expressing (C: yeah) if all the time, you're not coming out with what you're feeling

One of the most defining and pervasive features throughout the texts is the tendency of speakers to utilise naturalistic explanations that either implicitly or explicitly evoke the 'nature' of the 'self'. In the texts, clients primarily display their identities through making 'declarations' in the form of 'self-reports' to their therapists. During these declarations, the 'reality' of the 'self' is partially established through the clients' indexical use of personal pronouns such as 'I' and 'me'. Such 'self-talk' is encouraged and developed by the therapists who use the terms 'you', 'you're' and 'you've' in responding and commenting
upon the clients' declarations. This works to establish the 'self' as a 'real' entity and as the 'correct' object of therapeutic discourse.

Such structural and essentialist understandings of identity formation, i.e., the idea that there is a 'self' or 'personality' residing at the centre of who we are, structures therapeutic practice and discourse in such a way that the client is invited to make certain kinds of 'discoveries' about their 'true nature' and what troubles them. As evident in the first extract, therapy is constructed as a benign and emancipatory process involving "..bringing things together.." and "putting the pieces of your life together.." (line 47), which supposedly enables the client to 'discover' or 're-discover' his essential 'self', become more 'whole' and therefore live a life that is a more 'authentic' expression of his 'true nature'. The context for the 'discovery' - "This is me" (lines 53-54) - and the significance this realisation takes on are made possible on account of the guiding therapeutic goal of attaining self-knowledge or self-understanding, e.g. "To know who you are" (line 63), thus fulfilling the ancient injunction 'Know Thyself'.

The widespread cultural and therapeutic pursuit of uncovering the 'truth' of human life in the form of 'self-knowledge' is central across the texts and is influenced by what Foucault (1988) considered to be the central philosophical question of the modern era in Western society, namely, "what is the truth of who we are?" Integrally bound to the discourse of the 'individual', which elaborates norms of 'autonomy' and 'self-realisation', the workings of the 'will to truth' (Foucault, 1988) are visible in the texts as clients' expressions of life and of identity are set in contrast to images of more 'ideal' or 'natural' states of being. In the first extract the influence of the cultural and psychological imperative of 'facing up' ("Yeah and I ought to bring them in, sort, sort of line them all up and say well, look, There they all are" - lines 51-52) and 'being real' ("This is me, this is what happened..." - line 54) works to situate the client and their problems within such normative discourses that set standards for mental health and self-realisation. One implication of the discursive practices supporting this discourse, is that clients are encouraged to think that they have
to 'develop' or 'improve' themselves in order to close the gap between where they currently stand and more culturally and psychologically 'desirable' ways of being.

The prevalence of humanist and psychological discourse, along with the associated view that there exists an essential 'self' or human 'nature', has led to a great lament concerning "How comes it that we all start out originals and end up copies?" (Geertz, 1986, p.380). This has become of paramount concern and comes into focus in the texts as therapeutic work is motivated by a search to discover and overcome that which stands in the way of the client becoming who they 'truly' are.

Throughout the texts this 'will to truth' is discursively linked with the psychoanalytically derived notion of 'repression', which is construed as the guilty party; as being that which obscures and conceals from the client their 'true nature'. The idea that the client is in possession of an 'essential self', and that their 'true nature' is hidden to them through the forces of repression, is achieved as speakers employ and contrast metaphors of 'surface' and 'depth', 'inner' and 'outer', 'centre' and 'periphery' and 'conscious' and 'unconscious' during the therapeutic dialogue. In each instance the use of these metaphors creates a highly individualised image of the 'self' as a bounded and dynamic unit containing different parts or layers that are frequently in conflict. Furnished out of psychological and psychodynamic discourses, the client is depicted as being in possession of invisible or 'hidden' essences and elements (e.g. psychic material and 'unconscious' desires, emotions, needs and so on) which are seen as incorporating more 'truthful' statements about their 'true nature', and are held responsible for inducing illness through having not been expressed.

For example, in the opening sequence of the second extract (lines 352-355), the therapist employs the image and metaphor of the 'depth' of a person in order to suggest that there is something going on that is currently outside the client's awareness ("something deeper than that"). This is done in a tentative fashion ("It feels to me it's something about..."), which functions to reduce authoritative overtones and minimises the extent of the claims.
that follow. The suggestion that follows, i.e., that the client is lacking in 'depth', has nothing inside to give and is "empty and hollow" (line 354), is interspersed with several qualifiers, for example, "something about not", "somehow not having" and "it seems", which soften, and make it more difficult to contest, what could be seen as a rather negative and unpalatable description. The final qualifier - "I don't know whether that's actually the words..." (lines 354-5) - serves to downplay what the therapist has just said. In this account (as in others across the texts) it is emotion (e.g. "It feels to me..."), rather than speech or thought that is accorded privileged status and serves as the justificatory base to the therapist's assertions. As the therapist provides no other overt information (i.e., reference to personal experiences, professional training or theoretical allegiances through which one's knowledge claims are generated) here or at any other point in the texts, other than his 'feelings' to situate his assertions, it becomes difficult for the client to determine how they might take the views expressed by the therapist and it restricts the range of possible responses available to them.

Moreover, the dominance of 'deficit' discourse, for example "not having a depth inside" (line 353), locates problems squarely within the client who finds himself to be 'lacking' when viewed in relation to the 'truths' of human 'nature' and according to the psychological 'norms' championed by these 'truths'. In effect, the discursive practices associated with these discourses equate 'knowledge' and 'truth' with meaning 'objective' or 'intrinsic facts' about the 'nature' of people. This creates an in-built injunction that makes it difficult for the client to raise questions about the therapist's 'claims to knowledge' or about the socio-political and historical contexts giving rise to these 'truths'. Accordingly only those discourses relating to the 'individual self', 'human nature', 'feeling' and 'normality' tend to be encouraged and developed by the therapist (in accordance with psychodynamic theory), whereas other discourses relating to culture, gender, inequality and power are kept out. Consequently, the client in the second extract is compelled to make sense of his identity, lived experience and difficulties through the 'prism of emotion', which is privileged throughout the texts as a legitimate area for therapeutic scrutiny.
Notably, this subjugation occurs freely as the client does not rail against or contest the therapist's assertions. Rather, he fully enters into viewing and speaking of himself from within the discursive frame provided, e.g. "Well I do feel empty and hollow" (line 356). This piece of 'self-realisation' ("there's no doubt, yeah I feel there's nothing there") is offered unreservedly and is strengthened as the therapist reflects back to the client "nothing there" (line 357), which subtly encourages the client to continue in this vein. Having gained repeated and unconditional confirmation from the client (e.g. "Dead right..."), which is interspersed with affirmative noises (line 357), this exchange works to increase the veracity of the therapist's 'knowledge' claims, thus strengthening his position as an authority on the client's life and problems.

As the discursive practices within psychodynamic discourse include the notion that the client has 'unconscious feelings', which the therapist is superior at inferring and understanding, it becomes possible for the client's expressions of living and identity to be recast as 'surface manifestations' of 'repressed' emotions that are believed to be a more accurate or authentic expression of the client's 'true nature'. In the final part of the second extract (lines 358-363) the therapist offers the interpretation that the cause of the client's problems is a blockage of his 'true feelings', i.e., ",...there are things there that you're not able to say" (lines 358-359) "...you don't really come out with it" (line 361) and "...you're not coming out with what you're feeling." (lines 362-363). The act of interpretation is represented as a catalyst, bringing into the client's consciousness what was previously 'unconscious' or 'repressed'. This discursive practice constructs therapy as a process that psychologically 'liberates' the client's 'true nature' and 'self' from the forces of 'repression'. In doing so, it actively constitutes the subjectivities of an 'expert' therapist and an 'unknowing' client who is unable to understand himself without the aid of the therapist.

In summary, the analysis has gone some way towards exposing the ruse. In using 'techniques of the self' elaborated by therapists (e.g. modes of self inspection and
vocabularies of self-description) in the name of psychological liberation, clients are incited to scrutinise and act upon their emotions, their thoughts and their forms of conduct in order to become and express more authentically who they 'really' are. However, rather than 'revealing' something intrinsic about clients' 'essential self' or human 'nature', this poststructuralist reading of the texts highlights how the 'claims to knowledge' and 'truth' made by speakers work actively to constitute the self, rather than reveal a pre-existing entity, and in doing so reproduce culturally dominant forms of individuality.

As has been highlighted, speakers' subjectivity (including the problems for which they seek help) is constituted through modernist-derived psychological and psychodynamic discourses - that is, by the effect of power/knowledge. However, therapy in the name of psychological liberation arguably constitutes a blind spot to life as it is produced and as we produce it. The constitutive effects of power are largely invisible to speakers, who for the most part willingly embrace their own subjugation through the influence of presumed psychological 'truths'.

As such 'truths' are determined through relations of power, the final part of the analysis will attend to the local 'power relations' between therapist and client by examining the 'subject positions' made available to them in discourse.

**Extract 3: (Transcript 12)**

251 C: So I..I am at fault there because I don't show the affection. I
252 don't say anything nice. It...
253 T: Mm hm. Because it's hard for you to say nice things. (C: mm, mm..mm) It's hard for
254 you to show.. to show affection.
255 C: Yeah.
256 T: That's important.
257 C: Yeah.
258 T: There's something..I bet that's..I bet that's important. (C: yes) It's hard for
C: Um... If one relates it to say a meal, um...if a meal is very nice I...I might say, "That was a nice meal." But I tend to just um, I suppose take it for granted. (T: mm hm) I do sometimes say, "Yes, I enjoyed that meal." But I don't say, "Well you've put a lot of effort into it," or anything like that and I should. Um...on the other hand, if the meat's a bit tough or something like that, I will always tell her. (T: mm hm) So, that's not really...I really ought to be trying to give her more encouragement.

T: OK. You can see what you ought to do in all that quite clearly. I think what...what we need to do here, what's important for us to do is to look at what stops you. (C: yes) To look at what stops you from doing the things which when you stop to think about it, you can see are right. (C: yes) And...and I think we've touched on something that is...is pretty important in your life about showing affection. (C: mm) Because it comes up in relation to the...to the girls as well. And it comes up, I think it may come up also in relation to the whole business of working with people, and the kinds of friendly contact with people that you find difficult to make at work too. (C: mm) You will always keep your distance, go out for a walk, not talk about things. (C: mm) And it's not just angry feelings you're avoiding, I think it's...it's loving...it's loving feelings as well (C: mm) that you're not expressing.

Extract 4: (Transcript 8)


C: Yeah, I feel suddenly a lot... calmer. (T: mm.. do.. you look..) I think that actually having to say to you what I just said was.. I wanted to say it (T: yeah) you see it isn't easy to say.

T: Right..right.. I was aware of actually.. letting you go through that, because somehow it felt like you.. you have to tell the story, you had to say. (C: mm) you had to lead up to the point about what you realised at the weekend about (C: mm) maybe not going back. (C: mm) That actually it was important for you..

C: Well I find that hurtful to say, mm...
Extracts three and four provide further evidence of the influence of the discourse of the individual. At the local level of psychotherapeutic practice, the prevalence of this discourse has the effect of configuring and constraining the power relations, discursive practices and subject positions available to therapists and clients in particular ways. One notable effect, which features heavily across the texts, is that the therapeutic relationship and therapeutic interaction are virtually always represented as a one-way process. Only the client speaks, as it were, on their own behalf, whereas the therapist utilises a more or less established theoretical framework to classify and decode the client's expressions of life and identity according to the conceptual categories contained within psychodynamic discourse.

For example, at the beginning of extract 3 the client (referring to his relationship with his wife) tentatively and reflexively positions himself as being personally culpable ("So I...am at fault") on account of not showing affection or saying anything nice (lines 251-252). In response the therapist provides an explanation for the client's actions. On both charges, i.e., of not showing affection or saying nice things, the therapist tells the client that this is because "it's hard for you" (lines 253-254). Whilst to all intents and purposes this explanation is, no doubt, made with the client's best interests in mind, it nonetheless
inadvertently positions the client as being emotionally illiterate. Given the relative structural inequality of 'therapist as helper' and 'client as helped' it is perhaps not so surprising that up to this point in the exchange the client does not contest this position. Though he has not explicitly taken up or supplemented what has been said he appears to agree with the therapist, e.g. "mm, mm..mm" (line 253), "Yeah" (lines 255 & 257). As such, it is the therapist who is in a position to define what is significant, e.g. "That's important" (line 256), and how the client should understand his situation and what the 'correct' focus of their conversation should be.

The therapist reinforces his pronouncement - ".I bet that's..I bet that's important (C: yes) It's hard for you to show affection" (lines 258-259). Given the association with gambling and therefore 'risk taking', the use of the phrase 'I bet' might seem somewhat curious in the context of therapeutic discourse. Nevertheless it appears to work on two levels. On one hand it signals the conviction and certainty with which the assertion is being made. On the other it can be heard as a challenge (either agree or disagree with the claim) and as a prompt for the client to say more. It appears to have the desired effect as the client then provides the therapist with further information by relaying an example of what he might say to his wife following a meal she has made (lines 260-265). Through contrasting what he does say ("..I might say, 'That was a nice meal'") with what he doesn't say ("But I don't say, 'Well you've put a lot of effort into it', or anything like that and I should") the client implicitly confirms the therapist's 'bet' and simultaneously positions himself as being morally reprehensible. In effect, he accepts the position of emotional illiterate, i.e., as somebody who cannot understand or manage his emotions, which works both to justify and mask the call for therapeutic intervention.

A consistent and characteristic feature of the texts is a dialogic one-sidedness to the therapeutic exchanges. The client is encouraged to probe ever-deeper into their own psychological history and situation; however, the therapist reveals nothing of their self. Though ostensibly the sustained focus on the inner world of the individual appears to place the client at the centre of therapy, paradoxically it works to centre the therapists'
professional 'knowledge', 'expertise' and skill. This particular power relation is pervasive (albeit in an obfuscated form) because it operates in relation to supposed psychological 'truths' about 'human nature'. As such, the ways of being and discursive practices available to therapist and client are not seen as the effects of relations of power but rather as a 'natural' consequence of the process of psychological 'liberation'.

As apparent in the final part of extract 3 (lines 266-276), primacy is given to the client's inner dynamics, which ensures that the client views himself as the locus of responsibility. This is reinforced through the therapist's selective use of 'you' and 'we' or 'us'. For example, the therapist positions himself as an ally or comrade (and as part of the solution) - "...what we need to do here, what's important for us to do..." (lines 266-267) and "...we've touched on something that is...is pretty important in your life about showing affection" (lines 269-270) - which unwittingly draws attention away from his position as arbiter of 'reality' and the client's corresponding location as an 'object' of professional discourse/knowledges. However, at no point does the therapist acknowledge himself as part of the problem context, i.e., constituting therapeutic problems (as well as solutions) by the way he carries out the therapeutic interview and endeavour (O'Hanlon & Wilk, 1987). Instead the problem and ultimate responsibility for resolving it lies squarely with the client, e.g. "You can see what you ought to do in all that quite clearly" (line 266) and "To look at what stops you from doing the things which when you stop and think about it, you can see are right" (lines 267-269).

Having verbally drawn attention to and gained sufficient confirmation from the client - e.g. "Yes" (lines 267, 269) and "mm" (line 270) - that 'showing affection' is problematic, the therapist continues building a description of the problem that fits with psychodynamic theory. It is no coincidence then that psychodynamic discourse and practice (as with other models of therapy) engenders psychodynamic problems in the client. The therapist reinforces the problem definition by pointing out interpersonal situations that the problem 'comes up' in relation to and connects this with the client's avoidant responses - "You will always keep your distance, go out for a walk, not talk about things" (lines 273-274). As is
pervasive throughout the texts, this culminates in the construction of the problem as being the 'repression' or lack of expression of the client's 'angry' and 'loving' feelings, which in psychodynamic discourse are accorded privileged status as primary emotions (Rycroft, 1972). This particular construction of the problem contains within it the solution to the problem, i.e., unblock that which is repressed in order to 'liberate' the client thus enabling them to express more authentically who they 'really' are.

Though the therapist's account appears to be grounded in information obtained from the client in prior conversations, at no point is attention paid to any gaps, inconsistencies or contradictions in the client's narrative where he has shown or demonstrated affection in a satisfactory manner. This leads to totalising descriptions of the client as a person who cannot show affection. As such, the client is repeatedly placed on the deficit end of the adequacy/inadequacy continuum. Arguably, such descriptions are capturing of the client who is positioned as 'other' and is therefore subject to a marginalisation of their identity.

This particular relation, which entails the objectification of the client as they are positioned as the recipient of the therapist's professional 'knowledge' and skill, comes together in the idea and ideal that the client is the person who is changed as an outcome of therapy. This is clearly visible in extract 4. For example, the therapist observes "You're talking easier about it now" (line 351) and later "..your arm's still" (line 364). Likewise the client reports "Yeah, I feel suddenly a lot..calmer" (line 352) and "I feel much more peaceful.." (line 365). Thus the focus is on the ways in which the client is changed. Furthermore the passage through the therapeutic is constructed as an arduous and typically painful process that the client 'needs' to go through alone. The therapist responds positively - "Right..right" (line 355) - to the client's remark "you see it isn't easy to say" (lines 353-354) and discloses how he was aware of "..letting you go through that.." (line 355). To this end the therapist positions himself as a detached spectator who knows and can see what needs to happen but purposefully remains out of the way, which reinforces the onus on the client to accept individual responsibility. This particular construction of the change process, which invokes the image of the client having to 'go
through the fire' in order to 'come into the light', may seem somewhat 'cruel' to those not familiar with psychodynamic discourse, as the therapist appears to be purposefully withholding from the client. However, within psychodynamic discourse and practice this reflects the view that change is a painful process and journey that each person must ultimately navigate alone in order to achieve autonomous selfhood. Though the one-way account inherent in psychodynamic practice promotes psychological liberation and empowerment, a more cautious reading requires us to review the consequences and effects of such relations. At the end of the extract the client attributes change to having "been able to share that with you..." (line 369). However, reciprocity and a sense of equal exchange is by passed in this one-way account. Therapy becomes a 'gift', as the client changes whilst the therapist remains the same as an outcome of therapy. As such, this relation holds the potential to become one of domination due to the increased risk of the client feeling 'indebted' to the therapist. As Mause (1954) wrote regarding the potential hazards of such unequal relations, "To accept without returning or repaying more is to face subordination, to become a client and subservient...to receive something is dangerous not only because it is illicit to do so, but also because it comes morally, physically, and spiritually from a person" (in Epston & White, 1992).

Overview

In line with Parker's (1992) recommendation that we 'consider all tissues of meanings as texts' (p 7), this study used transcribed audio-recordings of psychotherapeutic sessions, viewed as constituting suitable texts for analysis, as the source of data. Within an empirical framework, the small sample used might seem questionable. However, in contrast to quantitative research where validity depends on a large sample, discourse analysis depends on a representative sample of texts, not participant numbers (Coyle, 2000). In order to be representative of the phenomena under consideration, the data being analysed needs to represent what Coyle (2000) refers to as a "variety of discursive forms" (p 247). The original study, from which the data were drawn, was quantitative in nature and specified clear objectives, strategies and techniques in the form of manualised
treatment protocols, in order to maximise control over therapist and patient variables. Though the quantitative measures taken in the original study to deliver a tightly controlled form of therapy were appropriate within the context of the original researchers' aims and method, the data generated do not exist in a vacuum and are not immune to the influence of broader cultural, psychological and psychotherapeutic discourse/knowledge within which they are located. As such, the random sample selected for this study, though small, provided sufficiently varied discursive forms both within and across accounts in order to be representative of the research topic.

Nonetheless, further criticism may be directed at only four extracts having been selected for discussion and it could be argued that the analysis was based on pre-determined ideas and upon an idiosyncratic framework. However, a discourse analytic approach attempts to make explicit the researcher's position and the relationship between theory, method and data. As such, the analysis does reflect the interplay between ideas developed as a result of my own experience of being a client and a therapist, reading of relevant literature and themes made available within the texts. Within the limited breadth of this study, the extracts selected for inclusion in the final report, were chosen as they provided good illustrations of themes that had emerged at an abstract level during the analytic process, whilst remaining grounded in the data. The account offered here is one possible construction made available by these texts and remains open to alternative interpretations. It has been presented to highlight aspects of psychotherapeutic discourse that this researcher takes to be salient and politically informative for the development and practice of psychological therapy.

Given the preceding discussion, the research has generated findings worthy of reflective consideration. In the first half of the analysis, the active constitution of the 'self' through culturally prevalent 'images of the individual' contained within humanist, psychological and psychodynamic discourses were rendered more visible. Speakers' 'knowledge' and discursive practices were seen to operate in relation to presumed psychological 'truths' concerning human 'nature' and the 'self', which had the effect of situating clients within
normative discourses of mental health and self-realisation. This operated in tandem with the construction of therapy as an emancipatory process, which 'liberates' clients' from the forces of 'repression'. A notable effect of this construction was that relations of power were obscured, as 'truth' was equated with 'objective' or intrinsic 'facts' about the nature of people. Consequently, clients were incited to embrace openly their own subjugation and view themselves as the sole locus of responsibility. The ways of talking, thinking, feeling and acting that were enacted served to reinforce, reproduce and support the discourse of the individual and at the same time silenced that which did not fit with this discourse. Thus the successful operation of power was proportional to its ability to hide its own mechanisms (Foucault, 1980) and was intimately connected to the continual constitution and recreation of the subject, i.e., the representation of the individual in discourse.

The relationship between 'knowledge', 'truth' and 'power' was further explored in the latter part of the analysis by homing in on the ways in which the 'knowledge' and discursive practices associated with psychodynamic theory and the discourse of the individual configured and constrained the power relations and subject positions available to speakers. Here, the therapeutic relationship and interaction were constructed as a one-way process wherein only the client was changed as a result of therapy. This particular representation of psychotherapeutic practice established a power relation that marginalized clients' identities as they were positioned as objects and recipients of the therapists' professional 'knowledge' and skill. As such, the subject positions made available to speakers were those of 'expert' therapist and 'unknowing' client, both of which facilitated and constrained their opportunities for action.

It might be argued that this particular study, which reinstates queries regarding the role of psychotherapeutic practice as a potentially normalising and socially regulative discipline, only points out what other researchers and clinicians already know, and that the concerns raised about power relations don't really matter if therapy manages to alleviate psychological distress. However, in light of Parker's (1997) observation that, "most psychologists live so comfortably in the subject positions that are laid out for them in the
psy-complex that even reflection on the consequences of these ways of speaking and writing [and practising] will seem strange or pointless to them" (p 124), it seems that such critique continues to be valid. It gains further momentum in relation to counselling psychology's ongoing commitment to reflective forms of practice (Woolfe, 1996). Perhaps more than anything else, this paper has drawn attention to the constitutive effects of discourse and the need for practitioners to acknowledge and embrace the ethical responsibility that they bear for the real effects of their work in the constitution of the lives of the clients who consult them. A discourse analytic approach provides one way in which counselling psychologists might attend to and examine the effects of the discourses they engage with in the context of therapy. This in turn might help to bridge the individual-social divide and assist practitioners to step outside the boundaries of what is familiar and known and to challenge the limits of our current ways of thinking.
Use of self

This research project came into being for many different reasons. Through my own personal history and experiences of life, I have come to prefer values of equality, mutuality and respect for difference. Seeing people being subjected to abusive, oppressive, unequal or disrespectful practices makes me feel angry. During the course of my adult life and upon entry to the culture of psychotherapy, I have become increasingly sensitised to and have attempted to acknowledge my own privileged cultural location as a white man subject to living in a male dominated culture. My experience of being personally and professionally oppressed, i.e., being objectified and negatively positioned, and my limited attempts at resistance, within the context of one particular clinical supervisory relationship, reinforced my preferred values and ways of being. As my experience of this particular relationship represented what I wished to avoid in my own work with clients, my desire to explore the implications and effects of such practices grew. As such, my decision to conduct research into the relationship between 'knowledge', 'truth' and 'power' represents an attempt to understand complex issues that touch upon and shape my own personal and professional identity and experience of life. It is set within the overarching context of developing my own preferred approach towards practice as a counselling psychologist. Above all I see my research as an ongoing personal, professional, political and ethical commitment to reflect upon, question and challenge the implications and effects of both my own and the wider psychological community’s practices. My hope is that this research will assist my own attempts to find ways of facilitating mutuality and shared understanding between clients and myself, thus minimising structural differences and inequality, whilst stimulating further reflection and debate amongst other counselling psychologists.

The process of conducting research was both stimulating and challenging. I quickly became aware of the sheer complexity of the issues I was attempting to investigate and felt that I had bitten off more than I could chew. Pressures to meet the multiple requirements associated with a Doctoral level training meant that the spectre of failure seemed to loom ever large in the background. I frequently felt bogged down and
overwhelmed by the richness and volume of the data, which were open to multiple interpretations. Perhaps the key dilemma I faced was in regard to what to include in the analysis. Though a discourse analytic framework does provide a means of being explicit about the relationship between the researchers own position and interestedness in relation to the data, I still felt constrained and uncertain. It was difficult trying to honour and do justice to my own interests and interpretations without falling into a solipsistic form of relativism. The most difficult part of the analysis, then, was trying to ensure that the themes that I had identified at an abstract level during the analytic process were grounded in the data and not just a case of me seeing what I wanted to see.

Whilst within the context of social constructionist and discourse analytic frameworks I find the open recognition that any research 'findings' are but one construction or interpretation available amongst a multitude, to be liberating, my own research efforts continued to be tinged with trepidation. Significantly, whilst explicitly attempting to say something about the relationship between 'knowledge', 'truth' and 'power within the context of psychotherapeutic practice, I am acutely aware of my own location within institutional and academic contexts. The subject position of 'trainee' and associated discourse of evaluation within which I am currently located, in reality means that some constructions and realities are more acceptable than others. Thus the ongoing challenge throughout the research was to construct an analysis that was shaped by the data but that also took into account the wider personal, professional and political contexts in which it was generated.
References


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27 June 2003

Mr Mark Craven
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Dear Mr Craven

Between the real and the not real: ‘knowledge’, ‘truth’, ‘power’ and the creation of clinical realities. A discourse analytic study of psychotherapeutic practice (ACE/2003/49/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2003/49/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 27 June 2003
Date of expiry of approval by the Advisory Committee on Ethics: 26 June 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr A Coyle, Supervisor, Dept of Psychology
Appendix B

Copy of Eighth Transcript

C = Client

T = Therapist

1 C: Um...I'm afraid I've had a...bad time. Um [5] I er... (sighs) [inaudible] last er... Friday. Um just to er... meet my deputy (sighs). Um.. [4] and I er.. I felt, you know, quite [3] confident about that um.. [4] I was.. I was.. a little apprehensive as I.. I went in, but I.. I assumed that I would be anyhow. And.. [8] and.. I'm sure he was.. trying to be.. [4] helpful and [4] and I just had er.. well I.. (sighs) [5] I er.. felt... that I was intruding.. [3] somehow. And er.. (sighs) [3] I the more we.. spoke um. [3] the sort of.. enormity of (sighs) [6] sort of what lay ahead of me to get back, er.. just seemed (sighs) quite gigantic really. Um.. (sighs) [7] I er.. sort of talked about what...what I.. hoped would be (sighs) sort of helpful programme for me for...the next two weeks and er [10] he had some doubts about whether... some of my ideas would be right because of [3] things that had happened since I've been away and [3] and then we talked about some of the things that had happened. Um.. [3] some of the things that he felt that I needed to come to terms with (sighs) if I was to er... to go back. Um.. [5] we spoke about a lot of things that had happened that.. had obviously gone very well. Um.. er.. I.. I feel that in doing that, he was.. trying to be assuring and yet. .in a way..

T: It felt like you..

17 C: I just felt (T: (un)needed in some way) (sighs) yes, I just felt out...outside it, and not understanding everything that um... he was saying (sighing) um... well I.. I.. I left the school um... feeling (sighs) um.. [3] I don't know... of.. [4] frightened I suppose, but I.. I sort of had this feeling again that.. I'd had some months ago about something um.. [2] awful that was going to happen. And um.. (sighs) well I... the rest of the day wasn't very happy for me. Um (sighs) I er.. I didn't really say very much, but I was very sort of weepy
and... um... I was able to control that to some extent in the evening when my... when N. came home. Um... but I didn't sleep at all in... at night, um... I just... I was hardly in bed really I... um [4] sort of... went back to the situation of all sort of things to do with school looming up and... er...

T: I mean you're... you're clearly kind of. distressed now.

C: Yes, I.. I feel... yeah.

T: Yeah, you're, you're all up tight and you're...

C: Yes. (sighs)

T: [5] Can we just.. go back to.. and stay with what.. the feeling as you left the school? (C: yes, mm.. ) You were.. you're talking, I mean there's.. there's the kind of enormity of what you saw before you. (C: mm) But then there was (C: sighs) you were talking about the frightened feeling.

C: Well I think I.. I'd run into the school.. although apprehensive Um.. I'd gone into school, I mean I.. you know.. I had been feeling better, a lot better than I'd been (T: mm hm) and er.. and yet in a way I was (sighs) sort of leaving with many of the same feelings that five months ago.. that morning. (T: mm) had just been.. all brought back and er I was feeling er.. (sighs) very much the same. (T: right) Um..

T: Right.. just.. just how you are now. I just. just noted that it's as if you're trying to sort of somehow hold everything...

C: Well I think I.. I'm.. I'm.. conscious that my.. I'm shaking and er.. I'm trying to stop that.

T: But it's that somehow you're trying.. you're trying to control and (C: mm) keep everything (C: sighs) everything in.

C: Well I'm trying to control them.. control my se-self, yes.

T: And if somehow, if you don't.. what will happen?

C: Well I.. I feel that I need to talk to you (T: yeah) and that.. yeah... if I'm.. if I don't.. just.. keep my grip and er.. that might become particularly difficult.

T: That showing emotions would be difficult?

C: [2] No.. that.. (sighs)

T: You want to talk..

C: If I want to talk to you (T: yes) I want to be able to.. (T: yeah) talk rather than
get held back by getting.. too upset.

T: Right. But as if somehow.. while you're talking to me, you're also using up and trying
to kind of.. keep on top of..

C: Mm. I-I-I want to talk to you (T: yeah) I want to tell you..

T: I-I hear.. I know that. (C: mm) But I'm.. I'm just also kind of.. (C: sighs) seeing
you in a lot of distress and.. that.. there's but somehow feeling like as if you've got
to sit on it and (C: mm) you can't somehow let it just..

C: No, I-I'm not worried about showing distress really, I just want to be able to talk.

T: Yeah, yeah.. yeah.

C: All right? (T: yeah) Mm.. I er..

T: I suppose it.. (C: sorry) I.. I want to say to you (C: yeah) it's OK to..

C: Right (sighs) mm.. (sighs) I um.. (sighs) I um.. [2] on Friday evening um.. very
late on Friday evening, there was a letter pushed through my door and it was
from my er. chairman of governors asking if I could meet him over the weekend. And
obviously my deputy had been in touch with him, and um.. so I went to see him on um.
Saturday morning for a couple of hours. And er. again, he was trying to be helpful, um..
(sighs) he was talking about er [3] strategies for going back I suppose and um.. that he
was concerned that [4] for my health and.. but also that he had to be concerned for the
school. that.. if I was to go back and lead the school that er.. I wasn't in a sort of
teacher's position where to a much greater extent.. er.. you can work your way back in.
And I understood what he was saying and.. I. and.. and.. I.. I couldn't argue with that.
Um, I mean, again, he was talking about things that had been happening within the school
and er.. I suppose that was more or less in emphasizing in a way um.. what my deputy
had said on Friday. (sighs) Er.. [2] (sighs, blows nose) [5] well.. Saturday afternoon, well
the rest of the weekend really was just a mess.. um.. (sighs). [4] Er.. N. and I tried to do
things um, rather than just sit about, but er.. I.. I again didn't sleep on Saturday night.
Um.. [3] I.. I got some.. I suppose I got some spasmodic sleep.. sleep on Sunday, um..
but it was sort of.. (sighs) I don't know, difficult to know how long I slept, but I kept
waking up in a panic sort of situation and er.. very hot and sweaty and.. upset and er.. I
spent quite a number of hours downstairs, reading and.. (sighs) [3] Yesterday er.. [3] I
was a bit more peaceful um.. I think, perhaps mainly because I.. I didn't do any walking on Saturday and Sunday and er.. although I was feeling.. very tender at the beginning of the morning, I did go out and walk and um.. I.. (sighs) I said.. well I think peaceful wasn't the right word. I did feel more peaceful about it, um.. last night I read to the.. the.. sort of early hours and then fell asleep and in fact didn't wake up till.. er.. sort of twenty to seven. And I think, knowing that I was going to come to see you today was again.. um..

[3] a help, um.. [6] but um.. (sighs) I.. I suppose I had some feelings at the weekend that.. that I hadn't had before. Um.. [6] I suppose was that I.. I didn't.. I didn't imagine that um, when I was with you last week that.. er.. I'd never get er.. as low as I-I have been again. I felt, you know, I really did feel.. not better, but much better than I had been, particularly looking back. Um.. but also, I just don't want to go through that situation again, but I think perhaps the thing that bothered me most was that N. 's been very upset this weekend and er.. (sighs).. I just don't want to put her.. (sighs, tearful) through what she's um.. had to go through (sighs).. over these past months. Um.. I mean she certainly.. was feeling happy about er, me last week and er.. (sighs)and was sort of plunged back into this [4] situation and this supportive role again. (sighs) I just don't feel I've got a right to.. .I know she would, [3] but I'm just very concerned about what it's.. er.. doing to her. I wouldn't do it to her. [7] I.. I had a telephone call from um.. my staffing officer yesterday, he.. I suppose either the school or my.. chairman [inaudible] must have contacted him. Er.. (blows nose) he's a man that I've.. sort of.. had a good deal of respect for over the years. Um.. [inaudible] he has.. on many occasions been very helpful and understanding, um.. so he wasn't the sort of person that I didn't know and er.. basically he.. he.. he.. er.. rang because somebody had said that there was a possibility that I was thinking of.. I might be going back soon. And that um.. that he.. he said that he.. that he needed to therefore let me know that.. when people had been off with a similar condition that.. .I've.. .I've been in for more than three months, that um.. the authority have somebody at the education department who er.. needed to see me to.. (sighs) er.. um.. agree I suppose with the.. the doctor's report that I am fit to resume. That's why he was ringing um.. but er.. (sighs) anyhow I.. [3] did talk to him about what had happened in fact over the weekend and er..

[6] he was understanding. [4] But I er.. [3] I suppose perhaps for the first time it..it.. it
just hit me that maybe [3] I might not be going back. That maybe er.. (sighs) [6] this has.. (tearful) in order to become.. well again, um.. [5] (sighs) [4] I won't be doing the job again. [4] I.. I suppose although it might seem a bit strange, it's just something that I've. not [inaudible].

T: Not come to you before?

C: No.. I.. (sighs)Even now I do feel that I am going to be right, but.. (sighs) I suppose it.. it sort of occurred to me last.. well.. 24 hours really that.. maybe, although that's so, that's [4] it wouldn't be fair on myself, N.. it's (sighs) that.. I may not be the right person for that job any more. Um.. that the same.. (sighs) situation may be triggered off when pressure inevitably would come on and.. (sighs) [9] um.. I'm finding that hard um.. and it isn't something that I wanted to happen. On the other hand.. there are some things that are more important than my job, er.. (sighs) [3] and obviously my health is one of them but I suppose really what's.. it's really (sighs) well, my health, yes and what a breakdown and that would mean to.. to N. and er.. the whole family situation really. (sighs deeply twice) (tearful) Anyhow I [5] did say to the staffing officers (blows nose) that I.. I wasn't being very good and.. but on Friday in fact I had seemed.. feeling quite positive and yet.. er.. a sort of.. a sort of very small immersion into the school scene.. had a quite a.. catastrophic effect. [4] And he said, well.. well. he certainly wouldn't be putting any pressure on to me with regard to resuming.. um.. that there would be certain consequences salary-wise that.. um.. up to now I.. I.. I've still been getting my salary, but in a few days in fact, I.. um.. I shall go onto half salary. Um.. but.. but um.. the authority just wanted me to get well and there.. there wouldn't be any pressure from them. Er.. (sighs) I did say to him, "What would be the con.. consequences in fact that.. if in fact [4] I wasn't able to resume? What.. what.. what would I need to do?" And um.. um.. he said, "Well, one thing is you mustn't do is.. if that it.. if it comes to that, if you, although in fact you said you must think about that when you feel at.. more in control of yourself than.. ." I was thinking when I spoke to him. Um.. (sighs) That.. if it.. if it came to that, um.. I would need to get in touch with the.. er.. what I mustn't do would be resign. That um.. I would need to get in touch with the DES and to a.. a contact at the education department (sighs) [3] and that.. that um.. I.. I-I should have to um, apply for um.. um.. I think.. I think he said a disability
pension. Um.. and that that would be. taken up by the Department of Education Science
and that. if.. if it did come to that that um.. I would need a.. I would need a statement
from my doctor.. and.. in support of.. in support of that claim. Um (sighs) but really.. um..
that was.. that was as much as he was able to say. A.. again he was very kind and
understanding and er.. (sighs)

T: [5] It seems like.. (C: sighs) you've had contact with a lot of people. (C: yes) All. ..of
whom. .have been kind (C: yes) understanding (C: mm) trying to.. [3] assure that the
[inaudible] will be.

C: Yeah.. there was.. although in fact, the consequences of my talking to my deputy and
my chairman of governors, um.. were that. .it made me extremely unhappy (T: right) and
worried (T: right) er..

T: It's.. it wasn't anything that anyone really said, though, something.. (C: it was just I
think.. ) something that came over you.

C: Well, something that came over me and also the um.. (sighs). the size of the task of
getting back, um.. was sort of.. so far greater than.. I'd ever anticipated..

T: Right, it's.. at that time (C: sighs) going in it.. so huge.

C: At the time.. whil-whilst I was in, and.. you see, at the time of.. it wasn't as huge when
I was..

T: No, time.. time.. going in.. it was.. it felt huge when you went in there..

C: Mm.. well it.. it.. when.. when I started talking, after I'd been talking, it was then..
that.. er.. I said it was.. sort of an apprehension of when I went in (T: mm) but.. I mean..
that was understandable um (T: mm) .. (sighs).. but um.. (sighs) [9] (sighs)

T: Right.. [2] people were assuring you and (C: well) understanding (C: well) but
somehow it feels like you. .

C: Probably were reassuring me (blows nose).. reassuring and.. I.. I don't think my.
deputy and the chairman were reassuring (T: right) um, I think that they were trying to
be helpful and (T: right) they weren't being antagonistic or (T: right) but um..

T: But the point is you.. you.. you took on, I mean, you're not.. you're holding yourself
now, you.. something happened.. listening to them and realizing, making you feel.. well,
just that this is somehow, this was an impossible, almost an impossible task. (C: yes) It felt impossible. (C: yes) How on earth can I do this?

C: Yes. Yes, I mean I.. I've been realistic enough to know, that it was going to be..

T: Yes, you.. you knew it would be.. you'd be apprehensive, you knew..

C: I knew it would be a huge task, yes.

T: Yeah, but nothing.. to match the.. (C: nothing to match) what it felt like when

[C: sighs] talked about.

C: No, no, when they tried.. no, no.. and er.. (sighs) so there.. there was that aspect of it and then my reaction to that and then the consequences for N. and (sighs) it was just awful really. In some ways it's been more awful than.. you know.. when it first happened.

Um.. in as much as (T: yeah, you've) I've had five months and er.. (T: yeah) help and er..

T: Yeah, but.. if you were talking there at.. it.. it.. I get the feeling somehow the.. [2] the.. you became in a way.. disappointed or.. at yourself somehow about not being able to..

C: Yes, yes.. I suppose I.. yes.. as well disappointed within myself, mm..

T: Mm.. and.. and then.. and the pain somehow about N., N.'s a real.. touched.. I mean that really touches a nerve in you.

C: Oh, yes, yes.. mmm..

T: You, I mean, you were distressed, you know, really distressed (C: mm, well I could see) and you could.. (C: the whole family situation) it was.. right..

C: I mean it has been under tremendous pressure anyhow, but er.. (T: inaudible) it's just that she shouldn't be having to (T: right) (sighs)

T: Do you.. do you.. it's this thing again of.. you.. you in the depths of despair, OK? [6] Your concern comes out for N.. of what she has to carry.

C: Well yes.

T: Yeah. That somehow it's.. [4] it's almost like somehow I can't burden her.

C: (sighs) Well I deal with it happening to me, but (crying) I just see it happen to her.
T: Right. It's almost like a way it could.. (C: sighs) the pain it causes her which hurts
almost more than pain that you've felt. seeing her distressed (C: yes) because of this. (C:
yes) And that's why..
C: I tried not to.
T: Yeah, the controlling bit (C: sighs) that you're trying. trying to sit on it (C: yes) a bit,
trying to. kind of (C: blows nose) keep it away from her. (C: yes) Seeing other
people hurt is almost. it is worse (C: sighs) somehow than you hurting.
C: [3] Yes, I'm er.. I um.. yes. I suppose I have got the feeling as well of (sighs). I
suppose in. in between. from my level, it. in myself there was some.. some bitterness
really which.. and.. I don't know if that's right. um.. [2] that the job should have done
this to me (T: to you) me, um.. yes.. mm..
T: And to N. therefore?
C: Oh yes, (T: yes) yes.. yes.. um.. [3] you see er. if you.. if you ask me to go out now,
in front of a group of children, and just teach them [4] I feel that that's.. perhaps even
something I could almost enjoy doing.
T: To give you something. (C: That?) You'd get something from that, you'd..
C: I. I.. I feel that that situation, I could cope with, but of course, I'm not in that situation
and er (T: mm hm) that isn't my job (T: right) but is here just the same, [inaudible]
(sighs).
T: [4] You hear what. OK, it's not your job. But even now you can sit here and say...
"That. that I could.. I could enjoy. (C: yes, I-I think I.. ) There's something in there that.
..mm.. I could give."
C: I think that I could still. given that situation, (T: mm hm) but of course that was the
situation I was getting more and more removed from (T: mm) and I did try to hang on to
that as much as I could and I was. still doing when I finished two days of.. of teaching.
Um.. and.. still enjoying that, but that. that isn't my job with my.. (sighs)
T: But. just. just staying there with what you.. what you've picked up as a feeling there,
that that's something you could do. (C: mm) Last week were kind of talking about sort of
feeling of you feeling related to things. Feeling like you could relate, mm.. [inaudible]
and being able to.. to relate, I was just picking up there, a feeling of.. you were talking
about teaching (C: mm) it almost felt like somehow there was something there that you felt, you know, there... there was you and there were the children (C: mm) and somehow you... that had a meaning for you. You knew what you could give (C: well.. .) and you knew what you.. what the job (C: mm) gave you. That somehow.. (C: yeah.. ) in.. in.. in the headships, somehow it's almost like..

C: [2] One of the great fears that boil up there, the sort of administrative (T: mm) although it's not.. not so much the administrative situa.. .I mean that's part of it, um.. er..
(sighs) it's the other things that.. have been brought into a head teacher's role that um..
(sighs) er.. I mean much of it is national curriculum. Um.. although in some ways that was a sort of last straw I think. All the things happening and happening (T: mm) so quickly, um.. I think if I'd had been in secondary education and it'd had been just.. sort of one.. one subject (T: mm hm) mm, maybe that um.. . [4] I could have taken, but it.. at..
..er.. with all these things happening in so many subjects at the same time and (T: mm) (sighs) er.. having to become responsible for and.. other groups of people that they're having to be answerable to and (T: mm) (sighs) it's um.. . [4] And I can see why people.. may be saying "That's the way a thing should be," mm..
(sighs) I can see why they're saying that, I.. I.. I.. it's just that when I went into a head teacher's job and [7] the job wasn't the job that it's.. (T: that it is now) has become and (T: and not as [inaudible]) and I.. I'm not.. it's not a job that [4] well if I was still teaching, it wouldn't be something that.. would appeal to me at all.

T: Being a head?
C: No. I suppose in the first case, I became a head because advisors advised me to apply and people encouraged me to apply and.. (T: mm) mm.. . [3] and so eventually I did and um..

T: But can.. (C: sighs) and as you just.. as you've talked through that (C: mm) wh- what I'm being struck by is.. the things that you've said during our meetings and just now, about. .of the things which are important to you, right from the very start, to you relationships are important. (C: mm, yes) That relationships are important. Clearly N. is incredibly important, I mean (C: yes) from your.. your feelings about her.. her.. thought you've been through. (C: mm) Um.. . [3] just earlier on, saying, you know, I mean.. this..
sort of coming here was important today (C: mm) and talking with somebody about (C: mm) talking here. (C: mm) And then, kind of, the depth of looking at that kind of mountain that's.. being a head, you can say.. "If I were to teach.. " it's one.. it's just when you said that, (C: mm) I got this feeling of.. you.. you.. as if somehow it's.. it was you again relating to children. There's something about.. (C: well.. ) good relationship, if you.. .with people. When you're with people.. and.. (C: yes) and somehow it has meaning and.. somehow you can touch those people and they can touch you, somehow. But (C: mm) somehow that.. that seems to.. that seems to give you something and you.. (C: yes) are somehow faced with this administrative, monolithic..

C: And this backlog of reading that I.. need to..

T: Or how.. as you.. as you were saying that, it was somehow becoming increasingly like.. this was worlds apart from what is important to you.. as you (C: yes, yes) as a person. (C: yes) What.. and when you said then, you know it's.. almost like you know, you have a choice now and you knew you.. it's not what you..

C: No, I wouldn't.. .no. No.

T: It's.. you see, it's almost like saying somehow in a way "Things which are there that feel like a mountain.. are not things which are important to me. What's important to me is N., (C: yes) N.'s feelings (C: yes) is my feeling about, you know, helping people, caring for people," (C: mm) those things are the thing which feel important to you. (C: yes)

That somehow.. that the headship thing, somehow it feels like there's nothing there that you can kind of..

C: Well it wasn't there (sighs) I've.. .I've never had any great desire to become a head. It wasn't a.. (T: inaudible) an ego.. trip, I mean.. (T: you were a boy.. you were) No.. I enjoyed my teaching (T: mm hm) um.. er.. thoroughly.

T: Enjoyed the teaching, but.. but the head, you were advised to..

C: Well, yes I.. I.. I.. I suppose I was supposed I was considered, well, I was advised, I never [3] sort of. .from the early days, I.. when I just thoroughly enjoyed my teaching (T: mm) um, and eventually was advised by my head and my advisor to apply for a deputy headship.. um, which I did um.. [4] I was still teaching full-time and enjoyed that position.
T: It's almost like because of teaching somehow you have still..

C: Oh, yes, well I.. (T: inaudible) I mean I was responsible for a great deal that happened.. er.. that.. that happened, um.. effectively I was sort of a deputy head in really.. in three schools. And.. first one quite a small school and then I was.. I had a very large school where I was designated head of junior department, which was.. er.. because it was a very large school and.. it was really a sort of deputy headship over the junior part of the school. And then I became deputy head of.. well I had a big school. Um, and I enjoyed (T: mm) the position and I enjoyed um, the responsibility of that, er.. [5] and moving into a headship I had a pretty clear idea as to how I would be as a head and. .er.. we've talked before about the fact that when I, the school that I went to, I.. found people who I.. [2] never saw.. that I hadn't come across before in teaching, some people, and er.. the school where they were, lots of.. personnel problems and that.. um, distressed me a great deal. Um.. but for my first sort of six years with that.. at that school, I still managed to teach for three days a week and do my headship job. Um, although it meant working long hours.. er.. long hours, I.. was prepared to do that and..

T: But that somehow because.. somehow you didn't want to give up that teaching.. (C: yes.. yeah, well.. in one way) in way you.. you couldn't..

C: In. .well I suppose I thought and I think I overdid it, looking back, um.. . [7] that I wanted a particular style of teaching in a particular rela.. relationship with (T: mm) kids, um but the best way perhaps to do it was.. to get in the classroom and do it myself. That was one reason, and the other reason was that.. there was certain things that I wanted to happen within the school and the only way I could free staff either.. to see those things happen or to train for them happening was to.. either take over a class or.. mm.. very often a number of classes, so.. mm.. very often the whole school was away. Um.. and that part um.. [3] no, um.. that didn't distress me at all and I.. [2] got a good deal of pleasure from that part, but um.. increasingly, of course the pressures of being that.. a lot of the things I enjoy doing because I.. I was spending a lot.. every dinner hour working with kids, or doing activities with children and er.. every Friday evening I stopped behind until quarter to nine with a series of clubs from half past three 'til quarter to nine, and again, thoroughly enjoy it. (T: mm hm) I wasn't being a martyr, I just enjoyed..
T: That's right, because it means something to you.
C: Yeah. But in the last two, two and a half years, well the dinner time activities have
had to go because it became impossible. I was the only one on duty and we had three
dinners.. duty sessions. Er.. nobody else um, was prepared to do a dinner
duty. Er.. the Saturday morning activities that, again, I er.. thoroughly enjoyed and
more hard to get into school on Saturday and do things. And my.. the Friday night..
group which I had with the older children, um.. had to go. because it was a trying.. to try and
catch up with the work that I hadn't been able to get through during the week and er.. so
in a way, I suppose the things I most enjoyed, all the relief from some of the things I
least enjoyed (T: mm) was taken away and.. and I suppose really, inevitably um it.. the
last straw arrived with (sighs) this tremendous flood of work with the national
curriculum.
T: You see.. as.. as you were talking there, and it's almost like in a way you said
earlier on in the session for the first time at the weekend, there was a thought of actually
maybe not being able to go back (C: mm) losing the, you know, being the head became
(C: mm) entered your world for the first time. (C: mm) But you're talking there, it's
almost like over a period of time you've gradually been losing the part of your work..
which (C: well, yes) is important to you.
C: That's right, and a sort of.. the way I envisaged um.. I would be best suited for doing
the job. (T: mm) You know.. er, I think it would be true that um, that the qualities
required of a head teacher in a primary school from now on, will be different to the ones
which were being required (T: mm) er.. in the past. That I think in the past um.. most
primary school head teachers, er.. probably became head teachers because in the first case
they were competent teachers, or good teachers.. and were able to accept responsibility.
But now, um.. well, their ability as teachers will not be.. need to be.. addressed. They
will require other skills which haven't been required to such a great extent anyhow, and
some of them um.. not at all, in the past. And um.. well, er, if.. if. if all that's
envisaged in primary education is to take place, well (sighs) so be it, but um..
suppose it's just not my scene really. It um... that's not quite true, it. is my scene, but I...
in... in the position of head teacher, er... would have obvious weaknesses.


C: Yeah, I feel suddenly a lot... calmer. (T: mm.. do.. you look.. ) I think that actually
having to say to you what I just said was... I wanted to say it (T: yeah) you see it isn't easy
to say.

T: Right. right.. I was aware of actually. letting you go through that, because somehow
it felt like you.. you have to tell the story, you had to say. (C: mm) you had to lead up to
the point about what you realised at the weekend about (C: mm) maybe not going back.

(C: mm) That actually it was important for you..

C: Well I find that hurtful to say, mm...

T: Yes. But somehow you had to say it rather than even me coming in and saying it for
you. (C: mm) I thought about that, but (C: yes) I felt like it was important for you... [2]
(C: mm) to own saying that. (C: yes) However painful it was. (C: yes) You see now
you're.. now you're talking about [4] I don't know... there's possibilities in way which is
not.. not getting so.. you're.. your arm's still..

C: Well I'm.. no, I'm not, I don't feel.. I don't feel, you know, I feel much more peaceful
(T: yeah) than.. than I was.. I don't know, ten.. quarter of an hour.. I don't know how long
ago it was (T: mm) um.. [5] mm...

T: Because somehow you've been able to...

C: Well, I.. I suppose that I'm just.. been able to share that with you.. really. Um..

T: [3] Rather than sitting on it and..

C: Yes. But I.. just the possibility of not returning, I've just never (T: it's a blow,
yeah) and never.. (sighs)

T: Something we'd never spoken about.

C: I've never re.. I never thought for one.. I really hadn't thought (T: mm) for one
minute that.. that sometime I wouldn't return. Now [3] I suppose that.. that the events of
this weekend just.. sort of thrust that upon me and the sort of consequences of going
through the next five months in the same way as last five months um.. [4] I'm just not
(T: mm) it's just something that I can't.. that I don't want to (sighs) really think about. [3]
(sighs)

(T: [6] Perhaps.. that made you.. sort of upset again over that?
C: A little, yeah.. yeah.

T: Catching your breath. (C: mm) [6] It feels like somehow you've.. I'm

wondering whether it feels in some way like. having walked through a barrier in some
way. Mm.. maybe that's not the best way of saying it, I mean, it feels like somehow now
you're looking at.. all possibilities.. in a way.

C: Mm.. what about, my future (T: mm) you mean? (T: yes) Yes, I don't.. I don't.. I don't
know what.. the possibilities are in a way, I mean the possibilities um.. are A) that
something happens over the next few weeks and that I'm.. and I'm altered yet again,
what.. what that likelihood is, I just don't know. I mean I don't know whether the way I
am today is a typical. response to somebody doing what I did on Friday, um.. and that it's
something that.. it's sort of phased out or.. [4] in a way it's something that I get over now,
I am, despite the way I'm feeling now, able to resume. Um.. but if I'm not able to resume
and I.. I have to therefore apply for this, um.. this disability pension um.. [7] um.. [3] I-I
suppose that the authority therefore on the DES have got to. agree that I am not able to
resume my duties and I don't know whether that is a (T: mm) a difficult matter or it's
um.. fairly straightforward and.. if they.. did say that um, I wasn't able to resume and that
I got a disability pension um.. [5] how I would use my time I've.. that being so, I don't
know, um. I say physically I feel.. [3] I don't feel an old man, put it that way. Um.. (T:
mm)but I guess I would want to try to do something anyhow, um.. exactly what it would
be I don't know, but I think I would want to do something, mm..

T: Could it be that (C: sighs) you know, it's.. you know, we.. we don't need to sit down
now and talk about.. options I suppose. (C: yeah) I was just.. [2] I was. .recognising
somehow that it feels like now you're looking at.. a range of things. (C: mm) You know,
it's almost like there's.. there's almost like greater uncertainty about the future in one way,
because, you know, would you be going back to work or (C: yeah) won't you or (C: yes)
whatever, but somehow being able to.. to look at those, to talk about those here as you are
(C: mm, mm) you know..
C: Yes.. I think perhaps because it.. as I say, I-I don't know, mm. In some ways, it.. I suppose having talked to you this afternoon. I'm.. I'm almost resigned in a way [4] to feeling I'm not going to be able to get back and that it wouldn't be the right thing.. for me or.. for N., to take that risk.. even. I suppose I.. in a way um, that's how I'm feeling at the moment.

T: Somehow like you've gone.. gone to a place where that's.. what's happens and saying to yourself, "Well.. that that.. that safeguards what I treasure, what I value. (C: yes) And maybe that's a better place for me to be now (C: mm) than facing that mountain, that gigantic mountain."

C: I think so really, er.. [4] yes, I think so really, um.. [6] but, I mean obviously that would have consequences, um.. [5] but the.. obviously.. well I-I think my health and. .our family life.. is more important than financial considerations. Um.. [10] if in fact I.. am not fit to resume and er.. do get a pension and [4] obviously some things will not be as easy and.. but maybe the sort of quality of er.. life may be er.. well, I.. I would think, I certainly feel would be.. better than it has been (T: mm hm) for the last two years particularly (sighs).

T: [4] You see, I think all.. all I'm wanting to (C: mm)to recognise not that one is.. right and the other is wrong (C: mm) but the fact that you're able to sit here and talk (C: mm) about those possibilities (C: mm) from, you know, sort of.. places at the weekend when you were clearly.. and earlier in the session when you were clearly.. talking about that (C: mm) as a.. as an option, as a possibility. (C: mm) You know, it's tremendously painful for you.

C: Mm, well, yeah, I suppose that part of the pain at the weekend was this.. [2] this acceptance yeah um.. (sighs) [6] my concern has been how long it would be before I did get back. (T: mm) Um.. [7] I mean when.. I mean.. I suppose scores of people over the last.. um.. [2] months have sort of said, "Oh, you.. you need to apply for early retirement," and it's just something that I just.. dismissed because it wasn't something that er.. to me, was going to happen and er.. [5] I'm aware of the fact that in fact, er.. a number of my friends who would be younger than me in fact have done that, er, but it wasn't something that er.. [2] I'd been interested in, er.. [3] But er..
T: I-I-I'm wondering, I'm wondering whether looking back you're feeling ups or.. annoyed or angry in some way that you went into school, somehow if you hadn't gone into school, well all this wouldn't have happened.

C: No, I.. no.. I.. (sighs) in some ways, no I don't feel that. Because I, you know, when I spoke to you last week, I really felt..

T: That's right, you.. seemed to be wanting to do...

C: Um.. sort of trying to sort of.. look at it from a pace back really, and trying to be detached about it. I mean, perhaps it was a good idea that I did go in, if only to.. I don't know. [3] Open my eyes to what the situation was perhaps.

T: [5] Something like that would be particularly painful if.. you.. felt.. "Oh, I wish I hadn't gone in [inaudible]."

C: Mm.. you see (sighs) last week, um.. I'm not saying that I never had any doubts or any sort of rotten moments but, most of the week I was looking forward to actually going in (T: mm) and say, feeling quite positive and thinking about the way I would organise the time when I was in and what I would do and who I needed to see. And.. I don't think I would have got much better than that if it'd had been next week or the week after or a month's time or two month's time, I don't think so. Um.. [2] er.. [5] and I suppose if I'd gone in in two month's time, I'd also been conscious about that it was two more months of things happening and er.. perhaps the consequences would have been even.. you know, the.. the size of the task would appear even greater than it did on Friday, although that would have been difficult.


C: [5] I Suppose what I'm thinking is, you know, I.. today is the.. [4] that perhaps the only way I'm going to be well again..

end of tape.
Notes for Contributors

Psychology and Psychotherapy Theory, Research and Practice is an international journal with a focus on the psychological aspects of mental health, psychological problems and their psychotherapeutic treatments. It aims to bring together the psychodynamic and psychological disciplines and this is reflected in the composition of the Editorial Team. Nevertheless, we welcome submissions from clinical health psychologists and researchers from any relevant professional background. The traditional orientation of the Journal has been towards systematic and empirical approaches, which were defined as core literacies but we now additionally welcome submissions of original theoretical and methodological articles of any kind provided they have a bearing upon vulnerability or, adjustment, assessment of, and recovery (treated or otherwise) from psychological disorders. The Journal aims to promote theoretical and research developments in the fields of subjective psychological states and dispositions, interpersonal attributes, behaviour and relationships and psychological therapies (including both process and outcome research) where mental health is concerned. Submission of systematic reviews and other research reports which explore evidence-based practice is also welcomed. Clinical or case studies will be considered only if they illustrate particularly novel forms of psychosurgery or innovative forms of therapy which carry important theoretical implications.

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Research in brief
On ‘mundane heterosexism’
Mark Craven

In a recent research article, Elizabeth Peel (2001) combined discourse analysis with lesbian feminist politics in order to explore subtle forms of heterosexism in language—a feature which she refers to as ‘mundane heterosexism’ because of its everyday nature. As one might expect from discourse analytic research, Peel lays down a persuasively comprehensive rationale for her study by looking in considerable detail at a range of issues which include understandings of subtle sexism, gender and sexuality, and discursive psychology and prejudice. A cogent argument is created, highlighting the need to focus upon and identify everyday, mundane forms of heterosexism in order to challenge prejudice stemming from heterocentric assumptions. The performative nature of language is established as the primary analytic focus in the research. Consequently, discourse analysis is deployed in uncovering the linguistic resources and techniques involved in the production of mundane heterosexism.

Taking data from lesbian and gay awareness training sessions, Peel uses principles taken from Potter and Wetherell’s (1987) discourse analytic approach alongside a lesbian feminist political sensibility to highlight how the ‘micro inequalities’ of heterosexism are constructed in talk. Three themes or ‘interpretive repertoires’ are presented, namely (i) prejudice against the heterosexual, (ii) non-heterosexuality as deficit and (iii) refusing diversity. These categories, it is emphasised, are seen as interlinked and as operating within the confines of liberal ideology. The analysis that subsequently unfolds is firmly grounded in the data, i.e., quotations are used to illustrate what is occurring in particular instances of talk. The analysis is successful in that it presents a persuasive account of how the micro-inequalities of heterosexism are constructed in talk.

A clear sense of reflexivity is in evidence as the author positions herself in relation to the topic being explored. I found the most noteworthy aspect of this work to be its clear real-world implications—something that is rather unusual in discourse analysis, which has been accused of lacking real-world relevance (Abraham & Hampson, 1996), despite the contrary claims of some leading discourse analysts (Willig, 1999).

The aim of fostering beneficial social change—by considering how mundane heterosexism is constructed with a view to developing strategies for its eradication—is obviously central to Peel’s intentions. She draws our attention towards two potential ways of challenging the oppressive discourse of heterosexism, i.e., through interactional, ‘in situ’ challenges and through broader societal campaigns and activism. However, whilst the analysis makes reference to the macro-level in this respect, the main emphasis is directed towards the micro-level of language in terms of theorising, analysis and suggested challenges. What is not sufficiently explored perhaps is the
process by which a micro-level discursive analysis might provide us with the tools to effect the sort of changes that Peel advocates—and how these changes might be effected. Of course, this criticism could also be levelled at many other discourse analytic papers which claim that a micro-level linguistic analysis can be used as a resource for meaningful social change—and here I appreciate that my own preference for a more thoroughly social, Foucauldian version of discourse analysis is showing. Whilst Peel’s research is commendable in that it uncovers the linguistic resources and techniques involved in the production of an oppressive social process, the emancipatory potential of this work might arguably be extended by also considering how the material context of social relations—including inequalities arising in the structural features of society—creates possibilities for and also constrains the discursive production of mundane heterosexism and in turn its potential eradication. It is increasingly being recognised that fruitful combinations of micro-level and more macro-level analyses may provide us with research that is maximally useful in political terms (Wetherell, 1998)—and, although both levels of analysis are readily discernible in Peel’s research, perhaps a little more of the latter might have been beneficial. But then, to paraphrase Mandy Rice-Davies’ famous observation, I would say that, wouldn’t I?

References